The Arc of Massachusetts
217 South Street
Waltham, MA 02453-2710

T: 781.891.6270
F: 781-891.6271
arcmass@arcmass.org
www.arcmass.org

Achieve with us.

For people with intellectual and developmental disabilities

Review of MassHealth Delivery System Restructuring

DRAFT Release May 3, 2016

Published by MassHealth April 14, 2016

MassHealth plans to restructure the delivery of services which it funds in Massachusetts. Many of our constituents receive services through the primary clinician program. MassHealth's plan is under the description of "integrated care". It will require the formation of "accountable care" organizations. Two of the models proposed required managed care organizations to be utilized. The information we review was published on April 14, 2016.

MassHealth utilizes three documents describing the restructuring and they are located at www.mass.gov/hhs/masshealth-innovations
or Google: MassHealth Innovations and select MassHealth Restructuring updates. These documents include a summary, overview and additional materials. These additional materials include over 50 pages and have the most detail. You may also wish to read the 2 page MassHealth release on the ARC of Massachusetts website which offers background on the system restructure.

Background:

Integration of care is the primary goal of MassHealth restructuring. This means that health entities (primary care practices, hospitals, public health centers, etc.) will serve as accountable care organizations (ACO) responsible for the entire cost of serving the individual. There are three different models that MassHealth will utilize, two of which include managed care organizations (MCO).

The MCO's role is to help ACOs manage the potential financial risk of taking full responsibility for care, including access to long term supports and services or LTSS.

Today MassHealth pays for services on a fee-for-service basis. However, as a rule, the rates it pays are lower than private insurance reimbursement and at a level that discourages physicians and practices from expanding their Medicaid patient base.

What will change for the consumer of service?

A fictitious but plausible example we will present is that of Mary Smith a MassHealth recipient living with a disability. She presently receives health care through a physician affiliated with Boston Medical Center. The physician group decides to develop an ACO (accountable care organization). With a "network" of specialists and other health related services. After 12 months, long-term support services (those services that already are delivered by MassHealth such as day habilitation, personal care or PCA services, AFC or adult foster care, homemakers, block nursing, etc.) will also be referred through the ACO. The ACO will be measured for quality of care (tracking prevention and wellness, chronic disease management, Behavioral health, long-term supports and services, unnecessary utilization of emergency and specialty services, and assessment of the patient experience) and how it manages the cost of care.

ACOs are expected to have collaboration or agreements with "Community partners" (CPs) who either have expertise in behavioral health or long-term supports and services (LTSS). In the latter case, the agencies must be able to provide LTSS assessments across multiple populations with disabilities. Additionally, agencies that provide services such as housing assistance or food (social determinants of health) will be part of an ACO network as well.

All ACOs must meet certification criteria as established by the Health Policy Commission (document January 29, 2016). Community BH and LTSS providers will be particularly interested in pages 10 and 11.

Underlying the MassHealth plan, is the assumption that if one entity (the ACO) is responsible for coordinating all the care one receives; than the individual will get all the care he or she needs while not wasting resources unnecessarily. This assumes that the ACO will become adequately acquainted with those it serves.

MassHealth will have to submit its changes for approval to the Center on Medicare and Medicaid (CMS) in regard to health care delivery. In May 2016, MassHealth will hold a 30-day public comment period with 2 public hearings on the changes (officially the state is changing its 1115 Waiver). These changes are submitted to CMS because the federal government is a financial partner in services delivery and must approve significant changes.
A pilot implementation of an ACO directed to those recipients in the PCC plan (Primary Care Clinician) launches by the end of this calendar year (2016). Members will be notified in the event they don't want to be part of the pilot plan. This requires solicitation to organizations, which may want to be part of the pilot this spring (SOON). During this summer, solicitation of practices and other health entities to become ACOs will begin for full implementation.

In October 2017, MassHealth begins the full role out of the plan including behavioral health partners, LTSS Partners (long term supports and services) and additional financial investments. The additional financial investment or DSRIP- "Delivery System Reform Incentive Payment" -this reflects the additional money which MassHealth hopes we will receive from the federal government to fund the restructuring. For example, the money will help ACOs ramp up, assist community partners (providers of LTSS or behavioral health), and provide for social needs not presently funded through MassHealth. In return for DSRIP, Massachusetts must slow the rise in health care spending mutually defined by the end of a five-year period (slow by 2.5%).
Statewide investments in plan include: health care workforce development, improved accommodations for people with disabilities, and other state priorities.

ACO criteria as developed by Health Policy Council -- http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/certification-programs/aco-rfc-draft-20151208-vfinal.pdf

Commentary
There are no surprises in the MassHealth release. We appreciate the efforts of planners to involve stakeholders throughout the process. They face a difficult task. The administration wishes to maintain a robust Medicaid (MassHealth) program while addressing the high rates of growth over recent years.

The most important phase of the project is ahead as it will define how the needed restructuring will provide access to quality health care for our constituents, those with intellectual and developmental disabilities. We won't know the answer to this question until more work is done on the operational aspect of the ACOs. Secondarily, we hope MassHealth can insure that LTSS will not be further restricted through the restructure process.
The Arc research report of 2008-2009, (in partnership with Ruth Freedman, Ph. D. and a graduate student at BU School of Social Work, and also published in Social Work journal on Health) documented that one of the key barriers to access to quality health care was lack of knowledge among health care practitioners. Such findings have been reflected in other studies including a report by the Surgeon General's office.

MassHealth will rely on health care entities to be care managers or coordinators: "At minimum, an ACO must include primary care providers." As we have discovered, the health system has limited or no knowledge about our population. How can we expect ACOs to develop expertise in a short amount of time?

Additionally the funding issue concerns us. Gridlock on the federal level has resulted in squeezing federal discretionary funds for community programs, some of which addressed social determinants of health. As the restructuring plan continues and dollars from the incentive program (DSRIP) winds down in the latter years, thoughtful consideration of how to incorporate funding for social determinants of health should be addressed.

Questions to resolve during operational phase include:

Will the investment into the ACO be sufficient for primary care practices to develop care management for our constituents? Will our constituents be forced to go to certain practices where knowledge is insured despite costs in time and travel?

It is important to be aware that some Community Partners may have expertise in disability specific behavioral health programs. There may be a need to subcontract for certain services to provide LTSS for all populations. Or perhaps a CP will be a partnership between a providers in different fields (I/DD, ASAP, ILC, BH).
How will health entities cooperate with an ACO if the entity is not part of the ACO? For example if the PCP (primary care practitioner) in an ACO has a consumer at a network hospital will they communicate adequately with the PCP or will they change the medications and other treatment modalities with minimal or no communication with the PCP?

Will the rates be sufficient so that the ACO, which is risk-sharing with MassHealth, can pay the rates at hospitals which are more costly and where members have received their care for years? Or will members have to go to certain hospitals for inpatient stay?

If specialty care is needed for our constituents at a higher level of expertise not available in the ACO network, will this be allowed? (Given lack of knowledge among practitioners, the need for this allowance is probable). Access to specialty care is currently a problem with the MA health network even without network limitations.

We encourage, as in existing MCO models, wellness and prevention services be made available through the ACO or CP that fit the needs of this group. Wellness and prevention program would have significant impact on long-term health and quality of life as well as long term healthcare utilization dollars.

How will the working relationship between ACO and CP (community partner) be defined? The plan states that the ACO will be encouraged to "buy" the service so there is an implication that an ACO will decide to deliver assessments and needed LTSS themselves.

The plan notes several bars to overcome before utilizing incentive funds for social determinants (similar to flex family support such as air conditioner for family where child has asthma, housing assistance, food, etc.) – these bars or items to check off before approval could be very time consuming. Who will decide *if* an ACO or a CP is picking the most "cost effective alternative, which is likely to improve health outcomes, or delay deterioration and insure that funding for such a need is not available elsewhere" [*and any other future 'ifs*]? More thought is needed regarding incentives for fiscal outcomes to ensure an individual's services are efficient and that barriers to necessary care are not the result of the process.

Accommodations for the individual's unique needs for specialized care are part of current care coordination. How will accommodations in behavioral health and LTSS be structured?

The total cost of care (TCOC) after year one is projected to include the MassHealth LTSS. How will the state determine the right figure to add in for this potential cost for all members? (It will be a certain cost for some members including those with I/DD?)

How will choice be respected in obtaining LTSS? For example, today people can change a PCA, AFC provider and/or day habilitation site.

As the dollars from the incentive program wind down (DSRIP) in later years, how will MassHealth determine how much money to set aside for social determinants and other state funded extras that are not start-up or capacity building related?

About The Arc…For 60 years, The Arc of Massachusetts has been helping families across the Commonwealth assure the well-being, safety, and happiness of their loved ones. Our core mission is to make sure individuals with intellectual and developmental disabilities and their families obtain the opportunities they need and deserve to lead full lives in the community. Along with our state-wide chapters and scores of partners, The Arc's advocacy has made an enormous difference. Today, the 200,000 individuals in Massachusetts who have disabilities are living better, community-centered lives as a result of The Arc's efforts on their behalf.