

DRAFT Meeting notes from July 31, 2018 Special IC Meeting

*Special* One Care Implementation Council Meeting

*Duals Demonstration 2.0: What Should We Be Asking For?*

One Ashburton Place, 21<sup>st</sup> Floor, Boston, MA

July 31, 2018 10:00 am – 12:00pm noon

Council Meeting attendees: Suzann Bedrosian, Dennis Heaphy (Chair), Jeff Keilson, David Matteodo, Henri McGill, Dan McHale, Dale Mitchell, Paul Styczko, Howard Trachtman (on phone), Sara Willig.

MassHealth, Key Stakeholders and Support Staff attendees: Corri Altman Moore (MassHealth), Maggie Carey (UMass), Daniel Cohen (MassHealth), Hilary Deignan (UMass), Andrew Falacci (UMass), Liz Goodman (MassHealth), Annika Grassl (DPC), Bill Henning (BCIL), Joshua Krintzman (Commonwealth Care Alliance), Colin Killick (DPC).

Handouts: Agenda, which will be available online at <https://www.mass.gov/service-details/one-care-implementation-council-0>

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### 1) Welcome/ Introductions

- a. One Care Implementation Council Chair Dennis Heaphy opened the meeting and introduced himself and asked that attendees (at Ashburton and on the phone) also introduce themselves.

### 2) The Chair reviewed a few of his concerns about Duals Demonstration 2.0 proposal for One Care, including:

- a. The one-year **lock-in** - MassHealth had proposed a one-year lock in at the beginning of One Care and the disabled community advocated against it.
- b. The emphasis on **enrollment to scale** as One Care grows; if not done well, it will mean **reduced person-centered care**. Other feedback at the meeting on this topic included:
  - i. One IC member discussed the need to keep focused on person-centeredness and procedures to help members get aligned properly to the right One Care Plan. He said that in the waiver populations, there was a lot of misalignment.
  - ii. Another member expressed concern that as One Care grows, the ability of the Plans to manage a *real*/person-centered planning process is reduced.
  - iii. The member further stated that guidance from MassHealth to the Plans on how to manage person centered planning would be useful, including caseload maximums and identifying the Plans' process of managing value-added supports to members (to reduce isolation, for example). He said, if there was a choice between guidance and creating a criteria for Plans to be judged on, he recommends guidance, so the Plans can be creative with how to implement the supports. The Chair offered that this should fall under what is currently called "community services", as should PCA cueing and prompting.
  - iv. One member said there is inadequacy of opt-out provisions for passive enrollment.
- c. **Quality measures** that seem to focus inordinately on return on investment and not a broader array of quality measures for all populations in One Care.

### 3) Maggie Carey from UMass reviewed the questions that IC leadership created for this discussion; sub-questions are also listed for Part I. Comments received from meeting participants are recorded below under each question.

#### *Part I: What criteria should MassHealth use for the One Care Duals Demonstration 2.0 Plan selection?*

##### Question 1: How can MassHealth use the IC more in Plan selection?

- a. One attendee said consumer input was important, particularly for IC members, and that they should be "at the table." He said in past years, consumers were respected and engaged with EOHHS.
  - i. EXAMPLE: A Plan has approached BCIL to talk with consumers about One Care and cultural competence to prepare for an application for Duals Demonstration 2.0. He said he was pleased about this but fears there may be no guarantee that an adequate level of consumer involvement will continue. He said **IC representation on cultural competence is important**.
- b. He continued with how the **definition of PCA services** came about and said in 2012 or 2013, there was a lot of discussion about PCA services (referred to as cueing and prompting) which resulted in using the term "**monitoring**". But he was not clear if this had been implemented.
- c. Another member agreed and said the program had not been implemented.

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- d. A member suggested there needs to be synergy between consumers and MassHealth **through the procurement.**
- e. A member suggested that best practices have been routine for many years and that people have learned from them. He said the best way to grow One Care is for **One Care Plans to support the member expanding their community of supports** and would like to see that as one of the criteria for Plans.
- f. One Member said that assistive technology and DME are currently separated which makes it difficult for her to figure out which agency to go to. She suggested **assistive technology be treated like DME.**
- g. The Chair suggested that this issue needs to be included in the criteria for Plans, particularly the issue of how Plans will address the disconnect between DDS and DMH. In addition, he suggested that access to technology in One Care should not be tied to employment, which is currently a Mass Rehab requirement.
- h. One member suggested that MassHealth should be using the IC more, especially in **plan selection** and that this should be a key part of the IC agenda for the next 1.5 years. He added that **a good portion of the IC agenda each month's meeting should be devoted to the development topics** that MassHealth thinks are important. He hopes MassHealth would want feedback and use the IC separately from the usual public policy process. Other suggestions for the relationship between MassHealth and the IC:

EXAMPLE: MassHealth is given 10 minutes each month at the IC meetings for updates, but these should be a larger proportion of these meetings. He said that making major changes to One Care and SCO are priorities.

EXAMPLE: The IC spent a lot of time with MassHealth discussing the nuances of passive enrollment because it was very important; MassHealth benefitted and so did the IC.

EXAMPLE: The other issue that may need discussion with the IC is **how to get more providers into One Care.**

- i. The Chair agreed and said that this also was relevant to provider adequacy, especially for those members needing behavioral health care. Another member said that the **low number of behavioral health providers** in One Care would be a good discussion for the IC and MassHealth.

### Question 2: How will MassHealth recognize problems with network adequacy (e.g., member surveys by region & by special populations and to analyze vendor capacity)?

- a. Specifically, the Chair asked about network adequacy and asked if the "bar should be lowered" in rural areas.
- b. Two members spoke up and both said that that the bar should not be lowered.  
EXAMPLE: One member noted there is limited access to specialists in the only ACO in Berkshire County. He said the ACO did not have adequate specialists, which required members travel to Boston for care. But given the complexities of some specialties, that made sense to him.
- c. There was also a discussion around the importance of specialists.  
EXAMPLE: The member's PCP may not necessarily be the most important relationship, so it is important to include specialists with whom a member may see more frequently.
- d. Regarding network adequacy, a member said he is concerned that if payments from MCOs to providers is not adequate, it will have an impact on provider participation.

**Question 3: What should Plans have to show MassHealth that assures person-centeredness *and* that they are maintaining and improving the One Care model?**

- a. One member expressed concern about elders not in the Frail Elders Waiver (FEW) but who receive home care services. If they are passively enrolled into SCO, they may be deemed “community well” and possibly lose their LTSS services they receive through the state home care program.
- b. An attendee said that a DPC survey revealed that about one-third of One Care members do not know about **care coordination** and did not feel in control of their care and, subsequently, had worse outcomes.
- c. A member said One Care **Plans should include one person who oversees facilitating the person-centered care plan process for members, with a maximum caseload of 50.**
- d. A member suggested value-added supports for members, like **community services and increasing community networks**, to decrease the likelihood a member would experience isolation.
- e. The Chair asked about how to make sure the new One Care will require Plans to ensure that people who need services (in rural areas for example) get what they need, even if it is out of their service area.

EXAMPLE: A member with muscular dystrophy had a provider who did not know the intricacies of how best to care for his complex disease, hence the importance of making sure the out-of-network options stay available for members with complex medical or behavioral health needs. This reinforces the need for the care team to be involved to make recommendations in consultation with the member (person-centered care). The Chair said the two issues are to preserve existing relationships between members and their providers but if a member’s condition requires additional expertise, there is the option of getting out-of-network care.

- f. Another member said the **tele-medicine in Tennessee is something to emulate here** since there are not enough specialists in rural areas of the state. He said this is important as One Care expands.
- g. A member asked if the **person-centered care plan gets “committed to paper”** so that everyone understands the framework, which will provide “teeth” to the care plan. He hopes that the anecdotes shared become standard and believes that flexibility from Plans and being financially feasible are possible.

**Question 4: How can Plans demonstrate cultural competency to MassHealth? (e.g., people in recovery, people with conditions that lead to isolation, people with housing and other challenges).**

- a. One member suggested **having universal reasonable accommodations forms** (due to language and healthcare literacy differences) to help consumers. She suggested to keep the form simple (check a box to indicate “this is what I have and this is what I need”). The member will share a form with the IC.
- b. Another member agreed and suggested that **text alerts to members about forthcoming notices from Plans or MassHealth** be used. He said many One Care members, especially those who are homeless, may not have access to emails and/or their address changes - but they do have cell phones.
- c. A member suggested that there needs to be more **feedback on assistive technology** (video or audio).

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- d. Another member suggested that **advanced technology be connected with DME** since currently it is difficult to navigate and is often better for members who work and therefore connected with DMH and DDS.
- e. A member suggested using more advanced technology, as well as providing training, for members who need it. Suggestions included town halls, mail, and web site enhancements, as the goal is to communicate with all populations.
- f. One Member suggested that there needs to be a new definition of “disabled” since a person with a disability has a different perspective than some providers on what it means to be healthy.  

EXAMPLE: *Physical* functionality should not be the only measurement used to determine health. People with disabilities should not be treated as if they have poor health outcomes (or limit their services) because some definitions of wellness do not meet medical criteria.
- g. One member reported that there is **robust peer support** and that the Plans also need to **support an individual’s self-advocacy skills**.
- h. Another member suggested the Plans offer MassHealth proof of how they are working with diverse communities and how they are using peer supports *now*, not what they plan to offer in the future. This will be an adequate measure of what they are willing to do in the future.
- i. Another member said she sees progress with working with the deaf community but wondered about **progress for the LGBT communities**.
- j. Another member added that he is concerned with **network adequacy for individuals who have autism**.
- k. The Chair said it is important to find out what the Plans are currently doing to ensure their providers have **accessible exam tables, accessible bathrooms** (for disabled members and those who are in the LGBT communities).

EXAMPLE: A member described examples of inadequate exam tables and exam equipment only coming in one size, which is limiting.

### Question 5: How can Plans address service gaps in LTSS and in promoting the recovery model? How can SDOH be included?

- a. One audience member said the biggest issue outside of healthcare is **housing** and that the higher rents throughout Massachusetts had made this situation even worse. He continued to say that referrals to BCIL or Home Start is not the solution and a more creative way is needed.
- b. He continued and asked about mechanisms in One Care (currently) that are linked to housing assistance and asked what Plans can do to address housing needs of members. He said that currently it is piecemeal and suggested that assistance needs to be coordinated and asked if Plans will help members stay in their homes (with **home modification**).
- c. An IC member said housing retention is *not* the first step; instead, Plans should work with the social service agencies to work with the member to find housing. He also said there needs to be more flexibility in paying for services that are helping members find adequate housing.

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EXAMPLE: Pine Street Inn provides outreach and housing searches through a private foundation.

EXAMPLE: In the ACO rollout, there is funding from DSRIP that is considered flexible dollars that are not attached to a medical procedure or diagnosis (need for air conditioner in home for asthma control which reduces ED visits).

- d. Another member told the story of how a Plan (in another state) made the commitment to a member for electronic devices to support the member's independence. He asked, what is the One Care plan proposing to support **flexibility in responding to a member's needs?**

EXAMPLE: A man just lost his wife and then his dog and had too many stray animals in his home. Because the Plan had flexibility and had the option to make decisions "in the moment," the Plan got the member to an animal therapist to address his grief and keep him in his home.

- e. The Chair asked if this was an example of some members having a multitude of challenges and if the health conditions were taken one by one, the member may not meet the threshold of medical necessity but combined, the member does.
- f. The member said it was not a cart blanche system of getting whatever the member wanted but a focus on having the member maintain a home in the community, live independently and reduce the risk of isolation. He also said the care plan for members should be done in the context of real person-centered care.

EXAMPLE: Another member relayed her story of requesting an i-Pad but since that was too expensive, the Plan offered a PC, which remains incompatible with everything she has and is unused. She said services offered should meet the member's needs and not defined by external criteria that has nothing to do with the member.

EXAMPLE: Giving a member a urine bag that ends up leaking and causing more health issues.

- g. One member said that **Plans being flexible (with services) is a good way they can address the service gaps in LTSS and promote the recovery model.**

EXAMPLE: Day-habilitation may be appropriate for some members, but it should not be the "catch-all" for all members. He says it should be determined on an individual basis, using a person-centered planning process. He also asked about the role of the Plans ensuring quality when a provider refers a member to Day-hab.

- h. One member suggested that it would be helpful to **have LTSS and/or the LTS Coordinator as an opt-out service** for members. If the member does not need LTSS, s/he can opt-out.

## Part II: What contract requirements should MassHealth have for the new One Care Plans?

- a. The Chair suggested that the three-way contact (between MassHealth, CMS and each Plan) include the requirement that **Plans support or fund housing searches;** and for Plans to demonstrate steps

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they will take to reduce the homeless rate for members. He also said services like connecting with social service providers will help members with housing searches.

- b. Another member pointed out that there is a high recidivism rate for members with behavioral health issues which is one of their biggest problems. He said a patient can only stay in-patient for 7-10 days but then needs a place to go to or they become homeless. He hopes the Plans can step in to help the member and to **decrease recidivism**.
- c. The Chair suggested that Plans be more **accountable for the care transitions** from institutional settings. He said it is already included in One Care but perhaps it is time to ask if it is working well.
- d. The Chair added that the care teams responsible for continuity of care are not currently involved in the care planning at the member's discharge and suggested this can be part of the three-way contact.
- e. The Chair and another member talked about the web sites and how they need to be more "friendly" and perhaps consolidate them. They suggest an **improvement in web site accessibility**.
- f. The Chair and an IC member discussed the need for the **payment structures for Duals Demonstration 2.0 not adversely affect network adequacy**. The member said that from the beginning of One Care, there were issues in the provider networks and while they have improved, he said, the underlying issue was the financing. He proposed that the improvements like setting the capitation rates are to be embraced and will attract MCOs. Conversely, he said, the proposal to limit how Plans pay providers is an obstacle for providers and MCOs engaging in One Care.
- g. Another member offered wisdom from her elderly aunt who advocated thinking "outside the box." The member suggested that providing One Care members with sufficient care *and* paying providers adequately should be the goal.

MassHealth's Corri Altman Moore asked IC members to look for an email from MassHealth asking about their plans to either continue with serving on the IC or leaving. She said she wants everyone to stay but appreciated knowing their plans.

The IC Chair thanked everyone for their participation. He asked that current IC members think about inviting new members. He added that he has been doing this type of leadership role for 20 years, so IC members should think about new members for leadership.