



**Community  
Catalyst**



## **A Call for Equity: Re-Committing to an Independent Living and Recovery-Centered Model of Care**

*Key Recommendations for State Medicaid Programs in Preparing State Medicaid Agency Contracts (SMACs) for Integrated Care Programs for Dually Eligible Individuals*

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## ABOUT THE AUTHORS AND PARTNERS

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### Partners

**Brandon G. Wilson**, DrPH, MHA, is the senior director of Community Catalyst’s Center for Community Engagement in Health Innovation. The Center conducts community-based research to understand better how inequities in the US health system drive poor health outcomes for historically excluded communities and drives practice and policy strategies based on its findings. Dr. Wilson is also a member of the organization’s senior management team. Previously, Dr. Wilson served as a public health adviser with the Centers for Medicare and Medicaid Services (CMS), Office of Minority Health, and as a social sciences researcher within the CMS Innovation Center. At the National Institutes of Health (NIH), Dr. Wilson led recruitment and retention efforts for increasing minority screening and enrollment in preventative and therapeutic vaccine

clinical trials and participation in the National Institute of Allergy and Infectious Diseases' community advisory board. Dr. Wilson also directed projects regarding the culture of patient safety quality improvement for the NIH's Clinical Center Office of the Director. Dr. Wilson received a master's degree in health systems management at George Mason University, and a Doctor of Public Health at Morgan State University. He holds a faculty appointment at the University of North Carolina–Chapel Hill's Gillings School of Global Public Health. His research interests include using patient-centered and indigenous models of care, health economics outcomes research, policy analysis, and community-based participatory and action research to eliminate health disparities and advance health equity in underserved and disinvested communities. In 2023, he wrote an article for the Health Affairs Forefront major series, Medicare and Medicaid Integration, called [Engaging Dual-Eligible Beneficiaries To Build Effective Integrated Care Programs](#). In this article, he expressed his belief that “to build a more transformative system that is more responsible and accountable to people and communities,” policy makers, health plans, and health systems must take a step back and ask dually eligible people: “What do you want.” Brandon also participated in a Health Affairs online event: [Briefing: Key Challenges Encountered By The Medicare and Medicaid Dually-Eligible Population](#).” This event also focused on the potential solutions to the key challenges.

**Leena Sharma**, MPP, is Director of Community Catalyst's Center for Community Engagement in Health Innovation. In her role as Director, Leena works alongside the Senior Director of the Center to carry out the various initiatives focused on ensuring that community voices are represented in health system transformation. Leena plays a leadership role within the organization particularly around improving programs and policies related to integrated care for individuals who are dually eligible for Medicare and Medicaid.

Previously, Leena worked at the Alzheimer's Association's Greater New Jersey Chapter as a public policy, advocacy, and volunteer coordinator. While there, Leena advanced public policy advocacy efforts on behalf of individuals who struggle with Alzheimer's disease and their caretakers. Leena received a bachelor's degree in political science from Rutgers University and a Master in Public Policy (MPP) from Monmouth University. Leena has made many contributions to this field. In celebration of Women's History Month in 2022, Arnold Ventures recognized Leena for her role in [empowering dually eligible individuals to improve their care experiences](#).

## A Dignity-Based Independent Living and Recovery Centered Model of Care

This brief aims to assist policy advocates and policymakers in their development of state Medicaid agency contracts (SMACs), as they strive to ensure dually eligible enrollees in a Medicare Advantage (MA) Dual Eligible Special Needs Plans have full access to benefits available under Medicare and state Medicaid policies. It seeks to address gaps in the Centers for Medicare and Medicaid Services (CMS) [rule changes](#) by strengthening state SMACs. While not all-encompassing, the brief introduces a whole, person-centered framework of healthcare delivery that advances health equity and the dignity of the individual. It recommends ways to strengthen opportunities for enrollees to access needed services to live meaningful lives in the community.

### WHY IS THIS BRIEF IMPORTANT TO DUALY ELIGIBLE INDIVIDUALS?

A dignity-based model of care (MOC) is based on the independent living (IL) civil rights and recovery movements, which led to the creation of [home and community-based services](#) (HCBS), the deinstitutionalization of persons with mental health diagnoses, and the ongoing shift in our understanding of substance misuse to a more whole-person understanding of addiction. Foundational to the independent living (IL) and recovery movements is the core belief that all people with disabilities across the lifespan are endowed with basic dignity and rights articulated under the [Americans with Disabilities Act](#) (ADA). For many people with disabilities, a high percentage of whom are dually eligible, these rights can only be realized if provided access to community-based [long-term services and supports](#) (LTSS) and recovery services, embracing the principles that include consumer choice, control, dignity of risk, and hope.

A significant percentage of dually eligible individuals face barriers to community integration and well-being resulting from the convergence of [unmet](#) long-term services and supports (LTSS) needs and social drivers of health. For example, key social drivers such as food and housing are compounded by a lack of personal care attendant (PCA) services, accessible transportation to food pantries and other nutritious food sources, and an absence of affordable, *accessible* [housing](#). Persons in recovery lack access to low-threshold housing or housing that supports maintaining housing stability and recovery. For Black people and other minority populations, all of these barriers to wellness are exacerbated by the compounding of racism and other forms of biases and discrimination.

To fulfill their mandate, MA D-SNPs must rebalance priorities from downstream medical solutions to more holistic ones requiring investment in upstream community-based interventions. Such interventions include investment in community-based LTSS and [peer-based recovery support](#) services. Medical care should shift away from institutional medical settings e.g., hospitals and clinics to home and community-based settings to support a more seamless integration of medical, recovery, LTSS and [social drivers](#) of health services. In this model of care (MOC), the

person drives the care team, and collaborates with the care team to establish goals for achieving wellness and a roadmap for attaining these goals. Finally, advocates, policymakers and other stakeholders must work together to develop a clear understanding and measurable method of addressing inequities rooted in racism and other forms of identity bias and discrimination that underlie barriers to wellness for Black, Indigenous, and people of color (BIPOC) populations.

**THIS BRIEF SEEKS TO ADVANCE TWO KEY GOALS:**

**GOAL 1. Elevate the importance of a dignity-based, independent living (IL) and recovery-centered model of care (ILR-MOC) grounded in the civil rights principles of the IL and recovery rights movement to achieve health equity for dually eligible individuals.** In this brief, the “independent living and recovery centered model of care” or “ILR-MOC” is used to refer to the dignity-based independent living (IL) and recovery-centered MOC, as created and operationalized by [Community Medical Alliance](#) (CMA). Disability equity requires a commitment to building relationships across populations of persons with disabilities with a focus on the intersectional challenges faced by BIPOC populations subjected to the compounding effects of racism and other identity-based forms of discrimination that go beyond [ableism](#).

**GOAL 2. Encourage a call to action by CMS, state Medicaid offices, and advocates.** Action is needed to: (1) maximize dually eligible individuals’ access to benefits available to them under Medicare and Medicaid, and (2) protect the rights of dually eligible individuals. The [2010 Affordable Care Act \(ACA\)](#) included creation of the [Center for Medicare and Medicaid Innovation \(CMMI\)](#). In 2011, CMMI established the Financial Alignment Initiative (FAI) Demonstration.<sup>1</sup> The demonstration aimed to enable states to integrate care for dually eligible individuals. Under the FAI demonstration, CMS offered a [capitated model](#) of integration, under which plans would operate under a three-way contract with CMS and the state Medicaid agency and receive a blended Medicare and Medicaid capitation rate. Under the capitated model, plans were required to provide seamlessly integrated Medicare and Medicaid benefits and services to plan enrollees. By 2026, states must shift from FAI demonstration authority to another platform. Most states will rely on the MA [Dual Eligible Special Needs Plans \(D-SNPs\)](#) platform to integrate care. D-SNPs are permanently authorized by federal statute.

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<sup>1</sup> [Pass enrollment\\_briefFINAL.pdf \(communitycatalyst.org\)](#)

## THIS BRIEF FOCUSES ON TWO KEY COMPONENTS OF INFORMATION:

COMPONENT 1. **A framework for ensuring that dually eligible individuals enrolled in a D-SNP have access to an Independent Living (IL) and Recovery MOC (ILR-MOC) to maximize the opportunity for dually eligible individuals to live healthy and meaningful lives in their chosen community setting.** The MOC hinges on a trust-based care team and care coordination model committed to advancing the inherent dignity of persons with disabilities. The brief is not intended to comprehensively cover all issues important in creating the D-SNP MOC.

COMPONENT 2. **A description of the ILR-MOC and toolkit with policy recommendations for embedding the ILR-MOC into state Medicaid agency contracts (SMACs).** The Centers for Medicare and Medicaid Services (CMS) requires all D-SNPs to have an executed SMAC with state Medicaid agencies. Most states operating under FAI demonstration authority today will operate as a D-SNP type in 2026. Disability advocates urge state Medicaid programs and CMS to be prescriptive in their SMACs and provide accompanying plan policy guidance to ensure that plans establish an ILR-MOC that provides enrollees access to the full array of Medicaid, Medicare, and other services needed to live healthy and meaningful lives in the community.

## KEY TAKEAWAYS

**#1. In contrast to CMA, a Medicare Advantage (MA) platform is grounded in a medical MOC, with evidence of practices that are antithetical to a person-centered approach.** Among disability advocates, the FAI's transition from a demonstration program to a D-SNP platform raises concerns. MA plans including D-SNPs have limited experience in operationalizing an ILR-MOC. Medicare's MOC is medically focused, and influenced by Medicare's payer role. Medicare's role is to provide all medically necessary services covered under Medicare. Medicare is the primary payer for acute and post-acute care for dually eligible individuals. At the same time, Medicaid's role focuses on community services including home-and community-based services.

To manage Medicare benefits, MA plans, including D-SNPs, use various practices such as prior authorizations that compromise access to medically necessary care, and undermine equity, Independent Living (IL), and recovery goals for individuals with disabilities. D-SNPs tend to have more experience investing in downstream services with a more direct return on investment (ROI) and less experience investing in upstream needs and innovations. Disability advocates are concerned about how D-SNPs will address the needs of complex populations due to: (1) the increasing role of private equity, and (2) the increasing use of opaque algorithms.

While it is true that private equity can help to expand innovative programs and bring them to scale quickly, it is also true that these same growth strategies can lead to standardized and off-the-shelf policies. Such policies are antithetical to equitable care and a person-centered approach. As a result, private equity can adversely affect plan enrollees, resulting in reduced quality of life, increased morbidity and mortality in populations with complex needs, and costs.

Increasing evidence shows that plans also use artificial intelligence (AI) algorithms to reduce service access. Using [algorithms](#) for purposes other than advancing equity and whole person-centered member goals is also antithetical to a person-centered approach because the plan's decision may not align with the individual's needs and the care team's recommendations. Plan models used to deny care are often opaque to enrollees, reducing the ability of enrollees to mount appeals. This is further exacerbated by plans defining algorithms and models as "[proprietary](#)." The increasing use of predictive models has caused concern among federal [policymakers](#) committed to ensuring that plan medical determinations are based on the individual's needs. The increasing use of private equity and algorithms in health care has many policymakers calling for transparency to keep plans aligned with person-centered approaches.

**#2. State SMACs should be grounded in trust-based and collaborative relationships with disability advocacy groups and groups serving minoritized populations with disproportionate percentages of persons with disabilities.** All integrated care programs should continue to evolve. In D-SNP, evolution depends upon a well-designed SMAC, plan investment in collaborative relationships that integrate the intersectional diversity of the disability community and require plans to build linkages with and between these diverse community-based organizations. Without creating linkages and addressing the intersectional dimensions of racism and ableism, which compound the effects of ableism on populations whose health outcomes have been negatively impacted by discrimination, D-SNP programs will never realize their full potential. Moreover, poor health outcomes for dually eligible individuals will persist.

**#3. The future success of D-SNPs depends on a care coordination model grounded in relationships based on trust and expertise.** States cannot mandate trust. They can, however, leverage SMACs to establish a framework with rules to create the right conditions for trust and personal relationships to take hold. Care coordinators should be empowered to make real-time decisions in response to the person-centered needs of people with disabilities, with benefits to enrollees and plans. Individuals will benefit from plans that adhere to the care planning processes in terms of better care experiences and outcomes. Plans will also benefit as dually eligible individuals find plans more appealing because they can trust their plans. Care coordinators must have expertise in understanding complex populations. To improve plan enrollee experience and outcomes, states can take steps that include: (1) setting minimum ratios of care coordinators to plan enrollees; (2) instituting minimum levels of care coordinator expertise for the highest complex populations; (3) establishing requirements to mitigate care coordinator conflict of interest to strengthen the [relationship](#) and trust between plan enrollees and care coordinators; and, (4) putting in place minimum standards for care planning development and coordination by care coordinators.



## An Historical Perspective on One of the Nation’s First Integrated Care Programs

More than 30 years ago, the nation’s first integrated care programs were established in Massachusetts by [Community Medical Alliance \(CMA\)](#). CMA operated in Greater Boston in partnership with disability advocates, serving as one of the nation’s earliest pre-paid integrated care programs, specifically designed for persons with severe disabilities and late-stage acquired-immunodeficiency-syndrome (AIDs).

CMA was a small, nimble program grounded in a dignity-based, independent living and recovery centered model of care (ILC-MOC) to advance equity and the capacity for addressing the upstream needs of persons with chronic conditions and disabilities. CMA’s MOC was grounded in trust and relationship, emphasizing the dignity of persons with disabilities. Committed to the values and principles of the independent living movement, the pioneering work of healthcare professionals invested in partnering with the disability community to create fully coordinated, whole-person-centered in-home care for persons with complex needs.<sup>2</sup> CMA’s leadership was invested in “empowering individuals with disabilities to take control of their lives and live independently,” according to the [Boston Center for Independent Living \(BCIL\)](#). The CMA Board of Directors included representatives from the disability community to ensure its MOC maintained its commitment to consumer choice, control, and dignity of risk. As a result, CMA’s ethos remained true to its “North Star” and commitment to advancing the rights of persons with disabilities to live healthy and meaningful lives in the community.

The MOC was streamlined, focusing on reducing barriers to services and maximizing access to benefits. The MOC emphasized providing upstream services to assist members to achieve independent living and recovery-centered goals by increasing services that maximized opportunities for community integration, reducing isolation and loneliness, and promoting interdependence. The MOC drew on literature showing that adequate and appropriate durable medical equipment (DME) and Personal-Care Attendant (PCA) services reduce preventable emergency department (ED) visits and hospitalizations. CMA’s MOC demonstrated that operating under a capitated model for people with complex needs is achievable. CMA attributes these savings to their MOC commitment to investing in upstream interventions such as DME to prevent expensive hospitalizations related to decubitus ulcers or diversionary services for those with mental health conditions. See **Exhibit 1** for a summary of the ten key features of CMA’s MOC.

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<sup>2</sup> Master, R., Dreyfus, T., Connors, S., Tobias, C., Zhou, Z., & Kronick, R. (1996). The Community Medical Alliance: an integrated system of care in Greater Boston for people with severe disability and AIDS. *Managed Care Quarterly*, 4(2), 26-37. Glover, M., Master, R. J., & Meyers, A. R. (1996). Boston’s Community Medical Group (BCMG): a national model of prepaid, managed, care for independently, living persons with spinal cord injuries (SCI). *American Rehabilitation*, 24(4).



Of note, the Massachusetts One Care program was shaped around an ILR-MOC established more than 30 years ago by Community Medical Alliance (CMA). CMA provided the blueprint for the One Care program. For more information about the One Care program, see the “One Care Case Study” in this brief's final section.

**Exhibit 1. Ten Key Features of CMA’s Model of Care**

<b>CMA’s Model of Care (MOC)</b>	
<b>1</b>	The MOC was grounded in trust, with the full support of the disability community.
<b>2</b>	Home was the locus of care.
<b>3</b>	A home-based integrated care team that included paramedics.
<b>4</b>	CMA ensured consistency of staff in the home.
<b>5</b>	Individuals had direct, personalized, streamlined communication and access to care coordinators.
<b>6</b>	The individual’s care coordinator was part of the care team.
<b>7</b>	The care coordinator was integrated into the care team seamlessly.
<b>8</b>	Care coordinators had real-time decision-making authority over needed services.
<b>9</b>	Individuals had ultimate choice over the care coordinator.
<b>10</b>	CMA used care planning processes over utilization management (UM) processes.

***It is important to note that, while focused on the dignity and rights of persons with disabilities embodied in the independent living movement, CMA’s MOC was only in the beginning stage of integrating recovery-centered care. So, even the CMA MOC was limited in its capacity and competency in providing truly person-centered recovery services to its members. The MOC must continue to evolve in a recovery-centered direction, requiring upstream investment into community alternatives for individuals with mental health needs.***

**CMA’s Personalized MOC with Direct and Streamlined Communication to Care Coordinators**

The MOC was very personalized, providing persons with disabilities with direct and streamlined communication with care coordinators. The MOC also supported consistency in staff in the home. The care coordinator assisted in training PCAs. The care coordinator had a first-hand, ongoing understanding of the person in their home or other environments. The care coordinator provided access to services and support for enrollees whenever needed. The care coordinator made real-time utilization management (UM) decisions.

### CMA's Home-Based Integrated Care Team

The home-based integrated care team was central to CMA's MOC. The care coordinator, usually an NP, was a care team member. The seamless integration of the care coordinator into the care team reduced the risk of UM systems countering authorization of equipment or services needed by an individual, which had already been agreed upon within the care team. The care coordinator had decision-making authority and the ability to make decisions at that moment. CMA worked to ensure flexibility in enrollee choice of care coordinators to increase enrollee engagement and agency.

### CMA's Personalized Care Model Provided Early Evidence of Savings

CMA provided early evidence that bending the cost curve is achievable while providing boutique-level personalized care. The model successfully reduced preventable ED visits, hospitalizations, and nursing home stays. CMA's success was based on investing in durable medical equipment and other upstream services and providing enrollees access to a porous network. CMA's keystone was the role of the care coordinator. The purpose of the care coordinator role was to ensure that enrollees received all services they were entitled to and needed to live independently in the community. The care coordinator was the decision maker, care team facilitator, and care team member providing in-home care.

#### **Figure 1.**

##### **Dr. Robert Master Offers Reflections on CMA (2023)**

In the 1990s, Dr. Robert Master established the Community Medical Alliance (CMA), in collaboration with the Massachusetts Medicaid program, pioneering what is now known as the nation's first risk-adjusted [prepaid care model](#) for Medicaid eligible individuals with severe disabilities and acquired-immunodeficiency-syndrome (AIDs). At the time, they were the two most expensive Medicaid populations, with the lion's share of costs going to fund recurrent hospitalizations. Dr. Master has a long history of providing dignity-focused, person-centered care for persons with complex needs. The locus of care was the home with nurse practitioners driving the care team. The practice evolved into the larger Boston Community Medical Group (BCMG), which became CMA. CMA became Commonwealth Care Alliance (CCA), which Dr. Master left and eventually established [Feltin Community Care](#) to "restore responsive, interdisciplinary care in the home; promote independence; and advance the goals of health equity throughout the Commonwealth." Feltin provides primary care and a more person-centered alternative to existing Medicare-Medicaid Plans (MMPs) participating the FAI demonstration in Massachusetts.

### **Voluntary, Population-Based Program**

Approximately 300 individuals with CDC-defined AIDS and 250 individuals with involved disabilities requiring extensive LTSS [Long-Term Services and Supports such as Home and Community Based Services] who live independently, voluntarily enrolled in the pilot program. Both populations received comprehensive interdisciplinary care at home, with same-day responses to new problems as they arose. Both populations functioned as empowered collaborators in their care.

### **Team Authorized the Care**

For those with disabilities, LTSS allocation was determined by individualized care plans developed by the clinical team in collaboration with those with disabilities for PCA [Personal Care Attendant] hours and critically important DME [Durable Medical Equipment] rather than anonymously based on strict medical necessity criteria for services.

### **NCQA Evaluation: From Pilot Status to Permanent Option**

The evaluation conducted by NCQA [National Committee for Quality Assurance] found that hospitalizations decreased by 60 percent; flap procedures for Stage IV pressure sores decreased by 50 percent; grievances and appeals and disputes over LTSS allocation decreased to less than a handful in a calendar year; satisfaction was exceedingly high; and, the increased costs of the interdisciplinary primary care team and enhanced LTSS was more than offset by reductions in hospitalizations and post-hospital institutional stays. For those with AIDS, the evaluation also cited similar reductions in hospitalizations, increased satisfaction, and decreased costs. In 1996, based on NCQA's recommendation, the program moved from pilot status to a permanent option for MassHealth members."

To learn more about "Supporting People with Severe Disability or Late-Stage AIDS to Live with Dignity at Home: Lessons from the Community Medical Alliance Demonstration, 1992-1996," see the [video](#) and presentation prepared by [Dr. Lisa Iezzoni](#).

### **FIDE SNPs Should Lean into the Independent Living and Recovery Model of Care**

From the perspective of disability advocates, today's [Fully Integrated Dual Eligible Special Needs Plans \(FIDE SNPs\)](#) or FIDE SNP models should continue to evolve to be considered an ILR-MOC. Informed by our experience, we know that many integrated care programs primarily provide telephonic care coordination to its enrollees. The care coordinator is not a member of the care team. Rather, the care coordinator is a plan representative, working in consultation with the team to support enrollee access to services. Unfortunately, from an enrollee perspective, this construct creates an anonymous and transactional care coordination model, creating an inherent conflict of interest as the care coordinator represents the plan or the payer. In another plan, the care coordinator is contracted by the insurer from a for-profit care coordination entity.

Many plans have a MOC requiring enrollees to take many actions, with many points of engagement, before reaching their care coordinators and providers. Clinical care team enrollees no longer make real-time decisions around implementing interventions, introducing new risks for enrollees.

Under the Financial Alignment Initiative (FAI) demonstration, the Medicare-Medicaid Plans (MMPs) operated today without a standard definition or set of best practices in care coordination. This problem is not unique to the MMPs; it is a universal problem. What this means is that individuals who are dually eligible are not able to have their needs met adequately for reasons that include: (1) the lack of adequate and conflict-mitigated care coordination; (2) failure to rebalance spending away from brick-and-mortar medical interventions to upstream community-based mental health and long-term care services that optimize health and independence; and, (3) inflexible medically-based insurance models with authorization processes and decisions based on automated algorithms, at odds with whole person-centered care processes and plans required to achieve health equity.

### **The Imperative to Evolve the MOC**

As we move into the next era of integrated care programs, CMS, state Medicaid programs, plans, disability advocates, and dually eligible individuals should come together to build upon the MOC by including all key features found in the early effective programs. They should design and operationalize an ILR-MOC, along with creating permutations of the ILR-MOC tailored to the intersectional needs of minoritized populations at the intersection of ableism and racism.

Future models should also address diverse needs such as palliative health and home care. As described by the California Department of Health Care Services (DHCS), beginning in 2024, California will require its D-SNPs to offer [palliative care services](#) for its members. DHCS defines palliative care as “specialized medical care for people with serious illnesses. This type of care focuses on relieving the illness’s symptoms and suffering. It can be provided along with curative treatment. The goal is to improve the quality of life for both the member and the family.”

Figure 2.

**Dr. Robert Master: Three Key Rules for Plans (2023)**

Dr. Robert Master outlines three important rules for plans serving dually eligible individuals residing in the community with the highest medical and LTSS needs, leveraging his expertise and experiences in Massachusetts.

**Rule #1: Plans should allocate LTSS based on care plans.** State SMACs must require plans that serve enrollees with complex care needs to allocate LTSS based on individual care plans developed by enrollees with their care coordinators and care teams. Care plans should ideally be developed in a setting of the enrollee's choice, such as their home, or at a minimum, using communication preferences as determined by the enrollee. Communication preferences may include but are not limited to virtual, phone, relay service, or primary language. Care plans should include both medical and non-medical goals.

**Rule #2: Plans should be transparent about their LTSS allocation policies.** States should develop transparency requirements for all plans to ensure that data reported back to the state is consistent and provide the state information that enables it to hold D-SNPs accountable, maximizing enrollee access to Medicaid and Medicare benefits in a person-centered way. Allocation policies require D-SNPs to rebalance the allocation of resources to LTSS and other upstream preventative services. SMACs should protect enrollees from care plan development and determination of LTSS needs via non-transparent, member-anonymous payer-developed criteria. This D-SNP practice is antithetical to the goals of promoting independence. It reduces service access and causes delays, grievances, and unnecessary appeals.

**Rule #3. Plans should promote effective, responsive primary care.** The primary care ecosystem in Massachusetts is collapsing with practices closing, clinicians exiting and even for the healthy, long waits to find a primary care provider (PCP). For those with complex needs, and mobility impairments, the current state is potentially an existential threat for those with the greatest needs.

Note: Readers should note that, under the current One Care program, those with the highest LTSS needs are enrolled in "C3 – Community Tier 3 – High Community Need. Individuals who have a daily skilled need, including two or more Activities of Daily Living (ADL) limitations AND three days of skilled nursing need; and individuals with 4 or more ADL limitations. C3 includes two subsets: (1) C3B: for C3 individuals with certain diagnoses (e.g., quadriplegia, ALS, Muscular Dystrophy and Respirator dependence) leading to costs considerably above the average for current C3; and (2) C3A: for remaining C3 individuals. See [enrollment](#) report.

### **New CMS Rules Lack Requirements to De-Medicalize Care Delivery**

Unfortunately, the D-SNP models, evolving under the new CMS rules, do not include specific requirements for plans to de-medicalize care delivery by rebalancing LTSS. Without clear guidelines requiring plans to invest in LTSS, upstream social determinants of health (SDOH) services, and recovery and diversionary services, many plans will continue to carry out practices that lead to preventable ED visits and hospitalizations.

In partnership with states, CMS should continue to work together to reduce restrictive [utilization management \(UM\)](#) processes and diagnosis-based medical-necessity codes and adopt innovations spearheaded by CMA in Massachusetts and the PACE, [On Lok Senior Health Services](#), in California. CMA and PACE MOCs designed processes around the needs of the populations they were created to serve. These "boutique" initiatives improved the financing and delivery of care to chronically ill and disabled populations – yet the very anchors that made these models successful are missing from the D-SNP model. CMA's commitment to independent living was one of the most important anchors of the model. The medical model used by many D-SNPs misses an important focus on risk-adjusted payment structures to support investment in upstream mental health, LTSS, and social drivers of health (SDOH), all necessary to reduce health disparities and health inequities. Also, D-SNPs are not mandated to provide a wide range of acute and long-term services tailored to the individual's needs. The CMS [rule changes](#) also fail to establish a conflict-free care coordination system that streamlines access to the person's medical, social, and other needs and fosters trust between the care team and the enrollee.

### **The LTSS Rebalancing Record Among States**

One of the most compelling reasons for the evolution of the MOC is to advance the rebalancing of care from institutional settings to the community. The latest [2020 CMS data](#) on LTSS expenditures highlight the opportunities that health care delivery has to shift more care delivery to the community while reducing reliance on institutional services. While it is true that the nation has made progress on Medicaid LTSS rebalancing, several states and many individuals are at risk of being left behind.

At the start of the FAI demonstration models, Home and Community-Based Services (HCBS) spending accounted for about 50 percent of total Medicaid LTSS spending. Twenty-three states had rebalanced LTSS spending. In 2020, HCBS accounted for 62.5 percent of total Medicaid LTSS spending, representing an increase in HCBS spending of 12.5 percentage points. Thirty-seven states had rebalanced LTSS spending.

However, 14 states have not rebalanced their Medicaid LTSS expenditures. Close to 2 million dually eligible individuals reside in these 14 states, where HCBS spending accounts for only 43 percent of total Medicaid LTSS spending. Unfortunately, these states have never rebalanced their LTSS expenditures, signaling a major equity issue for all persons with disabilities and older adults which has disproportionately affected Black residents. The authors observed that the

following 14 states are not rebalanced: Alabama, Florida, Hawaii, Indiana, Kentucky, Louisiana, Michigan, Mississippi, New Hampshire, New Jersey, North Dakota, Oklahoma, South Carolina, and West Virginia.

### **Looking Forward: CMS and State Opportunities**

CMS and state Medicaid programs have an important opportunity and imperative to leverage their state Medicaid agency contracts (SMACs) to establish an MOC that advances personal dignity and health equity as fundamental components of care delivery. An ILR-MOC would help to advance health equity, rebalance Medicaid LTSS spending, increase spending on recovery services, press for quality measurement improvements, and create opportunities for plans to enroll new members.

Plan success is inextricably linked to support from the disability community. See **Exhibit 1** for recommendations for state leaders to advance a sustainable integrated program that dually eligible individuals will wish to join.

### **Recommendations for State Leaders**

The disability community prepared the following recommendations for states, based on the key assumption that CMS will provide states with capacity funds to advance sustainable integrated care programs for dually eligible individuals. States have an ethical imperative to provide guidance and direction to plans to advance independent living and recovery for persons with disabilities including those with substance use disorder.

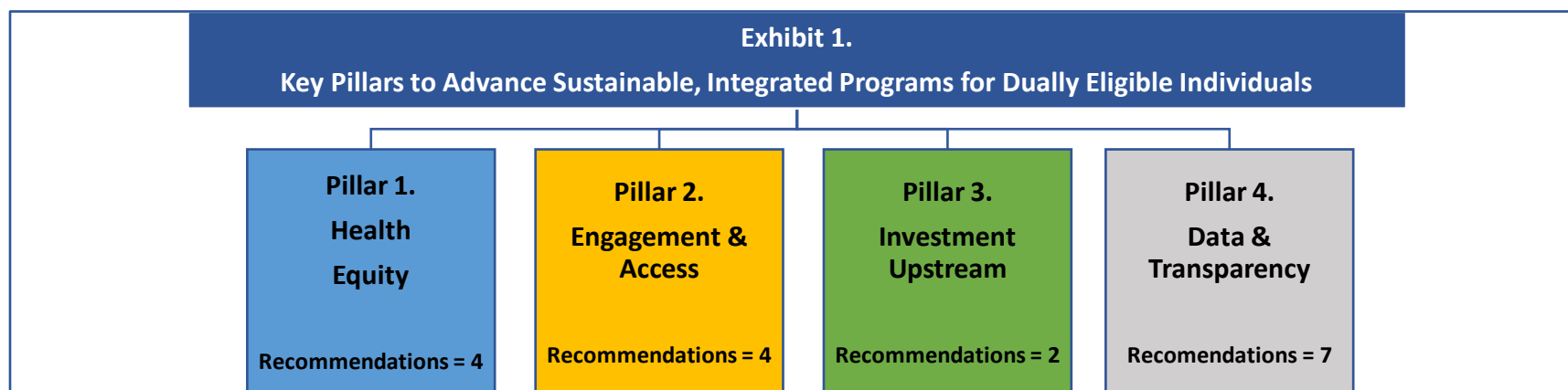
States are encouraged to include the following recommendations in their SMACs. We have categorized recommendations by pillar however, some recommendations overlap pillars. These recommendations could serve as a starter checklist for policymakers and disability advocates nationwide.



## A CALL TO EQUITY TOOLKIT: Re-Committing to an Independent Living and Recovery-Centered Model of Care

In recognition of the importance of integrated care programs for the ability of dually eligible individuals to live well, this toolkit is designed to assist stakeholders in creating better programs. It outlines recommendations for policymakers to consider when preparing their state Medicaid agency contracts (SMACs). SMACs, typically amended annually, are a potent policy tool used by states to enhance integrated care programs. States can translate these recommendations into contract language to operationalize them. According to a January 2024 presentation by the Medicaid and CHIP Payment Advisory Committee (MACPAC), “CMS officials said states are free to include any requirements as long as they do not conflict with federal law.” That being said, some states may not fully grasp the flexibility they have with SMACs, while others may lack the staff capacity or knowledge to capitalize on the opportunity to create better programs fully. To learn more about SMACs and sample language, follow the Integrated Care Resource Center (ICRC) [link](#).

**Exhibit 1** provides an overview of the toolkit’s pillars, followed by recommendations organized by four key pillars.



	Recommendations for States to Include in SMACs	Pillar 1. Equity	Pillar 2. Engagement	Pillar 3. Investment	Pillar 4. Transparency
1	<b>Independent Living and Recovery.</b> Identify principles to guide upstream prevention strategies and community-based services for the SMAC to advance Independent Living principles of consumer choice, control, dignity of risk, and recovery principles that includes hope, resilience, and community.	1.1			
2	<b>Intersectional Approach.</b> Provide guidance and establish requirements for plans to take an intersectional approach to persons and populations minoritized due to BIPOC, RELD, SOGIE, or other identities, whose health and service needs may differ from those of their counterparts who are white, male, and heterosexual. The data should be stratified by disability type and rating category.	1.2			
3	<b>Root Causes.</b> Require plans to address the underlying causes of disparities, including ableism, racism, stigma, and bias, as well as more complex intersectional inequities that compound health disparities.	1.3			
4	<b>Impact of Voices.</b> Measure the impact of disability voices on state SMACs, including the quantifiable impact on shared principles that shaped the SMAC and improve the MOC. SMACs must outline specific methods to be used to promote the voices of minoritized populations subject to stigma, bias and discrimination in the healthcare delivery system and larger society.	1.4			
5	<b>Implementation Councils.</b> Establish Implementation Councils to address the specific goals, needs, and priorities of dually eligible individual eligible to enroll in D-SNPs. These councils could be modeled after consumer-led councils in <a href="#">Massachusetts</a> and <a href="#">Rhode Island</a> , to address the specific goals, needs, and priorities of dually eligible individuals eligible to enroll in D-SNPs.		2.1		
6	<b>Oversight Role.</b> Engage D-SNP enrollees to strengthen the state’s oversight role of integrated programs including the MOC in alignment with state financial goals.		2.2		
7	<b>Policy Frame.</b> Engage disability experts including dually eligible individuals and advocates, to frame the policy and answer financial and operational questions for plans. States must leverage the insights and questions of disability experts and hold plans accountable for answering their questions, which are critical to		2.3		

	Recommendations for States to Include in SMACs	Pillar 1. Equity	Pillar 2. Engagement	Pillar 3. Investment	Pillar 4. Transparency
	the sustainability of these programs. Accountability strategies should include statutory as well as regulatory requirements.				
8	<b>Advertising and Outreach.</b> Engage disability advocates to develop and oversee plan advertising and outreach to individuals to enroll in D-SNPs. D-SNP look-alike plans exist outside of the state’s Medicaid contract purview. States might partner with advocates to develop regulations to limit or eliminate D-SNP look-alike plans, consistent with <a href="#">CMS direction</a> , or develop <a href="#">secret-shopper</a> programs to monitor and ensure plan adherence to requirements.		2.4		
9	<b>Payment Policy.</b> Provide plans with guidance and requirements on payment policy for community-based organizations (CBOs) including guidelines for adopting outcomes-based, non-fee-for-service and value-based contracting vehicles for grassroots and capital-strapped organizations to ensure dually eligible access to CBOs with expertise in addressing SDOH and providing peer recovery services and HCBS.			3.1	
10	<b>Investment Plan.</b> Require plans to prepare an investment plan to bend the cost curve on medical spending by increasing spending on community interventions, such as peer services ranging from community health workers (CHWs) to certified peer specialists (CPSs) and certified recovery coaches (CRCs), personal care attendants (PCAs), durable medical equipment (DME) and diversionary services, all of which are supported by the disability community. Protect enrollees from investment in upstream community-based services that require direct savings on medical spending. Such investment strategies can lead to reduced access to community-based services if return on investment (ROI) is not realized. In addition, the investment plan should also include strategies for decreasing isolation and loneliness in populations with low hospitalization and emergency department rates.			3.2	
11	<b>Data Collection.</b> The state must be able to make direct comparisons across D-SNPs. To do so, they should collect and standardize data across all plans to reduce state administrative burden, respond to disability advocates, and provide D-SNP enrollees with plain language and “apples-to-apples” comparison data.				4.1

	Recommendations for States to Include in SMACs	Pillar 1. Equity	Pillar 2. Engagement	Pillar 3. Investment	Pillar 4. Transparency
12	<p><b>Artificial Intelligence (AI) and Utilization Management (UM).</b> Require D-SNPs to provide detailed reporting on the use of AI, UM, denial notices and appeals; and impose penalties on plans when delays and denials are inappropriate. According to the U.S. Department of Health and Human Services, AI can also “contribute to existing health disparities for certain populations based on race, ethnicity, gender, age, or other demographic factors.” See <a href="#">source</a>.</p>				4.2
13	<p><b>Care Coordinators.</b> Require plans to give Care Coordinators service authorization authority to reduce conflict of interest and health disparities in access and outcomes for populations with disabilities, as compared to the general population; and create a care coordination team with staffing ratios that match the populations’ needs and are based on “best outcomes.” Require plans to provide in person care coordination and in-home coordination to enrollees with complex medical, behavioral health and social needs.</p>				4.3
14	<p><b>Care Planning and Care Plans.</b> States should set minimum standards and requirements across plans to reduce state burden and increase state capacity to measure plan care integration, rebalancing of services, investment in equitable outcomes and care plan personalization. Minimum care plan requirements should include (1) the individual's social, behavioral health and oral health goals as well as medical goals with associated services to be provided to assist in achieving those goals, (2) In Lieu of Services (ILOS) which are alternative services that Medicaid plans can provide instead of Medicaid benefits without needing waiver approval and go beyond standard care, (3) contact information and responsibility of care team members providing services that support the enrollee's achievement of identified goals, and (4) timelines or journey map outlining authorization of services, delivery of services, and description of how the plan supports the enrollee's ability to achieve their identified goals. It is important that tools, processes, and measures advance care coordination and integration of services for persons with complex medical, behavioral health and other needs. Finally, the plan should provide information on the care planning team including paid and unpaid team members.</p>				4.4

BRIEF #2 | ELEVATING THE INDEPENDENT LIVING (IL) AND RECOVERY MODEL OF CARE TO ACHIEVE EQUITY FOR DUALY ELIGIBLE INDIVIDUALS

	Recommendations for States to Include in SMACs	Pillar 1. Equity	Pillar 2. Engagement	Pillar 3. Investment	Pillar 4. Transparency
15	<b>Key Performance Indicators (KPIs).</b> Develop KPIs for multiple purposes: (1) to measure and track the impact of the disability community on the MOC design process, plan investments; and (2) to evaluate D-SNP performance on several metrics related to approval rates, denial rates, appeals’ outcomes, and timeliness of responses.				4.5
16	<b>Dashboard.</b> Establish a public-facing dashboard reporting on KPIs that matter to dually eligible individuals, including denials and the percentage of appeals overturned in favor of the enrollee, based on data collected from plans in a prescribed and standardized format.				4.6
17	<b>Transparency Guidelines.</b> Establish transparency guidelines and requirements for plans to protect dually eligible individuals’ rights to access Medicaid and Medicare services.				4.7
18	<b>Plan Practices.</b> It requires plans to establish practices that ensure that state or disability advocates or D-SNP enrollees can carry out robust oversight of plans’ policies, practices, and procedures				4.8

## A CALL TO EQUITY TOOLKIT: Re-Committing to an Independent Living and Recovery-Centered MOC (ILR-MOC)

### *Ten Ways to Leverage the SMAC to Advance the ILR-MOC*

Exhibit 2 presents ten SMAC recommendations for state leadership consideration, to advance the ILR-MOC.

<b>Exhibit 2. Ten SMAC Recommendations to Advance the ILR-MOC</b>		
<b>#</b>	<b>Rule</b>	<b>Definition</b>
<b>1</b>	<b>Conflict-free care coordination.</b>	SMACs should ensure that the <a href="#">care coordinator</a> is a member of the person’s care team and has decision-making authority and autonomy from the plan. The care coordinator provides conflict-free services and builds trust by being able to access the services needed, thereby building a relationship with the individual. Insurance plan care coordinators have an inherent <a href="#">conflict of interest</a> as the plan, the payer, has a profit incentive to reduce access to services. The insurance plan care coordinator care-plan development process is misaligned with CMS person-centered care planning, which is meant to advance an individual’s life goals, services, and supports needed to achieve them and improve their lives. Regardless of being conflict-free, care coordinators should be fully integrated into the plan’s functions around care planning, medical necessity, and any form of authorization. This includes advocating for member modifications or denials of requested services when that occurs. A key role that a care coordinator can play is in supporting member access to in lieu of services.
<b>2</b>	<b>Low caseloads and Health Homes.</b>	SMACs should require plans to provide <a href="#">Health Home</a> services to ensure whole person-centered care that integrates all primary, acute, and other services needed to support the whole person. According to Medicaid, Health Homes should be made available for people with two or more chronic conditions, persons with chronic conditions at risk of a second condition, and persons with one or more serious and persistent mental health conditions. Higher payments are made for Intensive Health Home Care Coordination, which involves a higher ratio of FTEs to health home beneficiaries. Because of the more intensive needs of people in Health Homes, there should be higher ratios of FTE care coordinators to

<b>Exhibit 2.</b> <b>Ten SMAC Recommendations to Advance the ILR-MOC</b>		
<b>#</b>	<b>Rule</b>	<b>Definition</b>
		enrollee ratios. In <a href="#">Washington</a> state, the Mental Health Council Input requested enrollee-to-care coordination ratios not exceeding <a href="#">50:1</a> . These changes are necessary to build trust and a relationship between the enrollee and their plan. Having a conflict-free coordinator also ensures continuity of care across plans and systems.
<b>3</b>	<b>In-home visits.</b>	SMACs should ensure that plans operationalize a broad definition of in-home care. In-home care is not narrowly defined. Home is where the person is. Home includes shelters, streets, or any other location. The care coordinator should be a member of the person’s care team and have decision-making authority to develop trust between the enrollee and their care team. The care coordinator should regularly visit to a member’s home or other setting as necessary, such as a homeless shelter. The plan should augment the in-home services of the care coordinator by contracting with specially trained paramedics. This training should include addressing the medical and mental health needs of members. In-home care should include certified recovery coaches, peer specialists, and community health workers (CHWs). The care coordinator should be a guest in the person’s home, regardless of the home's location.
<b>4</b>	<b>Diverse staffing model and paramedics.</b>	SMACs should ensure that plans develop a staffing model that prioritizes in-home care provided by staff that reflects the diversity of the population across REALD and SOGIE. The plans should track the alignment between the staff and membership and show evidence of progress in achieving alignment. The SMAC should also ensure home care staff network adequacy, especially in rural and medically underserved populations.
<b>5</b>	<b>Whole-person care team planning.</b>	SMAC should ensure that the care team is engaged in the care planning process, which is demonstrated by attendance. SMACs should hold plans accountable by ensuring a quality measure to ensure that members receive verifiable whole-person-centered care team planning.
<b>6</b>	<b>Non-medical care plan goals.</b>	SMACs should include requirements that the care planning process and plan include and address non-medical goals, including: (1) who provides the services; and (2) when the services are provided, the time frames for providing services, and service plans.
<b>7</b>	<b>Flexible benefits.</b>	SMACs should include requirements for plans to provide services to members that go beyond Medicaid or Medicare guidelines to support the ability of the enrollee to achieve their medical, independent living and and recovery goals. Flexible benefits should not be narrowly defined as benefits to address social



<b>Exhibit 2.</b>		
<b>Ten SMAC Recommendations to Advance the ILR-MOC</b>		
<b>#</b>	<b>Rule</b>	<b>Definition</b>
		determinants of health. Flexible benefits should help to reduce isolation, loneliness, and other impactors that lead to reduced quality of life and increased morbidity.
<b>8</b>	<b>Equity: Robust disparity plan.</b>	SMACs should ensure that plans reduce <a href="#">disparities in access</a> to services such as HCBS and outcomes such as morbidity or mortality that might be connected with racism. As identified by <a href="#">The Commonwealth Fund</a> , plans should be required to: (1) Increase data capacity to inform health equity efforts that improve care. It is incumbent on states to ensure that the information provided by D-SNPs is complete and accurate. (2) Design interventions that address structural racism and include them in their SMAC proposals. (3) Partner with members and communities to advance health equity at the community level, including working with communities to identify preventative care practices that reflect the values of the community. (4) Leverage capitated contracts to ensure plans are rewarded for reducing disparities and penalized for not impacting or worsening disparities. In addition, plans should be required to set out specific strategies they will use to address stigma, which, identified by SAMHSA, is a <a href="#">major barrier</a> to care for persons with mental health and substance use disorder.
<b>9</b>	<b>Equity: An intersectional approach.</b>	SMACs should ensure that plans advance a MOC that is grounded in equity. States should hold plans accountable to quality measures that address factors and barriers affecting minoritized populations at an intersectional level. The SMAC should include guidance that requires plans to take an intersectional approach to persons and populations minoritized because of REALD, SOGIE, or other identities whose health and service needs may differ from those of a white, heterosexual male.
<b>10</b>	<b>Performance Measurement.</b>	SMACs should ensure that states have the ability to measure plans based on their performance on Medicare and Medicaid requirements, and expectations and that they can meet the needs of the specific populations served. Star ratings are currently used to measure the experience of the population. The star rating system, however, is inadequate for disability advocates. According to the <a href="#">Centers for Medicare and Medicaid Services</a> (CMS), star ratings are intended to help “Medicare consumers compare the quality of Medicare health and drug plans being offered so they are empowered to make the best health care decisions for them.” Many states do not think the star rating system should be applied to D-SNPs and should have more control over plan ratings and evaluation criteria. States need to be able to create a

<b>Exhibit 2.</b>		
<b>Ten SMAC Recommendations to Advance the ILR-MOC</b>		
<b>#</b>	<b>Rule</b>	<b>Definition</b>
		<p>Framework to ensure that star ratings reflect the Medicaid contractual requirements. State Medicaid requirements could include rebalancing spending, addressing equity, expanding community partnerships, and investing in diversionary services. Medicaid requirements may vary from state to state to account for the unique needs and cultures of the state, such as Native American and immigrant populations, other demographic and socio-economic factors, and the state’s policy environment and care delivery systems. By allowing states to use a hybrid D-SNP Medicare Advantage star rating system, dually eligible individuals can use objective plan performance measures when choosing a plan.</p>

## THE MEDICAID LTSS REBALANCING RECORD (2020)

Figure 1.

### Medicaid LTSS Rebalancing: The 2020 Record Among States

**Key Takeaway:** Plans are responsible for driving rebalancing to reduce inequities across states where they operate. This includes reducing nursing home rates and HCBS waiting lists. The following table indicates that many states (14) are not rebalanced. In states that are not rebalanced, the percentage of the total Black population is 15 percent, compared to 11 percent in the 37 rebalanced states.

State Rebalancing Category		States (2020)			FBDEs		HCBS % of LTSS (2020)				
		States: Number	States: %	% of State Pop: Black	FBDEs	FBDEs % by Category	HCBS % of LTSS (2020)	State Category Relative to Avg.	Range: Low	Range: High	Percentage Pt. Diff.: High and Low Range
A	Rebalanced states including DC: HCBS % of LTSS > 50%	37	73%	11%	6.848 m.	78%	65.8%	3.3%	50.2%	83.9%	33.7%
B	Not Rebalanced states: HCBS % of LTSS < 50%	14	27%	15%	1.981 m.	22%	43.3%	-19.2%	32.0%	49.3%	17.3%
<b>All States including DC</b>		<b>51</b>	<b>100%</b>	<b>12%</b>	<b>8.829 m.</b>	<b>100%</b>	<b>62.5%</b>	<b>n.a.</b>	<b>32.0%</b>	<b>83.9%</b>	<b>51.9%</b>

Notes: The authors' table is based on several data sources, including the [Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2020](#). HCBS = Home and community-based services. LTSS = Long-term services and supports. DC = District of Columbia. FBDEs = Full benefit dually eligibles. The 14 states that are not rebalanced: Alabama, Florida, Hawaii, Indiana, Kentucky, Louisiana, Michigan, Mississippi, New Hampshire, New Jersey, North Dakota, Oklahoma, South Carolina, and West Virginia.

## THE ONE CARE PROGRAM

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### Figure 1. The One Care Program: The Transition from Demonstration to Permanent Status

The Massachusetts’ One Care program (“One Care”) is the only Financial Alignment Initiative (FAI) demonstration in the country designed for adults 21-64 years of age, covered under Medicaid and Medicare, also known as dually eligible. To the disability community, One Care is more than an integrated care program providing Medicaid and Medicare services. One Care offers hope for equity, and a dignity-based, independent living and recovery-centered model of care for providing services and support to people with disabilities to live meaningful lives in the community. One Care was modeled after the dignity-based ILR-MOC established by the Community Medical Alliance (CMA), designed by the pioneers of the early integrated care programs.

In partnership with the Centers for Medicare and Medicaid Services (CMS), MassHealth created One Care with significant engagement from the disability community. MassHealth and CMS currently administer the program under FAI demonstration authority. Together, they contract with One Care plans, providing Medicaid and Medicare services. Per the federal rule, MassHealth will convert One Care from demonstration to permanent authority by the end of 2025. This federal rule introduced a major shift in MassHealth and CMS’s administrative and policy relationship. Starting in 2026, the One Care program will operate as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), bringing together Medicaid and Medicare services for this population in a new way. FIDE SNPs are part of the Medicare Advantage (MA) family of plans. MassHealth will administer the One Care program in a new way with the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for Medicare Advantage (MA) plans. CMS oversees MA plans, of which there are many types. The FIDE SNP may be the best option for MassHealth to preserve and build upon the One Care demonstration program as the most integrated of all D-SNP types.

As federal rules require, MassHealth will prepare a state Medicaid agency contract (SMAC), which all One Care FIDE SNPs must sign. CMS will have the responsibility and authority to review and approve MassHealth’s SMAC. MassHealth has an important opportunity to leverage the SMAC to advance equity and re-commit to the independent living and recovery-centered MOC.

## Figure 2. The One Care Program: Moving from Model to Scale

Over the last decade, the One Care program has achieved many goals and successes. It has also faced barriers as insurance plans have fallen back on MOCs that focus on the insurer's ROI and market share goals over the needs of the populations they are to serve. Over 40,000 dually eligible individuals are enrolled in the One Care program, receiving access to Medicare and Medicaid benefits integrated through a single plan, providing enrollees with a much better care experience than the fee-for-service (FFS) system. With CMS support, the [One Care Implementation Council \(IC\)](#) and MassHealth have worked closely to engage One Care plans in activities to build and strengthen the program. The One Care IC has held monthly [council meetings](#) for more than 10 years, since 2013.

### MassHealth's Efforts to Reinforce the One Care MOC: The Care Model Focus Initiative (CMFI)

In 2021, the One Care IC and MassHealth intensified their oversight efforts, to support One Care's evolution. These efforts came in response to enrollee and advocate complaints of reduced quality of care coordination and increased fracturing of the One Care model resulting from shifting of insurance plan policies and practices from the original MOC. Complaints focused on increased care coordinator caseloads, reduced competency, and increased denials of LTSS, including personal care attendant hours (PCAs) and durable medical equipment (DME). These concerns were captured during a 2021 [One Care IC Town Hall](#).

In response to these concerns, MassHealth launched the [Care Model Focus Initiative \(CMFI\)](#), engaging enrollees, health plans, the One Care Implementation Council, advocates, and our MassHealth internal teams to drill down to "continue and improve upon the important work of One Care."

As described by MassHealth, the program had reached an "important inflection point."

"MassHealth aims to redouble efforts to ensure the One Care model works as intended at present and in the future." MassHealth created CMFI "to intensify efforts to identify and take the action steps that will result in greater alignment, clearer expectations, and increased focus on performance around key aspects of enrollee experience, service delivery, and program accountability in One Care."

MassHealth examined One Care's Model's current state across ten domains, as shown in the following table.

<b>The Ten Domains of MassHealth’s Care Model Focus Initiative (CMFI)</b>	
<b>1</b>	Person-centered care
<b>2</b>	Care team roles and composition
<b>3</b>	Assessment process/timing
<b>4</b>	Individualized care plans (ICPs)
<b>5</b>	Care coordination, including LTSS and behavioral health (BH)
<b>6</b>	Enrollee experience and satisfaction
<b>7</b>	Enrollee protections
<b>8</b>	Communications to and from enrollees
<b>9</b>	Health equity for One Care enrollees
<b>10</b>	Care model performance indicators

In 2022, as MassHealth worked with One Care members, it announced six areas of One Care’s MOC needing increased focus. MassHealth identified several areas of concern, including LTSS denials. MassHealth highlighted that: “service denials [for LTSS] may not be consistent with the person-centered care plan. The reasons for denials are unclear to Enrollees, and notice language is complex. The relationship between ICPs [integrated care plans] and health plan evaluation functions needs alignment.”

As of 2023, MassHealth and the One Care IC are working to address CMFI’s findings, hoping that the One Care program continues evolving. It is the hope of disability advocates that One Care becomes an independent living and recovery model of care (ILR-MOC). CMS has taken notice of MassHealth’s efforts to evolve the One Care MOC. CMS’s [fifth evaluation](#) reported: “EOHHS implemented a Care Model Focus Initiative (CMFI) in January 2022 to improve performance around key aspects of beneficiary experience, service delivery, and operational accountability aimed at reinforcing the person-centered design goals of One Care.”

### Figure 3. The One Care Program: LTSS Denials

#### Key Takeaways

In late 2021, MassHealth launched the Care Model Focus Initiative (CMFI). As a result of this initiative, MassHealth developed the Long-Term Services and Supports (LTSS) Denial Process Review and LTSS Denial Escalations procedures to verify that LTSS denials align with the MassHealth One Care model.

Based on MassHealth's focused on collecting data from One Care plans, the state presented both general and specific findings in late 2023. The findings are provided below. These findings underscore the importance of transparency in holding plans accountable to operationalizing an ILR- MOC. States such as Massachusetts demonstrate the importance of working with plans to examine the data to ensure fidelity to developing individualized care plans (ICPs).

#### General Findings: Personal Care Attendants (PCA)

Many ICPs were not person-centered and did not include:

- Supporting information as to why service was requested/denied,
- Alternative care options for denied PCA services, and/or
- Creative use of PCAs.

Many LTSS Denial Summary Form submissions did not include information on whether an Enrollee was offered a Long Term Supports Coordinator (LTS-C), if Enrollee accepted or refused an LTS-C, and/or the most recent Comprehensive Assessment date.

Many Denial Notices did not include substantive LTSS service reduction/denial reasoning.

#### Specific Findings: December 2022 PCA Statistics

- Most LTSS denial cases did not meet all process review criteria.
- Most LTSS denial cases did not meet all ICP criteria.