

Meeting Minutes October 11, 2022 – One Care Implementation Council Meeting

Meeting Location: Zoom

Date: October 11, 2022, 10:00 AM – 12:00 PM

Council Member attendees: Suzann Bedrosian, Crystal Evans (Vice Chair), Dennis Heaphy (Chair), Jeff Keilson, David Matteodo, Kestrell Verlager, Chris White, Sara Willig, Darrell Wright.

Council Members not in attendance: Dan McHale

Key Stakeholders and Presenters: Corri Altman Moore (MassHealth), Leslie Diaz (My Ombudsman), Tony Dodek (UHC), Deanna Simonds (UHC), Lisa Fulchino (THU), Mark Waggoner (CCA), Ben Chin (CMS), Robin Callahan (CMFI Coordinator for MassHealth).

Meeting Support from UMass Chan Medical School: Hilary Deignan, Kasey Delgado, Cassidy DiRamio, Catie Geary, Maddy Vinton.

Presentations/Discussions: Agenda; September 13, 2022, Implementation Council (IC) meeting minutes; MassHealth Presentation *Massachusetts Duals Demonstration Transition Plan to an Integrated D-SNP*; IC Presentation *Implementation Council October 11, 2022*.

[Documents available online](#)

Executive Summary and Action Items:

Welcome/review September 13, 2022, meeting minutes

Crystal Evans, IC Vice Chair, opened the meeting and confirmed that the September 13, 2022, IC meeting minutes were approved as written.

MassHealth Updates

Corri Altman Moore, Director of Integrated Care at MassHealth, presented *Massachusetts Duals Demonstration Transition Plan to an Integrated D-SNP* providing an overview of the purpose, stakeholder engagement plan, policy and operational considerations, and the timeline of the Medicare Medicaid Plan (MMP) to Dual Eligible Special Needs Plan (D-SNP) transition.

IC Updates

Dennis Heaphy, Implementation Council (IC) Chair, and Crystal Evans, IC Co-Chair, presented the IC presentation *Implementation Council October 11, 2022*, which included a discussion about the transition from MMP to D-SNP, an overview of the revised mission statement and recruitment language, and an overview of the Long-Term Supports - Coordinator (LTS-C) workstream.

Meeting Minutes:

Welcome/review September 13, 2022, meeting minutes

Crystal Evans, Implementation Council (IC) Vice Chair, opened the meeting and confirmed that the September 13, 2022, IC meeting minutes were approved as written.

MassHealth Updates

Corri Altman Moore, Director of Integrated Care at MassHealth, presented *Massachusetts Duals Demonstration Transition Plan to an Integrated D-SNP* providing an overview of the purpose, stakeholder engagement plan, policy and operational considerations, and the timeline of the Medicare Medicaid Plan (MMP) to Dual Eligible Special Needs Plan (D-SNP) transition.

IC Updates

Dennis Heaphy, Implementation Council (IC) Chair, and Crystal Evans, IC Co-Chair, presented the IC presentation *Implementation Council October 11, 2022*, which included a discussion about the transition from MMP to D-SNP, an overview of the revised mission statement and recruitment language, and an overview of the Long-Term Supports - Coordinator (LTS-C) workstream.

Questions/Comments

MMP transition to D-SNP Discussion

- IC member stated they are still trying to understand how this transition is going to affect members on an individual level.
- IC member stated it is good to hear MassHealth is trying to protect the current One Care benefits and maintain My Ombudsman services.
- IC member stated that they liked the idea of creating work groups with IC member participation to help with the D-SNP transition planning process.
- IC member expressed concern about the transition and stated many One Care members do not trust Medicaid and Medicare to do what is best for them.
- IC member stated they hope the care coordinator will become an in-system advocate for members.
- IC member asked if there are two or three things MassHealth can point to that are anticipated to be improvements under this transition.
 - MassHealth stated they do not want to speak for the Center for Medicare and Medicaid Services (CMS), but the D-SNP structure exists in statute as a federal law and doesn't have an end point. In contrast, the demonstration authority for Medicare Medicaid Plans (MMP) that One Care currently falls under require reauthorization every few years which includes negotiations between the CMS administration and MassHealth.
 - MassHealth stated there are probably going to be some differences between the MMP approach and the D-SNP approach, but it is a path to make sure One Care continues which is a positive step for One Care. MassHealth stated they hope to find solutions to issues that have been and will be identified through this transition process.

- MassHealth stated this a change and they do not know exactly what it will look like at the end point, and some of the outcomes are going to depend on the specific choices that are made in the transition plan.
- IC member asked if this transition to D-SNPs is something that is happening nationally.
 - MassHealth stated this is happening nationally. MassHealth stated CMS wants to stop using the MMP demonstration authority as it exists today.
 - IC member suggested that CMS is trying to create a more uniform D-SNP system to help dual-eligibles across the country.
- IC member expressed concern that transitioning to a D-SNP will have a negative impact on the unique financing model that One Care currently operates under.
- IC member questioned how the IC will ensure CMS remains fully involved.
 - MassHealth stated this transition to D-SNPs intends to raise the bar in care for Dual eligibles in many states, but that One Care is already running above the bar.
- IC member stated MassHealth should create a statement to CMS that One Care will keep the benefits One Care members already have and just add any additional benefits gained from becoming a D-SNP.
- IC member stated that care partners need to be trained to understand the needs of disabled people and the difference between disability and being sick or injured. IC member questioned how a health plan or care provider can serve a population if they do not understand the basic needs of that population.
- IC member stated they feel MassHealth is committed to ensuring that One Care does not lose ground.
- IC member stated the timing of the Care Model Focus Initiative (CMFI) was excellent because it came before this transition from MMP to D-SNP and that what was learned from CMFI will drive improvements in One Care and will drive the work that is done between MassHealth, CMS, and the plans.
 - IC member stated they believe the council has a responsibility to act as advocates in this transition process and to uphold the improvements that were discussed during CMFI.
 - IC member stated they believe that One Care has many good aspects, but there are improvement areas that should not be lost sight of during this transition from MMP to D-SNP.
- IC member stated there should be trainings for care team members regarding how to treat and serve disabled persons to maintain the autonomy and voice of One Care members.
- IC member stated they believe the commercial insurance industry does not understand and does not meet the needs of people with disabilities. IC member stated they think the council needs to continue to work to change the commercial insurance model in partnership with MassHealth, CMS, and the plans.
- IC member asked if MassHealth can create an in-system advocate to help members navigate the health plan.
- IC member asked how to prioritize next steps.
 - IC member stated the first place to start is looking towards the end point of what they want One Care to be and improving where things are not working right now.

- IC member stated there are still a lot of remaining challenges but that there are also a lot of opportunities no matter the structure of the program at the federal level.
- IC Member stated that leadership from MassHealth and collaboration with the IC and all stakeholders is critical to a successful transition.
- IC member stated it is important for the One Care program to evolve by focusing on the priorities that came out of CMFI.
- IC member stated it would be nice to have trackable data that can be referred to two years from now to evaluate the impact of the changes of transitioning from a MMP to a D-SNP program.
- IC member stated the transition from MMP to D-SNP will call for increased transparency from both MassHealth and the plans.

Discussion on revised IC mission statement:

“The mission of the One Care Implementation Council is to harness consumer expertise, working in partnership with key stakeholders, to establish One Care as an integrated healthcare plan in the Commonwealth and a nationwide model for persons with disabilities that is whole person-centered, advances health equity, addresses health-related social needs, and prioritizes self-determination, independent living, and recovery goals of the disability rights movement(s).”

- IC member stated that the mission statement makes it sound like the only goal of the disability rights movement is recovery.
 - MassHealth stated it may be easier to see the balance between different priority areas in bulleted form.
- MassHealth stated the IC should consider a different verb to replace “establish.”
- MassHealth suggested that now the mission of the IC is to continue to *advance* One Care and to ensure One Care continues to operate in a way that serves its members well.
 - IC member suggested replacing “establish” with the verbs “preserving” or “improving.”

Discussion on revised Disability Statement:

“Disability is a social construct that is not easy to define. All members of One Care are eligible for MassHealth and Medicare because they meet the medical definition of “disabled.” Some people embrace their identity as a person with a disability. Other people do not self-identify as disabled because of stigma or marginalization. Race, gender, and other factors play into whether a person discloses their disability or whether they believe they have a disability.”

- IC member stated the above statement is not a definition of disability.
 - IC member stated any definition of disability is, at best, not fully inclusive or narrows down disability into something that can be confining.
- IC member suggested the word “federal” should be added in front of “medical definition” to eliminate ambiguity.
- IC member asked if “class and culture” can be added to “race and gender.”

- IC member asked if the definition of disability that a person needs to meet to be eligible for Medicare and Medicaid is the federal definition.
 - IC member stated there are federal standards of disability people must meet in order to be eligible for MassHealth and Medicare.
 - IC member stated they do not know if the statement should include anything about the federal definition.
 - IC member stated they think including the federal definition, is highly relevant especially due to the recent addition of long COVID to the federal definition.
- IC member stated they don't think there is an agreed upon definition of "disabled."
- IC member stated the ideas of disability as a definition and disability as an identity are conflicting or contrasting ideas about disability.
- IC member stated the sentence can be reframed to highlight the contrast between state and federal definitions of disability and the IC view on disability.
- IC member suggested writing "While there is this federal definition in order to be eligible for benefits, we, the Implementation Council, as part of the disability rights movement, do not provide a definition of disability." IC member stated this will make it more clear why there are two perspectives.

Long Term Supports - Coordinator (LTS-C) Discussion

- IC member stated they would prefer a word other than "operationalized" used when discussing how the Long Term Supports - Coordinator (LTS-C) is involved in independent living and recovery principles.
- IC member stated that the LTS-C role and integration with the care team has been an issue since the inception of One Care.
- It would be helpful if small groups of IC members had discussions plan by plan to learn about how things are going and what the issues are. IC member suggested to improve the role, Community Based Organizations (CBOs) and organizations involved should have a voice in defining the role.
- IC member stated an LTS-C would work with a member in their plan to find resources, services in community that would support the member's wellness, independence, and recovery goals. IC member stated this is what they meant by having an in-system advocate. The in-system advocate would know everyone who could help to support the member.
 - IC member asked if it is confusing having the two titles of care coordinator and LTS-C.
 - IC member stated the LTS-C role is something that needs to be clarified and improved.
- IC member stated there are not enough LTS-Cs to meet member need and that there is confusion created by the word "coordinator" in the title.
 - IC member stated that members need to feel comfortable talking to the person in this role and having a lot of turnover makes it difficult to develop the necessary relationship.
- IC member questioned what the biggest LTS-C implementation challenge will be for plans.
- IC member asked if any organizations, beyond the Independent Living Centers (ILCs) and Aging Service Access Points (ASAPs), have more specialized LTS-Cs.

- IC member stated provider agencies do not provide an LTS-C or care coordination services to make sure the LTS-C is a conflict-free role.
- IC member asked how to ensure the LTS-C understands the difference between hands-on care versus those who need support to initiate or complete a task.
 - IC member stated the LTS-C is not there to provide direct services. IC member stated the job of the LTS-C is to listen and interact with the member through the independent living lens and determine what services the member needs for them to live in the community.
- IC member asked how to ensure the LTS-C is understanding the barriers to independence with somebody whose disabilities are less visible than a physical disability.
 - IC member stated the LTS-C's role is about understanding what the member's needs, goals, and hopes are and how the goals may be met with One Care.
 - IC member stated the LTS-C improvements will come from determining what is the system in place where people can get support either within the agency that is providing the LTS-C or looking at other resources for that training, supervision, and ongoing training.
 - IC member stated it is essential to build a trusting relationship between the LTS-C, the care partner, and other members of the care team.
- IC member stated they do not know who their LTS-C is and that they have found there is no way to quickly identify who a member's LTS-C is.
- CMFI stated the kickoff for the LTS-C CMFI Work Group, which will look at the current state of the LTS-C role and how to improve it, is happening soon.
 - CMFI stated UMass Chan will collect materials and conduct several interviews over a several month-long process to gather as much input, documents, data, and opinions as they can to make this role more meaningful.
- IC member stated the LTS-C role is an example of work being done to make sure that One Care is meeting the needs of members.
- IC member stated they believe the MMP to D-SNP transition is going to be a challenge, but there are still opportunities for IC members to ensure the growth and improvement of One Care.
- MassHealth stated the LTS-C role is one of the fundamental pieces that they look at to ensure that members' needs are being met.
- IC member stated they believe one of the challenges in the LTS-C work is that the systems that currently exist are not set up for what the LTS-C work is trying to do.
- IC member asked if there is currently a way to have the LTS-C and the care coordinator talk to each other.
 - IC member stated they think the LTS-C and care coordinator should be able to coordinate and engage with each other.
- CMFI stated that the LTS-C work group will focus on how to make these connections happen and how to make the role respected and effective.

The meeting was adjourned.

Dennis Heaphy, One Care Implementation Council Chair

As everyone is aware, come 2025, One Care will be moving away from the Medicare-Medicaid Plan (MMP) model to a Fully Integrated Dual Eligible (D-SNP) model.¹ These changes are not coming for another two years.

Today is a time to follow-up on last week's MassHealth presentation and ask questions. We need to begin to put these changes into context. We need to understand how these changes will affect the role of the Council, the larger disability community, and providers.

This is the first of many conversations that will take place.

MassHealth Comments to CMS

On March 7, 2022, MassHealth wrote to CMS regarding the final rule and its failure to address the overlapping and at times conflicting requirements of Medicare and Medicaid regulations, and the administrative and cost burdens that will fall upon MassHealth as a result of the final rule.

It has been nearly 10 years since One Care's fully aligned plan model began. The final rule turns back the clock on a decade of progress.

To quote MassHealth: "It is perplexing that CMS declines to go further in its rulemaking for products serving dual eligible members to address the conflicts in governance. Without this aligned, reconciled view, integration will remain elusive."²

Following on the words of MassHealth, the One Care plan loses the three-way contract, aligned funding streams, shared savings, and other elements key to the potential success of the plan.

We now face an important question: Why should people with disabilities Medicaid and Medicare under the age of 65 put their trust in One Care?

As someone invested in the success of One Care, I think it is only right to ask this question since the answer will impact so many people who are low-income with complex medical, behavioral health, and LTSS needs.

One Care is at an important inflection point and its record to date has been mixed. People like me and others on the Council can give testimony to how important One Care has been in helping us to maintain our health and ability to live in the community. At the same time, we can share stories about barriers to care that did not exist four years ago but are the result of increased use of commercial insurance practices, such as: 1) administrative denials, 2) authorization delays, 3) delays in payments to providers, 4) network adequacy and service reductions affecting a range of services including oral health, and, 5) inappropriate utilization management practices that include increased use of proprietary automated decision-making tools, and inadequate or ineffective care coordination.

1

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjy_K3Njtf6AhXqkIkEHZheCs8QFnoECBoQAQ&url=https%3A%2F%2Fwww.mass.gov%2Fdoc%2Fone-care-initial-plan-for-transition-process%2Fdownload&usq=AOvVaw1rfpFm6DymhoRjWIGGiuVV

2

<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiG1cO4htf6AhVvj4kEHVf3AU0QFnoECBIQAQ&url=https%3A%2F%2Fwww.mass.gov%2Fdoc%2Fmassachusetts-comments-on-cms-duals-proposed-rule-march-7-2022%2Fdownload&usq=AOvVaw0e0-HWIOJ2z8pY2jdcQ5hb>

These were not just the experiences of Council members, but other One Care members. These experiences reflect practices antithetical to One Care's goals. And these experiences are why MassHealth established CMFI. The work of which continues, but we must be honest, the work is made that much more daunting as a result of the changes being put on One Care by CMS.

At the end of the day, One Care's special sauce is the MassHealth benefit package plus Medicare benefits provided in an integrated person—centered coordinated manner.

The plan's role is simple. It is to maximize consumer access to these benefits in a manner that supports an individual's ability to live a meaningful life in the community that includes access to all the services needed to live that life. This means delivering the services at the right time, the right place, at the right amount and in keeping with independent living and recovery principles. Investment in these upstream services is important to reduce unnecessary hospitalizations and emergency department visits. And when there is acute care use in hospital and in ED settings, it's imperative that plans support seamless continuity of care and care transitions regardless of setting and need – be it a psychiatric facility, a detox center, or a rehab setting.

While we have a deep respect for MassHealth and its commitment to maximizing the MassHealth benefit by offering generous and enhanced LTSS and behavioral health services, and social services, we also know that the MassHealth budget is increasing as a percentage of the state budget every year. This will inevitably lead to increased pressures on MassHealth to reduce One Care costs.

When MassHealth costs increase, what will happen to the One Care benefits?

Maximum Out-Of-Pocket (MOOP)

MassHealth has been very concerned about the impact of the Maximum Out-Of-Pocket (MOOP) on the MassHealth budget. The answer to this question is especially important, given that NO out-of-pocket expenses is one of the primary reasons that members enroll in the One Care plan.

FIDE SNPs are not the same.

From the start of One Care, the Council has been requesting a clear apples-to-apples comparison between the One Care and SCO plans.³

How will plans differ their benefit package based on differences in population and population needs?

- How will plans address the needs of “frail elders” to maintain people safely in their homes versus the needs of adults to operationalize the independent living philosophy and maximize people's ability to participate in the community?
- How do utilization management functions differ? How are they the same?

When will the Council receive this comparison information? Passive Enrollment

MassHealth has been consistent in its rationale for passive enrollment as necessary to support the sustainability of One Care, while simultaneously concerned about the quality of the plan. Therefore, the Council and disability have been consistent in their opposition to passive enrollment as a means of growing the One Care scale.

³ SCO stands for Senior Care Options plan.

The Council and disability community have worked with MassHealth to make passive enrollment more tenable. However, the stakes are much higher, since the linkage between the growth and quality of One Care is elusive.

How can MassHealth justify asking dual eligible individuals to passively forfeit their Medicare statutory right of choice of providers, absent an appropriate comparison and satisfaction rates between the One Care population and dual eligible population in the fee-for-service system?

It is also important to note that MassHealth will have to rely on the Medicare Improvement for Patients and Providers Act (MIPPA) plan. This will result in an increased administrative burden for the state and instability in the dollars available to maintain adequate and appropriate targeted outreach to dual eligible beneficiaries about their rights.

It is urgent that MassHealth work with the Council, larger disability community, their allies, and providers to put appropriate protections in place to incentivize active enrollment.

Joint Oversight of One Care and SCO Plans

CMS has an obligation to work with MassHealth to establish joint oversight of One Care and SCO plans. While less than optimal, joint calls may create some opportunity for ongoing understanding by CMS of ongoing challenges with One Care.

CMS also has an obligation to build relationships between Medicare staff and MassHealth staff to reduce barriers in alignment resulting from Medicare staff lacking in understanding of Medicaid and the unique needs of the dual eligible population under 65.

The Council is committed to working with CMS and MassHealth to reduce the fractured oversight of the One Care plan that will result from its transition to a FIDE SNP platform.

What are the barriers that will prevent appropriate federal and state oversight of One Care?⁴

There are many potential barriers ahead of us. We cannot take the benefits of the MMP model for granted, as we move from an MMP platform to a FIDE SNP platform.

Under the Medicaid-Medicaid Plan (MMP) model, we took it for granted that CMS and MassHealth would work together to educate members, including people with disabilities under 65, and to harmonize and align the Medicare and Medicaid plans.

- No single contract but separate contracts. All D-SNPs have executed SMAC contracts with state Medicaid agencies. A SMAC is a "State Medicaid Agency Contract" (SMAC), also known as a MIPPA contract. The contract must include Medicare-Medicaid integration requirements and, unified appeals and grievance processes for some D-SNPs.⁵
- No joint MLR but separate MLRs and no ability to capture Medicare savings. Under the MMP model, Medical Loss Ratio (MLR) reports were far from perfect, but they served to measure plan spending relative to plan revenue for total Medicare and Medicaid plan. Now, the MLRs will be separate. A joint MLR is needed to track and oversee plan spending, plan margins, and support actuarial soundness, and set targets for plan performance.

⁴ <https://aspe.hhs.gov/reports/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-challenges-0>

⁵ [D-SNPs: Integration & Unified Appeals & Grievance Requirements | CMS](#)

- Separate practices. Does capitated managed care at scale even work for vulnerable populations, given that insurance companies create barriers to adequate and appropriate quality care for members by prescribing when and where members can receive care, narrowing provider networks, reducing provider payment rates, and instituting other practices?

We have many important conversations ahead of us. We look forward to collaborating with MassHealth and CMS to put this right.