

**One Care Implementation Council Meeting
The Boston Society of Architects – 290 Congress St.
Boston, MA
January 15, 2019 10:00 am – 12:00 pm**

Council Member attendees: Suzann Bedrosian, Dennis Heaphy (Chair), Crystal Evans, Jeffrey Keilson, David Matteodo, Henri McGill, Dan McHale, Dale Mitchell, Paul Styczko and Sara Willig.

Key Stakeholders and Support Staff attendees: Corri Altman Moore (MassHealth), Jennifer Baron (CMS), Maggie Carey (UMMS), Amanda Cassel Kraft (MassHealth), Daniel Cohen (MassHealth), Hilary Deignan (UMMS), Andrew Falacci (UMMS), Raymond Gomez (Tufts Unify), Josh Krintzman (CCA), Roseanne Mitrano (MassHealth), Jennifer Morazes (My Ombudsman), Holly Robinson (CMS) (by phone), John Ruiz (CCA).

Unable to Attend:

Handouts: Agenda; Draft minutes from December 11th IC meeting, MassHealth presentation, IC presentation *Discussion Points on Care Coordination and Network Adequacy*.

Documents will be available online at <https://www.mass.gov/service-details/one-care-implementation-council>

1) Welcome/Review of Agenda/Introductions

Paul Styczko, Implementation Council Member, opened the meeting and asked participants to state their name before speaking in order to help people on the phone and people with vision impairments.

2) Review of December 11th IC Meeting Minutes

Council Member asked the Council if there were any suggestions or concerns about the meeting minutes from the December 11th 2018 IC meeting. With no objections, the minutes were approved.

3) MassHealth Presentation:

Corri Altman Moore, MassHealth Director of Policy, delivered the MassHealth presentation to the Council. The presentation outlined the original Capitated Duals Demonstration from 2013 that includes One Care and also confirms the importance of the consumer voice in One Care. The presentation outlined One Care services, including care coordination. Additionally, the presentation described the Duals Demonstration 2.0 and the One Care plan re-procurement. The presentation provided a brief overview of what MassHealth is expecting from Plans in the re-procurement process.

- Council Member stated that the variations in what PCA services One Care covers versus what Medicaid covers can be hard to navigate for PCAs.
- Member stated that in union trainings, the PCAs are being told that they cannot provide services that the PCAs are supposed to provide for One Care members. The Member asked if there is a way to educate the PCA unions on the program differences in One Care, so they can appropriately train PCAs about the services they will be expected to provide for One Care members.
- Council Member asked MassHealth to consider helping the unions update their information on the additional services One Care covers beyond what services MassHealth covers. It would be beneficial to have the unions add a One Care element to their trainings.
 - MassHealth acknowledged there is confusion on what services are covered under Once Care and what services are covered by other MassHealth plans. There is a need to update the guidance and reinforce how One Care is different than other MassHealth plans since One Care Plans cover different services.
 - MassHealth explained their intent to provide a specific definition of the PCA roles in the new contract. The definition will include information on cuing and monitoring.
 - MassHealth hopes to work with the IC and the stakeholder community to create more guidance documentation for the PCA union trainings and other organizations to use during trainings.

- Council Member asked MassHealth how it plans to help assist individuals with cueing and monitoring if those individuals have trouble initiating care and expressing their needs in the first place.
 - MassHealth stated it plans to address the specifics of cueing and monitoring with the updated definition it will be writing. The PCA should also be able to help with these logistics, and the definition should help better prepare the PCA.
 - A member of the public stated there were not specific trainings on cueing and monitoring back in 2013 at the start of the demonstration. He said there were models for trainings reviewed from work done in the Intellectual and Developmental Disability (IDD) community, and that the documents could be reviewed, adopted and implemented now.
 - MassHealth also stated the One Care Plans think that the PCAs are providing cueing and monitoring, outlining a possible disconnect.
- Council Member suggested individuals need support to be able to advocate for themselves. Training PCAs may not be enough to fully educate individuals on the various services covered and the ways by which they can ask for those services to meet their needs. Some members may need support and training to advocate for themselves when working with their PCAs.
- Council Member suggested some people may need services not directly connected to the PCA. Connecting the guidance and training only to PCA services may not be effective in educating members on all the types of services offered.
- Member of the public asked what was causing the RFR delay and whether it would be possible to extend the date for when plans must be ready to cover One Care, so they can get things ready – such as a possible mid-year launch for 2020?
 - MassHealth explained the impact of the delay will be taken into consideration and will be addressed in the RFR materials when released.
- Council Member asked if MassHealth had decided on specific changes to policy on fixed and passive enrollment?
 - MassHealth has not come to any final decision and wants the current presentation and discussion to focus on what is expected of the Plans and what is outlined in the current demonstration.
- Council Member asked if MassHealth has a strategy to get more bidders than the previous procurement?
 - MassHealth stated they are expecting a good number of bidders. The first One Care demonstration had 10 plans submit bids, 6 plans entered into negotiations with 3 becoming One Care plans. The goal is to attract plans that are creative and flexible. There is also the opportunity for plans to cover areas of the state where there is no coverage now; MassHealth is hoping to expand One Care so it is state-wide.
- Council Member asked if Plans will be able to bid on One Care and SCO separately.
 - The procurements for One Care and SCO are separate, however MassHealth may give preference to plans already in One Care. MassHealth is hoping to bring

both SCO and One Care under demonstration authority – which right now only One Care is under.

- Member of the public asked if the IC would have a role in reviewing the bids for the Duals 2.0 demonstration.
 - MassHealth explained consumer members will be placed on a committee to review the programmatic responses to the RFR. The committee will meet with the MassHealth program management team and discuss the findings
- Council Member asked if there was an update on the IC Member procurement.
 - MassHealth is in the reviewing process and did not have an update at the time. MassHealth said there currently is a sufficient number of applicants.

4) Presentation on Utilization of One Care amongst the Homeless Population:

Henri McGill, IC Member representing Pine Street Inn, gave a verbal presentation on homeless populations and utilization of, and relationship with, the One Care program. Henri will be doing a more in-depth presentation on this topic at a future IC meeting.

The presentation discussed the impact of homelessness on the disability community. For example, an estimated 66% of the homeless population has self-reported a disability and an estimated 46% of the population has self-reported two or more disabilities. While these percentages are substantial, he said, 80% of the homeless disability population opted to not enroll in One Care.

The presenter reviewed that this introduces two opportunities for engagement. First, how can MassHealth and One Care better engage with the One Care eligible chronically homeless population – to encourage One Care enrollment? Second, how can MassHealth / One Care better engage and provide services to people before they become “chronically homeless” – perhaps preventing chronic homelessness?

- MassHealth asked if there is a clear understanding of why chronically homeless individuals are not interested in One Care? They asked if it was a fear of joining a new program?
 - Presenter explained there is some fear of One Care and some lack of education about what One Care provides. The biggest factor is likely that individuals value their provider relationship and for the homeless population this relationship might be the one constant in their life. For this population having to lose these important provider relationships can be enough to make them not want to join One Care. Additionally, a small percentage of this population are treated through the Boston Health Care for the Homeless Program through MGH and don't want to join One Care because they would lose access to their providers who are in Partners.

- Council Member suggested individuals may not understand what the One Care program involves because the language is not at a 5th grade reading level, which consumers often require.
- Council Member suggested that for the homeless population, One Care might feel like one more thing to deal with. The additional logistics of changing healthcare providers is burdensome, especially for this population that is constantly trying to arrange for a place to sleep / shelter space etc. There should be incentives – such as access to places to do laundry for free - to get more homeless individuals to sign up.
- Council Member mentioned how in her own experience 5 or so years ago one program serving homeless populations did not see people with disabilities as part of the service population – the organization only considered “homelessness” service needs. Additionally, she said she was not able to stay at a shelter with a therapy dog; people with disabilities need to have access to shelters and other services.
 - The presenter reported the shelter system has evolved around disability. Pine Street Inn and other shelters allow service dog / therapy dogs as an accommodation.
 - He also said the reimbursement rate for programs for the homeless population are also very low (for example the Community Support for People Experiencing Chronic Homelessness program (CSPECH) reimburses only \$17.30 per day). Yet the case managers at Pine Street have a minimum caseload of 10 people per month that must be seen to ensure payment of their salary. This is difficult.

5) IC Presentation Discussion on Care Coordination and Network Adequacy:

The Council Chair, Dennis Heaphy, led a presentation and discussion on care coordination and network adequacy. The presentation used data released on COMMBUYS by MassHealth in December 2018. Specifically, the presentation provided an overview of Plan spending in 2017, addressed a need to rebalance spending, initiated a discussion on action steps for information sharing and started a dialogue with the Plans to share additional data and further discuss care coordination and network adequacy at a future IC meeting.

- CMS asked what the relationship is between utilization and spending, and if there is a difference in the correlation between funds spent on services and utilization costs within the FFS and One Care models? She said it is important to look at the issue from the utilization perspective.
 - Council Chair stated the numbers do not tell the full story and pointed to the five-year trend specifically. The trend shows a reduction in utilization spending and should be considered.
 - CMS mentioned how in-patient BH services tend to be paid by Medicare (estimated at 40%) and that this could affect the numbers.

- Also, CMS stressed the importance of looking at the full picture - both utilization of peer supports and costs data.
 - For example, analyzing whether peer support services can help reduce the length of stay in the hospital setting.
- The representative from My Ombudsman explained how care coordination comes up a lot in the complaints received. Care coordination can help keep individuals out of the hospital setting, however individuals often don't know who their care coordinator is.
- My Ombudsman also stated they handled one call with an individual who wanted to change their care coordinator because the coordinator was not coordinating the member's care. The My Ombudsman office was initially told by the One Care plan that inadequate care coordination was not a justified reason for an individual to be able to change their care coordinator. My Ombudsman was able to change the coordinator for the One Care member eventually – and the member was very happy with the new care coordinator.
- MassHealth stated that while the data released does not depict the full picture, it does show we haven't understood the magnitude of community spending versus acute spending.
 - MassHealth said they intend to work with the Plans to have the Plans explain how they will bring in community supports to reduce acute care utilization.
 - Council Member suggested the presentation began to show a shift to community care from acute care, but suggested more data showing the shift is necessary.
 - Council Members suggested a MassHealth Dashboard would be helpful in making the data and outcomes more transparent and accessible.
 - MassHealth confirmed the intent to create a publicly facing Data Dashboard.
 - MassHealth asked to work with the IC to ensure the data displayed aligns with the IC's goals.
 - The Dashboard would incorporate data for the ACO program too, as the ACO data goals are closely aligned with goals for One Care. A comprehensive Dashboard should provide the IC and consumers with valuable data.
 - MassHealth added the ACO program has a lot of funding from DSRIP for updating systems.
 - Council Member stated One Care does not benefit from any DSRIP funds. This is a concern for the financial stability of the program moving forward. There is a need to be creative and go beyond the numbers to work towards health equity and to focus on members' goals. The IC wants to work with MassHealth to advance population health. Two core areas to focus on are care coordination and network adequacy.
 - MassHealth explained the Plans also have requirements and make annual admissions to Medicare when they submit for Medicaid covered services.

MassHealth determines how adequate the Plans are performing with these services.

- Council Member suggested the Council is not looking for the “letter of the law” but simply to hear from the Plans how they record what services in their network are being used and if how they identify networks gaps where members are not able to get services they need.
- MassHealth explained the Plans should be tracking items such as how many PCP offices are taking new patients within the Plans’ networks.
 - Council Member stated the IC is interested in the data and hopes the Plans will be able to present it to the Council.
- The CCA representative explained the questions and accompanying materials are helpful for the Plan in understanding what questions the Council has for the Plan to answer and what items the Plan should specifically address. Some of the items fall under contract requirements and those questions will be easier to answer. Other items have less data and will not be as easy to answer. Nonetheless, he said, CCA will look at ways to get information on the more population-based issues and report the finding.
- The Tufts representative explained its intent to help the Council but explained how the questions on equity and health disparities may be difficult to answer with the current data. He asked if the Council could discuss the request in more depth with the Plans to clarify the specific questions the Council is looking to have answered and what data the Council believes will answer those questions.
- The Tufts representative then suggested looking closer at BH, SUD and PCP policy to identify gaps. Tufts would also like to work with the Council to identify other elements the Plan can analyze deeper.
 - Council Member explained how care coordination, specifically LTS-C, within the Plans is critical to the shifting in spending patterns from acute spending to more community-based spending. He said the LTS-C role needs to be strengthened and more standards need to be added and that these standards should include performance outcomes, timeliness and consumer satisfaction.
 - Council Member supported looking into care coordination, utilization of LTS-C services and peer support for more information.

6) Public Comment:

- Individual from Boston Center for Independent Living (BCIL) emphasized the need for improvement in the LTS-C role and strengthening of the program. He said it may be helpful to hear directly from those individuals performing this service.
 - Council Member asked if individuals within BCIL have input on care coordination and if there is any information to be shared.
 - Council Member explained the Behavioral Health Community Partner (BH CP) program from Boston Community Health for the Homeless has already seen an increased rate of participation by individuals who have care coordination. The

Council Member also mentioned how these individuals sometimes receive help from outside service agencies separate from their Plan. They said the Plan then reimburses the agency for the services provided. Additionally, it will be important to analyze the services members receive from providers outside of the network or the program, as members often have existing relationships outside of the One Care program. He said there is a need to design the program to allow members to receive services outside of the program designated network, so they can continue working with their desired provider without having to leave the One Care program. For example, a care coordinator may need to help facilitate a member's services with an out of network BH provider. Doing so may require expanding the definition of care coordination in One Care to allow coordination outside of the Plans' networks.

- Council Member stated it is important to determine who does care coordination for the Plans (for example does the care coordinator need to be a nurse). Council Member wanted to understand how flexible the care coordination role is for Plans. Additional questions include:
 - How is the care coordination done?
 - How many members does a care coordinator work with?
 - What is the care coordinators role in the care team?
- Council Member suggested questions to add to the list:
 - What is the turnover rate the Plans experience in care coordination?
 - Are there ways of getting data on continuity of care?
 - Would it be helpful to have data on continuity of care?
- MassHealth suggested it would be helpful for Council Members and MassHealth to have a phone call with Plan Representatives to discuss items such as:
 - What are the differences in needs members have for coordination for behavioral health verses medical needs?
 - Are there issues with care coordination capacity?
 - Council Member confirmed that a call between the plans, MassHealth and the Council chair is planned.
- Council Member asked if the Plans know if a member's care coordinator is in communication with the member while the member is in a BH hospital?
 - Tufts explained there is no pre-authorization and the care coordinators would require a notification of the member receiving inpatient services to provide additional coordination services.
 - Council Member stated it would be important to learn if the member is seen by the care coordinator while in the hospital or when discharged.
- Council Member suggested continuity of care is an additional point to gather information– specifically, how care transitions are performed.

- Council Member explained individuals with high BH needs require advocates to help delegate care coordination. CCA has started a pilot program to delegate these services for individuals with BH needs. Often, it is helpful when individuals see a clinician in both the in-patient and out-patient settings.
- Council Member suggested the method for the work with the Plans is to set goals instead of requirements, which allows creativity and flexibility. It also leaves areas to build incentives into the contract for value-based payments and other creative programming.
- CMS explained there will be space for more individualized approaches and innovation and that Plans will have flexibility contracting with their own providers to run creative programming.
- MassHealth explained the MassHealth presentation will be posted as part of the Implementation Council materials soon.

The Upcoming meetings were announced, and the meeting was adjourned:

Tuesday February 12, 2019

10:00-12:00

Boston Society of Architects (BSA)

290 Congress Street

Suite 200 – Pearl Street Conference Room

Boston, MA 02210

Tuesday March 12, 2019

10:00-12:00

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