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HEALTHCARE

Community Behavioral Health & Accountable Care: What We Know and What We Have Yet to Learn

November 15, 2018

Healthcare Reform and Systems Transformation: Key Terms

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- ▶ **Accountable Care Organization (ACO)** - network of physicians, hospitals and other health care providers working together to provide integrated health care for their patients with the goals of improving health and containing costs. ACOs enter into population-based payment models with payers and are held financially accountable for care cost and quality.
- ▶ **Behavioral Health Community Partner (BH CP)** - a community-based entity which contracts with EOHHS and partners with MassHealth-contracted ACOs and MCOs, providers, social services organizations and community resources to support MassHealth members with complex behavioral health needs.
- ▶ **Delivery System Reform Incentive Payments (DSRIP) Program** – a program of time-limited federal investments to support the transition of health care providers to value-based care.
- ▶ **Managed Behavioral Health Organization (MBHO)** – a specialty entity that manages and/or provides covered behavioral health services.
- ▶ **Managed Care Organization (MCO)** – an entity that provides and/or arranges for covered services under a capitated payment arrangement that is licensed and accredited by the Massachusetts Division of Insurance as a Health Maintenance Organization (HMO).
- ▶ **Section 1115 Demonstration (or Waiver)** – the Social Security Act allows states to seek permission to waive certain provisions of federal Medicaid law and receive flexibility to design and improve programs to meet unique state needs. In November 2016, the U.S. government approved Massachusetts’ request to amend and extend its existing Section 1115 waiver for 5 years.
- ▶ **Social Determinants of Health (SDH or SDOH)** – the “structural determinants and conditions in which people are born, grow, love, work and age.” These include factors like education, housing status, employment, socioeconomic status, physical environment, and access to health care.

MassHealth Systems Transformation: Goals and Drivers

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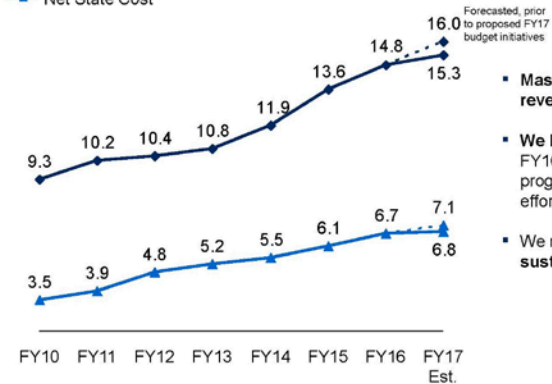
- ▶ Ensure financial sustainability of MassHealth
- ▶ Improve population health and care coordination through payment reform and value-based payment models
- ▶ Improve integration of physical and behavioral health care
- ▶ Scale innovative approaches for populations receiving long-term services and supports

MassHealth growth trajectory

Source: MassHealth Restructuring Overview, April 2016

MassHealth Program Spending*
\$ billions

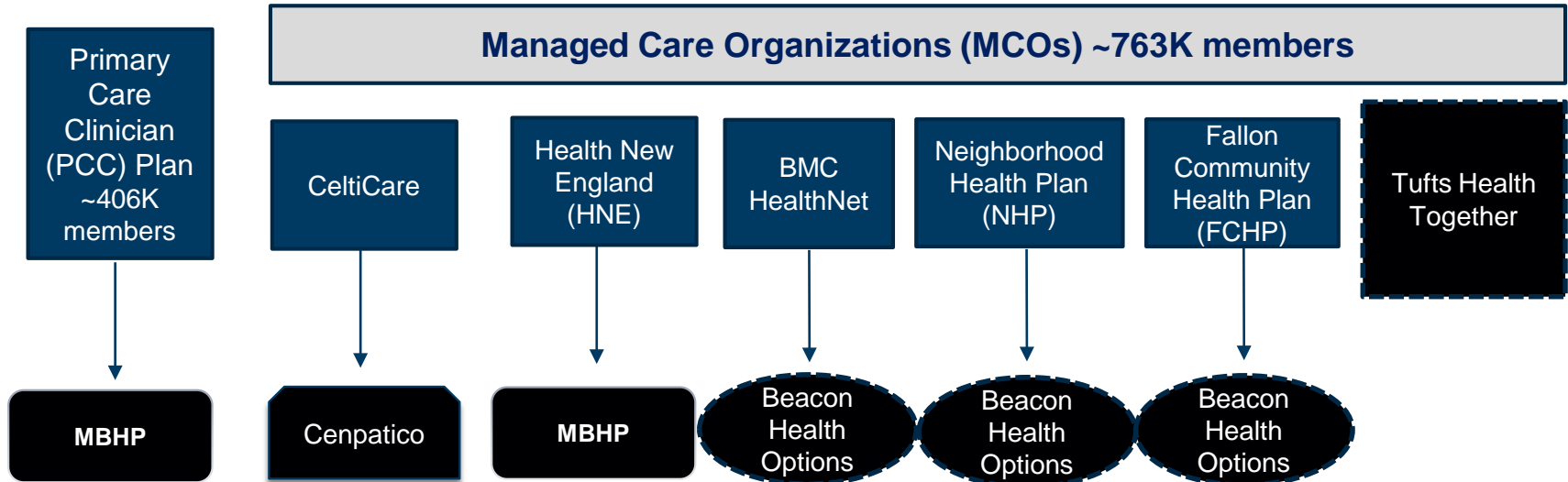
— Gross Program Spend
— Net State Cost



- MassHealth has significantly outpaced revenue growth for the Commonwealth
- We have brought down growth for FY16 and FY17 through near-term program integrity, operational and other efforts
- We must ensure long-term sustainability of the program

MassHealth Managed Care Landscape: Pre-Implementation

Options Available to Non-Dually Eligible MassHealth Managed Care Members *through February 2018*



Darkest blue shading indicates MH/SUD management/access

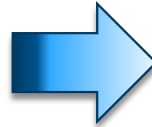
Each MCO operates in one or more of five MassHealth regions: Northern, Greater Boston, Southern, Central, and Western

MassHealth Systems Transformation: Approach

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Former Model

- Rewards volume
- Built to address emergency or short-term medical events; difficult for members to navigate the system
- Multiple doctors treating the same patient for the same condition without talking to each other
- Limited transparency into quality and efficiency of care
- Patient information often stored in silos or paper medical records



Sustainable Model

- Rewards outcomes and value
- Member's health managed seamlessly across providers and over time (not visit by visit)
- Providers act as a team to ensure coordination of right services
- Easy to understand quality and cost data made available to consumers and providers
- Appropriate electronic health information available across care teams and with consumers

Systems Transformation: Key Components

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- ▶ **Accountable Care Organizations (ACOs)** (\$1.1B investment) - provider-led organizations that coordinate care, have an enhanced role for primary care, and are rewarded for value (improving total cost of care and outcomes), not volume
- ▶ **Community Partners (CPs)** (\$547M investment) - provider-led, community-based entities focused on the member that partner w/ ACOs and collaborates w/ MCOs, providers, and social services/community resources to support improved care delivery & member experience
 - *Two types:* Behavioral Health (BH) and Long Term Services and Supports (LTSS)
- ▶ **Statewide Investments** (\$188M investment) – Healthcare workforce development and training, targeted technical assistance for providers; improved accommodations for people with disabilities; other priorities like ED boarding
- ▶ **Managed Care Organizations (MCOs)** – expected to work with ACO providers and CPs to improve care delivery and population health management

System Transformation: ACOs

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- ▶ DSRIP Investment: \$1.1B (over 5 years)
- ▶ Accountable Care Organizations (ACOs) have responsibility for Total Cost of Care (TCOC) for managed care spend (physical and behavioral health – LTSS spend phased in over time) and performance on quality measures
- ▶ Emphasis on Primary Care. ACOs are responsible for
 - team-based care management,
 - coordinating care,
 - managing care transitions,
 - conducting comprehensive assessments, and
 - developing person-centered care plans
- ▶ Dedicated “flexible services” funds to address social determinants of health (SDOH)

System Transformation: BH and LTSS CPs

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- ▶ “Community-based entities” to help MassHealth members with high BH or complex LTSS needs navigate care
- ▶ ACOs and MCOs required to partner with area CPs and vice versa
- ▶ Leverage expertise and capabilities of existing community-based organizations serving populations with BH and/or LTSS needs
- ▶ Break down existing silos, deliver integrated care, and address SDH
- ▶ BH CPs will deliver Health Home-type supports
 - Outreach and active engagement
 - Comprehensive assessment and person-centered treatment planning
 - Care transitions
 - Health and wellness coaching
 - Connection to community, social and flexible services
 - Care coordination and Care management
 - Medication reconciliation

System Transformation: BH CP Selection Criteria

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- ▶ Community-based provider or consortium of community-based providers with experience and expertise supporting populations with serious mental illness (SMI), substance use disorder (SUD), and co-occurring disorders. Demonstrate via at least one service within each of the following:
 - *Community based mental health services* (e.g., CBFS, ESP, PACT, CSP, CSPECH, crisis stabilization, respite services, residential services)
 - *Substance Use Disorder treatment services* (e.g., ATS, CSS, SOAP, MAT, outpatient SUD treatment)
 - *Outpatient mental health services* (e.g., clinical, day treatment, medication, intensive outpatient); and
 - *Integrated care management services* (e.g., One Care Health Home, MBHP PBCM, Here For You, ICC, grant-based and care management programs)
- ▶ MassHealth and/or MassHealth-contracted Managed Care Entity Provider; and,
- ▶ At least one service contract with a state agency such as DMH, DPH/BSAS or DCF.

System Transformation: BH CP Support Eligibility

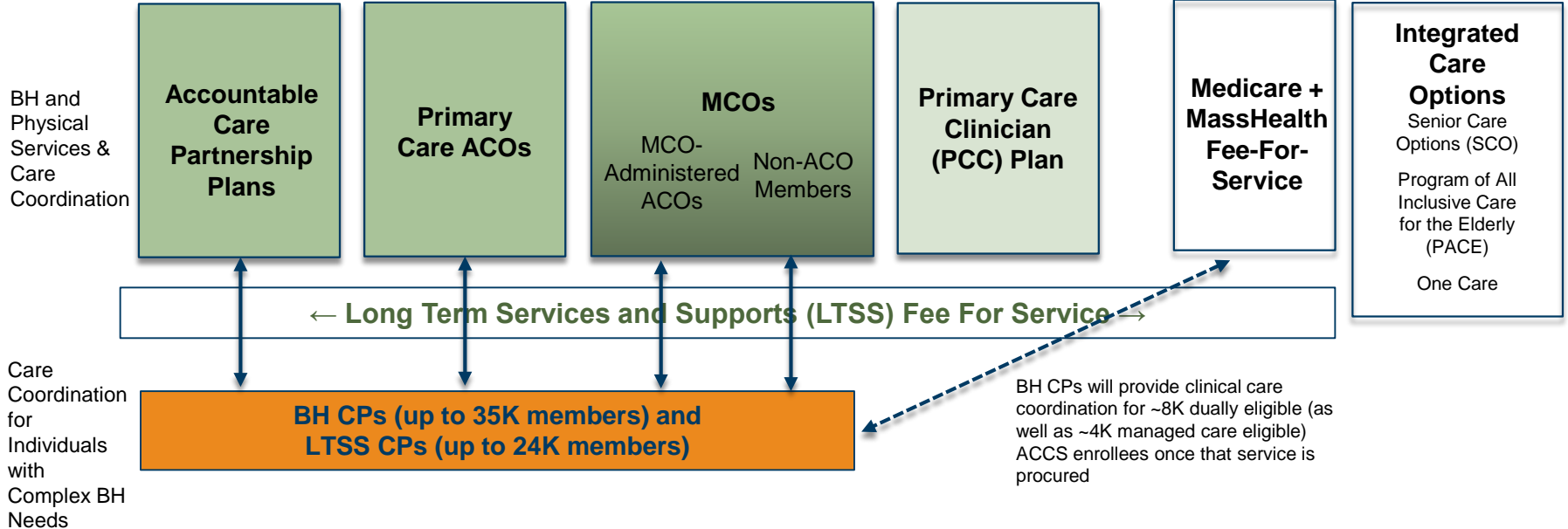
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- ▶ **Adult with SMI and/or SUD (21 and older)**
 - Analytic Pathway
 - Identified via claims– diagnosis *plus* utilization, select comorbidity, or other factor, e.g. DMH involvement
 - Where MassHealth member has a relationship to a BH CP, the member will be assigned to that BH CP
 - MassHealth estimates ~60,000 eligible, ~35,000 to be served at any given time
 - Qualitative/Referral Pathway – through ACO or MCO, process TBD
 - If BH and LTSS needs, member offered BH CP supports
 - For Members 18-20 years w/SUD, EOHHS may refer for BH CP Support (instead of CSA).
- ▶ **Children/Youth with SED (under 21)**
 - Intensive Care Coordination through *existing Community Service Agencies (CSAs)*
 - CSAs eligible to respond to RFR for DSRIP infrastructure dollars, but no DSRIP service payment (currently a Medicaid State Plan service)

CP Supports Availability to MassHealth Members

Managed Care Eligible (1.2M members)

Duals, FFS + Integrated Options (0.7M)



System Transformation: BH and LTSS CPs

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- ▶ DSRIP Investment: ~\$547M (over 5 years)
- ▶ For BH CPs
 - Dedicated funds for infrastructure (capitated payment, phases down \$35-\$5 pmpm)
 - Dedicated funds for CP care coordination services (capitated payment; \$180 pmpm; \$250 pmpm CBFS)
 - Potential for quality bonuses (metrics TBD)
 - All funding streams have incremental portions at-risk (payment withhold) tied to performance, e.g., Y1 = 0%, Y2 = 5%, Y3 = 10%, Y4 = 15%, Y5 = 20%.
 - Performance metrics
- ▶ MassHealth pays CP directly for 5 years. After 5 years, assumption is CPs have demonstrated ROI and negotiate with ACOs/MCOs for sustainability

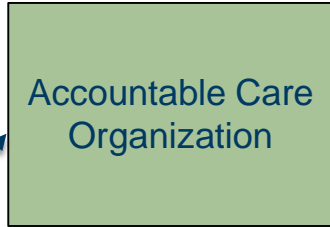
System Transformation: BH CP Performance Measures

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- ▶ DSRIP Accountability Score – At-Risk \$ Tied to Score w/ Weighted Domains
 - **Prevention and Wellness (5%)**: prenatal care; annual wellness visit
 - **Chronic disease management (5%)**: COPD/asthma admissions and medication; diabetes admissions
 - **Behavioral Health (10%)**: AOD treatment initiation/engagement; follow-up MH hospitalization (7 days OP; 3 days BH CP)
 - **Member Experience (10%)**: access; care planning; participation in care planning; quality and appropriateness; health and wellness; social connectedness; self-determination; Functioning; self-report outcomes; satisfaction.
 - **Integration (10%)**: social service screening; utilization of flexible services; BH OP utilization
 - **Avoidable Utilization (10%)**: All-Cause readmission; preventable ED visit
 - **Engagement (50%)**: 90-day assessment/care plan; rate of care plan completion

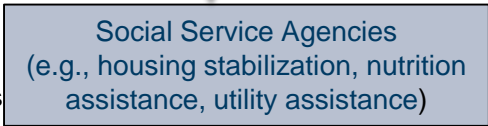
The ACO, BH CP, and Provider Care Relationships

Most ACO Members

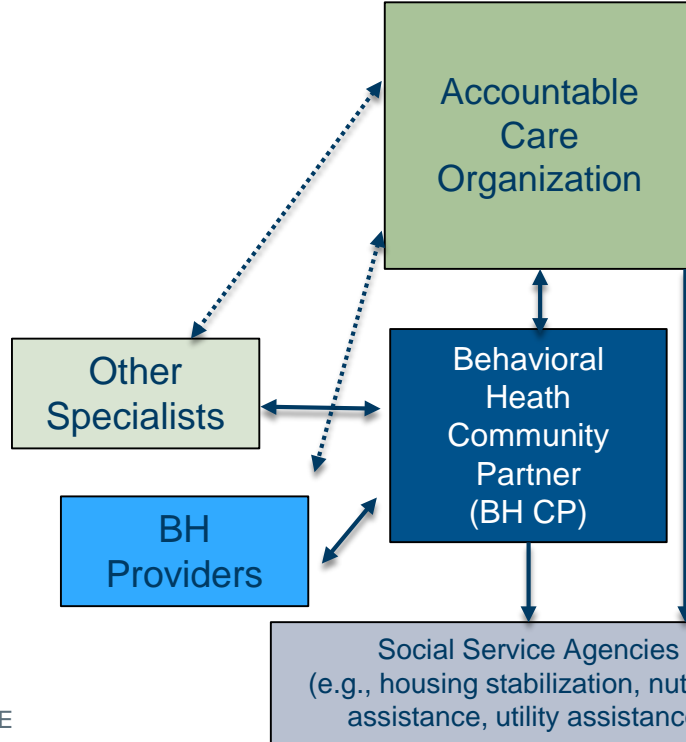


ACOs will coordinate care - primary, BH, other specialists - and supports for the overwhelming majority of their members (est. 850,000 ACO members)

ACOs will have dedicated "flexible services" funding to address social determinants of health (SDH) for target populations



ACO Members with High BH Needs



For subset of ACO members that have complex BH needs (up to 60,000 eligible), BH CPs will coordinate medical, BH, and LTSS care and will assist with SDH supports

System Transformation: Children

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- Process for Children
 - Like adults, children will follow their Primary Care Clinician (PCC) into that PCC's plan choice
 - In a MassHealth household, each managed care eligible member may choose (or be assigned to) their own health plan
- Children in DCF or DYS Custody
 - 75% of these children/youth (~15,000) will remain with MassHealth FFS and MBHP , i.e., no assignment to ACO or MCO, etc.
 - If the child/youth address is listed in MassHealth systems as the Area Office, the child/youth remains in MassHealth FFS/MBHP.
 - Of the 5,000 children/youth who are managed care eligible, ~2,000 will go to MCOs and ~3,000 to ACOs
 - Children/youth who are in the care or custody of DCF or DYS “can change health plans at any time for any reason.”

System Transformation: CBHI –What's Changing?

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Nothing!

- As is the case today, MCEs will be required to:
 - For children under 21, pay a 15-minute case rate for Case Consultation, Family Consultation, and Collateral Contact services at a rate at or above one quarter of the 60 minute rate paid for individual outpatient therapy
 - Pay at or above EOHHS-set floor rates for Family Support and Training Services, In-Home Behavioral Services, and Therapeutic Mentoring Services, In-Home Therapy Services and Mobile Crisis Intervention (MCI);
 - Reminder: Family Support and Training, In-Home Behavioral and Therapeutic Mentoring are available only to MassHealth Standard and CommonHealth members. All MassHealth members under 21 can access In-Home Therapy and Mobile Crisis Intervention, if medically necessary. This is not changing.

System Transformation: Children and CSAs

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- Community Service Agencies (CSAs) will continue to deliver services as they do today
 - Medical necessity criteria and service specifications are unchanged
 - CSAs will be paid for services as they are today

- Eligible to respond to RFR for DSRIP infrastructure/capacity funds
 - Allowable domains include workforce development, infrastructure, and technology
 - Investments must improve integration with MCOs, ACOs and primary care providers
 - Must partner with ACOs and MCOs in its service area
 - Accountable for quality measures
 - ❖ Well child visits; oral evaluation, dental; follow-up after hospitalization for mental illness; member experience (wraparound experience, etc.); avoidable hospital admissions, avoidable ED utilization, CSA comprehensive care plan completion within 90 days.

System Transformation: ACOs – Focus on Primary Care

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- ▶ A MassHealth member whose Primary Care Clinician (PCC) has joined a MassHealth ACO will *follow that PCC into the ACO*



Note: The member must live in the ACO service area in order to follow their PCC

System Transformation: Primary Care Exclusivity

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- ▶ MassHealth envisions a primary care-driven, person-focused care experience for members, particularly for ACO enrollees
- ▶ **Primary Care Exclusivity** –Each ACO's Primary Care Clinicians (PCCs) participate **exclusively** with that ACO. They cannot serve MassHealth members who belong to other ACOs, an MCO, or the PCC Plan as Primary Care Clinicians
 - A member must join the ACO to receive primary care services from that provider. This also means that a member that chooses a PCC who is in an ACO will be assigned to that ACO.
 - Primary care providers can still provide specialty services to members outside of their ACO, but cannot have them assigned to their primary care panels.
- ▶ This primary care exclusivity is enforced at the **practice- or entity-level**.
- ▶ Applies only with respect to MassHealth managed care eligible members.
 - PCCs may provide primary care to MassHealth FFS members - including dually eligible individuals, One Care members, SCO members, Medicare beneficiaries, commercial patients, etc.
- ▶ **No Specialist Exclusivity** - Exclusivity requirement does **not** apply to specialties such as BH.



System Transformation: ACOs – 3 Models

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▶ **Accountable Care Partnership Plan (Model A)** - A single ACO partnered w/ single MCO

- Paid prospective capitated rate for attributed members (full insurance risk)
- All enrolled members receive primary care from that ACO's PCCs
- Members can see any other providers in the plan's network, e.g., BH providers
- Can serve a smaller geography than a MassHealth region

13 Accountable Care Partnership Plans Contracted

▶ **Primary Care ACO (Model B)** - ACO contracts w/ MassHealth

- Shared savings/losses based on TCOC and quality performance for attributed members
- All enrolled members receive primary care from that ACO's PCCs
- Aside from their PCC, members can see any provider in the MassHealth BH network (MBHP) or the PCC Plan Network for other specialties
- May have "referral circles" which gives direct access to specialists without PCC referral (N/A for BH services)

3 Primary Care ACOs Contracted

▶ **MCO-Administered ACO (Model C)** - An ACO that contracts w/ one or more MCOs

- Accountable to MCO through shared savings/losses (MassHealth must approve)
- Members enroll in an MCO and choose (or attributed to) an ACO based on PCC selection
- Members can see any other provider such as BH in their MCO's network

1 MCO-Administered ACO Contracted

Systems Transformation: MCOs

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- ▶ MCOs have important role in ACO implementation
 - ☆ Remain insurer, pay claims, and work with partner Accountable Care Partnership Plans and the MCO-Administered ACO to improve care delivery and support care integration
 - ☆ Support ACO partners to build provider capacity, including providing population health management analytics
- ▶ MCOs will continue as a *standalone* option on smaller scale – fewer plans and fewer MassHealth members

Systems Transformation: PCC Plan

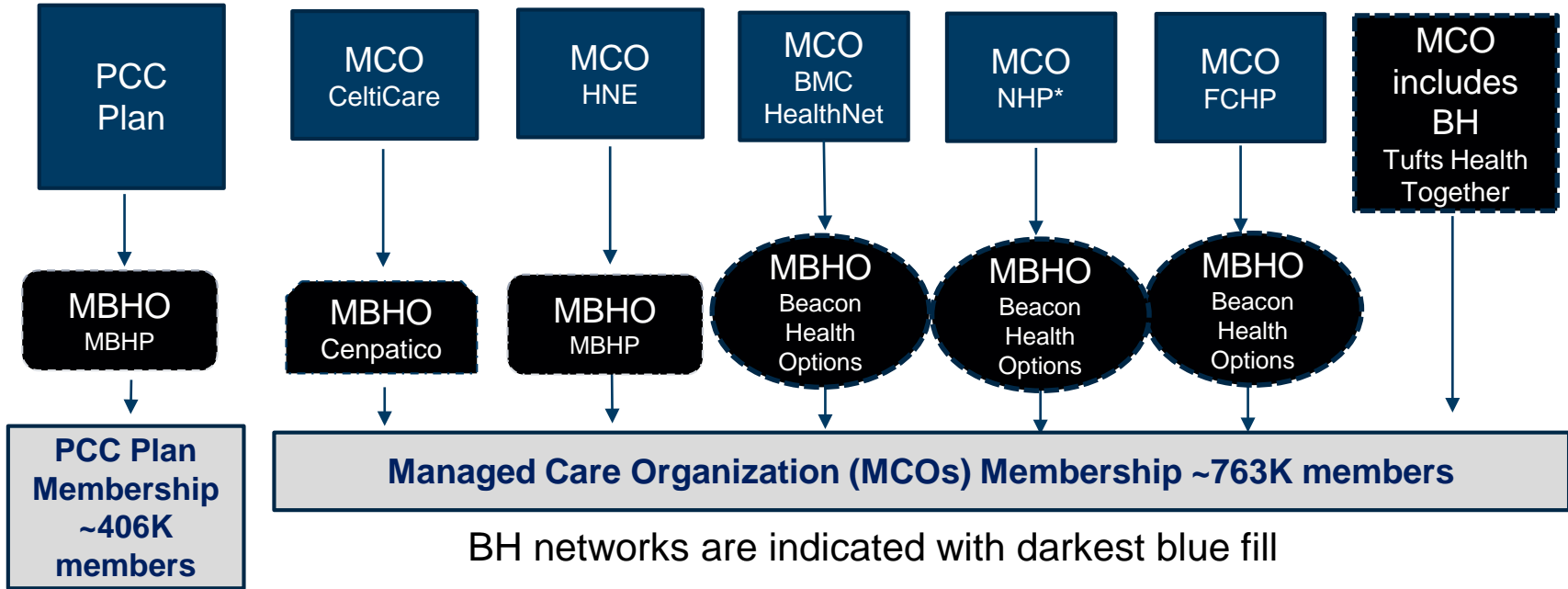
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- Primary Care Clinician (PCC) Plan continues as option
- Massachusetts Behavioral Health Partnership (MBHP) continues as BH manager for PCC Plan members
- Upcoming changes may include:
 - Significantly reduced plan membership
 - Differential co-pays (higher co-pays in PCC Plan vs. ACO/MCO options)
 - Tighter physician and pharmacy networks

Today's MassHealth Managed Care Options

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Plan models and options available to managed care-eligible MassHealth members through February 2018.



* NHP will be transitioning management of behavioral health benefits to Optum on January 1, 2019

MassHealth Managed Care Options March 2018

Accountable Care Partnership Plans (Model A) Integrated ACO/MCO	Primary Care ACO (Model B) No MCO. Contracts directly w/ MassHealth (MBHP)	MCO-Administered ACO (Model C)	MCO	PCC Plan (MBHP)
<ol style="list-style-type: none"> 1. Be Healthy Partnership 2. Berkshire Fallon Health Collaborative 3. BMC HealthNet Plan Signature Alliance 4. BMC HealthNet Plan Community Alliance 5. BMC HealthNet Plan Mercy Alliance 6. BMC HealthNet Plan Southcoast Alliance 7. Fallon 365 Care 8. My Care Family 9. Tufts Health Together w/ Atrius Health 10. Tufts Health Together w/ BIDCO 11. Tufts Health Together w/ Boston Children's ACO 12. Tufts Health Together w/ CHA 13. Wellforce 	<ol style="list-style-type: none"> 1. Community Care Cooperative 2. Partners Healthcare ACO 3. Steward Medicaid Network ACO 	<ol style="list-style-type: none"> 1. Lahey Clinical Performance Network 	<ol style="list-style-type: none"> 1. BMC HealthNet Plan 2. Tufts Health Together 	

What We Know


- ▶ Systems transformation is hard
- ▶ MassHealth can successfully plan, design and implement major operational transformations
- ▶ Stakeholder engagement/involvement in planning, design and implementation is critical to successful operational change
- ▶ Overcoming HIT challenges must be a top priority for all stakeholders; e.g. event notifications; appropriate sharing of patient information
- ▶ Team-base care is hard

What We Know

- ▶ MassHealth members eligible for Community Partners coordination are hard to engage for a number of reasons
- ▶ MassHealth is committed to expanding treatment options for dually-diagnosed individuals
- ▶ Access to critical behavioral health services is still insufficient

What We Don't Know

- ▶ Will this work? Will DSRIP investment lead to improved quality of care and controlled costs?
- ▶ Will the full range of health care providers embrace this vision?
- ▶ Will integration truly take hold?
 - ▣ Integration of primary and behavioral care;
 - ▣ Integration of state contracted services with “medically necessary services”;
 - ▣ Integration of mental health and substance use disorder services;
 - ▣ Integration of Social Determinants of Health (SDH) services with medical services



Vic DiGravio, President/CEO

Association for Behavioral Healthcare

vdigravio@abhmass.org

508-647-83845