One Care Implementation Council discussion points

JANUARY 15, 2019

Today's Agenda:

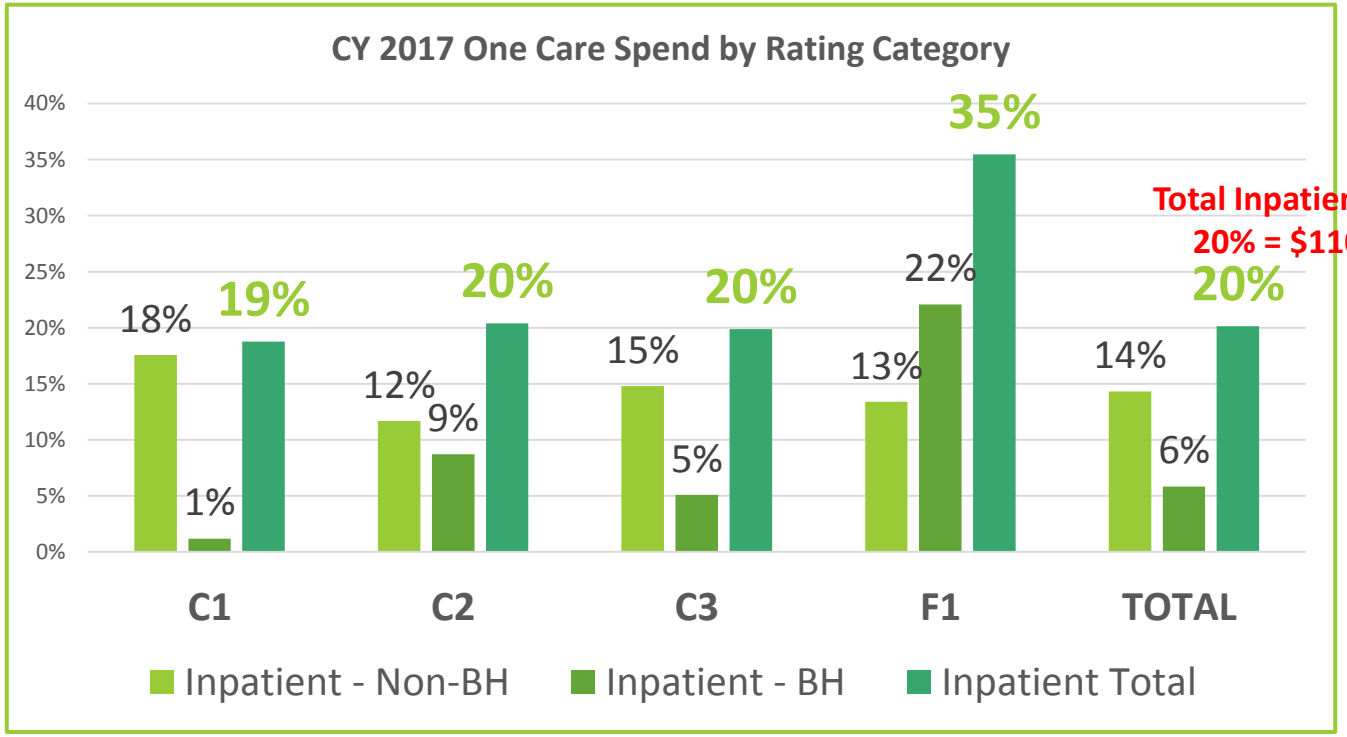
- Provide an overview of Plan spending in 2017 as background for need to shift spending into the community, away from institutions.
- The initial goal is to discuss initial action steps to move the process of information sharing forward.
- There are no expectations that plans will provide specific data today;

Why Health Equity?

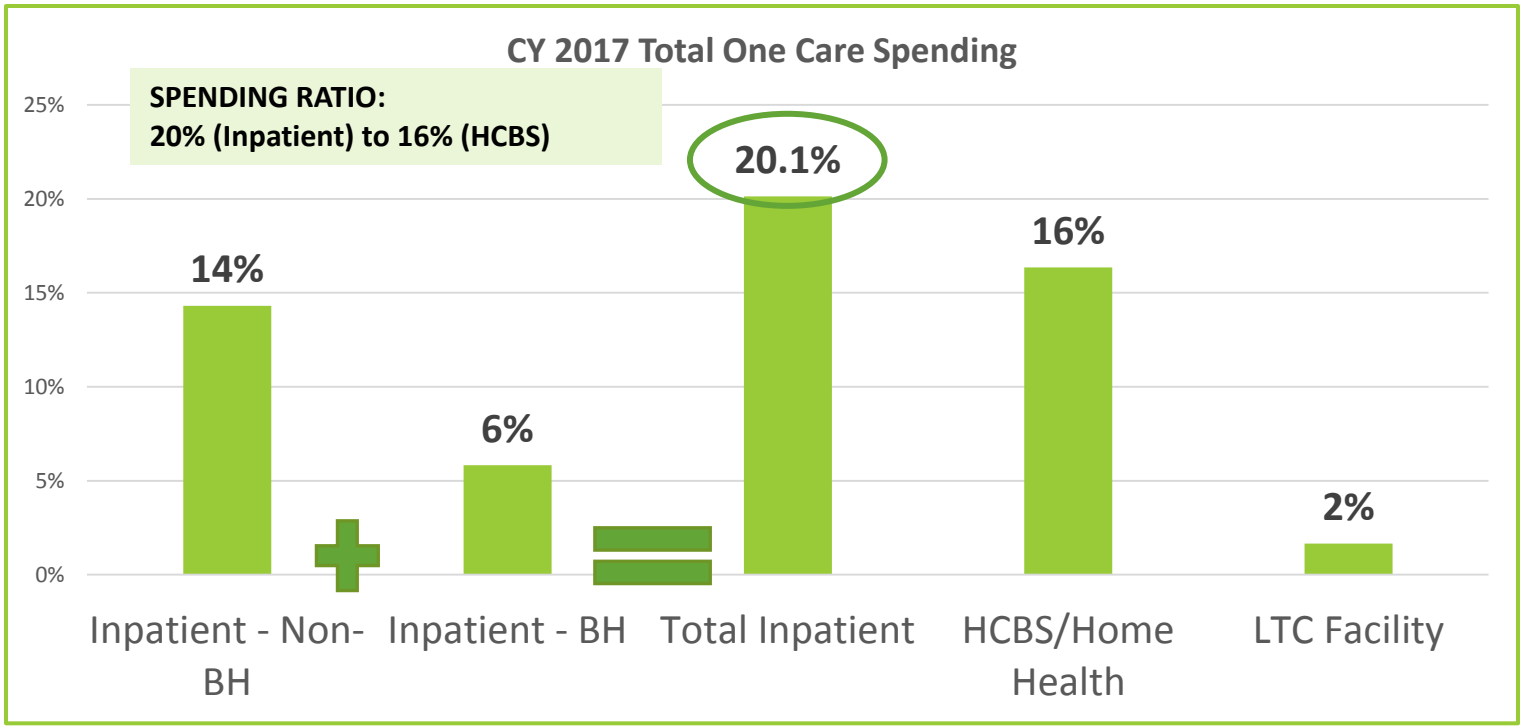
- ✓Rebalancing in spending by Plans remains limited.
  - ✓Spending on institutional care remains high.
- ✓Limited rebalancing in spending is in part due to the ongoing FFS contracting practices by plans with providers.
  - ✓PMPM rates do not incentivize innovation.
  - ✓Alternative payment methodologies have the potential to support innovation
- ✓A population focus can move the needle on equity as well as bending the cost curve.
  - ✓Care coordination in collaboration with CBOs to advance common goals can advance equity in health and wellness at the community level.
  - ✓Proactively shaping networks around population needs can advance equity

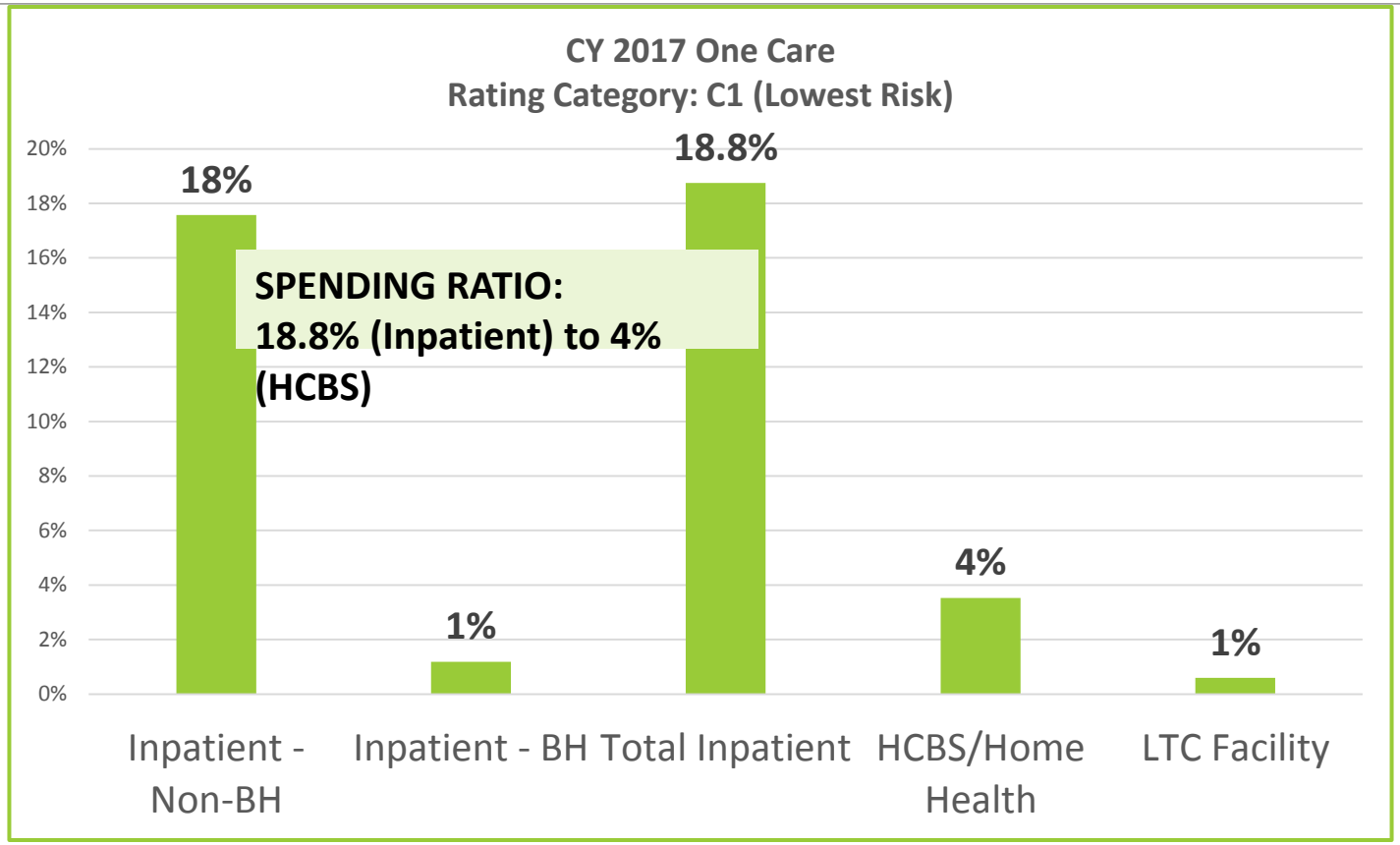
The following slides contain data based on the Massachusetts Executive Offices of Health and Human Services Databook (Dec 2018)

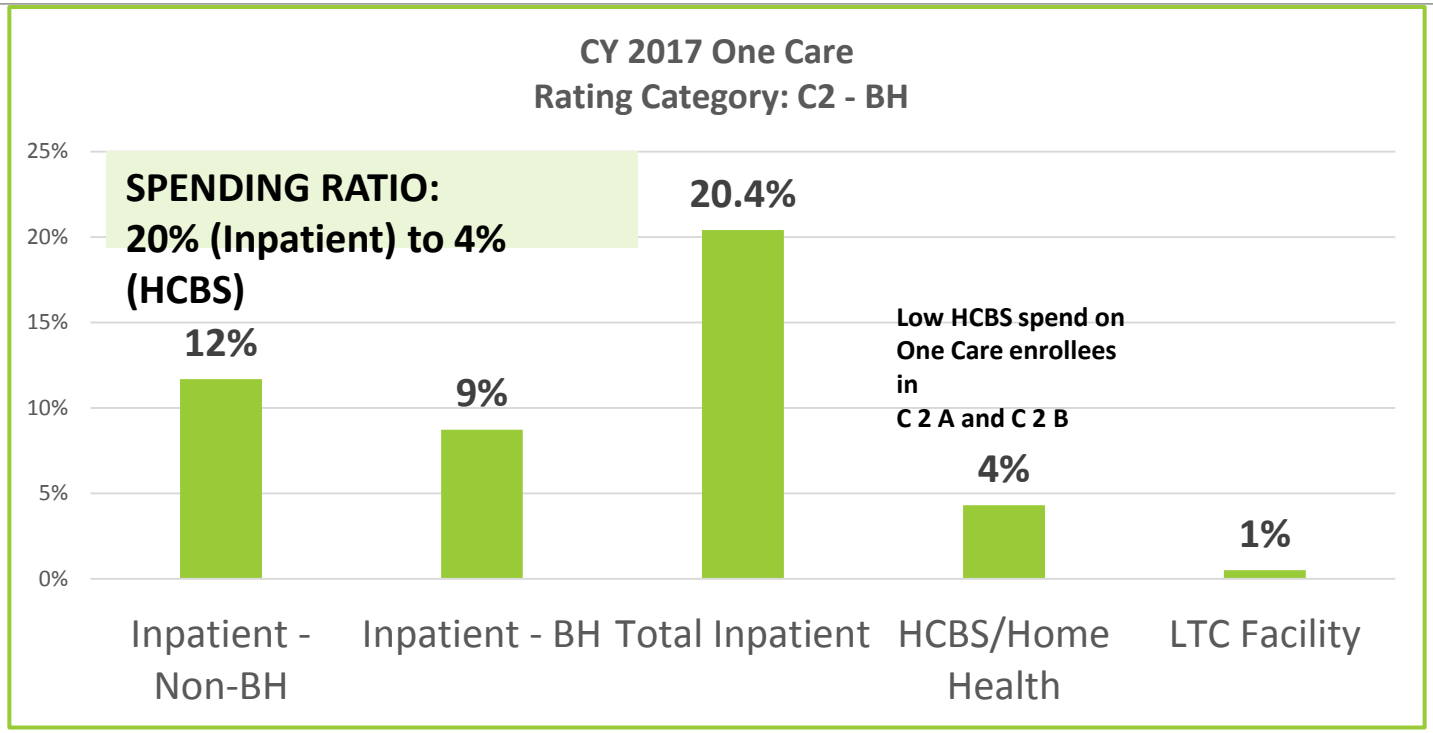
Can we spend less on inpatient and expand the community delivery system?

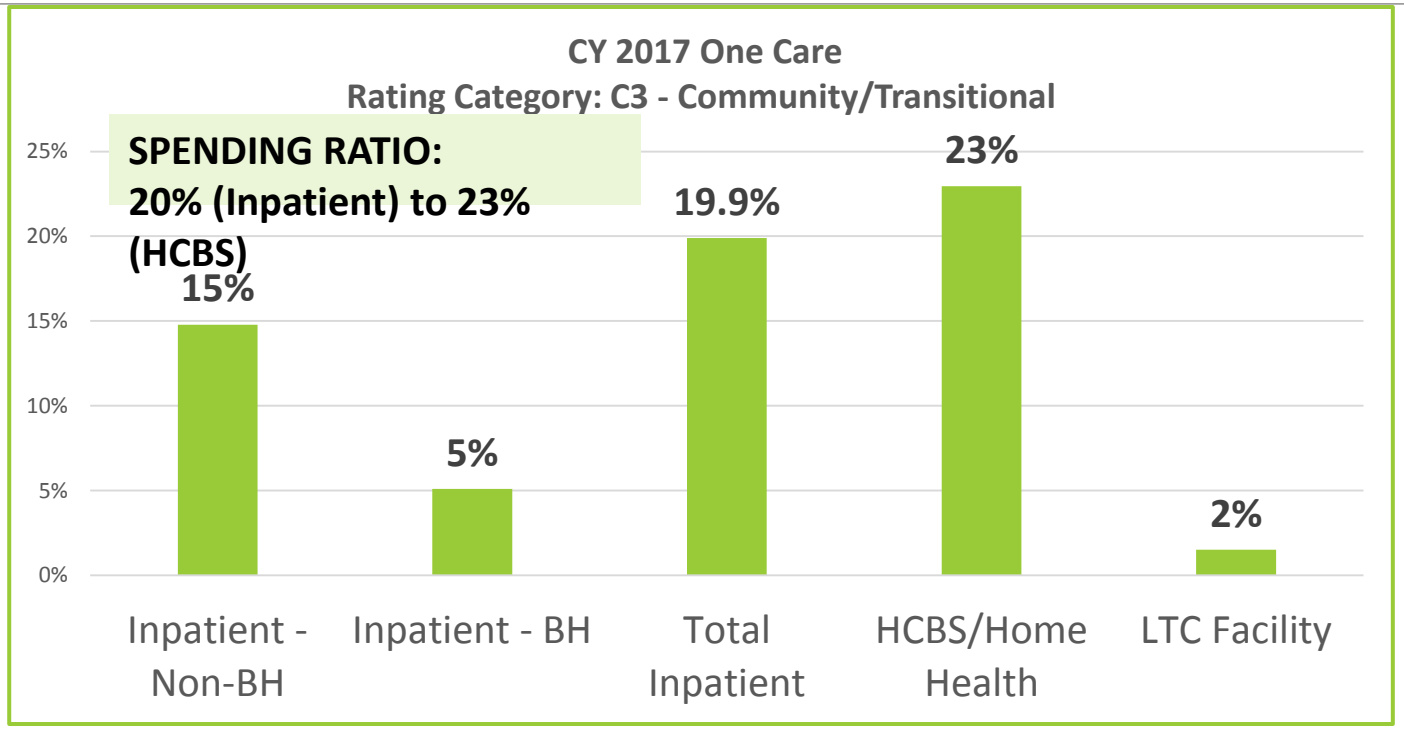


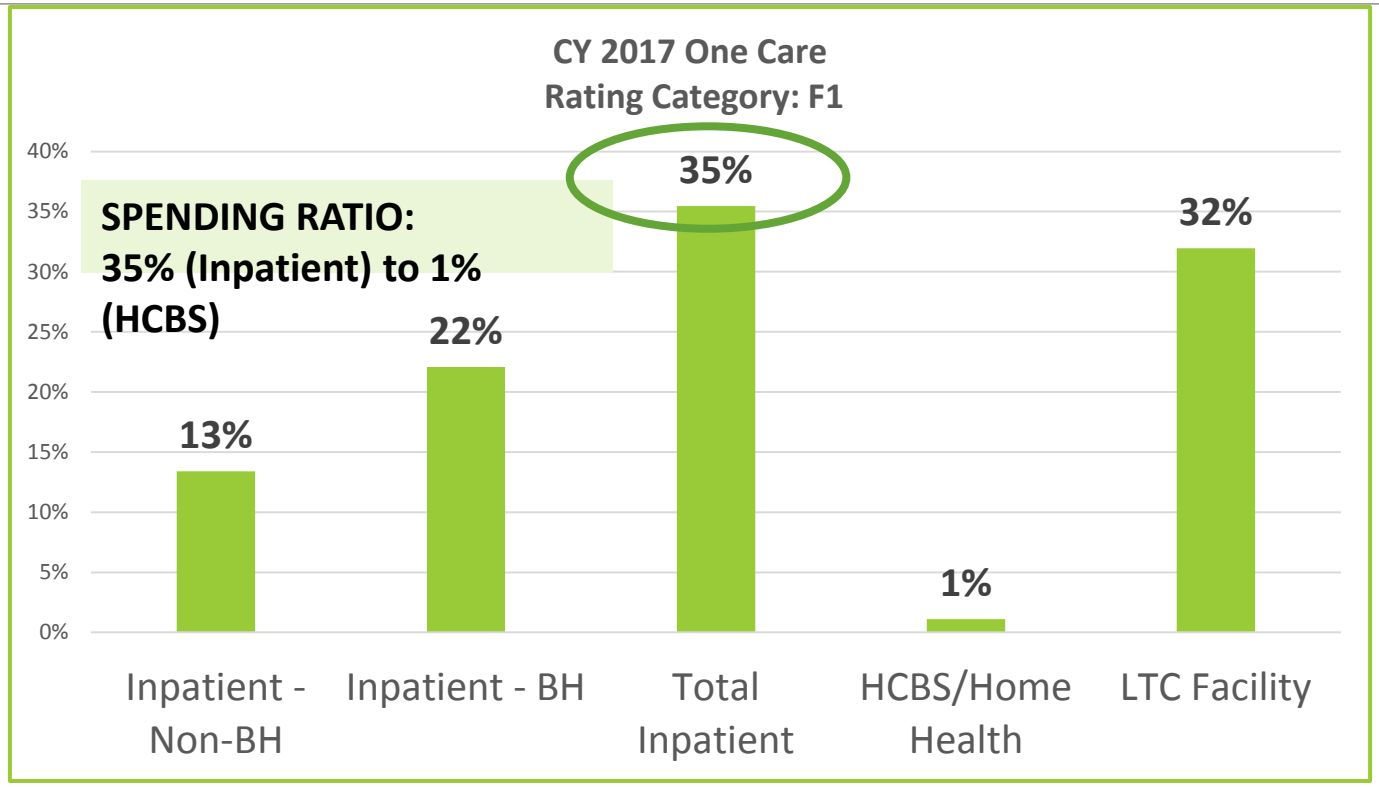
Total Inpatient Spending
20% = $110 Million


CY 2017 Total One Care Spending
SPENDING RATIO:
20% (Inpatient) to 16% (HCBS)
25%
20%
15%
10%
5%
0%
14%
6%
20.1%
16%
2%
Inpatient - Non-BH
Inpatient - BH
Total Inpatient
HCBS/Home Health
LTC Facility


CY 2017 One Care
Rating Category: C1 (Lowest Risk)
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
18%
1%
18.8%
4%
1%
SPENDING RATIO:
18.8% (Inpatient) to 4% (HCBS)
Inpatient - Non-BH
Inpatient - BH
Total Inpatient
HCBS/Home Health
LTC Facility


CY 2017 One Care
Rating Category: C2 - BH
SPENDING RATIO:
20% (Inpatient) to 4% (HCBS)
25%
20%
15%
10%
5%
0%
12%
9%
20.4%
4%
1%
Low HCBS spend on One Care enrollees in C 2 A and C 2 B
Inpatient - Non-BH
Inpatient - BH
Total Inpatient
HCBS/Home Health
LTC Facility


CY 2017 One Care
Rating Category: C3 - Community/Transitional
SPENDING RATIO:
20% (Inpatient) to 23% (HCBS)
25%
20%
15%
10%
5%
0%
15%
5%
19.9%
23%
2%
Inpatient - Non-BH
Inpatient - BH
Total Inpatient
HCBS/Home Health
LTC Facility


CY 2017 One Care
Rating Category: F1
SPENDING RATIO:
35% (Inpatient) to 1%
(HCBS)
40%
35%
30%
25%
20%
15%
10%
5%
0%
13%
22%
35%
1%
32%
Inpatient - Non-BH
Inpatient - BH
Total Inpatient
HCBS/Home Health
LTC Facility

Why Health Equity?

Disparities in health and wellness impact people within ethnic and minority populations and other groups as well (including inequities for One Care members based on their diagnosis, rating category or other identifying quality such as sexual orientation or gender identity).

NEXT STEPS:

- The IC wants to work with the One Care Plans and MassHealth in advancing health equity and reduction in disparities.
- The IC recognizes that translating population health concepts into healthcare practice is a complex undertaking; so we look forward to working with consumers, Plans, CBOs and MassHealth to create a comprehensive strategy that will put equity into practice.

NEXT STEPS:

The IC hopes the One Care Plans will be able to provide the Council data on the evidence base being used to support the practices and interventions they are using as well as how they are monitoring and measuring the quality of care coordination and network adequacy strategies currently in place to:

- ensure the needs of peoples are being met;
- are advancing health equity and reducing health disparities.

NEXT STEPS:

Based on the ongoing themes being reported by people in One Care, there are two topics the IC wants to bring into discussion in February and March:

- Network adequacy
- Care coordination

Discussion

Network adequacy, slide 1/2

- What data do Plans use to determine network adequacy?
- How do Plans monitor and address barriers to network providers or gaps with network adequacy that prevent people from accessing services they need?
- What data is available concerning percentage of providers who are taking new people?
- What data do the Plans have about percentage of people who are denied access because providers are not taking new patients?

Network adequacy, slide 2/2

- What data do the Plans have on wait time for specialists? Are other services offered in lieu of specialties (ex: psychiatry) if the wait time is too long?
- Are there specific gaps in network adequacy?
  - Example: women's health services or other provider categories, like Certified Peer Specialists or social workers whose background reflect the people they serve?
- What are the types of providers Plans may have trouble finding for people?

Care Coordination

- How does each Plan build a care team? And how does each Plan take into consideration the skill set of the care coordinator and the needs of the member?
- What algorithm [or method] is used to determine the care coordinator to member ratio?
- What is the typical caseload for a care coordinator, based on the rating categories and complexity of cases?
- How do Plans determine the appropriate case mix? And what are typical problems?
- What are the turnover rates for care coordination staff?
- How do Plans measure quality across different care coordinators?

Slide 1/2:
On a more granular level, are care coordinators:

- Adequately supporting the needs of people and navigating their care?
  - For example, connecting people with specialists, making appointments with specialists, confirming visits, scheduling preventive services, conducting medication reconciliations and ordering refills.
- Addressing gaps in care by proactively addressing the needs of people who are overdue for services or who have complex substance use, mental health, medical or SDOH needs?
  - For example, navigating the provider system to find upstream services to reduce the need of people with mental health diagnoses to access diversionary mental health services or mental health related hospitalizations.
- Monitoring a person's clinical and self-reported health and quality of life at the population level?
  - e.g. by race, ethnicity and GLBQT status.

Slide 2/2:
On a more granular level, are care coordinators:

- Actively supporting the rights of people to access single case agreements for people needing services not adequately met by providers in a Plans network?
  - For example, assisting the people with epilepsy that specialists inside the Plan network have not been able to effectively manage to locate a specialist out of network and proactively seek a single case agreement with an out-of-network specialist.
- Managing a person's care transition from hospital or other setting to community settings?
  - For example, having a community health worker at a person's home at the time of her discharge from the hospital.