

ADDP Annual Conference

MANAGED CARE 101

“NEW LANGUAGE, NEW WAYS OF THINKING”

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ADDP Annual Conference

Managed Care 101

“Why are we talking about this? We’re not medical professionals!”

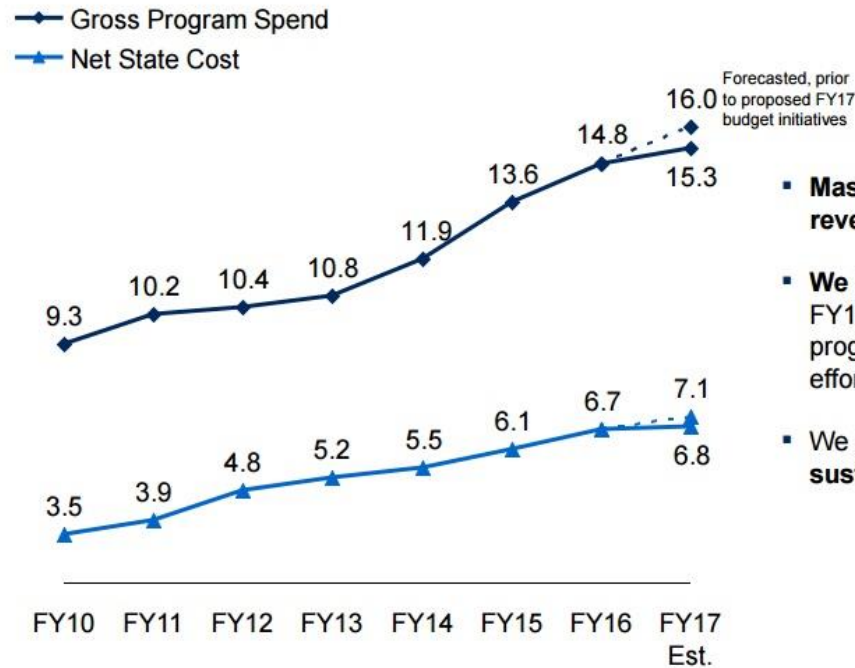
Spending in the MA Health account and EOHHS is growing at an unsustainable rate.

This year the EOHHS lines account for 40% of the entire state budget.

Our sector is primarily funded through health care dollars & the services we deliver impact the health of those we serve.

Mass Health Growth Trajectory

MassHealth Program Spending*
\$ billions



- **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**

Managed Care 101

Where is all this coming from in the first place?

The existing federal waiver programs have actually been imposing some level of “managed care” into LTSS services for years.

Affordable Care Act of 2010 created the infrastructure for what’s happening across the country today.

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Continued:

Most people on MA Health are already in managed care networks for their medical and behavioral health needs

Primary focus of the MA Health Innovations Team is to reduce fragmentation within the current system in order to increase efficiency and provide optimal results.

ACA Provisions

Key Affordable Care Act (ACA; PPACA or Obama-Care)
Provisions relative to managed care:

1. Designed to BOTH improve health care outcomes and reduce increases in health care costs over time.
2. Provided incentives to states to encourage experimentation with service delivery models to achieve the goals of #1.

ACA Provisions

Key ACA Provisions (relative to managed care) continued:

3. Expanded Medicaid Eligibility
4. Allowed for the creation of new entities to facilitate managed care innovation and effectiveness.
5. Allowed for different payment models to healthcare providers.

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WARNING!!

**THE FOLLOWING SLIDES CONTAIN NEW, SOMETIMES
CONFUSING VOCABULARY!**

Don't let it scare you though. We're here to explain 😊!

Delivery System Reform Incentive Payment

Major Incentive from the federal government to states through the Section 1115 Waiver programs to encourage states to test new service delivery and payment models for their Medicaid programs.

DSRIP funds are **federal** funds *used* to fund healthcare system processes: *infrastructure development* and *system redesign*. These can be defined fairly broadly and can vary considerably from state to state.

Delivery System Reform Incentive Payment

DSRIP funds are then *tied* to metrics which need to be achieved for the state to continue receiving this federal support.

These outcomes are typically associated with *Clinical Outcome Improvements* and *Population Focused Improvements*.

Delivery System Reform Incentive Payment

DSRIP funds have to be deemed *budget neutral* because they are part of the 1115 Waivers.

States ask for increased federal monies based upon the ***anticipated savings from the project being proposed.***

DSRIP Funding

MA is seeking upwards of \$2 billion in DSRIP funding as part of their proposal to the Centers for Medicare and Medicaid Services (CMS).

CMS is the federal entity who has to approve all applications for DSRIP funding and 1115 Waiver programs.

Accountable Care Organizations (ACOs)

What are they?

A healthcare organization characterized by a payment and care delivery model tying provider reimbursements to quality metrics and reductions in the total cost of care for specific populations.

Generally speaking these entities tend to consist of very large healthcare networks.

Accountable Care Organizations (ACOs)

Similar organizations already in place in MA through the Senior Care and One Care (duals) programs including: Senior Whole Health, Commonwealth Care Alliance, Network Health and others.

It is expected that groups like Partners, Steward, Atrius and other large hospital networks and insurance companies will seek to become ACOs in MA.

Why ACOs?

Accountable care involves financial risk (and reward) sharing between the state and the ACOs.

Considering the *billions of dollars* involved in bringing managed care to MA Health, only large entities with intimate knowledge of the medical services network and significant financial resources will be able to feasibly take on this level of risk.

Why ACOs?

Accountable Care also involves significant quality accountability. As such, ACOs need to be able to affect and measure service quality and provide *care coordination to all consumers* on an ongoing basis.

What are Health Homes (Certified Community Partners)?

Also an element created through the ACA, Health Homes are typically provider networks who are responsible for the care coordination of all aspects of service provision and health promotion amongst specialty patient populations.

Common specialty populations for Health Homes include: intellectual and developmental disabilities (**I/DD**) and serious and persistent mental illness (**SMI**).

Care Coordination

The care coordination responsibilities of health homes include:

- Making referrals for services
- Authorizing services (not always)
- Providing supports to family members of patients in the health home

Care Coordination

The care coordination responsibilities (continued):

- Comprehensive care management
- Comprehensive transitional care follow-up. States have latitude as to how they define Health Homes.

Health Homes - Who are they?

Health Homes are provider networks (they can take on many different forms and levels of collaboration) with specific expertise serving targeted, specialty populations.

MA already has some health homes in place for specialty populations through the One Care program.

ACOs and Health Homes

Do they (ACOs and Health Homes) work?

In some ways that is too broad a question because it depends on how the system is designed. Right now there are many different “experiments” going on in states throughout the country.

In MA we have some evidence through Senior Care and One Care projects that managed care *can* help to “bend the curve” (slow the rate of healthcare spending growth).

How is managed care supposed to work?

The basic theory is that if we produce a system that is truly *person-centered* within a well-coordinated network of service providers we could both improve healthcare outcomes and save money.

In other words, focusing on improved quality and better service integration can help control long-term healthcare costs for people.

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Proponents of managed care also point to the current fee-for-service system as driving much of the healthcare spending since providers will make more money by performing more discrete services.

In behavioral terms, the current system reinforces the healthcare system for performing as many different services as they possibly can.

Global Payment Model

Managed care seeks to flip the whole healthcare paradigm on its head by changing how people get paid by moving towards a *global payment model (GPM)*.

Global Payment Model: This is a model of healthcare reimbursement to providers where ***attributed providers*** (typically primary care physicians or physician groups) receive a capitated payment for each of the patients they treat. Such payments are generally made on a per-member/per-month (**PM/PM**) basis.

Global Payment Model

In theory this incentivizes the providers to deliver only those services which are essential to effectively diagnose and treat a specific issue because providers are generally able to keep all or part of any savings achieved.

This is a core feature of most ACO-type managed care systems.

How would this payment structure help?

It would get the ACOs, and consequently the big hospital networks, to think differently about capacity.

Right now, a hospital CEO sees each bed as a profit-center. In a GPM scenario, each bed becomes an expense to be managed/minimized since every day a bed is unused the more savings the ACO/hospital group will earn.

Attribution

So how would individual patients/consumers become part of an ACO?

Through a process called *attribution*.

Attribution: This term refers to the manner in which individual are assigned to an ACO through specific service providers (most often the primary care physician) for purposes of financial risk/reward sharing and care coordination responsibilities.

Attribution

Ideally, attribution is made based upon the voluntary choice and identification of a specific physician by the individual.

In situations where either the person has not made a clear selection of physician then attribution is made based upon which healthcare providers the person has seen most often within a given time period.

Attribution

In modified-ACO arrangements where there are also Health Homes in place for specific specialty populations (as is envisioned in the MA Health reform plans currently being finalized) separate attribution can be made around financial risk/reward sharing (to the ACO) and for care coordination (to the Health Home).

How do we fit in as I/DD providers?

Proposed timeline for the MA Health Innovations project
(all subject to change):

FY '17: ACOs and Health Homes identified, likely pilot to occur.

FY '18: ACOs to take over all medical and behavioral health service accountability.

How do we fit in as I/DD providers?

Proposed timeline (continued):

FY '19: ACOs take over accountability for State Plan services.

FY '20- FY '22: Assessment of performance of the new system; determine if Waiver Services and Senior Care and One Care programs should get rolled into this larger model.

Pros of Managed Care

Pros:

- 1) There is evidence through the Senior Care and One Care programs that managed care systems can improve quality of life and help reduce total healthcare spending on a per person basis.
- 2) Individuals who sign up for managed care systems often receive better benefits. For example, people who signed up for the One Care program receive better dental benefits than those offered to consumers in non-managed plans.

Pros of Managed Care

Pros (continued):

- 3) Prospect of incentives that will lead to greater I/DD expertise being developed within the medical and behavioral health fields because better quality of care can lead to reduced long-term cost-of-care.
- 4) The people who have been leading this change effort within the state government have been open and collaborative throughout the planning process.

Cons of Managed Care

- 1) This effort represents major change to the existing service system. No “tinkering around the edges” here. Change can be scary until you can see how it actually works.
- 2) There will almost certainly be many points of adaptation for providers to work through and thoroughly understand in order to best inform and support the people we serve and their families.

Final thoughts...

This new system is focused on persons with MA Health as their primary health coverage. Since many persons with I/DD have both Medicare and MA Health they won't be part of this new initiative (at least for the first three years).

That being said, *important changes to our service system ARE taking place.* Is your strategic planning up-to-date?

Final thoughts...

There will be MANY details which have yet to emerge. Pay attention! Items such as Health Home composition/affiliations; ACO capacity requirements; rates for services, number of regions/ACOs/Health Homes etc., are still unknowns right now.

This is a great time for reflection/self-assessment...

- How are your organization's IT/analytics?
- What are the outcomes that set your agency apart from others'?
- What do you do that might be attractive to an ACO?

Managed Care 101: Questions

