The MassHealth Accountable Care Organization Program: Uncovering Opportunities to Drive Future Success

EXECUTIVE SUMMARY

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ABOUT THE MASSACHUSETTS MEDICAID POLICY INSTITUTE

The Massachusetts Medicaid Policy Institute (MMPI)—a program of the Blue Cross Blue Shield of Massachusetts Foundation—is an independent and nonpartisan source of information and analysis about the Massachusetts Medicaid program, MassHealth. MMPI's mission is to promote the development of effective Medicaid policy solutions through research and policy analysis.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center committed to improving health care quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs.

ABOUT JOHN SNOW, INC. (JSI)

John Snow, Inc. (JSI) is a global organization committed to better health care for all. In the United States, JSI works with public and private sector clients to overcome complex health care challenges. JSI delivers collaborative, customized approaches to improve the health of individuals and communities, in particular populations that are low-resourced and living in vulnerable conditions.

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NOTE FROM THE MASSACHUSETTS MEDICAID POLICY INSTITUTE

This analysis of MassHealth's Accountable Care Organization (ACO) program is primarily based on qualitative interviews conducted with 34 individuals, who represent stakeholders directly involved in and affected by the ACO program. These interviews were conducted between fall 2019 and spring 2020; the great majority were conducted prior to two major events that have since shaped the priorities of policymakers, administrators, and stakeholders in Massachusetts' health care system:

- **The global COVID-19 pandemic,** which has infected over 600,000 and killed more than 17,000 Massachusetts residents, triggered a marked uptick in behavioral health challenges, and dramatically increased the social needs of Massachusetts residents. These effects are especially pronounced in economically and socially marginalized communities and communities of color—which are disproportionately served by MassHealth and by the stakeholders interviewed for this report.
- **Increased national recognition of longstanding structural racism and racial injustices.** The murder of George Floyd in May 2020 brought renewed attention to racism and its devastating effects that pervade nearly every aspect of American life—including our health care system. In the wake of this heartbreaking event, Massachusetts' health care stakeholders have renewed their commitment to addressing and remedying health inequities that kill tens of thousands of people of color in the United States every year.*

These events surfaced two important reminders relevant to the MassHealth ACO program: 1) that communities that are economically, socially, and racially marginalized bear disproportionate health and economic burdens and need enhanced attention in our policies and programs, and 2) that being proactive about addressing structural racism and resulting health inequities must be at the forefront of our policy and program development considerations.

Because most interviews were conducted prior to these pivotal events, these themes are largely absent from this report. They are significant issues that must be considered as policymakers and administrators continue to build on and refine the MassHealth ACO program.

*Satcher D et al. "What If We Were Equal? A Comparison of the Black-White Mortality Gap in 1960 and 2000." Health Affairs. Vol 24(2). 2005. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.24.2.459.

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The MassHealth[1] Accountable Care Organization (ACO) program began in March 2018 with the goal of fundamentally transforming the way health care is delivered to MassHealth members by encouraging integrated, coordinated care and holding providers accountable for quality and total cost of care. ACOs are provider-led organizations that can consist of one or more provider organizations and in some instances a managed care organization (MCO). Implementing the ACO model has significantly shifted the way members' care is managed and how MassHealth pays for health care services. The ACO program offers the potential to deeply impact members' care experiences and health outcomes, and also the long-term costs to the state of delivering care to MassHealth enrollees.

What is an 1115 waiver?

In order to test program innovations, states may request approval from the federal government to gain flexibility in how they deliver and pay for Medicaid services under federal Medicaid regulations. Massachusetts' waiver first took effect in 1997 and has evolved through six extensions to expand coverage, support the safety net, provide incentives for delivery system innovations, and serve as a platform for health care reform.

The MassHealth ACO program was authorized as part of the state's Delivery System Reform Incentive Payment (DSRIP) program 1115 waiver, which allocates $1.8 billion over five years (July 1, 2017–June 30, 2022) to transform the Commonwealth's Medicaid delivery system (see sidebar for more information on 1115 waivers).[2,3] Over the ACO program's first two years of operation, MassHealth entered into value-based payment (VBP) contracts[4] with ACOs. Under these contracts, ACOs take financial accountability for the cost, quality, and experience of care for their members. ACOs' cost accountability includes physical health services like physician and hospital services, as well as behavioral health (BH)[5] and pharmacy services. These VBP contracts are designed to move away from a fee-for-service (FFS) model—which reimburses based on the *volume* of services provided—to one that reimburses based on the *value* ACOs provide by holding them accountable for both the health of members and the cost of care for them. To help accomplish these goals, MassHealth's reform efforts also include the Community Partners (CP) Program and the Flexible Services Program. ACOs are required to contract with CPs, which are community-based entities that focus on supporting MassHealth members with

For ease of reading, all types of MassHealth ACOs—including those with MCO involvement—will be referred to as "ACOs" in this report.

The MassHealth ACO program has three different ACO "types", or models. Model A ACOs are Accountable Care Partnership ACOs, where a provider organization or group of provider organizations work with a single MCO to form an ACO. Model B ACOs are Primary Care ACOs, where a provider organization or group of provider organizations directly contract with MassHealth, and MCOs are not involved. Model C ACOs are MCO-Administered ACOs where a provider organization contracts with multiple MCOs and the MCOs contract with MassHealth.

For more information on the ACO models, please see *What to Know About ACOs: The Latest on MassHealth Accountable Care Organizations*.

1 MassHealth is the umbrella name for two programs: Massachusetts' Medicaid program, and Massachusetts' Children's Health Insurance Program (CHIP).

2 Mass.gov. "Massachusetts Delivery System Reform Incentive Payment Program." Available at: https://www.mass.gov/info-details/massachusetts-delivery-system-reform-incentive-payment-program.

3 Mass.gov. "Currently Approved 1115 MassHealth Demonstration ('Waiver')" Available at: https://www.mass.gov/service-details/1115-masshealth-demonstration-waiver.

4 For more information on VBP, see the Health Care Payment Learning and Action Network Alternative Payment Model Framework. Available at: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

5 Behavioral health care is commonly defined as including mental health care and substance use disorder treatment services.

BH or long-term services and supports (LTSS)[6] needs, or both. The Flexible Services Program allows ACOs to spend Medicaid funds to address eligible MassHealth members' nonmedical health-related social needs (HRSNs), including health-related nutrition and housing supports.[7,8] ACOs are encouraged but not required to work with community-based Social Service Organizations (SSOs)[9] to deliver these services.

The Massachusetts Medicaid Policy Institute (MMPI), a program of the Blue Cross Blue Shield of Massachusetts Foundation, enlisted the Center for Health Care Strategies (CHCS) and John Snow, Inc. (JSI) to perform a qualitative analysis of the MassHealth ACO program to determine what is working well, identify challenges stakeholders are facing, and recommend ways to strengthen the ACO program. This qualitative analysis is designed to complement the formal qualitative and quantitative evaluation that will be conducted by the University of Massachusetts, and to provide a timely resource to inform policy and program improvements available to the state through its 1115 waiver renewal in 2022 and other opportunities. To accomplish this goal, CHCS and JSI interviewed 34 individuals, representing 21 ACOs, MCOs, CPs, and SSOs that participate in the program as well as other stakeholders, such as advocacy organizations and trade associations (see Appendix C in the full report for a list of the organizations represented in the interviews). Drawing from the interviews, CHCS and JSI identified key themes pertaining to aspects of the ACO program that are working well or can be optimized, and they also developed a set of programmatic recommendations to improve the ACO program.

Key Themes

This analysis found that interviewees support the ACO program and are committed to its success, with a sizable majority believing that the ACO program is helping to provide better care to MassHealth members. The analysis also found opportunities for the ACO program to be improved, noting that the complexity of the ACO program has created problems that have affected the speed and efficiency of implementation. Five key themes emerged from the interviews:

1. **Interviewees Overwhelmingly Support the Accountable Care Organization Program and Praise MassHealth's Stakeholder Engagement Efforts to Improve It.** Interviewees consistently voiced support for the ACO program's goals, including shifting away from FFS, which reimburses based on volume of services provided, to a VBP model, which reimburses based on the value provided to members. They also shared positive developments that came about as a result of the ACO program, such as improving coordination among the many health care and SSOs serving MassHealth members (see details in the themes below). In addition, they noted that a positive working relationship with MassHealth led to improvements to the ACO program following the initial implementation.

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6 The U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy defines long-term services and supports as: "LTSS encompass a variety of health, health-related, and social services that assist individuals with functional limitations due to physical, cognitive, or mental conditions or disabilities. LTSS includes assistance with activities of daily living (ADLs, such as eating, bathing, and dressing) and instrumental activities of daily living (IADLs, such as housekeeping and managing money) over an extended period of time. The goal of LTSS is to facilitate optimal functioning among people with disabilities." For more information, please see: NT Thach and JM Weiner. "An Overview of Long-Term Services and Supports and Medicaid: Final Report." U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. May 2018. Available at: https://aspe.hhs.gov/basic-report/overview-long-term-services-and-supports-and-medicaid-final-report#.

7 Mass.gov "Massachusetts Delivery System Reform Incentive Payment Program." Available at: https://www.mass.gov/info-details/massachusetts-delivery-system-reform-incentive-payment-program#flexible-services-.

8 Mass.gov. "MassHealth Accountable Care Organization Flexible Services." October 2019. Available at: https://www.mass.gov/doc/flexible-services-program-summary/download.

9 SSOs are defined as organizations that have demonstrated success providing social services to MassHealth members in a culturally competent way and have the capacity to partner with ACOs and accommodate an increased number of referrals. For more information, please see: Center for Health Law and Policy Innovation, Harvard Law School. "Flexible Services Program: Guidance Document Companion Guide." August 2019. Available at: https://www.chlpi.org/wp-content/uploads/2013/12/Flexible-Services-Guidance-Document-Companion-Slides-vF.pdf.

2. **Interviewees Report Progress Toward Improving Care Delivery but Acknowledge That Making a Measurable Impact on Health Outcomes Takes Time.** Interviewees—including representatives of ACOs, MCOs, CPs, and SSOs—indicated that the program has allowed them to improve members' care through the development of care coordination programs and by enhancing many programs that were already in place. The interviewees also noted that the ACO program has encouraged the expansion of their organizations' approaches to addressing HRSNs, which has the potential to help improve health equity. However, interviewees acknowledged that their progress was still in the early stages, and that it was unlikely that these impacts would be reflected yet in quantitative health outcome and total cost of care measures. Because rigorous evaluation of a program as expansive as the ACO program takes time, many interventions targeting HRSNs take a lot of upfront investment, and the health care cost savings that result from these interventions may accrue over the longer term.[10]

3. **The Accountable Care Organization Program Sparked the Formation of Beneficial Partnerships Among Accountable Care Organizations, Community Partners, and Social Service Organizations.** The value of the new relationships established and the strengthening of existing relationships that the ACO program enabled was perhaps the benefit cited most by interviewees. While many ACOs, CPs, and SSOs were already working together, many relationships became more formalized, collaborative, and productive. This progress was not easy, though, as the final two themes explore in more detail.

4. **The Community Partner Program's Complexity Created a Burden for Accountable Care Organizations and Community Partners.** Interviewees expressed frustration with the structure of the CP Program, noting that it was rigid, administratively complex, and sometimes served as an impediment to successful care coordination. While many interviewees acknowledged the benefits of ACOs and CPs working together, many also indicated that the care planning, contracting, and data-sharing processes were burdensome and inefficient.

5. **The Flexible Services Program Is Promising, but Relationships Between Accountable Care Organizations and Social Service Organizations Could Benefit from More Structure.** One particularly innovative element of the ACO program was its development of the Flexible Services Program, and interviewees lauded the potential of the program's approach to address MassHealth members' HRSNs. However, SSOs and ACOs faced difficulties working together due to the cultural differences between the two types of organizations, their respective resources, and the level of effort required for SSOs to adapt to working within the structures of the ACO program.[11] In contrast to interviewees' perspective on the CP Program, many interviewees indicated that additional structure to or guidance on ACO-SSO relationships would be beneficial. While the right balance between too much and not enough structure is difficult to establish, implementation of these programs is iterative and something that must be continually revisited to identify opportunities for improvements and efficiencies.

Interviewees shared additional noteworthy observations about elements of the ACO program, including (1) valuing the Patient and Family Advisory Boards and Consumer Advisory Boards; (2) suggesting strategies to streamline data sharing among ACOs, CPs, and SSOs; (3) expressing concern about the adequacy and accuracy of the ACO program's risk adjustment model, one of the first in Medicaid nationally that adjusts for social factors; (4) observing insufficient focus on the pediatric population; and (5) expressing concerns about the program's sustainability once federal DSRIP funding runs out.

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10 Recognizing that interventions addressing HRSNs require up-front investments and may not equate to immediate health care savings, the 1115 waiver agreement between the state and the federal government did *not* assume cost savings in the first two years of program implementation.

11 For more information on the experiences of CBOs working with ACOs in Massachusetts, please see another BCBSMA Foundation report, "How Are Massachusetts Community-Based Organizations Responding to the Health Care Sector's Entry into Social Determinants of Health?" (November 2018). Available at https://bluecrossmafoundation.org/sites/default/files/download/publication/BCBSF_CommunityBasedOrgs-SDOH_Nov302018_final.pdf.

Programmatic Recommendations

While acknowledging areas in need of improvement, overall these findings indicate continued support for the ACO program from key stakeholders and suggest meaningful progress toward key program goals. MassHealth should continue to build trusting relationships with, and successful engagement of, stakeholders in the ACO program. This has been a great strength of the implementation process, and could be leveraged to continue to improve the ACO program and address issues such as further refining risk adjustment for social factors, more meaningfully integrating the pediatric population, and developing a program sustainability plan. This collaborative process can also facilitate future ACO program success by helping strengthen two key areas:

- **Improve Communication and Data Sharing Among Accountable Care Organizations, Community Partners, and Social Service Organizations.** Many interviewees noted that data sharing among ACOs, CPs, and SSOs and variation in the way care coordination was performed across organizations created a significant administrative burden, duplications of effort, and inefficiency. While MassHealth has provided significant infrastructure funding and technical assistance to CPs and SSOs, interviewees report that this support has not been sufficient to overcome the challenges noted. MassHealth could help ACOs, CPs, and SSOs alleviate this burden by creating standardized protocols outlining how organizations can more effectively share information and coordinate care.
- **Address Structural Elements That Hinder Partnerships in the Community Partners and Flexible Services Programs.** Interviewees noted several structural elements that hindered partnerships in the CP and Flexible Services Programs. To further strengthen the ACO program, MassHealth could continue to work with stakeholders to improve the CP Program and address some of the barriers to establishing ACO-SSO relationships, such as developing an ACO-SSO model contract template.

Despite the challenges to date, Massachusetts has had an experience similar to and in many cases more successful than those of other states implementing bold delivery system reforms. Although there is more work to do, there is also much that has been accomplished in the ACO program's early years. The trusting relationship between MassHealth and its stakeholders, the new or strengthened relationships among and across health care organizations and SSOs in the state, and the demonstrated commitment of health care organizations to improve care coordination and address HRSNs, are significant positive developments that bode well for further improving the ACO program and helping it reach its full potential.


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