One Care 2.0: Three Way Contract Recommendations

Massachusetts One Care Implementation Council

April 9, 2019

Outline

- **Establish a Cohesive Framework**
  - Maintain Commitment to One Care vision
  - Build a common goal
  - Back to basics
  - Health equity and wellness collaborative improvement projects (HEWIPs)
- **Comprehensive Assessment, Care Planning and Care Coordination**
  - Person-centered care plan
- **Quality and Data Transparency**
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  - National Core Indicators
  - CAHPS and HEDIS
  - LTSS
  - Recovery Services
  - Substance Use Disorder (SUD)
  - Social Determinants of Health (SDOH)
  - Direct Care Workers and Informal Caregivers
- **Priorities Not Addressed in This Presentation**

“Culture Eats Strategy For Breakfast” Peter Drucker

Cultural barriers:

- State and federal priorities focus on:
  - reducing cost rather than increasing revenue streams putting pressure on vulnerable populations to find solutions in midst of increasing need and decreasing funding;
  - increasing reliance on large managed care entities to resolve care coordination, escalating costs, and reduced revenue stream challenges.

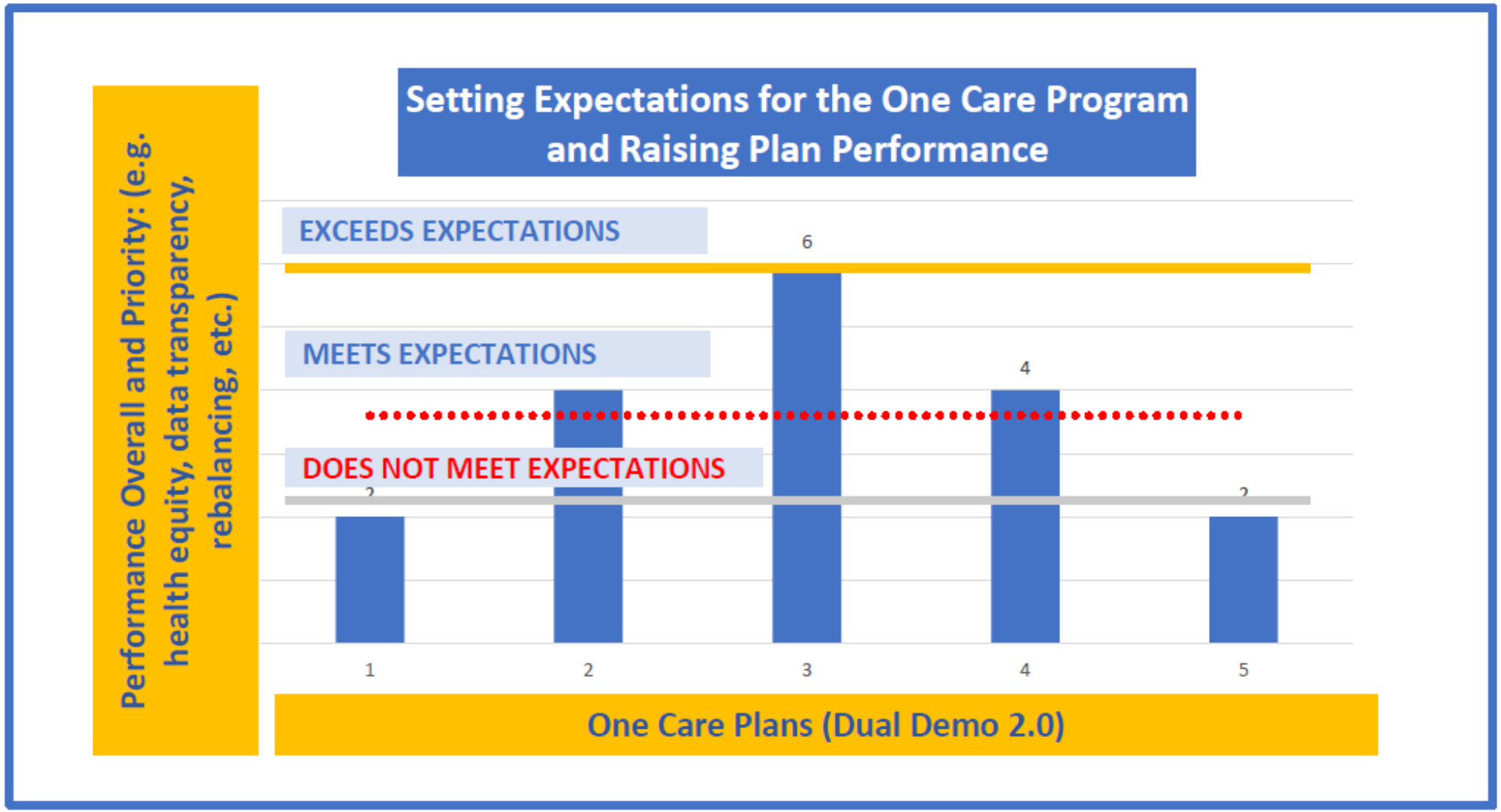
- Large medically driven insurance companies focus on:
  - ROI and lack cultural competency or systems integrity needed to bring about meaningful change;
  - overlay commercial plan strategies in shaping care delivery; Utilization Management systems use population-based medical necessity criteria to make care decisions;
  - FFS contracting practices with CBOs perpetuate inequities.

- Small Community Based Organizations (CBOs):
  - lack parity in voice needed to impact medical culture;
  - focus on community wellness versus medical outcomes;
  - siloed emphasis on populations they represent rather than intersectional priorities e.g. recognition that ASL communication access is an intersectional concern across all populations.

Establish a Cohesive Framework

The Council urges CMS and MassHealth to strengthen key components foundational to driving plan performance and improving the current One Care demonstration.

- set high expectations or risk the creation of a demonstration that lowers the bar from where we are today;
- prioritize comprehensive assessment, care planning and care coordination;
- integrate LTS Coordinator, Certified Peer Specialists and Certified Recovery Coaches in care planning and care coordination;
- refocus on quality measures and data transparency;
- advance health equity and wellness, and independent living and recovery principles.


Setting Expectations for the One Care Program and Raising Plan Performance
Performance Overall and Priority: (e.g. health equity, data transparency, rebalancing, etc.)
EXCEEDS EXPECTATIONS
MEETS EXPECTATIONS
DOES NOT MEET EXPECTATIONS
2
6
4
2
1
2
3
4
5
One Care Plans (Dual Demo 2.0)

Maintain Commitment to One Care vision

- Integrate recommendations and address concerns raised by DAAHR, *e.g. No lock-in*.

- Operationalize independent living and recovery principles into all aspects of One Care, *e.g. Integrate LTS coordinator, Certified Peer Specialists, Certified Recovery Coaches in comprehensive assessment phase.*

- Comprehensive assessment, care planning, care coordination, emphasis on care planning that *and* provision of services that maximize member opportunity for meaningful community integration, *e.g. social services that address SDOH and impactors that lead to inequities.*

- Establish comprehensive assessment requirements beyond minimum MDS to remove inequities in access to One Care benefits that might result from plan specific inadequacies in the assessment process, *e.g. Prioritize member access to services over plan "proprietary" assessment tools.*

- Insert clear guidelines to ensure utilization management serves the interest of members, not plans, *e.g. Determination of need defined by "off-the-shelf" medical necessity medical necessity algorithms.*

Build a Common Goal*

- Address current gaps in data collection and transparency
- Impact high need and utilization populations
- Reduce gaps in access to community services e.g. SDOH needs, in populations with lower direct medical costs
- Focus on health equity and wellness and reduce disparities
- Rebalance spending
- Reduce institutionalization
- Define One Care quality strategy
- Establish dashboard
- Create a quality report card:
  - Identify performance targets
  - LTSS survey results
  - Behavioral health survey results
  - CAHPS, HEDIS and other outcome measures

*https://reportcards.ncqa.org/#/health-plans/list?insurance=Medicaid

*https://www.health.ny.gov/health_care/managed_care/reports/docs/health_comp_report/health_comp_report_2017.pdf

Back to Basics: Impact 6% of Duals Populations Driving Costs

Plans must:

- outline objectives, benchmarks, timeline, interventions, tasks, partners and strategies for increasing quality of care and bending the cost curve for this segment of the duals population;
- identify how they will leverage dual funding stream potential to rebalance spending and achieve the plan's identified objectives;
- outline value-based purchasing methods for contracting with CBOs;
- define person centered care planning strategies that circumvent utilization management medical necessity criteria to advance person centered care planning and plan objective for addressing the needs of the population;
- give details of markers to be used in assessing plan strategy and impact.

Health Equity and Wellness Collaborative Improvement Projects (HEWIPs)*

The One Care Council will recommend HEWIPs to MassHealth. The HEWIPs must focus on improving the care and services provided to One Care members.

The Implementation Council, in partnership with MassHealth, will request plans to submit:

- interventions that will advance the HEWIPs goal. The interventions must be clear, precisely defined, time specific and address a critical issue that One Care members face, in either clinical or non-clinical areas;
- clear objectives and quality that are in alignment with the HEWIPs goal;
- measurable indicators to assess the effectiveness of the interventions, including a cohesive set of member, provider and community interventions.

Example: Reducing Racial and Ethnic Disparities in the Management of Depression: Improving integration of recovery principles into person centered care planning within first three years of contract.

HEWIPs are to be conducted on a three year cycle.

*https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6646D-ENG

Comprehensive Assessment, Care Planning and Care Coordination*

Successful health plan care coordination for One Care members is centered on:

- Building relationships
- Empowering individuals to identify their goals and preferences
- Supporting and empowering members to achieve those goals using culturally and linguistically appropriate methods

*https://mn.gov/dhs/partners-and-providers/program-overviews/long-term-services-and-supports/person-centered-practices/

Person Centered Care Planning*

- Goal: support people so they can fully engage in their community.
- “Person-centered planning" describes common values and methods that focuses on people, not programs.
- A person-centered support system assists people:
  - Build or maintain relationships with their families and friends
  - Live as independently as possible
  - Engage in productive activities, such as employment
  - Participate in community life.

*https://mn.gov/dhs/partners-and-providers/program-overviews/long-term-services-and-supports/person-centered-practices/

Person-Centered Care Coordinator

- High member satisfaction is positively correlated with:
  - Having a relationship with a care coordinator and how to access the care coordinator;
  - Having access to resources rather than having to work to get the coordination they need and want;
  - Reduced adverse events and better health and quality of life outcomes.
- Three way contracts should include value based arrangements to engage PCP's in care coordination to increase integration without work of care coordinators.*

* https://www.macpac.gov/wp-content/uploads/2019/03/Care-Coordination-in-Integrated-Care-Programs-Serving-Dually-Eligible-Beneficiaries.pdf

Quality and Data Transparency

"MassHealth has identified its intent to scale innovative approaches for populations receiving long-term services and supports" as a key priority.*

"Massachusetts has a number of innovative public and private LTSS programs and initiatives at the state level and in local communities that have yet to be meaningfully evaluated for quality, cost, or efficacy, or whose evaluation findings have not been used to inform programmatic, financial, and strategic decisions regarding LTSS or MassHealth reform."

*https://bluecrossmafoundation.org/sites/default/files/download/publication/MassHealth_LTSS_report_FINAL%205.11.16.pdf

Quality Measures: IC Engagement

Three-way contracts require MassHealth to work with the implementation Council and *experts identified by the Council* to:

- assess the current One Care quality measures commit to creating robust quality measures prior to finalizing One Care contracts. The process should result in a slate of measures that:
  - Increase accountability of plans to outcomes commensurate with unique opportunities to advance quality outcomes within the capitated dual funding stream.
  - Have value as well as validity
  - Target advancements of measuring quality of outcomes
  - Go beyond measures of "low hanging fruit" e.g. claims/encounter data
  - Advance the science of quality measures for recovery, LTSS and SUD services
  - Includes questions from the CAHPS® Home- and Community-Based Services Supplemental Survey

CAHPS (Supplemental) and HEDIS Measures

Work with the implementation Council and *experts identified by the Council* to ensure quality measures include meaningful outcomes in:

- **LTSS**
- **Recovery Services**
- **Substance Use Disorder (SUD)**
- **Social Determinants of Health (SDOH)**
- **Direct Care Workers and Informal Caregivers**

National Core Indicators*

Work with the implementation Council and *experts identified by the Council* to adapt National Core Indicators to meet needs of One Care population:

- Individual Outcomes
- Health, Welfare, and Rights
- System Performance
- Staff Stability
- Family Indicators

E.g. Individual outcome indicators address how well the public system aids One Care members to work, participate in their communities, have friends and sustain relationships, and exercise choice and self-determination. Other indicators in this domain probe how satisfied individuals are with services and supports.

* https://www.nationalcoreindicators.org/indicators/

Public Dashboard: Quarterly Monitoring Updates

Three way contracts should include requirements that MassHealth will monitor One Care plans and provide a quarterly dashboard report. The dashboard should monitor care performance dimensions identified in consultation with the Implementation Council and Council identified experts including:

- Enrollment
- Disenrollment
- Grievances
- Continuity of care
- Fair hearings

https://www.dhcs.ca.gov/services/Pages/MMCDSPDMonitorDashbrd.aspx

Priorities Not Addressed in This Presentation

Recommendations put forward by DAAHR and previous documents submitted to CMS and MassHealth by the Council:

1. **Health Equity and Access to Services:**

    - Special enrollment period / fixed enrollment rules and exceptions
    - Continuity of care
    - Out-of-network providers
    - Greater diversity in LTSS services
    - Pharmacy covered products
    - Day services
    - Accessibility needs
    - Utilization management
    - PCA services

Priorities Not Addressed in This Presentation

2. Assessment and Care Coordination:

- Comprehensive assessment and care planning process
- LTS coordinator
- Value-based Purchasing Methods in contracts with Community-based Organizations (CBOs)
- Certified peer specialists/certified recovery coaches
- Independent living philosophy and recovery learning principles

Priorities Not Addressed in This Presentation

3. Accountability and Standardization for Outcome Measures:

- Consumer engagement
- Definition of medical necessity
- Clarity on conflicts between Medicare and MassHealth rules
- Data collection and transparency
- Clarity on Community Advisory Committee (CAC) language
- Clarity on estate recovery
- Clarity on Community Support Services
- Clarity on Medicaid Management Information Systems (MMIS)

Shifting paradigm: Massachusetts takes pride in the Red Sox and Patriots.
Minnesotans are proud of their social workers!

Shifting the paradigm in Massachusetts from a medical model to independent living and recovery model is a heavy lift.

- What questions do you have for the Council regarding the presentation?
- What is our timeframe for continuing to influence the three-way contract?
- What will CMS do to strengthen the requirements for MassHealth to anchor One Care 2.0 growth to scale? This includes requirements to meet population-based health goals that demonstrate advancements in quality of outcomes, particularly in the LTSS space.
- How will CMS address concerns put forward by the Council and DAAHR to protect the most vulnerable dual eligibles from being locked into plans that do not meet their needs and made lead to harm?
- What steps will CMS take to ensure financial alignment advances more creative, less restrictive use of dual funding stream to support nonmedical needs of one care members who "fall into the gap" because they do not have immediate high cost needs?
- What steps will CMS take to advance health equity?