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A CONVENING OF GRANTEES ON THE COMMONWEALTH CARE BRIDGE PROGRAM

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EXPANDING ACCESS TO HEALTH CARE

EXECUTIVE SUMMARY

In August, 2009, legal immigrants who have been in the United State for fewer than five years, also known as aliens with special status (AWSS), lost their eligibility for health insurance coverage under Commonwealth Care. The eligibility rules changed after state lawmakers, responding to radically reduced revenue collections, voted to eliminate the AWSS population from the Commonwealth Care program that they had been participating in under the state's Medicaid waiver. These spending cuts targeting the AWSS immigrants saved state dollars while avoiding sacrificing any of the federal funds that Massachusetts receives for Commonwealth Care. By October, the Patrick Administration had created the Commonwealth Care Bridge Program, a publicly-subsidized health insurance program with reduced benefits for AWSS no longer eligible for Commonwealth Care. The program is administered by CeltiCare and cost the state $40 million, approximately one-third of the cost to insure AWSS in Commonwealth Care.

In response to numerous questions and concerns about the Commonwealth Care Bridge Program by grantees who work with AWSS, the Blue Cross Blue Shield of Massachusetts Foundation hosted an informational discussion December 9, 2009 among grantees, government officials, health insurance executives, and consumer advocates. Titled "A Convening of Grantees on the Commonwealth Care Bridge Program," the event had three components:

1. An informational panel on how the Commonwealth Care Bridge Program was created. Panel participants were Glen Shor of the Massachusetts Executive Office for Administration and Finance, Ben Walker of the Office of Medicaid, and Brian Rosman of Health Care For All; Patrick Holland of the Connector Authority and Meg Kroeplin of Community Partners were also scheduled to participate, but inclement weather kept them from attending.

2. CeltiCare President and Chief Executive Officer Richard Lynch of CeltiCare then talked about the details of the program, and answered questions.
3. Finally, attendees of the event divided into small groups based on geographic region and discussed their experiences with the program; comments generated by the small groups were later shared with all attendees.

MORNING PANEL "How Did We Get Here?" MORE »

Several themes emerged from the information panel with Shor, Walker, and Rosman:

- Federal reimbursement policy drove the decision of state lawmakers to make AWSS ineligible for public insurance.
- Public officials did what they could to maintain benefits given the funds allotted.
- There was very little time in which to devise a plan to sustain benefits, and few involved in the planning actually believed it was possible to come up with a way to keep AWSS insured. Pressure put on the state by consumer advocates built critical support for the plan.
- There is an ongoing need to plan for next year and beyond and the administration is currently developing a range of options so that they are best prepared to respond to whatever level of funding is authorized in the FY11 budget.

CELTICARE PRESENTATION "Where Are We Now?" MORE »

Richard Lynch's presentation included a review of how the health insurer won the contract for the Commonwealth Care Bridge Program; an outline of the plan's strategy to expand its network across the state; and an overview of member costs and enrollment figures. He then answered questions about services provided and information collected by CeltiCare's call center.

FEEDBACK FROM PARTICIPANTS

At the end of the event, participants were asked to fill out a brief survey about the meeting. Twenty-nine forms were returned. A majority of participants ranked the morning panel and presentation by Richard Lynch as "useful." (Sixteen gave the morning panel a four on a scale of one to five and eight gave it a five, with five being the highest rating; 18 rated Lynch's presentation a four, with 4 rating it a five.) But the small group discussions were a clear favorite of participants (seven participants gave it a four, 16 gave it a five, and one enthusiastic attendee gave the small group discussions a "5++"). In comments, participants praised the small group sessions for the information sharing that took place: "Very good to hear in more detail what others are dealing with in other parts of the region," wrote one. "Probably the most useful is hearing what people on the ground are experiencing," wrote another. Participants also noted that they liked the opportunity to hear from officials in state government: "Communication between the decisionmakers and the people affected by those decisions is critical if we are really working towards preventive care," wrote one. "Learning about the legislative part of this decision made it clearer to me," wrote another. Of the eight comments offered in response to the question, "What are future needs that would be helpful in thinking about or addressing this issue?" four addressed the need for better communications: "Communications strategies geared specifically at the challenges of the immigrant population"; "Storytelling investment — we don't have time to collect stories — we need someone (perhaps BCBS Foundation?) to lend assistance to capture what we're hearing from folks"; "Connection between advocacy/policy community and direct services are crucial"; and "What concrete ways can grantees receive current updated info on CeltiCare or other program changes."

MORNING PANEL "How Did We Get Here?"


MODERATOR

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PANELIST

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Assistant Secretary
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PANELIST

BEN WALKER
Director of Federal Finance,
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PANELIST

BRIAN ROSMAN
Director of Research,
Health Care For All

PANEL DISCUSSION

ANAY RADER WALLACK **What was your role in the creation of the Commonwealth Care Bridge Program?**

GLEN SHOR The Administration faced a real possibility that this population would have no coverage at all. You can view Bridge as compared with Commonwealth Care program, or you can look at it on its own and evaluate based on if there hadn't been anything there. It was not the goal of the Patrick Administration to separate certain immigrant populations. Overall, the Administration is doing its best to lobby the federal government to get coverage for this group. Today, we view the coverage that we have through the Commonwealth Care Bridge Program as fairly comprehensive, given that it was set-up over an extraordinary time period. The situation definitely highlights coverage at a price; if you had asked me a few months ago if something like this would have been possible, we would have said no. Therefore if this is not all it could be, is that necessarily a bad thing? We are proud of all the work we did to get this far and we can't lose sight of the ultimate goal, which is not to lose coverage for this population. Where we are now is better than nothing.

BEN WALKER We have interest in using both a retrospective, but also prospective lens. We are interested in hearing what folks think, especially as we prepare for next year. The troubles that we anticipate in 2011 are not necessarily the same as in 2010. We had planned to cover the population for half the cost, then got half of that money. In a few short months, we had to figure out how to cover this population. Time and cost constraints were key factors and we had to act swiftly to make it work. A guiding principle that we maintained to the extent we could was finding a way to provide comprehensive coverage. If you had asked us earlier if we could end up with comprehensive coverage for that level of money, we would have said no. When there is a way to get the full benefit back to the population, we will be happy to act. The series of events led us to have to jump right in to operationalize the program, minimize the coverage gap, coordinate between agencies, and so on.

BRIAN ROSMAN I want to thank the Foundation for giving a voice to a voteless and near-voiceless group, and to the Patrick Administration. The bad guys in this scenario are the Federal Government, going as far back as the Clinton Administration which decided not to fund legal immigrants in this population, and the State Legislature. The Governor consistently fought for this population. When it comes time to fix this for 2011, we need to focus on the Legislature to help them understand the value of funding full coverage for this population. Congress has the option to amend this as part of health reform, and senators have voiced their support through an amendment to cover the AWSS population. Health Care For All did not have a role in creating and starting the Bridge program, but we have offered gentle critique. There hasn't been a role for the community and advocates, and we could have helped refine a better program. I understand the pressure and time constraints given the situation, but I think in the end it would have been better if we could have been more involved. If we end up in 2011 with a Bridge program that doesn't have full funding, we want a way for stakeholders and those that work with immigrants to have some input. We have proposed a way to provide the Health Safety Net as an option for immigrants, the importance of the population being aware of different resources in different parts of the state, and ways to use the state's leverage to require all providers to contract for this group (as it is with Medicaid).

ANAY RADER WALLACK **One theme that has come through from what you've all shared is that the program was created amidst difficult parameters. The state is trying to do what it can given limited resources. As you look ahead, what can we learn from this to inform the next budget cycle, and what parallels have we drawn from Chapter 58?**

GLEN SHOR I am not sure I totally share Brian's view about the lack of a role of the advocacy community in creating the Bridge program. Without the efforts of the advocates and hospitals, in conjunction with the Administration's pressure on the Legislature, we could have wound up with no money. They have made a major contribution in this effort. Brian said that it was ultimately the Administration's decision about Bridge, but I think it was also the Legislature's decision. A lot of insecurities that we faced this time around can reoccur. We will continue to face cost pressures, and there won't be a federal reimbursement policy change (even if it passes, the amendment that Brian highlighted in Congress will not go into effect immediately). Even if the economy recovers, state finances are likely to lag, and we don't expect a trajectory that will allow miracles to happen. We also face a major fiscal challenge that we've been balancing with enhanced Medicaid funds, which ends December 31, 2010. So in the middle of FY2011, the need to balance goes away, but similar implementation challenges are likely. The Administration will file their budget on Jan 27, 2010, followed by a time period when the Legislature will consider their respective budgets. However, there is also a period of uncertainty which tends to be resolved by the deadline in July. There are a number of dynamics that we faced in creating this program that may very well be present in moving forward.

BEN WALKER A lesson that we've had reinforced through this process is that of the unpredictability of the Legislative budget process. We expect similar financial constraints, and anticipate that we will have to overprepare, and come up with every scenario that may come out of Legislature's budget. Now that we know, we can say in more concrete terms what some serious geographical access issues are. With more time, we can in essence overprepare.

BRIAN ROSMAN While it is justifiable to be proud of the coverage offered through the Bridge program, I think it's important to acknowledge that coverage doesn't equal care. Significant barriers to care that remain include a lack of providers (of which geography can determine one's access), transportation, networks and so on. We're interested in aspects of the program like care usage and the needs of people in program. We also need to focus on whether there are other levers the state has to make this program better. We are glad to be hearing the acknowledgement that there is something fundamentally wrong with the decision to separate legal immigrants and legal citizens. We consider it an original sin to carve out a separate program for people who live here, pay taxes, and are a part of our communities.

ANAY RADER WALLACK **Knowing what we face in the immediate future, what factors need to be considered when designing a future program for this or new populations?**

GLEN SHOR Ben raised a good point, which is that the legislative process intersects with the planning process for providing coverage. We need to think of all potential options and to proceed despite a level of uncertainty. For any state initiative, but especially with this one, as we think about funding options within a context of the larger state budget with all of its cost constraints and competing demands, it is important to appreciate tradeoffs between different needs. It always feels like a zero sum game in state government.

BEN WALKER Ditto.

BRIAN ROSMAN One group we haven't mentioned, which needs to be included, is legal immigrants who are ineligible for Bridge because they joined the category after August 1st. We don't know the number of people who are impacted, how they are getting care, and to the extent that they are on Health Safety Net and the state is getting federal reimbursement for their care, they ought to be incorporated in the equation somehow. We need to also think about how federal revenue gets used. The budget has an artificial revenue constraint, which is that Massachusetts doesn't collect all the federal revenue available. We should take steps as other states do so we can collect more revenue.

QUESTIONS & ANSWERS WITH CONVENING PARTICIPANTS

From Lindsey Tucker, Health Care For All Glen, the first step in the budget process is the Governor releasing his proposed version. Many advocates want full coverage back to Commonwealth Care. Can you share any information on what Commonwealth Care would look like with or without the AWSS population, and in particular what the budget might look like?

GLEN SHOR The Administration is actively engaged at this point in building the House 2 budget, which is an extraordinary complex exercise, like playing chess on 50 levels. Dealing with the whole budget involves consideration of not just one program, but decisions about spending in other social service areas (education, housing, etc), as well as the impact of the availability of funds in health care. The budget will include careful consideration of the AWSS issue, the Bridge program, and a vision of moving forward. The process is already in play at the moment. We are very well aware from the advocacy community of the visions they have for the AWSS population in ensuring coverage. Part of the process involves analyzing many cost scenarios. It is an intense period now for policy development.

From Andrew Cohen, Center for Health Law and Economics This is a question for a lot of people here. Given that there's not much data available now, we're curious to know what have been some successes and challenges, specifically in regards to CeltiCare's limited network, challenges of cost (both to the program and individuals), and access.

BRIAN ROSMAN In channeling Meg Kroeplin, who couldn't be here today, I think of Berkshire County. I remember being here [at the Hoagland Pincus Conference Center] for the first Connector meeting after Chapter 58 was passed in April 2006, and Commonwealth Care was rolled out in October of that year. The Bridge program was passed in July and for the western and central parts of the state, the program had until December 1st of this year to initiate the program, which should have been enough time to build a network. Meg would say that there's a serious need to address challenges in western Mass.

GLEN SHOR We have Richard Lynch from CeltiCare here, and this should give him a flavor of questions he's going to get in terms of how CeltiCare has filled out networks, and how it's handling need-based care out of network. There's no question that contracting in western Mass was a challenge, and I think we have different perspectives as to what "has not happened yet." With one exception, CeltiCare has covered every section in every area of central and western Mass. That one exception includes a gap of 16 or so individuals. They have made remarkable headway in central and western mass within a short timeframe.

BEN WALKER Until yesterday, two service areas were not approved, and yesterday CeltiCare and North Adams came to terms. I am sure Richard will be reporting that they are continuing to engage in network development.

From Vicky Pulos, Mass Law Reform Institute Glen, you referred to a program that the Administration had in mind in case they got $70 million to work with. What were some of those features?

GLEN SHOR The administration was looking at a number of options, and the best way to answer that is that it was something closely resembling the Commonwealth Care benefit, though not identical. We indicated at that time what we thought it would cost to provide that kind of health package through MCOs. This speaks to the fact that when we got $40 million, the initial reaction was "What are we going to do with this? It's not enough." Ultimately, we were pleased to see that there was a way to provide comprehensive coverage at that price tag and we were able to offer more than we thought we could have.

From Cheri Andes, Greater Boston Interfaith Organization Do you anticipate that we would be able to provide the same coverage next year for the same price tag?

BEN WALKER No, we do not anticipate that we would be able to. We are developing ideas now, and don't think that we could have done it for $40 million without CeltiCare stepping up. Rather, what $40 million got us was similar to what we had envisioned, but with different benefits, one MCO, and coverage that did not cover the full year. By pure math, it would be challenging to proceed for a full year with the same Bridge program with $40 million. As was mentioned in regards to the need to overprepare, we need to consider what we could do if we got anything within the range of $0 to $150 million. It will certainly involve collaboration with the Legislature and the Administration, but it is tough to say at this point.

GLEN SHOR That is a good question that inquiring minds will be pondering over in the coming months.

CELTICARE PRESENTATION "Where Are We Now?"

Richard Lynch, the President and Chief Executive Officer of CeltiCare Health Plan of Massachusetts, Inc., was introduced and provided programmatic updates on the Commonwealth Care Bridge program. Below is a synopsis of the points that he covered.

- Richard has been doing his best to get out and connect with folks to get feedback about what is going on with the Bridge program.
- CeltiCare is a Boston-based health plan. Its senior management team is comprised of local people with roots in Massachusetts' communities. The company thought it was important to have people who were familiar with the landscape in the state. Richard was the first employee and built its operations.
- On May 1, 2009, the health plan officially opened its doors. It went live in July with Commonwealth Care, and is now the fifth MCO in the program.
- The Patrick Administration, Connector, EOHHS and the Executive Office of Administration and Finance approached CeltiCare and all health plans in mid-August, explaining that the AWSS population had not been included in the state budget. However, the Administration had $40 million, and asked the MCOs to put together proposals to cover the population.
- CeltiCare had about a week to submit the proposal. Together with key providers CeltiCare proposed the plan that is available today through the Bridge program. It would not have been possible without the help of a few stakeholders: 1) Caritas Christi provided a signifi-

cant subsidy; 2) Partners HealthCare put $5 million into the program to help subsidize/offset the cost of benefits; and 3) CeltiCare stepped up to underwrite the program.

- Commonwealth Care Bridge is a limited network program, in part so it can obtain deeper discounts. It has what it considers a creative approach to benefit design, with an emphasis on primary care and disease management as well as the following benefits:
  – The pharmacy benefit is two-tiered ($0 v. $50);
  – There is no copay for primary care visits;
  – Members have an innovative healthy rewards account where they are able to access up to $150 provided by CeltiCare through a debit card to use for certain services (i.e. a primary care visit).
- CeltiCare is committed to establishing a network in the western part of the state, and now has included North Adams. They are still working with hospitals in Central Berkshire County.

Provider Network

The goal of having an expanded network has been a significant focus for CeltiCare as it transitioned from a program focused on the eastern part of the state to one that is statewide. The network currently includes 5,000 providers, including 57 community health centers and 31 hospitals. Continued expansion of the network will include an emphasis on community health centers, and less so on hospitals. The plan does not intend to add a lot more hospitals at this point.

Enrollment

As of December, the plan has enrolled 25,690 members. CeltiCare has sent bilingual welcome packets in Spanish and English, and made outreach calls to every person who is enrolled. There are approximately 120 members in Pittsfield who are not yet enrolled and for whom the plan is hoping to get a contract as soon as possible.

Education

CeltiCare has reached out to every member by phone; over 64,000 outbound calls have been made to connect with members about the program. Most of the customer service reps are bilingual, and there is access to a language line that has been used liberally. The calls have also resulted in over 8,400 health risk screenings, which in turn led to 622 in-depth assessments within the first three months.

Health Risk Screenings

By completing a health risk screening, members benefit by getting $50 deposited onto a debit card for use on health coverage services. This kind of response is encouraging, especially given that English is not the predominant language for most members of this program.

Health Risk Assessments

Based on these screenings, over 600 members were referred into case management to complete a more in-depth health risk assessment.

Medical Management

259 members were referred to *Nurtur*, a program for diabetes management. CeltiCare identified over 300 people with complex care needs that they were able to connect with and refer into care.

Member Services

The call center receives about 360 calls a day. Call center staff include bilingual representatives and can tap into other call centers that are entirely bilingual if necessary. Data shows that the center has answered 96% of incoming calls within 30 seconds. Member handbooks have also been translated into Brazilian Portuguese, French, Vietnamese, and other languages.

Pharmacy Services

CeltiCare still doesn't have a lot of data available. However, some aspects came to light via the plan's medical director, including that there is a significant population within the Bridge membership that is diabetic. As such, there might be an issue for this population with insulin, which does not have a generic equivalent. This led CeltiCare to make a change to its diabetic supply as a means of addressing the potential cost barrier that arose. This also led CeltiCare to go back and look at the rest of the drugs that might cause similar issues, and the state worked quickly with them to make some changes. The new drug list is posted on its website at www.celticarehealthplan.com. Changes have been made to copays for brand name drugs that have no generic equivalent within the same therapeutic class. Richard encouraged grantees that have clients that are facing similar issues, to contact the plan and they will continue to evaluate this aspect of their benefits.

Transition of Care

Richard indicated that the plan prioritizes that members get the care they need. Therefore, if there are instances where a member has to go through a care transition and English is not their primary language, or if someone is in the middle of an acute course of treatment during transition, CeltiCare will do what it can to not disrupt care. Other instances include abstaining from transitions in care when someone is pregnant or members who need to carry on with an oncologist during a course of chemotherapy.

QUESTIONS & ANSWERS

Richard Lynch and Brenda Saunders of CeltiCare fielded questions from participants. Below is a recap of the questions and answers segment of the presentation.

Q. What about eye care, and are there other specialties that are having problems with access?

A. Vision and dental have both been carved out of the benefit design. There is no perfect answer here. With $40 million, something had to give somewhere, and we thought the benefits you see in the program were the right way to go. In terms of other specialties, I am not sure. Particularly if someone needs care from a specialist that we don't have, we will find an out-of-network specialist to see them.

Q. When people do report pregnancy or a chronic illness that may qualify them for a benefit package through MassHealth, are your reps trained to help facilitate calls placed to MassHealth or the Connector to update them with that info?

A. Yes, our clinical folks do this. We do make these referrals when we become aware of an individual's situation.

Q. There is a lack of current information on the website as it relates to doctors. How up-to-date do you hope to keep the website?

A. I hope to keep ours up-to-date to the minute, but that's not possible right now given the speed with which we are growing the network. The best way to get information on providers is to call our customer service line.

Q. What will it cost to do this program year round in year two?

A. I don't know. We collectively put this program together in an effort to provide an opportunity to best cover this population. We have to be honest that it's not something that would make sense to fund at $40 million, and this is something we need to tell you and the Ad-

ministration. We were able to put this together with the help and generosity of a few organizations, but we're not sure what will happen in July at this point. There are a variety of options, but most will be more than the $40 million price tag. My organization has been focused on taking care of what we have in front of us now, and we haven't thought much about July or for next year, other than saying that we are going to need more funding, as $40 million will not be enough.

Q. Why doesn't CeltiCare use the money obtained from the risk assessment for providing eye care and dental?

A. People could use that money for eye care or dental, or for IRS-defined qualified medical expenses. The $150 can be used for any health care expenses deductible on their taxes.

Q. I deal with Commonwealth Care Bridge members who have been here [in the U.S.] for more than five years. Who do they call to update that they have been here for more than five years?

A. The state wants the calls to go through the Connector. But if you wish to avoid the Connector, contact the MassHealth Enrollment Center (MEC), which has four offices throughout the state, and provide them with that information. The client would have to prove their status with immigration documents. Also, not everyone gets bumped up by virtue of being here for five years, only certain groups do.

Q. For the people that we serve, the way this happened was inconvenient for them – they had to change providers, it's difficult to communicate with them, and so on. How will it be going forward? Will it change again?

A. I don't know sitting here today. There are a lot of possibilities, and I wouldn't want to speculate. Given state budget issues, this will be taken up in the context of the state budget shortfall. I don't know what will happen with this population in July in regards to CeltiCare.

Q. Do you have a sense of the number of people who were approved for out-of-network services (i.e. specialty services)?

A. If that is a knowable number, I don't have it here, other than high profile cases (i.e. kidney transplants). One place to get this information would be from our claims data. We knew we would have to accommodate people getting care out-of-network, especially at community health centers, so we decided early on that we would approve care at community health centers. So for the first month or two, we will have what looks like a lot of out of network care, but from people who will or did ultimately come from within the network. Health centers and other providers have been great about working with us. My experience in the state is that providers are interested in working with us in regards to this community of patients.

AUDIENCE COMMENT Other MCOs and MassHealth will take it upon themselves to autoenroll a member when they don't choose. Is that a good approach? For next year, we think it would be beneficial to think about autoenrolling a client when they start out without a provider.

Q. The process of rolling out a program provides an opportunity to learn about what didn't work so well, and what could work better next time. One such aspect is the great information that your customer service reps seem to be collecting about your members, a lot of which seems to be collected for the first time. We think this gives us an opportunity to learn about the people the program is serving. What is your goal for this data? How will it inform the decisions you make going forward?

A. We are collecting information through a variety of health risk assessments that will help us learn about the needs of these folks and make sure they get connected with care. We have tried many things here and have thoughts about issues like what happens with a limited network and benefits when you have a short time to implement a program. We can learn from how the program was rolled out to understand what implications this

might have in the long run. That said, we won't have a good picture of what the data looks like until maybe this time next year. We have had a lot of anecdotes from concerned people about what will happen to a vulnerable population. We've tried to be careful about this and think we've got most of the concerns, but there may be stories out there about disruptions in care. We want to hear these stories, and they can also inform policy decisions at the state level. We will use our data to inform those decisions wherever we can.

Q. We can see in the Foundation's monthly reporting the after-effects of the communications that come from MCOs and the Connector. It is interesting to see your protocol for outreach, including calling members twice, etc. As a comment and suggestion, this population in particular is used to going to outreach and enrollment workers for process and navigation assistance. In the instances where you have a planned communication coming up, there would be a benefit to having a one-page communication plan disseminated to community-based workers, so that they have a warning, and know in advance how to assist their clients. When there is clarity about what will happen to this population, it is always good to let service grantees know your plan, so that they have time to prepare.

A. We have appreciated how engaged all of you are. It is a good thing that these Bridge members have access to folks like you. We didn't engage the community as much as we could have, and I am learning that in this process.

AUDIENCE COMMENT There are channels to reach community health workers – please feel free to contact us [Massachusetts Association of Community Health Workers] to discuss how to best contact them.

Q. Do you have your own Permission to Share Information form?

A. I don't believe we have a specific form at this time, but we can look into it.

Q. As a community health worker, we have a culture of how we care for our patients and one such aspect is having the same info coming to us that is going to them so we know how to educate that person. We are not receiving anything – we have no information and it is chaotic out there. As a question about your literature, is the information available in languages other than English and Spanish, and are they downloadable? I don't see Haitian Creole, for example.

A. We do have the capability of translating the material into Haitian Creole. We have been doing this based on languages with the highest demand, so you can definitely request this. We have brought CeltiCare bags with all the info, including what was received by members in their Welcome Packets.

Q. If we call on behalf of a patient, will customer representatives speak to us if the patient is not with us?

A. Yes, but there may be limits in terms of what we can say.

Q. Have you had contact with the legislature, such as being asked to do a briefing on this plan?

A. I have not been asked to do a briefing, but we have been speaking with legislators about what we are doing. I've met with various delegations that have questions, and made myself available. I anticipate having a long schedule of speaking with legislators.

FEEDBACK Suggestion to create a type of release form for MCOs to talk with community health workers, as it would address problems across the board. It might be good for the Office of Medicaid to take this up, as it would encompass programs.

RESPONSE Carolyn Pitzi from the Office of Medicaid said that she would take this back to MassHealth, and that there may be a more standardized form forthcoming that could be universal for all MCOs.

SMALL GROUPS "What's Ahead?"

Steve Belec of the Mayor's Health Line at the Boston Public Health Commission presents feedback from the Boston/Greater Boston Small Group that took place in the afternoon.

GREATER BOSTON AND BOSTON SMALL GROUP

WHAT DO WE KNOW

- Program is possibly ending
- Coverage could shift
- Vendor could change
- Decisions depend on the Legislature, then the Connector, then the Administration
- State is in a financial hole

POSSIBILITIES

- Need the ability to identify patients, especially if coverage changes, and ways to contact them about these changes
  - *Resource:* community health centers
  - *Connections plus:* CeltiCare program for clients without steady access to a phone
- Option to move Bridge back to Commonwealth Care, otherwise risk of dropping off to nothing
- Environment: Cost containment/payment reform
- CHCs: Networks? Contracts are good, network access is an issue

- Access issues: Vision, dental
- Access issues: No information on debit card described earlier
  – *Resource:* Communication to community (e.g. about debit program)
- New need for transportation (e.g. community-based organization current provides)
  – *Resource wanted:* List of hospitals and health centers not working with Bridge
- Comprehensive list of services provided/not provided by Bridge (what exists, where to go)

ISSUES/QUESTIONS

- *Question:* If no money available, what would we want to see as an alternative?
  – E.g. Health Safety Net – depends on availability geographically
  – E.g. Rx, pregnant women
  – Navigation around switching programs especially special interest populations
- *Issue:* People misclassified
  – Attention been paid so far, e.g. direct outreach
  – Need statistics on who upgraded, who is moving between plans
  – Documentation issues (e.g. self-report vs. need for more information)
    Advocacy tips, advice on how to talk to MECs
    MassHealth: want better info on their systems
- *AWSS on HSN* – what do they look like?
  – Total implementation → post-CeltiCare implementation → moving between programs → total numbers, usage, etc.
- Issue: pregnant women, soon to be eligible children, which programs, etc.
- Need clearer understanding of policies around vision (emergency covered, etc.)

HIGHLIGHTS/KEY ISSUES

1. Advocacy/policy challenge for next year
   - **a.** Hard to challenge CeltiCare – hard to at least maintain for next year
   - **b.** Current clients vs. next year
   - **c.** How to recognize good job so far vs. need/want more ($, coverage) going forward
2. If more money available, may allow for expanded network/coverage
   - **a.** Expand transportation, coverage, etc.
3. Open communication between community organizations and state
   - **a.** How to effectively use available benefits
   - **b.** How to effectively educate about uncovered services

Keisha DeJesus of Stanley Street Treatment and Resources presents feedback from the North and South Small Group that took place in the afternoon.

NORTH AND SOUTH SMALL GROUP

TRANSITION PROCESS

- Following the cut-off, notices were an extreme source of gaps in coverage for clients.
- Lowell Community Health Center witnessed clients being assigned to other PCPs, and prescription drug coverage becoming a serious issue.
- Stanley Street Treatment and Resources was the recipient of a lot of phone calls about confusion over what type of coverage clients had.
- Cambodian Mutual Assistance Association had to assist clients whose providers didn't accept CeltiCare, and clients wanted to know more about what this change meant.
- This process created a very similar type of confusion when compared with Commonwealth Care.

- Clients began canceling appointments with specialists, or were having to choose new specialists.
- Most clients are going to physician offices.
- Boston Medical Center not being contracted with CeltiCare poses a significant challenge.
- While most clients have overall successfully transitioned, the challenges lie mostly around provider networks.
- Contracting – having appropriate providers listed is important.
- Language barriers seem to represent 95% of the problem, and emphasize the lack of resources available.
- Lack of data around languages spoken by affected population.
- Babel form that is used for languages other that English and Spanish is not that helpful.
- Language line is also not that effective.
- Grantees are looking to send health center communications to supplement MCOs.
- Communications from an entity that they are not familiar with can cause a barrier – grantees seek to ease complication and confusion.
- When changes are about to occur, inform CHWs and advocates.
- Grantees want to know CeltiCare representatives.
- MTFs are helpful, but do not provide ample opportunities for questions.
- Many patients have providers who are not yet in the system – credentialing updates are necessary.
- Patients are wrongfully billed by providers who are not in the network.
- It is very early in the process to monitor the implementation of Commonwealth Care Bridge.
- There is confusion between the Commonwealth Care MCO and other health plans, as well as with CeltiCare.

Antonia (Toni) McGuire of Great Brook Valley Health Center presents feedback from the Central and Western MA Small Group that took place in the afternoon.

CENTRAL AND WEST SMALL GROUP

CONTRACTING

Issues related to provider network contracting

- So far, there is a limited network and participants are dissatisfied with the network change.
- How broad does the network need to be to accommodate patients affected? Currently, some doctors are not able to take on more patients.
- There was concern about the need to build relationships and contracts with St. Vincent's Hospital (the hospital that has contracted with CeltiCare). Health Center needs to establish new relationships with St. Vincent's, as many of its patients will now be instructed to go there. They do not have a referral process with St. Vincent's and many CHC providers do not have privileges there, adding to concerns about lack of continuity of care. There is concern that patients who are unfamiliar with St. Vincent's will continue to go to UMass.
- It was noted that CeltiCare has agreed to cover initial visits with providers during the contracting process.
- CeltiCare is knowledgeable regarding the contracting process and has been providing information via customer service reps. CeltiCare has tried to be as undisruptive as possible.

Front desk issues faced by clinics and community health workers

- Patients come to clinics with materials and with their Bridge insurance card because they do not know why they have received them. People do not understand their outreach packet materials.

- They have had to deal with pharmacies, especially CVS, and speak with their representatives to be educated. There are still some questions as to whether Walgreens accepts this insurance.
- A major issue concerns provider assignment: patients do not know the new provider to which they have been assigned.
- When a participant comes to a clinic or community health center that has not yet contracted with CeltiCare, that organization takes his or her name and says that it will get in touch once they are contracted.

OUTREACH & ENROLLMENT

Outreach packets and other materials

- Outreach packets have been distributed in Spanish and in English, however participants do not understand and/or do not know what to do with them. These packets could be more comprehensive.
- There is a need for materials to be in more languages than just Spanish and English. This population is diverse and speaks many languages, especially Portuguese.

Determination of Patient Eligibility/Status

- Providers are much more informed than patients; when a patient's status has changed, providers and community health centers direct patients to report their change in status.
- However, there are adequate resources in place to determine a person's status and eligibility. Community health workers, etc. can call MassHealth and/or direct the patient to a MassHealth Enrollment Center (MEC).

There is confusion/reservation about whether this is a public charge and might affect future eligibility for visas or citizenship application.

Connecting patients to newly assigned physicians/PCPs

- Patients do not want to go to new providers, with whom they are not familiar
- Some of these providers have waiting lists or are not accepting new patients. However, it was noted that preselected PCPs are taking new patients.
- When patients are hesitant to go to a new doctor, CHCs do not enroll that new provider, but instead contact CeltiCare regarding a provider change.
- Cultural and linguistic competencies are not as strong with some providers as with others.
- It is better to give a patient the option to choose a PCP. Autoenrolling patients to a PCP they do not know is unfair.
- Patients cancel appointments because they don't know what will happen.

Holyoke experience

- Health Access Network → concern with information.
- Concern that Western MA is spread out, and there isn't much public transportation available.
- It is important to have more network providers.

Worcester experience

- Bridge vs. HSN? → HSN
- Even in Metrowest, patients will go to a CHC anyway because of its cultural and linguistic capacity.
- Pharmacy remains an issue for Metrowest.

HSN v. Commonwealth Care Bridge vs. Mass Health Essential: Which is the better option?

- HSN pharmacy covered in-house; HSN is the better option because you can find your way around prescriptions.
- Specialists/ambulance, etc. are not covered by HSN, but perhaps only a minority of patients require these.
- MH Essential not as good for people with disabilities.

Impact on Community Health Centers

- CHCs act as conduits of information.
- There has not been an erosion of trust between patients and CHCs, as patients are concerned with the now. Patients know that CHCs are there to help, their dissatisfaction is not directed at them.

Hospital preparedness

- At this point, it appears that there is enough access at St. Vincent's, but that there will be a cap at some point. In addition, St. Vincent's will be faced with new cultural and linguistic challenges.

Other

- HSN 2 and 3 seems to be working for dental coverage.

Participants, in addition to the pre-registered group:

- Cindy Marti, Carolyn Pitzi, Brian Rosman, Bob Seifert, Toby Guevin, Vicky Pulos

Blue Cross Blue Shield of Massachusetts Foundation
A Convening of Grantees on the
Commonwealth Care Bridge Program

Wednesday, December 9, 2009
10:00 AM to 3:30 PM
Hoagland Pincus Conference Center
222 Maple Ave
Shrewsbury, MA 01545-2732

The Blue Cross Blue Shield of Massachusetts Foundation invites you to attend a grantee convening about the AWSS population and their transition to the Commonwealth Care Bridge Program. Participants will:

- **Engage in dialogue with Commonwealth Care Bridge CeltiCare representatives regarding implementation**
- **Identify ways to preserve health care access during a time of limited resources and**
- **Draw lessons from the process and decisions that led to the Bridge Program**

Speakers include Richard Lynch, President & CEO
CeltiCare Health Plan

Due to space restrictions, we are asking that organizations send no more than 2 representatives, which should include staff who directly assist clients with health care access, and their supervisors

Lunch will be provided
Please RSVP using attached form

For more information, contact Jen Chow at
Jennifer.Chow@bcbsma.com or 617-246-3509

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION

A CONVENING OF GRANTEES ON THE COMMONWEALTH CARE BRIDGE PROGRAM