

Meeting Minutes July 9, 2019 – One Care Implementation Council Meeting

Meeting Location: The Boston Society of Architects – 290 Congress St., Boston, MA

Date: July 9, 2019 10:00 AM – 12:00 PM

Council Member attendees: Francesca Abbey, Crystal Evans, Dennis Heaphy (Chair), David Matteodo, Henri McGill (by phone), Dan McHale, Paul Styczko, Alicia Verlager, Sara Willig, Darrell Wright

Key Stakeholders and Support Staff attendees: Corri Altman Moore (MassHealth), Jennifer Baron (CMS), Maggie Carey (UMMS), Hilary Deignan (UMMS), Raymond Gomez (Tufts Unify), Jennifer Morazes (My Ombudsman), Whitney Moyer (MassHealth), Leah Smith (CCA)

Unable to attend: Suzann Bedrosian, Cathleen Connell, Elizabeth Jasse, Jeffrey Keilson, Dale Mitchell, Chris White

Handouts: Agenda; Draft minutes from June 11, 2019 IC meeting, CMS presentation, Health Care for All Presentation

[Documents available online](#)

Executive Summary and Action Items:

Implementation Council Elections

The Implementation Council elections for Chair and Vice Chair(s) will be held during the October Council Meeting. The Council expects that the current leadership structure will continue, with one Chair and two Vice Chairs who work together to set priorities and plan meeting agendas, unless the Council would like to restructure this.

One Care Demonstration Evaluation Update

Jennifer Baron from the Medicare-Medicaid Coordination Office at Centers for Medicare and Medicaid Services (CMS), presented *Evaluation Update: One Care Demonstration under the Financial Alignment Initiative* PowerPoint that summarized the qualitative and quantitative One Care evaluation results that were released in May 2019. The evaluation is based on data from 2015 and 2016.

Oral Health Presentation

Neetu Singh, DMD, MPH, the Oral Health Program Director for Health Care for All (HCFA), presented *Reducing Health Disparities by Integrating Oral Health into One Care 2.0*, advocating the health benefits that would result from full integration of oral health into the One Care program.

Action Items:

- The Council will have further discussions on how to create closed communication loops between providers and to develop oral health quality measures.

Next Steps with Plan Presentations

Dennis Heaphy, Implementation Council (IC) Chair, stated that the Council will continue the conversation with Plans and MassHealth about care coordination, care integration, and quality measures over the next few months.

Action Items:

- The Council plans to develop a strategy for how to work more closely with the Plan Consumer Advisory Councils (CACs).
- The Council will work with the Plans and MassHealth to develop a strategy for how to best get answers to the Councils remaining questions from the case study presentations.

IC Work Group Opportunities

Dennis Heaphy, IC chair, stated that the Council is interested in creating work groups that will start meeting by October. The purpose of the work groups would be to ensure that all IC member priorities are represented in the Council priorities. The work groups will create action steps that can

be implemented by the Council. Work group topics might include women's health, operationalizing health equity, and addressing health disparities.

Action Items:

- The Council will meet in August without the Plans or MassHealth to discuss creating workgroups.

Meeting Minutes:

1. Welcome/ Meeting Minutes

Paul Styczko, Implementation Council Member, opened the meeting. With no comments, the June 11, 2019 Implementation Council meeting minutes were approved.

2. One Care Demonstration Evaluation Update

Jennifer Baron from the Medicare-Medicaid Coordination Office at Centers for Medicare and Medicaid Services (CMS), presented *Evaluation Update: One Care Demonstration under the Financial Alignment Initiative* PowerPoint that summarized the qualitative and quantitative One Care evaluation results that were released in May 2019. The evaluation is based on data from 2015 and 2016.

- Council Member asked how the CMS findings align with the State findings? The state findings showed some savings on Medicaid spending which wasn't evident in the CMS presentation.
 - CMS stated that there is a lag in these evaluations - the data used for this CMS evaluation is from 2015/2016. Additionally, the Medicare cost data used in this evaluation report is based on the adjusted rate that CMS pays to the plans which is different than the actual plan costs. Therefore, there is not a direct link to service utilization or plan spending on home care and inpatient care.
- Council Member asked if there was any analysis of claims to see what the costs would be if services were provided fee for services (FFS) versus through One Care.
 - CMS confirmed that there is no FFS comparison done. The evaluation uses the out of state comparison group.
- Plan Representative asked if CMS had any theories as to why the evaluation showed an increase in inpatient hospitalizations.
 - CMS stated that there are a lot of theories about why this might be. One explanation could be that One Care has a more gradual approach to enrollment compared to the other states in the comparison group. This evaluation is looking at a period of time and not following a cohort of enrollees to follow utilization over time. Increased costs and inpatient hospitalization can be needed to stabilize new enrollees.
 - CMS will potentially try a different approach to how they analyze this data for Duals 2.0.
 - CCA has analyzed how service utilization looks for a cohort of enrollees over time, but CMS has not validated that data.

- MassHealth suggested that one unique feature of One Care is that the demonstration focuses on people with disabilities aged 21 – 64. Many programs serve populations that are 21 and older (with no age limit) or that are over 65. Perhaps there is something about the target age group of One Care enrollees that gives different results on the evaluation.
 - CMS clarified that the comparison group for the evaluation was people under 65.
- Plan Representative asked if there were any specifics about how Medicaid data could be incorporated in the evaluation in the future.
 - CMS stated that it is difficult to get Medicaid data from states at this time making it difficult to compare One Care Medicaid data with comparison Medicaid data from other states. There is a transition right now on how CMS gets data from the states which is creating quality issues – and that is what is holding up this process.
- Council Member asked if CMS is responding to the lack of Medicare savings and / or losses that were found in this report?
 - CMS made some changes to the rates around the time of the evaluation including the savings percentage attached to the rates and the cap to rates paid to plans – so the results of the evaluation were not a surprise to CMS.
- Ombudsman asked whether the comparison group used for the evaluation matched for things like the number of Deaf individuals.
 - CMS stated that the comparison groups were matched for geographic characteristics, demonstration type and enrollee age but there was not a diagnosis comparison. The assumption was that the prevalence of specific conditions (such as epilepsy) or the proportion of Deaf enrollees would be similar in the comparison groups.
- Council Member stated the report findings provided mixed feedback in regard to enrollee access to services and providers working as a team. It was also reported that enrollees had concerns about One Care staff turnover. This remains consistent with what the Council has heard from members.
- Council Member thought it would be helpful to compare authorizations for non-medical / home-based services with emergency department and inpatient visits. Council Member also suggested CMS break the data down by race and gender.
- Council Member asked if it was possible to do comparisons of the data by risk category?
 - CMS stated that the evaluation has not looked at data by risk category. The evaluation does not currently break the data down as granularly as is being suggested.
- Council Member asked if CMS has any recommendations on how to address some of the issues observed in the report such as the emergency department visits?
 - CMS stated that some of the issues in the evaluation have been addressed since 2016. For example, the increase in inpatient hospitalizations was due to the need to stabilize members when they first join One Care. To this point, there was notable improvement in the number of inpatient hospitalizations in 2016, compared to

2015. It is also important to note that this evaluation tool is meant to look at the One Care program broadly – and not for making specific programmatic changes.

- Council Member asked if it would be possible in the future to break down data to differentiate between new enrollees in need of stabilization versus long-term members.
 - CMS stated that the format of the data for the evaluation cannot do that comparison, but that breakdown could come from other data sources such as MassHealth or the Plans.
- Council Member acknowledged that hospitalizations among new One Care members would be understandably high but hypothesized that emergency department and inpatient visits are reduced for long term One Care enrollees.
- MassHealth agreed that a cohort comparison looking at new enrollees versus long term enrollees would be useful. Reducing churn and creating stable MassHealth enrollment status for members would also likely help with these outcomes.
- Council Member asked how we can show that One Care is working when we don't have any data showing, for example, a reduction in in Emergency Department visits and hospitalizations over time.
 - MassHealth stated that while there is not independently verified data at this time showing the success of One Care there is early plan-level analysis that points in that direction.

3. Oral Health

Neetu Singh, DMD, MPH, the Oral Health Program Director for Health Care for All (HCFA), presented *Reducing Health Disparities by Integrating Oral Health into One Care 2.0*, advocating the health benefits that would result from full integration of oral health into the One Care program.

- Council Member asked if the high utilization of the emergency department (ED) for dental issues could be due to the high number of hospitals in Massachusetts?
 - HCFA stated that the high ED utilization rates were more likely due to a lack of dental insurance or of available dentists.
- Council Member asked if the high rates of young adults with going to the emergency department for dental issues was due to diet or something about our culture?
 - HCFA stated that diet and cultural factors could influence the high ED utilization rates but that lack of coverage is probably the overarching issue. The American Dental Association and the Dental Quality Alliance are considering how to evaluate risk-based care depending on a person's risk for dental conditions.
- Council Member stated that oral health should be part of the annual assessment done for One Care members. Would closing the feedback loop be accomplished by having the dentist communicate to the PCP what was seen at the dental visit?
 - HCFA agreed that closing the feedback loop would require the dental provider to tell the PCP that they saw you, explaining what they saw during the visit, and then sharing dental care recommendations.

- Council Member asked if the care plan should be changed as a result of the dental providers report to the PCP (for example: need to fill 3 cavities, train the PCA on oral health etc.).
 - HCFA stated that this information should be reflected in the care plans. Additionally, the communication should go both ways – with the dentist communicating about oral health with the PCP and the PCP communicating medical needs to the dentist including medications and medical conditions that the enrollee has.
- Council Member suggested that there are a number of barriers to dental care for people with disabilities. For example, people with developmental disabilities or anxiety may need sedation during dental work. Similarly, people with physical disabilities often cannot physically access dental offices.
 - HCFA acknowledged that these access barriers are difficult issues to address in the dental community.
- Council Member suggested that access to dental care should be a One Care quality measure.
- Council Member stated that the issues with getting care that is appropriate for the disability population may lead to lower participation in oral health.
 - HCFA agreed that any dental practice caring for One Care members should have training on caring for high need populations. There is significant room for improvement in provider education around caring for high need / complex care populations
- Council Member stated that there is a need for American Sign Language (ASL) interpreters for the Deaf population to ensure access to oral health care.
- Council Member asked what percentage of oral health providers accept MassHealth / One Care payment.
 - HCFA stated that the shortage of dental providers that accept MassHealth is most pronounced in Western MA and on Cape Cod and the Islands.
- Council Member asked if there have been any discussions in the medical and dental professional organizations about finding ways to close to communication loop – such as shared access to Electronic Health Records (EHR). There is currently no infrastructure for this communication.
 - HCFA agreed that it can be a challenge getting providers to communicate across systems for many reasons but stated that Boston Healthcare for the Homeless is a good example of how shared EHRs and communication can happen between dental providers and medical providers. Quality Measures can also create incentives for collaboration.
- Council Member asked if MassHealth cover sedation dentistry for adults? Is this even an option?
 - MassHealth stated that this is an option for One Care members who necessitate sedation for oral health care. Dental anesthesiologists should be available in One Care networks.

- Council Member asked the best practices for ensuring dentists are working closely with medical providers.
- Council Member stated that bi-directional care will require a more formal partnership between medical and dental care providers. Council Member suggested the Council should have further discussions on how to create closed communication loops between providers and to develop oral health quality measures.

4. Next Steps with Plan Presentations

Dennis Heaphy, Implementation Council (IC) Chair, stated that the Council will continue the conversation with Plans and MassHealth about care coordination, care integration, and quality measures over the next few months. The Council will work with the Plans and MassHealth to develop a strategy for how to best get answers to the Councils remaining questions from the case study presentations. The Council also plans to develop a strategy for how to work more closely with the Plan Consumer Advisory Councils (CACs).

5. IC Work Group Opportunities

Dennis Heaphy, IC chair, stated that the Council is interested in creating work groups that will start meeting by October. The purpose of the work groups would be to ensure that all IC member priorities are represented in the Council priorities. The work groups will create action steps that can be implemented by the Council. Work group topics might include women’s health, operationalizing health equity, and addressing health disparities.

- Council Member suggested that the Council meet in August without the plans or MassHealth to discuss creating workgroups.

6. Public Comment:

- MassHealth stated that conversations about leadership structure of the Implementation Council need to happen prior to elections.
 - The IC elections will be during the October IC Meeting. The Council expects that the current leadership structure will continue, with one Chair and two Vice Chairs who work together to set priorities and plan meeting agendas, unless the Council would like to restructure this.

The meeting was adjourned; future meetings are planned for

Upcoming Meetings:

Tuesday September 10, 2019

10:00-12:00

Boston Society of Architects (BSA)

290 Congress Street

Suite 200 – Pearl Street Conference Room

Boston, MA 02210

Tuesday October 8, 2019

10:00-12:00

Boston Society of Architects (BSA)

290 Congress Street

Suite 200 – Pearl Street Conference Room

Boston, MA 02210