What are Accountable Care Organizations & Can They Meaningfully Address Social Determinants?

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NOVEMBER 29, 2017
Presentation Overview

1. A brief history of health reform in MA
2. What are ACOs?
3. What is MassHealth? What’s the “waiver” all about?
4. MassHealth ACOs + public health?
5. Q&A + discussion
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History of Health Reform in MA

Chapter 58 (2006) – Coverage and access “RomneyCare”

Chapter 305 (2008) – Cost containment

Chapter 288 (2010) – Cost containment

Chapter 224 (2012) – Cost containment, payment and delivery system reform

Chapter XXX (2018) – Cost containment, payment and delivery system reform CONTINUED.....
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What is an ACO?

Three key elements:

A network of providers (doctors, hospitals, specialists, CHCs)...

...which shares financial and medical responsibility for providing coordinated care to patients...

...with the goals of improving health, increasing quality, and reducing cost.
Key Features of ACOs

- **Coordination of care**
  - Across providers/settings – docs, hospitals, CHCs, specialists

- **Move Away From Fee For Service**
  - Bundled/global payments
  - Financial incentives to focus on wellness and “population health” management
  - Avoid unnecessary duplication, reduce medical errors

- **Risk Adjustment**
  - Acknowledge that certain factors, including SDOH needs, impact costs

- **Quality Measures**
  - Protections against ACOs denying needed care

- **Consumer/patient engagement**
ACOs - Good or Bad?

“Changes underway in the financing and delivery system are not inherently good or bad for consumers in general, or for vulnerable populations in particular.

“Whether they have a positive or negative impact will depend on how they are implemented. It will be largely up to consumers and their advocates to ensure the impact is positive.”

Source: Community Catalyst, The Path to a People-Centered Health System
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What is MassHealth?

• Combined Medicaid and Children’s Health Insurance Program

• Safety Net for nearly 1.9 million people in MA

• Between 2014-2016 MassHealth spending increased 11.5%/year
  • Compared to 3.5%/year for other state spending

• State spending on MassHealth comprises 24% of the state budget
  • 40% including federal spending

MASSHEALTH IS IMPORTANT TO MANY POPULATION GROUPS

PERCENT OF SELECT MASSACHUSETTS POPULATIONS COVERED BY MASSHEALTH, 2015

- All children: 42%
- All non-elderly adults (age 19-64): 25%
- All seniors: 16%
- Births (child born in last 12 months): 39%
- Nursing facility residents: 59%
- People in families earning <133% FPL: 60%
- People with disabilities (broad definition*): 51%
- People with disabilities (require assistance with self-care): 56%
- Medicare beneficiaries: 25%

*Deaf or serious difficulty hearing; blind or serious difficulty seeing; cognitive, ambulatory, self care or independent living difficulty

More than four in 10 children in Massachusetts and about one-quarter of adults under age 65 are MassHealth members. MassHealth is an especially important source of coverage for people with low income (below 133% FPL), of whom three-fifths are members, and people with disabilities, of whom more than half rely on MassHealth. Six out of 10 nursing home residents are MassHealth members.

MassHealth Waiver Basics - 1

- “1115 Waiver” – agreement with federal Centers for Medicare and Medicaid Services (CMS)
- 5-year agreement (2018-2022) on how to operate and fund MassHealth
- Authorizes > $52 billion in spending over 5 years
- Generates > $29 billion of federal funds
- Budget Neutral Over 5 Years for Federal Government
- Focus on moving members into ACOs – 1.25 million members are eligible
Waiver Basics - 2

- Major focus on mental health, substance use disorders and long term services and supports (LTSS)
- Community Partners - Behavioral Health & LTSS
  - Promote integration, continuity, and quality of care for members with complex needs
- Flexible Services
  - Services to transition from institution to community, physical activity and nutrition, support for survivors of violence, maintain a safe and healthy living environment
- New upfront funds to build infrastructure - $1.8B
Timeline

• Waiver signed – November 2016
• Contracts signed with 17 ACOs and 26 Community Partners – August 2017
• Flexible Services protocol finalized – January 2018? (estimated)
• ACOs begin operating – March 2018
• Community Partners begin operating – June 2018
• Flexible Services service delivery begins – January 2019? (tentative)
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What’s this have to do with public health?

• Incentives to focus on **preventive care**.

• Greater focus on **chronic disease prevention and management**.

• Opportunity to **understand needs and outcomes** by race/ethnicity, income, etc.

• Opportunity to **screen for social determinant of health** needs.

• Opportunity to **engage community-based services and providers** to mitigate impact of SDOH on health.

• Opportunities to **engage/collaborate with public health + community leaders** to change underlying SDOH.
Features of MassHealth ACO Program to Watch

1. Risk Adjustment
2. Social Determinants Screening
3. Community Partner program
4. Flexible Services program
5. Support for Community Health Workers
6. Social Services Integration Work Group
1. Risk Adjustment

- Recognizes that social determinants impact health status and cost of care
- Goal is to adjust payments to ACOs to cover increased cost of medical care
- Not designed to reward prevention/address underlying causes

Model developed by Dr. Arlene Ash of UMass Medical School
1. Risk Adjustment (con’t)

Using SDOH Data In Rate Setting: MassHealth Risk Adjustment Model, Arlene Ash, December 2016

1. **Age** (10 age categories for each male and female)

2. **Disability** (DMH, DDS client; eligible for Medicaid due to disability)

3. **Behavioral health** (serious mental illness, substance use disorder)

4. **Housing issues** (people with 3 or more addresses in a calendar year or ICD code for homelessness)

5. **Neighborhood Stress Score**
1. Risk Adjustment (con’t)

Using SDOH Data In Rate Setting: MassHealth Risk Adjustment Model, Arlene Ash, December 2016

Neighborhood Stress Score (NSS7)

A measure of “economic stress” summarizing 7 census variable identified in a principal components analysis:

- % of families with incomes < 100% FPL
- % < 200% of FPL
- % of adults who are unemployed
- % of households receiving public assistance
- % of households with no car
- % of households with children and a single parent
- % of people age 25 or older who have no HS degree

NSS7 is standardized (Mean = 0; SD = 1)
2. Social Determinants Screening

• MassHealth ACOs will be required to screen for SDOH
  • Sometimes called “health-related social needs” or HRSN
  • Not expected to require common tool

• Federal “Accountable Health Communities” Pilot has developed 5-domain, 10-question screening tool
  • Housing Instability
  • Food Insecurity
  • Transportation Needs
  • Utility Needs
  • Interpersonal Safety
2. Social Determinants Screening (con’t)

Example – Housing Instability Screen (CMS Tool)

1. What is your housing situation today?

  o I do not have housing
    o I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park
  
  o I have housing today, but I am worried about losing housing in the future.

  o I have housing

2. Social Determinants Screening (con’t)

Example – Housing Instability Screen (CMS Tool)

2. Think about the place you live. Do you have problems with any of the following?

- Bug infestation
- Mold
- Lead paint or pipes
- Inadequate heat
- Oven or stove not working
- No or not working smoke detectors
- Water leaks
- None of the above

2. Social Determinants Screening (con’t)

Example – Utility Needs Screen (CMS Tool)

In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- Yes
- No
- Already shut off

2. Social Determinants Screening (con’t)

Example – Food Insecurity Screen (CMS Tool)

1. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true  - Sometimes true  - Never true

2. Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.

- Often true
- Sometimes true
- Never true

3. Community Partner Program

**Behavioral Health Community Partner**

Responsible for care management and coordination for populations with significant BH needs

**Long Term Services and Supports (LTSS) Community Partner**

Provide LTSS care coordination and navigation to populations with complex LTSS needs

Source: MassHealth, MassHealth Payment and Care Delivery Innovation - Meeting with ACOs and MCOs on Community Partners program and Flexible Services, September 12, 2017.
### What will Community Partners do for members?

<table>
<thead>
<tr>
<th>BH CP Functions</th>
<th>LTSS CP Functions</th>
<th>LTSS Component of Care Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Care Management</strong></td>
<td><strong>LTSS Component of Care Coordination</strong></td>
<td></td>
</tr>
<tr>
<td>1. Outreach and engagement;</td>
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<td></td>
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<tr>
<td>2. Comprehensive assessment and person-centered treatment planning;</td>
<td>2. LTSS Care Planning including Choice Counseling;</td>
<td></td>
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<tr>
<td>3. Care Coordination &amp; Care Management, including across</td>
<td>3. Care Team Participation;</td>
<td></td>
</tr>
<tr>
<td>1. Medical</td>
<td>4. LTSS Care Coordination;</td>
<td></td>
</tr>
<tr>
<td>2. Behavioral Health</td>
<td>5. Support for Transitions of Care;</td>
<td></td>
</tr>
<tr>
<td>3. Long Term Services and Supports;</td>
<td>6. Health and Wellness Coaching; and</td>
<td></td>
</tr>
<tr>
<td>4. Care Transitions;</td>
<td>7. Connection to Social Services and Community Resources, including Flexible Services</td>
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<td>5. Medication Reconciliation;</td>
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## 4. Flexible Services Program

*March 2017 draft shared with advocates*

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<tr>
<th>Flexible Service Domain</th>
<th>Examples of Possible Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Transition services for individuals transitioning from institutional settings into community settings</strong> – reduce health risks and costs while transitioning</td>
<td>One-time assistance for first month’s rent/utilities, skills training to promote independent living</td>
</tr>
<tr>
<td><strong>2. Home and community-based services to divert individuals from institutional placements</strong> – assist in maintaining housing in community setting</td>
<td>Skills training to prevent behaviors that jeopardize housing, connect members to support/assistance or vouchers, advocacy for disability accommodation</td>
</tr>
<tr>
<td><strong>3. Maintain a safe and healthy living environment</strong> – increase member’s functioning and independence related to a medical condition, promote home safety</td>
<td>Home assessment and modifications (e.g., grab bars, non-skid strips, mattress/pillow covers), skills training to negotiate w/ landlords and promote safe home</td>
</tr>
<tr>
<td><strong>4. Physical activity and nutrition</strong> – promote health by increasing activity and access to affordable healthy food</td>
<td>Programs that improve access and acquisition of healthy food and active lifestyle, goods and services that promote healthy behaviors, skills training</td>
</tr>
<tr>
<td><strong>5. Experience of violence support</strong> – facilitate connections to services of a DPH-funded provider or EOHHS-funded agency</td>
<td>One-one-one counseling and support groups, temporary goods, youth at risk programs</td>
</tr>
<tr>
<td><strong>6. Other individual goods and services</strong> – not previously covered and provides benefit and support</td>
<td>Literacy programs, expectant parents programs, ESL classes, stress reduction class</td>
</tr>
</tbody>
</table>

4. Flexible Services Program

*September 2017 updated, more limited program, shared with advocates*

**Flexible Services Program background**

- Proposed Flexible Services Program identified in MassHealth's Delivery System Reform Incentive Plan (DSRIP) protocol
- Flexible Services Program allows ACOs to utilize a portion of their funds to pilot innovative approaches to social service integration that address social determinants of health within MassHealth ACOs
- ACOs will be able to seek reimbursement from MassHealth for goods and services within specific focus areas identified by MassHealth
  - MassHealth will define specific categories of allowable goods and services under each focus area

**Amended Flexible Services Primary Focus Areas – to be negotiated with CMS**

1. **Community Transition Services**: goods and services to support individuals transitioning from institutional settings into community-based settings
2. **Community Support Services**: goods and services to promote community-based tenancy and stability (divert from institutional placement)
3. Supports to maintain a **safe and healthy living environment**
4. Supports to promote **access to appropriate nutrition**
4. Flexible Services Program

*September 2017 updated, more limited program, shared with advocates*

**Proposed Flexible Services Program design**

**Programmatic**

- ACOs will **not be able to address every social service need of every member through the Flexible Services Program**
  - ACOs will need to **identify target population(s)** for the Flexible Services Program

- ACOs will design their Flexible Services Program as a **cohesive set of goods and services**
  - Other states (OR, WA, CO, MD) have pilot programs that integrate social services supports into healthcare systems as a means to improve healthcare utilization and health outcomes, and decrease total cost of care (return on investment)
  - MassHealth is evaluating the possibility of requiring certain focus areas that have the strongest evidence (e.g., transitional supports, community tenancy supports, specific nutritional supports)
  - MassHealth will provide guidance to ACOs to help structure their Flexible Services Program

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*We understand that the federal government will not approve this proposed program and is requiring that is be further limited – no details have been shared publicly yet.*
5. Support for Community Health Workers

Anticipated Need

• ACOs will hire > 90 CHWs
• Community Partners will hire > 1,100 Care Coordinators

Current Scenario

• > 100 people on waitlists at existing training programs
• Underutilization of hired CHWs while waiting for training
• Low pay and burnout among CHWs
5. Support for Community Health Workers (con’t)

Workforce Development Grant Program
(proposal, pending revision and approval)

To enable members of the extended healthcare workforce to more effectively operate in a new health care system

• **Community Health Worker and Peer Specialist Training Capacity Expansion Grants:** Increase the number of well-trained CHWs and peer specialists in ACOs and CPs

• **Community Health Worker Supervisor Training Grants:** Retain CHWs in ACOs and CPs by supporting supervisors of CHWs

• **Recovery Coach Supervisor Training Incentive Fund:** Increase the number of trained supervisors of recovery coaches in ACOs and CPs
6. Social Services Integration Work Group

15-20 members, representing:
• Provider organizations, ACOs, MCOs
• Payers
• Community-based organizations
• Consumer and family/caregiver advocates
• Academia and/or researchers

Experts in:
• Behavioral health + long-term services and supports (LTSS)
• Social determinants of health
• Payment model design, data analysis, actuarial rate setting
• Health policy
• Evaluation and quality measures
6. Social Services Integration Work Group (con’t)

Identify and evaluate:

• Strategies for social services integration in care delivery
• Population data to inform social services resources and needs
• Systems for linking MassHealth members to social services supports
• Processes for monitoring and quality assessment of social service
• Workforce development and training needs and resources.
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Health Care For All HelpLine

1-800-272-4232

- The HelpLine Counselors are Navigators trained by the Health Connector and MassHealth
- Assist callers in determining their insurance options, completing applications, troubleshooting coverage issues and more!
- Applications are completed over the phone
- Counselors speak Spanish, Portuguese and English
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MASSACHUSETTS PUBLIC HEALTH ASSOCIATION  
Action for Equity in Health  

HEALTH CARE FOR ALL
MassHealth ACOs

1. Atrius Health with Tufts Health Public Plans
2. Baystate Health Care Alliance with Health New England
3. Beth Israel Deaconess Care Organization with Tufts Health Public Plans
4. Boston Accountable Care Organization with Boston Medical Center HealthNet Plan
5. Cambridge Health Alliance with Tufts Health Public Plans
6. Children’s Hospital Integrated Care Organization with Tufts Health Public Plans
7. Community Care Cooperative, an organization of 13 federally qualified health centers.
8. Health Collaborative of the Berkshires with Fallon Community Health Plan
9. Lahey Health
10. Mercy Health Accountable Care Organization with Boston Medical Center HealthNet Plan
11. Merrimack Valley ACO with Neighborhood Health Plan
12. Partners HealthCare ACO
13. Reliant Medical Group with Fallon Community Health Plan
14. Signature Healthcare Corporation with Boston Medical Center HealthNet Plan
15. Southcoast Health Network with Boston Medical Center HealthNet Plan
16. Steward Medicaid Care Network
17. Wellforce with Fallon Community Health Plan
Long Term Services and Supports (LTSS) Community Partners

1. Alternatives Unlimited
2. Boston LTSS Community Partners
3. Boston Medical Center
4. Elder Services of Merrimack Valley
5. Family Service Association
6. Innovative Care Partners
7. Seven Hills Family Services, Inc.
8. WestMass Elder Care
| 1. | Behavioral Health Network |
| 2. | Behavioral Health Partners of Metrowest |
| 3. | Boston Health Care for the Homeless Program |
| 4. | Clinical Support Options |
| 5. | Community Counseling of Bristol County |
| 6. | Community Healthlink |
| 7. | Eastern Massachusetts Community Partners |
| 8. | Eliot Community Human Services |
| 9. | High Point Treatment Center |
| 10. | Innovative Care Partners |
| 11. | Lowell Community Health Center |
| 12. | Lahey Behavioral Health Services |
| 13. | Riverside Community Care |
| 14. | South Shore Mental Health Center |
| 15. | Southeast Community Partnership |
| 16. | Stanley Street Treatment and Resources |
| 17. | The Bridge of Central Massachusetts |
| 18. | The Brien Center for Mental Health and Substance Abuse Services |