

August 29, 2013

Robin Callahan
Deputy Medicaid Director
MassHealth/EOHHS
One Ashburton Place, 11th floor
Boston, MA 02108

Dear Robin,

In follow-up to the motion carried at the Implementation Council (IC) meeting on July 15, a workgroup was convened to put forward a proposal to you on two matters: to establish priorities for the IC for the next several months and develop a response to the presentation by Alexis Henry. This document, shared with Council members, provides recommendations that have come from this workgroup.

The Implementation Council workgroup believes the Council has an obligation to consumers to help develop, implement and monitor One Care within the framework of the reduced scale of One Care. Having three plans covering a reduced geographic area within an extended, more population-based rollout enables MassHealth and the Council to do more robust population-based monitoring than might have been possible with six plans covering the entire state. Further, the workgroup views the reduced scale of One Care as an opportunity to create a much more informed and effective Implementation Council able to assist MassHealth.

The workgroup has identified three overarching objectives:

- To improve the transparency and information sharing of MassHealth.
- To educate and sustain commitments of the IC members.
- To educate consumers about monitoring of One Care and involve them in the process.

If met, these objectives will enable the IC to perform its role of advising MassHealth and supporting the success of OC by having improved access to critical information in a timely way. The suggestions below include potential presentations and workgroups to be initiated prior to January 1.

Immediate Priorities

I. Monitoring

1. A small workgroup of IC members should meet with Alexis Henry and any appropriate MassHealth staff prior to the September 20 Council meeting to further refine the monitoring strategy that has been outlined. The dashboard concept is applauded, but requires further refinement so that it is more population appropriate, both in methodology for data collection and types of data. Traditional research methodologies do not seem appropriate and may act as barriers to getting appropriate data on consumer experience. This may be particularly true for

people who are homeless, deaf, have intellectual and developmental disabilities or other disabilities/situations that require alternative means of investigation.

The outcome of this meeting would be presented to the Council on September 20 for discussion, including topics that include but are not limited to:

- a. An enhanced list of early warning indicators.
 - b. Specific suggestions for data collection methodology so that it provides more opportunity for face-to-face surveys and focus groups.
 - c. Particular ideas for monitoring that also utilize the expertise and leadership of people with disabilities beyond the Council to develop indicators, conduct surveys and focus groups and participate in analysis of data collected.
 - d. Specific ways in which suggestions submitted by Implementation Council members following the August meeting can be included in monitoring One Care.
 - e. Any barriers to developing a more robust monitoring and dashboard design that does not meet IC expectations.
2. MassHealth make a presentation to Council members at the September 20 meeting on the following items:
- a. A clear outline of data reporting requirements for Plans.
 - b. How it plans to use Medicaid and Medicare enrollee utilization of billable services in monitoring of One Care.
 - c. Barriers to accessing data from Plans, Medicaid and Medicare.
 - d. Time frames for accessing data from these resources.
 - e. How findings will be used to evaluate and, when appropriate, impact the rollout of OC, capitation rates and contract requirements.
3. A workgroup convening by late September to develop a rationale and structure for independent monitoring of One Care by consumers. It is suggested that the small work group be comprised of Council members, key MassHealth staff, and consumer/consumer advocates not already on the Implementation Council. Topics for discussion include:
- a. The conflict of interest inherent in the state monitoring itself.
 - b. Defining the role of such an entity and its relationship with MassHealth, One Care Plans, providers and enrollees.
 - c. Identifying existing expertise to carry out this monitoring function within the consumer community.
 - d. Developing specific suggestions to the Implementation Council on types of access to data, enrollees and other resources necessary to carry out this independent monitoring function.

Please note that other specific recommendations to the presentation on monitoring are contained in an appendix to this document.

II. **Financing and Financial Data**

The workgroup is concerned that Council members lack the appropriate information about the financing of One Care and the three way contract to provide appropriate guidance to MassHealth on issues that impact rate structures, allocation of funding by Plans to medical and LTSS, and protections for enrollees. It suggests that MassHealth provide a presentation at the October IC meeting that includes information on:

- a) The numbers used in developing rates.
- b) Medicare Risk Adjustments/ Rate Development.
- c) Medicaid Historic Expenditures / Rating Category Development.
- d) Differential impact of Rating Categories on Adequacy of Rates.
- e) Role of risk corridors, distribution of enrollees with high utilization rates and quality withholds.
- f) Adjustments to rates over time.
- g) A comparison of varying rates for C-1, C-2 and C-3 to historic average annual spending

III. **Understanding and Comparing the Three One Care Plans**

The workgroup believes it is important to be able to conduct an “apple to apple” comparison between the three plans. To promote transparency to make an equitable comparison possible, the workgroup suggests that MassHealth provide quarterly reports on marketing, enrollment, assessment and service provision by each plan in a format that allows for a clear comparison between the three plans. In addition, the workgroup suggests that the plans make a presentation to the Council at the November meeting, and to be carried over into the December meeting if necessary, on the following topics in a format to be designed by MassHealth, in collaboration with the IC. The topics include how each plan is or will:

- a) Conduct marketing and enrollment.
- b) Prepare to manage initial service continuity.
- c) Prepare to conduct an initial comprehensive assessment using IL-LTSS coordinators.
- d) Define a positive outcome for One Care as a plan.
- e) Incentivize service delivery by providers to improve care for enrollees.
- f) Adapt its strategy to be responsive to changes in enrollee composition, enrollment rates, and disenrollments.
- g) Other topics as determined.

The workgroup puts forward these recommendations in this document to MassHealth to promote our unified goal of promoting effective care and protecting consumers. We recognize the amount of work being done by MassHealth and applauds its efforts to date. We look forward to your response.

Thank you.

Sincerely,

Dennis Heaphy, IC co-chair

APPENDIX

Specific suggestions in response to the proposed monitoring strategy put forward in August by MassHealth. Please note that some of the below recommendations are included in the letter above.

- 1) The monitoring strategy set out by MassHealth does not include a programmatic response to findings as they develop. The workgroup requests that MassHealth develop a draft set of programmatic and financial responses that will be triggered as findings emerge. This will enable the Council to provide guidance to MassHealth's proposed responses.
- 2) The workgroup suggests that the mixed methodology proposed by UMass be changed so that it can more effectively access information from enrollees or potential enrollees. Of particular concern are populations that include people who are homeless, deaf or hard of hearing, people with intellectual disabilities/developmental disabilities, as well as other populations who cannot access the telephone or are uncomfortable/unable to provide feedback using standard research tools such as mail or telephones. Suggested changes to the methodology include:
 - a) The amount of surveys proposed, 6000 contacts/3000 returns, should be reformulated to enable more interviews and focus groups so a clearer understanding of the quantitative information needed to understand enrollee experience at the outset of OC can be obtained. There is a unique opportunity to do surveys that include open-ended questions and qualitative face-to-face interviews regarding participants' experiences in prior care and then compare that to the new program. These interviews could be accommodated and repeated over time for a range of additional learning given the large number of samples in the original proposal that could be reformulated.
 - b) Expanding the number of focus groups (currently at five) to learn about population-based needs and experiences. This is of particular importance in understanding unique population-based barriers to care that result in inequities in health care access and outcomes.
 - c) Expanding the five-minute survey to ten minutes or a time span that is responsive to the particular communication needs of a person or population.
 - d) Utilizing providers of services to people with disabilities to develop strategies for conducting surveys, interviews and focus groups. This includes but is not limited to groups such as the Massachusetts Organization for Addiction Recovery (MOAR), AIDS Action, ARC and Healthcare for the Homeless.
 - e) Including in the monitoring strategy a method, such as surveys of providers, to better understand how the relationship between providers and One Care Plans are functioning and the impact of those relationships on enrollee services.

- 3) The workgroup believes that consumer involvement in the development and execution of surveys, focus groups, and other consumer-input processes is necessary to assure effective engagement of the diverse array of consumer populations who may enroll in the demonstration, and that this also will help promote education about One Care to enrollees or potential enrollees in a manner that may be more effective than traditional research methodologies. This includes the use of Community-Based Participatory Action Research (CBPAR) that is facilitated by consumers.

Specific workgroup recommendations include:

- a) That the UMass project team be led by a community-based disability organization.
 - b) And that surveys and interviews be designed and conducted by people with disabilities in collaboration with UMass leadership and that data analysis include consumer experts.
- 4) Early warning indicators should include, but not be limited to, the below items. To the extent possible and in coordination with the Council, it is requested that the dashboard include these data points:
- a. Access to care
 - i. Shine encounters
 - ii. Enrollments/Opt outs/Disenrollments
 - iii. Continuity of services past the 90-day required period
 - iv. Change in services after the comprehensive assessment and plan development
 - v. Denials of services
 - vi. Number of relay calls by deaf and hard of hearing enrollees and potential enrollees
 - b. Quality of care
 - i. Completed on-time assessments
 - ii. Completed on-time LTSS assessments
 - iii. ER utilization/avoidable hospitalizations/facility stays
 - iv. Expanded HCBS and community behavioral health service utilization (i.e. access to Community Support Program for People Experiencing Chronic Homelessness (CSPECH))
 - v. Approved requests for transportation
 - vi. Some prioritized portion of the 104 “Core Quality Measures” defined in the OneCare contracts

- vii. Satisfaction data (on OneCare Plans and providers)

- c. Complaints
 - i. Complaints to ombudspersn (could be in any of the categories above)
 - ii. HIPPA breaches
 - iii. Other

- d. Financials
 - i. Financial data by service category
 - ii. Changes in plan expenditure patterns be reported on a quarterly basis
 - iii. Overall financial performance of the initiative (costs for Medicare, Medicaid, and savings)

- d. LTSS
 - i. Number of enrollees who were offered LTSS coordination
 - ii. Number of enrollees who declined LTSS coordinators
 - iii. Number of enrollees who were assessed by LTSS coordinators
 - iiii. Number of members who change LTSS coordinators

All of these reports would be most helpful if provided by Plan, county, rating category, assignment/voluntary, and, to the extent possible, sub-populations by diagnoses, race, ethnicity, sex, gender identity, homeless status, and self-identifying as member of GBLT community.