What to Know About One Care: A Detailed Look at its Upcoming Transition

SEPTEMBER 2024

MASSACHUSETTS FOUNDATION
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ACKNOWLEDGMENTS

The Blue Cross Blue Shield of Massachusetts Foundation would like to thank Ellen Breslin, Principal at Health Management Associates, for her expertise, consultation on this project, and helpful feedback on early drafts.

Note: This report offers a detailed and technical explanation of the One Care program, its upcoming transition, and the potential impacts of these changes. For readers interested in a higher-level overview of One Care and its upcoming transition, please see the complementary report *What to Know About One Care: A High-Level Overview of its Upcoming Transition*.

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GLOSSARY

D-SNP	Dual Eligible Special Needs Plan (D-SNP): A type of Medicare Advantage product designed to serve the needs of people who are dually eligible for Medicaid and Medicare.
EAE	Exclusively Aligned Enrollment (EAE): An enrollment mechanism where D-SNPs only enroll individuals for their Medicare coverage who also receive their Medicaid benefits through the same health plan.
FAI and MMP	Financial Alignment Initiative (FAI): A demonstration authority within the Centers for Medicare & Medicaid Services (CMS) that currently allows for a three-way contract between a state, CMS, and a Medicare-Medicaid Plan (MMP). *Note that throughout this brief, Massachusetts' MMP, One Care, is also referred to as "the demonstration."*
FIDE SNP	Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP): A type of D-SNP model that covers Medicare and at least Medicaid primary and acute care and long-term services and supports. As of 2025, FIDE SNPs may only enroll individuals who also receive their Medicaid benefits through the same health plan.
LTSS	Long-Term Services and Supports (LTSS): Types of supports that are needed by individuals experiencing difficulty with activities of daily living, self care, and disease management. LTSS include extended nursing home stays and personal care services.
SMAC	State Medicaid Agency Contract (SMAC): An executed contract that all D-SNPs must have with state Medicaid agencies and that specifies program requirements, including those around care coordination, reporting, and oversight.

INTRODUCTION

Although 12.5 million older adults and people with disabilities are enrolled in both Medicare and Medicaid nationally, the two programs were not designed to work together. While many individuals who are enrolled in both programs (referred to as "people who are dual eligible" or "dual eligible individuals" throughout this report) experience significant medical, social, and care coordination needs, these individuals, their caregivers, and their providers must often navigate two complex sets of programs and policies that are fragmented and at times conflicting. As a result, people who are dual eligible often experience access barriers and program confusion.[i] In addition, they are more likely to receive misinformation, or incomplete information, because benefit counselors, providers, plans, and caregivers often understand one program (Medicare or Medicaid) but not both.

In Massachusetts, there are about 312,000 people who are dual eligible,[ii] and up to 40 percent of those individuals are people living with physical, intellectual, or developmental disabilities who are under age 65.[iii] To help address the challenges faced by these dual eligible individuals, the Commonwealth designed a specialized program, One Care, that launched in 2013. One Care is an "integrated care" program that serves dual eligible individuals with disabilities age 21 to 64 at the time of enrollment.[a] One Care, like other integrated care programs, aims to coordinate Medicare and Medicaid benefits and streamline services and financing through a single health plan to ease access to high-quality care for its members (see box below for more information on Medicare and Medicaid integration), and it has achieved high levels of integration and alignment across Medicare and Medicaid. Members served by One Care often have behavioral health needs and also typically require medical and personal care services to assist with activities of daily living such as eating, bathing, and dressing (these services are known as long-term services and supports, or LTSS). One Care was designed specifically to address these behavioral health and LTSS needs, and to meet an important priority for people who are dual eligible: a desire to live independently and recover in the community.

MEDICARE AND MEDICAID INTEGRATION

Integration (or integrated care) refers to coordinating Medicare and Medicaid benefits for people who are dual eligible and streamlining services and financing through a single health care delivery system. The goal of integration is to improve individuals' care experience, improve the quality of care, and reduce costs.

Because Medicare is a federal program and Medicaid is run at the state level with federal oversight, states need to partner with the federal government to implement integrated care programs. As such, the One Care program currently operates as a "demonstration" under a specific federal authority that enables states to contract with private health plans to align Medicare and Medicaid coverage and financing. In May 2022, the federal agency that administers Medicare and Medicaid (the Centers for Medicare & Medicaid Services, or CMS) finalized a rule that ends the demonstration under which One Care currently operates. The dual demonstrations will end on December 31, 2025.

When the demonstration ends, Massachusetts will need to transition the One Care program to a different federal authority. While the One Care program itself will remain, operating it under a new authority with different rules and structures means there will be some program changes. In particular, the transition creates barriers to maintaining all of the integration and alignment across the Medicare and Medicaid programs that it has achieved under its current program authority. However, working closely with people who are dual eligible, advocates, and other key stakeholders, Massachusetts has designed a plan to preserve the care model and benefits of One Care, and adopted alternative approaches to providing as integrated an experience for members as possible. MassHealth has committed to ensuring a transition that is as seamless as possible for the dual eligible individuals covered under the current program.

[a] Individuals under age 65 can qualify for Medicare – and thus become dual eligible – if they have certain disabilities and have received Social Security Disability benefits for 24 months. These Medicare members are dual eligible if they also meet the state eligibility requirements for Medicaid.

The purpose of this issue brief is to provide background on the One Care program and to educate policymakers, advocates, and other stakeholders of the plan to transition this program. The research for this project included an environmental scan and literature review regarding Massachusetts' current One Care program design, including its evaluation, successes, and challenges. It also included interviews with four key stakeholders: a One Care behavioral health provider, a One Care plan, a consumer advocate, and MassHealth (Massachusetts' name for two programs combined: Medicaid and the Children's Health Insurance Program) officials.

This brief has two main sections: the first (*One Care Program Overview*) provides background on the One Care program as it exists today, and the second (*One Care's Upcoming Transition*) explains One Care's upcoming transition, including MassHealth's plans to preserve as many of One Care's key features as possible.

BACKGROUND

CHALLENGES FOR PEOPLE WHO ARE DUAL ELIGIBLE

For people who are dual eligible, Medicare is the primary payer for health care services and covers core medical services, prescription drugs, some behavioral health services, and some durable medical equipment (including but not limited to blood sugar monitors, wheelchairs, crutches, and hospital beds). Medicaid also covers many of these services and fills remaining gaps in care by providing LTSS (such as personal care services, day programming, in-home supports, and extended nursing home stays), additional behavioral health services, and benefits like dental, vision, transportation to medical appointments, and hearing aids. For many individuals who are dual eligible, Medicaid also helps pay their Medicare premiums and cost sharing (such as co-payments and deductibles).

Although receiving coverage from both Medicare and Medicaid offers individuals a broader set of benefits, it can also lead to:

- **Confusion for individuals and fragmentation in their care experience.** People who are dual eligible are subject to two programs for accessing their health benefits. This can mean two eligibility and enrollment processes, two provider networks, two benefit packages, and two sets of member materials. In addition to being confusing for individuals, this can lead to duplicative or missed services and poorer health outcomes due to the delivery of health services and benefits not being coordinated across the two programs.[iv]

  Because Medicaid is the primary payer for LTSS but Medicare is the primary payer for many other health services, it can be especially challenging to coordinate individuals' LTSS needs with their medical care. These siloed systems can be a hurdle, for example, when members want to transition from hospital stays (paid for by Medicare) back into communities with appropriate LTSS (paid for by Medicaid).

  Additionally, because the majority of people who are dual eligible are in a fee-for-service (FFS) delivery system, they have little access to the person-centered care coordination or care management supports that are typically offered by Medicare or Medicaid managed care programs.[b] This exacerbates confusion and care fragmentation and means less opportunity to focus on addressing the health and wellness goals of people who are dual eligible.

- **Potential cost shifting between the federal government and states.** Investments in Medicare or Medicaid benefits and care coordination can lead to savings that accrue to the other program. For example, Medicaid investments in services like behavioral health and LTSS for dual eligible individuals reduce unnecessary use of

[b] Managed care is a way of providing health care coverage with the goal of managing cost, utilization, and quality. Medicaid agencies contract with managed care organizations to provide benefits and additional services to members. Medicaid agencies typically pay managed care organizations a set payment per member per month (i.e., a capitated payment) for providing these services.

hospital and emergency department services paid by Medicare. Conversely, successful Medicare approaches to post-acute and transitions of care models can prevent long-stay nursing facility care, which results in savings to Medicaid. However, there is not a direct way for Medicaid or Medicare to share in the savings they generate for the other program, which can create a disincentive for states to invest in Medicaid services that accrue to Medicare savings and vice versa.

- **Challenges for payers and providers serving people who are dual eligible.** Payers and providers serving people who are dual eligible can experience administrative difficulties. For example, providers experience challenges with submitting separate claims for Medicare and Medicaid services.[v] Also, when claims accrue separately to Medicaid and Medicare, each payer faces barriers to understanding the total cost of an individual's care.

This misalignment can not only reduce quality of care for people who are dual eligible, it also has implications for cost. People who are dual eligible are a historically high-cost population due to their complex health needs necessitating greater and more comprehensive care.[vi, vii] Misalignment across both programs can lead to duplicative health care and administrative costs, increasing Medicare and Medicaid spending.

MEDICARE–MEDICAID PLANS

In response to the challenges outlined above, CMS launched the Financial Alignment Initiative (FAI) demonstration in 2011. The FAI allows states to contract with private health insurance companies to offer dual eligible individuals integrated Medicare and Medicaid benefits through a single health plan, known as a Medicare-Medicaid plan (MMP). A total of nine states launched MMP demonstration programs.[c] Two key features of the MMP model promote integration at the administrative, financial, and clinical levels:

- **A single, three-way contract between the state, CMS, and the MMP.** This single contract allows states to optimize integration of Medicare and Medicaid benefits and enables streamlined joint program oversight by the state and CMS.
- **Financial alignment between Medicare and Medicaid.** The single, three-way contract also enables MMPs to be paid through a pool of dollars that combines federal and state funding, and for CMS and states to jointly share in plans' savings or losses. This structure creates a stronger incentive for states to invest in, for example, expanding or enhancing behavioral health and LTSS for people who are dual eligible in a way that could improve care and reduce the overall cost of care for this population. This financial alignment better supports an integrated delivery system where CMS, the state, and the plan experience shared financial incentives to maximize health outcomes and financial savings.

ONE CARE PROGRAM OVERVIEW

One Care is the Commonwealth's MMP demonstration. One Care is the only MMP program in the country designed exclusively to meet the medical, LTSS, and behavioral health needs of adult dual eligible individuals with disabilities who are under the age of 65 at the time of enrollment (see Figure 1 below for an overview of all the programs in the Commonwealth that serve people who are dual eligible). Currently, MassHealth contracts with three One Care health plans (Commonwealth Care Alliance [CCA], Tufts Health One Care, and UnitedHealthcare), serving about 42,000 dual eligible members under age 65 in the Commonwealth. As of December 2023, 63 percent of people statewide who are eligible for One Care were unenrolled in the program.[viii] See Appendix A for an overview of key milestones throughout One Care's history and evolution.

[c] These nine states are: California, Illinois, Massachusetts, Michigan, Minnesota, Ohio, Rhode Island, South Carolina, and Texas.

FIGURE 1. INTEGRATED CARE PROGRAMS SERVING PEOPLE WHO ARE DUAL ELIGIBLE IN THE COMMONWEALTH[IX]

ONE CARE

Serves individuals with full MassHealth and Medicare coverage who are age 21–64 at the time of enrollment. Provides the full spectrum of Medicare and Medicaid services, including LTSS, dental, and behavioral health. One Care plans receive a risk-adjusted amount of money for each member, regardless of the volume of services a member receives (i.e., a capitated payment).

SENIOR CARE OPTIONS (SCO)

Serves individuals age 65 and over with MassHealth; most also have Medicare coverage. Provides the full spectrum of Medicare and Medicaid services, including LTSS, dental, and behavioral health. All benefits are covered through a capitated payment to Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), a type of Medicare Advantage plan* that offers a high level of integration for dual eligible members.

*Medicare members can choose to receive their Medicare benefits through private health plans, known as Medicare Advantage plans.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)[X]

Serves individuals age 55 or older who are eligible for nursing facility care but live in the community. PACE provides comprehensive medical care and supportive services, including home- and community-based services, dental, and behavioral health. Most PACE participants are dual eligible.

KEY PROGRAMMATIC FEATURES OF ONE CARE

In addition to the integration goals common to all MMPs, One Care originated out of a desire to support the behavioral health and LTSS needs of MassHealth members and to facilitate independent living and recovery in the community. The following features of One Care advance these two objectives:

A person-centered care model and expanded benefits. One Care's model of care aims to take a person-centered and holistic view of each member's goals and needs, informed by the member themself, to ensure that the environment around them fulfills their health care needs and supports their goals to thrive independently in the community. Key components of the care model (and benefits that help support it) include:

- *The interdisciplinary care team (ICT):* Each member is served by their own unique ICT. The goal of the ICT is to ensure coordinated care delivery and management across members' full set of medical, behavioral, LTSS, and social needs. It is meant to operationalize a member's individualized care plan (see below). Core members of each ICT are the member, their care coordinator, and their primary care provider, but may include a range of other providers and caretakers depending on the needs of the individual member.
- *Comprehensive assessment:* The first step in the care coordination process is conducting a comprehensive assessment of the member's needs. One Care plans are required to conduct this assessment for each member within 90 days of enrollment into One Care. The assessment should be inclusive of (but not limited to) the member's health, behavioral health, functional status and LTSS needs, social supports, and housing/home environment and nutritional needs.
- *Individualized Care Plans (ICPs):* The comprehensive assessment will help the member and their ICT to develop an ICP, which is meant to help organize the member's physical and behavioral health care as well as any LTSS. In addition to listing all providers and medications, the ICP will contain the member's health, independent living, and recovery goals, preferences, and concerns. Importantly, each ICP will contain an agreed-upon set of steps to address these goals and concerns.

- *Long-Term Supports Coordinators (LTS Coordinators):* To help ensure that members receive necessary LTSS, and that these services coordinate as seamlessly as possible with the rest of the member's medical and behavioral health services, One Care plans are required to make an LTS Coordinator available to each member. LTS Coordinators' jobs are to help members identify and understand their needs, identify community services and resources to meet those needs, and help members advocate for those needs when they are not being met by their One Care plan. Importantly, LTS Coordinators do not work for One Care plans; instead, they come from independent community organizations and are experts in areas like independent living, recovery, and aging. LTS Coordinators are intended to be a conflict-free, independent voice on a member's ICT.

- *Expanded benefits:* Under One Care, eligible individuals enroll in a single One Care plan that covers all standard Medicare and Medicaid services, as well as expanded services available under the demonstration. These expanded benefits are responsive to the complexity of the One Care population's needs across behavioral health and LTSS. Accordingly, expanded benefits in One Care include: (1) access to the diversionary behavioral health services available through MassHealth's other managed care programs; these services, such as community crisis stabilization services and outpatient addiction treatment services, are intended to keep people out of hospitals and institutional settings (2) expanded amount, duration, or scope of certain Medicaid State Plan services such as durable medical equipment and personal assistance services (assistance with activities of daily living, such as getting dressed, eating, using the restroom, and getting into or out of a vehicle); and (3) additional community-based services such as peer support from people with lived experience with mental health conditions and substance use disorders, home modifications, and nonmedical transportation to enable the member to access community services, activities, and resources to foster independence and support full participation in the community.

- *Flexible benefits:* Capitated payments in One Care afford One Care plans greater flexibility to offer benefits tailored to meet the individual needs of members. Specifically, One Care plans (at their own discretion) have the opportunity to offer what are known as "flexible benefits," or benefits that go beyond the standard Medicare and Medicaid benefits and are in addition to the expanded benefits described earlier.[xii] For example, over the course of the demonstration, One Care plans reported providing benefits or services such as gym memberships, support to complete adult education courses, and noise-blocking headphones for certain individuals.[xiii] Flexible benefits are intended to help address a member's individualized set of care needs, and support their goals to live independent and meaningful lives in their community, consistent with the member's ICP. Flexible benefits have been especially important for One Care members with significant LTSS, behavioral health, or social needs (e.g., food insecurity).[xiv]

Meaningful member engagement. The spirit of One Care – that care should be person-centered – is carried out in part by MassHealth's commitment to ensuring that members themselves help guide the Commonwealth's policy and program design and decisions about One Care. One Care members engage in policy and programmatic decisions through two key structures:

- *The One Care Implementation Council:* The One Care Implementation Council is a working committee established by the Commonwealth to ensure stakeholders, including members, have an active role in the implementation of One Care. At least half of all council members are MassHealth members with disabilities or family members or guardians of MassHealth members with disabilities. Council members also include advocates and peers from community-based organizations, consumer advocacy organizations, service providers, trade associations, and unions. The council's roles and responsibilities include, but are not limited to, advising the Commonwealth on One Care and related dual eligible matters, examining quality in the program, reviewing issues raised through the grievances and appeals process, and examining access to services. Although CMS is not an official member of the council, CMS officials regularly attend meetings to engage with MassHealth and

council members on key aspects of the demonstration and, more recently, its transition. The One Care Implementation Council is widely held by members and key stakeholders as a model in effectively engaging consumers and their advocates in policy and program change.

- *Plan-specific member advisory boards:* One Care plans are required to establish a member advisory board, or include members on the plan's governance board, for members to provide regular feedback to plans on One Care and care delivery experiences.[d] Member advisory boards must meet at least quarterly throughout the demonstration. These member advisory boards must include members, family members, and/or other caregivers that reflect the diversity within One Care's population, including individuals with disabilities. One Care plans are required to report annually to the Commonwealth on these advisory boards, including meeting agendas and minutes.

Robust and aligned member protections. Because people who are dual eligible experience high rates of access barriers and program confusion, One Care incorporates strong member protections and oversight mechanisms to promote members' access to care without disruption. These include:

- *My Ombudsman:* The My Ombudsman program empowers and supports One Care members to resolve issues in how they experience services spanning health care, behavioral health, LTSS, flexible benefits, and care coordination.[e] My Ombudsman is currently operated by the Disability Policy Consortium, a nonprofit organization run by and for people with disabilities. The Commonwealth, like other demonstration states, receives temporary federal grant funding from CMS to support the provision of ombuds services for One Care members. This grant funding – which will end with the demonstration – supplements the Commonwealth's own contributions to fund the My Ombudsman program.

- *Unified appeals and grievance processes:* Two distinct processes exist through Medicare and Medicaid for individuals to express dissatisfaction with coverage and benefit determinations. The first (the appeals process) is for individuals wanting to challenge and reverse a coverage denial (e.g., a reduction in services requested or a denial to approve prescription drug coverage). The second (the grievance process) is for individuals to express formal complaints about any aspect of their experience with their coverage or delivery of care. However, Medicare and Medicaid each have different processes and timelines to guide how individuals navigate the appeals and grievance process, which means people who are dual eligible must typically navigate the complexity of determining whether their concern originated from a Medicare or a Medicaid service or experience before filing an appeal or grievance. To simplify these processes for members, One Care plans were required to create a single, unified appeals and grievances process with aligned timing, processes, and integrated notices, whether the issue is related to Medicare or Medicaid.

- *Aligned provider network adequacy requirements and oversight:* One Care plans are subject to tailored Medicare and Medicaid network standards. These One Care standards are designed with the unique needs of people who are dual eligible in mind (i.e., with a focus on ensuring members can access providers and services needed for rehabilitation, behavioral health recovery, and independent living).[xv] To ensure that One Care members are able to access a comprehensive provider network consistent with the principles above – including medical, behavioral health, pharmacy, and institutional and community-based LTSS providers – the Commonwealth works with CMS to review and assess the adequacy of One Care plan provider networks, inclusive of contracted Medicare and Medicaid provider types. This level of tailoring to dual eligible individuals' needs and state oversight over Medicare provider adequacy is atypical outside the MMP demonstrations.

[d] One Care plans satisfying this requirement by including members on the plan's governance board must ensure that members provide regular feedback to the governance board on issues regarding demonstration management and member care per CMS regulations.

[e] My Ombudsman was initially created as a singular, central contact for One Care members, though it has since been expanded to support all MassHealth members.

- *Continuity of care protections:* When people join One Care, or any other managed care plan, they are typically required to transition to providers in the plan's network within 90 days (i.e., "90-day transition period"), with some exceptions, such as those further detailed in this section. For some members, this may mean finding a new provider. This is especially difficult for the population served by One Care, which includes many individuals with behavioral health and other complex care needs, and for whom building trust with new providers can be challenging and take time.[xvi] Accordingly, One Care features strong continuity of care provisions that are not typical for dual eligible individuals outside of MMPs to support members in maintaining access to existing providers, maintaining access to LTSS services by honoring prior authorizations, or selecting new, in-network providers during the 90-day transition period. For example, One Care plans are required to reach out to a new member's out-of-network providers and provide information on becoming in-network providers. If best efforts fail and the member's current provider is not willing to enroll in the plan's provider network and transitioning the member to an in-network provider could be harmful or disrupt treatment, One Care plans are required to offer a single-case agreement. This allows the member to continue seeing that out-of-network provider if the provider is willing to continue serving the member at the in-network payment rate.

Unified member materials and communications. Member communication (including written materials, verbal communication, and customer service) ensures an individual understands their benefits, the providers they can access, and their rights. But people who are dual eligible often receive two sets of member materials (one for Medicare and one for Medicaid). This can result in redundant and sometimes conflicting notifications and potentially incorrect information due to differences in coverage rules between Medicare and Medicaid. To overcome these challenges, One Care members have access to:

- *Integrated member materials:* One Care members receive a single ID card providing access to all Medicare and Medicaid services and benefits, and an integrated member handbook, provider directory, and formulary. These integrated member materials undergo a joint CMS-Commonwealth review and approval process.

- *A single member services call center:* One Care members also have access to a single member services call center maintained by their plan with live member services representatives readily available for members to access information regarding their Medicare and Medicaid services and benefits.

Streamlined enrollment approach. The "default" Medicare coverage for people who are dual eligible is FFS Medicare, which is uncoordinated from FFS Medicaid or Medicaid managed care. The process for choosing an integrated care plan can be confusing. For example, even to enroll in a Dual Eligible Special Needs Plan (D-SNP), a common type of Medicare Advantage plan that enrolls people who are dual eligible and coordinates both their Medicare and Medicaid benefits, people must navigate multiple and often conflicting enrollment periods, timelines, and processes between the Medicare and Medicaid programs. To overcome these challenges, One Care featured the following attributes as part of its member enrollment approach:

- *Integrated and streamlined enrollment and disenrollment processes:* The Commonwealth – through an independent enrollment broker not affiliated with health plans – is responsible for all One Care enrollment and disenrollment, in collaboration and partnership with CMS. One Care members enroll in a single plan and dates for plan enrollments and disenrollments are aligned between Medicare and Medicaid. The Commonwealth sends a single set of enrollment and disenrollment forms and other member notices to members, rather than separate forms and notices for Medicare and Medicaid, respectively.

- *Passive/facilitated enrollment:* Throughout the demonstration, CMS afforded the Commonwealth flexibility to facilitate enrollment directly into One Care plans through what is known as "passive enrollment." Passive enrollment promotes access to the Commonwealth's most integrated coverage option available to dual eligible individuals by enrolling eligible individuals directly into a One Care plan as the "default" option. The Commonwealth uses an "intelligent assignment process," whereby best effort is made to match individuals with a One Care plan based on their existing primary care or other key providers via claims history. Individuals passively enrolled are provided with advance notice of the enrollment and may opt out or disenroll at any point. It is important to note that stakeholder experiences with passive enrollment have varied and evolved over the course of the demonstration (see box below).

EXPERIENCE WITH PASSIVE ENROLLMENT IN ONE CARE

Since the implementation of the One Care demonstration, stakeholders have reported mixed experiences with and perspectives on passive enrollment. For some, it was seen as a key tool to ensure that One Care's unique, person-centered care delivery model reached as many qualifying individuals as possible. For members, however, it was not always experienced as intended. For example, member focus groups across three demonstration states using passive enrollment (Massachusetts, Illinois, and Ohio) found that the passive enrollment process did not sufficiently inform people who are dual eligible that their health coverage was changing and what the impact might be on their current providers.[xvii]

Maximally aligned quality measurement. Outside of the One Care demonstration, states typically have limited visibility into Medicare quality performance for people who are dual eligible. Additionally, the quality measures that Medicare uses may not reflect the behavioral, socioeconomic, or functional complexity of people who are dual eligible; rather, Medicare measures were designed for a broader – and often healthier – age 65 and over population. Further, to date, states do not have authority to withhold funding or provide bonuses via Medicare payment to plans contingent on meeting state-defined quality thresholds.

To overcome these challenges, One Care sought to afford the Commonwealth greater visibility into Medicare quality performance, including on quality measures tailored to One Care members' unique experiences and needs. For example:

- *Quality measure reporting:* One Care plans are required to report their performance on several standardized measure sets (e.g., Healthcare Effectiveness Data and Information Set [HEDIS] measures and Consumer Assessment of Healthcare Providers and Systems [CAHPS] measures) and on their quality improvement activities to the Commonwealth. HEDIS measures for One Care plans measure access to and utilization of a number of preventive health measures including cancer screenings, advanced care planning, medication review, and functional status assessments, among others. CAHPS is the survey instrument through which One Care plans conduct their annual assessments of member experience and satisfaction. In addition to these Medicare measure sets, MassHealth also worked with CMS to design other quality measures tailored to the needs of One Care members that the plans report on, such as documentation of care goals and access to an LTS Coordinator.
- *Quality withholds:* To further incentivize quality improvement, CMS and the Commonwealth withhold a portion of the Medicare and Medicaid capitated payment, which has ranged from 1 to 2.75 percent over the course of One Care's demonstration. One Care plans may earn back the withheld amount upon meeting certain quality thresholds. These thresholds are based on a combination of the core national quality measures and the Commonwealth-specific performance measures designed for the target population of the One Care demonstration. If the One Care plan achieves its measures, the withheld amount is paid retrospectively to the plan.

THE IMPORTANCE OF STRONG PROGRAM OVERSIGHT IN ONE CARE

One Care has several unique program design and operational features, like strong care model approaches and robust stakeholder engagement strategies, that support program success. However, like many complex programs, One Care has experienced challenges in implementing these features as intended under the model. To help mitigate these challenges, MassHealth developed approaches to program oversight to help support continuous program improvements and address areas where One Care was falling short.

For example, plans have not consistently conducted the person-centered comprehensive assessment within 90 days of member enrollment as required. Even several years into the program, One Care plans reported difficulties in locating members for the initial assessments, and this was especially true for members who had been passively enrolled into the demonstration.[xviii]

Members have reported confusion between the roles of the care coordinator and the LTS Coordinator on the ICT. LTS Coordinators have a defined role in supporting independent living, wellness, and recovery goals, and are intentionally employed by independent community organizations (and not One Care plans), so that they can more independently advocate for member needs.[xix] Despite the support LTS Coordinators provide and their role as an official member of the care team, members have noted that the LTS Coordinator role is not well integrated within the delivery model.[xx] Further, One Care plans often do not adequately communicate with LTS Coordinators. This may be driven by different processes and procedures across plans, for example processes related to accessing enrollee records or how services are authorized.[xii] As a result, how and to what degree the LTS Coordinators are incorporated during ICT discussions is inconsistent.[xxii]

Fortunately, One Care had effective program oversight structures in place that enabled MassHealth to respond and adapt when the program experienced challenges. For example, the One Care Implementation Council allows members to provide ongoing input and feedback on their care in ways that help shape policy and programmatic decisions. The Implementation Council forum provides a venue to alert program administrators when a course-correction is needed.

Partially in response to Implementation Council feedback that One Care was losing some of its innovation and person-centeredness as it grew, MassHealth established the time-limited Care Model Focus Initiative (CMFI) in January 2022, which ended in July 2022.[xxiii] CMFI was comprised of core workgroup members – representatives from MassHealth, My Ombudsman, One Care plans, the Implementation Council, and CMS – that met regularly to discuss and reach alignment on actions to uphold the original goals of One Care and ensure fidelity to the principles of delivering member-centered, culturally competent care. For example, to ensure that LTS Coordinators and care coordinators' roles, responsibilities, and training priorities were clear to members and to others on the ICT, the CMFI recommended that the care coordinator role description be incorporated in member-facing materials and that contractual language describing the roles of both care coordinators and LTS Coordinators be enhanced to further reinforce and clarify the positions. Further, to ensure transparency on and accountability to the care model's performance, CMFI members recommended developing and producing a set of key performance indicators that provide additional insight into the overall health of the One Care clinical model, to be refreshed on a quarterly basis.

Although MassHealth has thoughtfully developed a comprehensive, robust, and member-centered integrated program model in One Care, the establishment of CMFI reflected the importance of strong program oversight and of MassHealth's commitment to ensuring that One Care is held accountable to its founding principles as the program grows and evolves over time.

ONE CARE'S UPCOMING TRANSITION

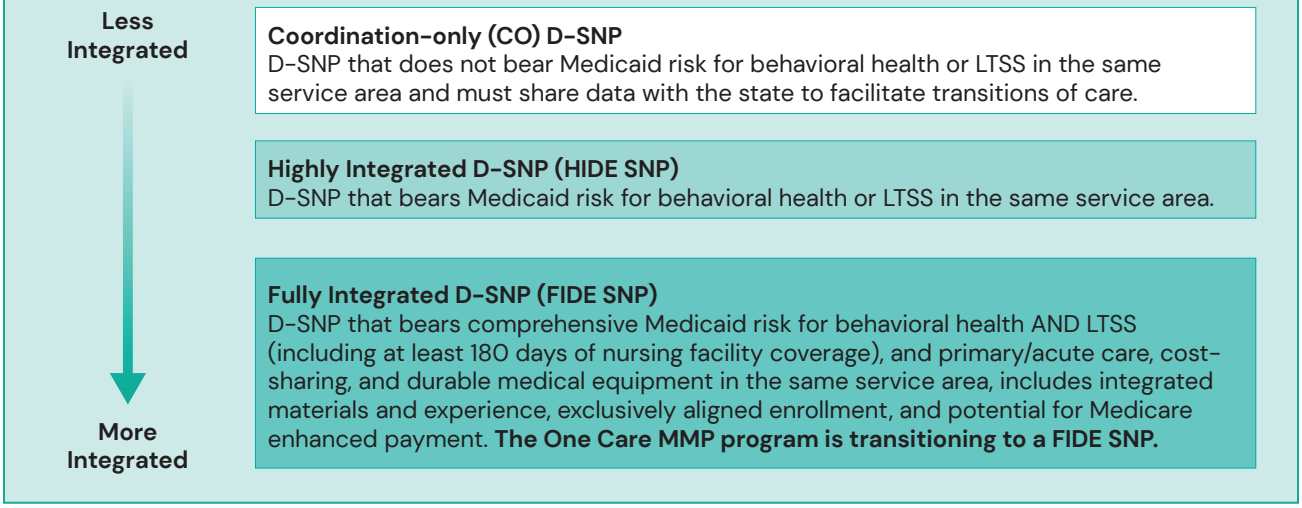
INTRODUCTION TO FULLY INTEGRATED DUAL ELIGIBLE SPECIAL NEEDS PLANS

As mentioned above, CMS is ending the demonstration authority that enabled One Care, the Medicare-Medicaid plan (MMP) model, effective December 31, 2025. MMPs were established to pilot a high level of integrated care for people who are dual eligible; however, since its inception, the integrated care landscape has evolved. Federal policies have allowed other types of models, like D-SNPs, to offer more coordinated and integrated care – and at a broader scale nationally – than what existed when MMPs first started.[xxiv] To ensure that best practices from the MMPs do not get lost post-transition, CMS is incorporating lessons learned from the MMP programs into D-SNPs, which is a permanent program authority, and is encouraging states to transition their MMP plans to that model.

Massachusetts intends to retain the One Care program by transitioning the program from an MMP to a specific type of D-SNP known as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) (see Figure 2). Medicare Advantage plans offer Medicare coverage through private insurance companies, and D-SNPs are a particular type of Medicare Advantage plan designed specifically to serve the unique needs of the dual eligible population. Unlike other Medicare Advantage plans, D-SNPs must enter into a contract with the state (known as the State Medicaid Agency Contract [SMAC]) that specifies program requirements, including those around care coordination, reporting, and oversight.

In most D-SNPs, individuals may receive their Medicare and Medicaid benefits from two different health plans, or receive their Medicaid benefits via fee-for-service. By contrast, a FIDE SNP is a type of D-SNP that can *exclusively* limit enrollment to individuals who also receive their Medicaid benefits through the same health plan; this is referred to as exclusively aligned enrollment (EAE). Starting in 2025, EAE will be required of all FIDE SNPs.[xxv] This means that if a person enrolls in Organization A's One Care FIDE SNP, they are opting to receive their Medicare benefits from Organization A's FIDE SNP and as a result will also receive their Medicaid benefits from Organization A's MassHealth plan.

FIGURE 2. THREE TYPES OF D-SNPS



With EAE, FIDE SNPs are able to centralize the delivery of Medicare and Medicaid benefits and services under one single health plan financially responsible for the full spectrum of the individual's Medicare and Medicaid experiences. Further, dual eligible individuals exclusively aligned in FIDE SNPs can expect more seamless experiences than members enrolled in D-SNPs that are not FIDE SNPs, through such approaches as unified appeals and grievance processes.[f]

The Commonwealth will transition One Care from an MMP to a FIDE SNP in order to maintain maximum integration for One Care members. Massachusetts already operates a different FIDE SNP program called Senior Care Options (SCO) that serves dual eligible members. However, this program is currently open only to dual eligible individuals age 65 and older and is designed to meet the specific needs of that population (see Figure 1 under *One Care Program Overview* for more information on SCO).

LIMITATIONS OF FIDE SNPS RELATIVE TO MMPS

The FIDE SNP model enables Medicare-Medicaid integration for people who are dual eligible, but it has some limitations relative to MMPs:

- **Rather than a single three-way contract between the state, CMS, and the MMP, as it is with the current One Care program, a single FIDE SNP will operate under two separate contracts: one contract between CMS and the plan, and one contract between MassHealth and the plan** (the SMAC, see box below). Having two separate contracts – one with CMS and one with MassHealth – introduces the possibility for misalignment and fragmentation within the FIDE SNP that does not exist in today's One Care program. For example, it lessens the opportunity to set joint standards for network adequacy and quality improvement.

THE ROLE OF STATE MEDICAID AGENCY CONTRACTS (SMACS) IN D-SNPS (INCLUDING FIDE SNPS)
The SMAC is the contract between MassHealth and the Medicare Advantage organization operating the D-SNP. SMACs have certain minimum requirements for D-SNPs; for example, they must enumerate the Medicaid benefits and cost-sharing protections for members offered by the plan. However, states have significant flexibility in tailoring the SMAC and including additional expectations for plans to further coordinate or integrate members' care. For the One Care FIDE SNP program specifically, the SMAC will also serve as the program's Medicaid managed care contract with MassHealth.[xxvi]

- **FIDE SNPs require separate federal and state funding streams for Medicare and Medicaid services, with no opportunity to directly share savings.** Currently under One Care, CMS and the Commonwealth each make monthly payments to One Care plans for their respective portions of the capitated rate. Capitation rates for One Care plans are based on baseline spending in both Medicare and Medicaid and anticipated savings that might result from integrated care, such as through reductions in hospital admissions, emergency room utilization, and unnecessary nursing facility admissions. The Commonwealth and CMS share risk for savings and losses with the plans, with the governmental entities splitting any recoupments or payments proportionate to their relative capitation contributions. The FIDE SNP model does not provide the same opportunity to promote financial alignment between CMS and the state. For example, states cannot share directly in a portion of Medicare savings accrued to the D-SNP. This could result in cost shifting from the federal government on to the state, since Medicaid's investments in LTSS and behavioral health services that help people avoid hospitalization ultimately result in savings on the Medicare side. Without the financial alignment tools that are inherent in the MMP model, alternative approaches to promote aligned incentives should be considered for FIDE SNPs.[xxvii]

[f] In some states, members may receive certain services outside of the FIDE SNP, for example through fee-for-service waivers or state plans.

FIGURE 3. CURRENT THREE-WAY CONTRACT STRUCTURE UNDER THE MMP

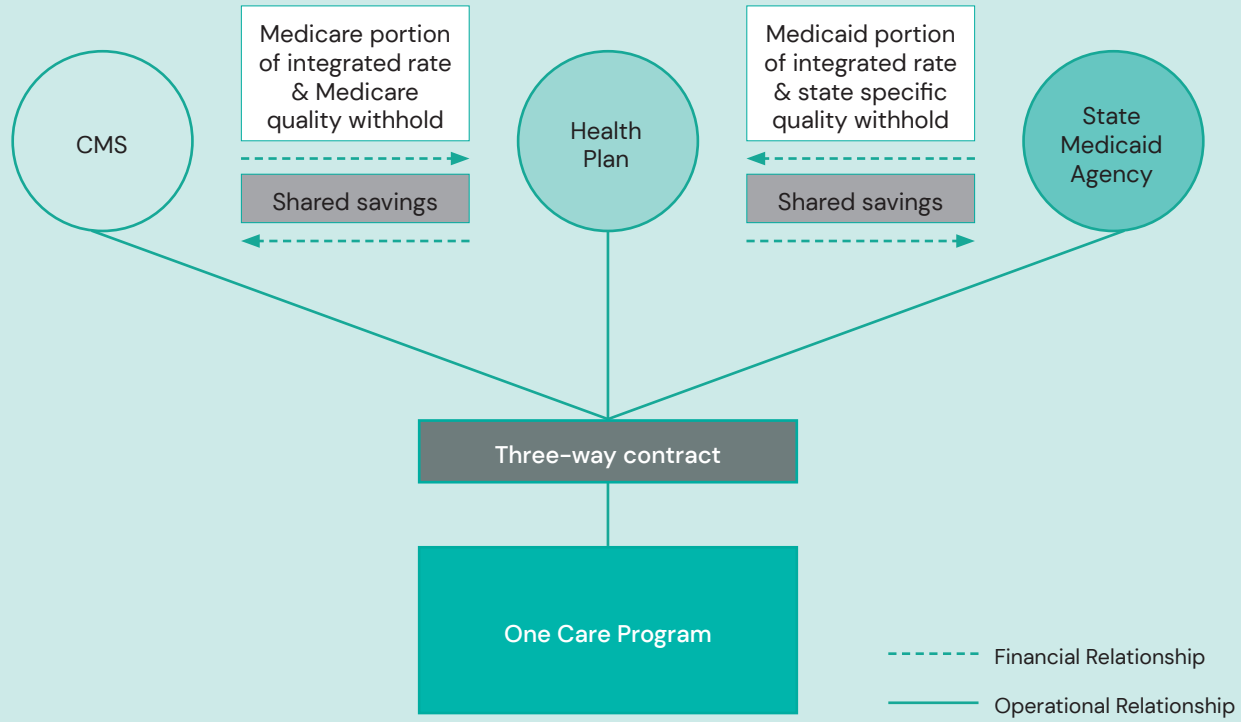
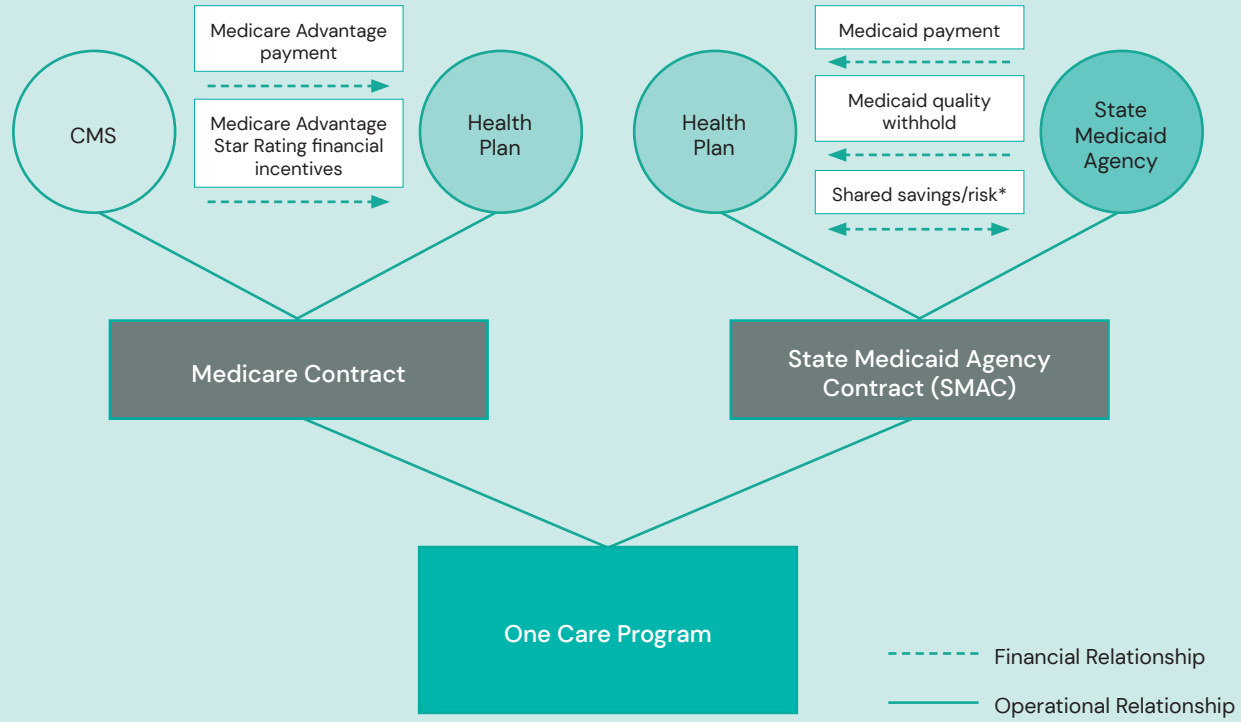


FIGURE 4. FUTURE TWO-CONTRACT STRUCTURE UNDER THE FIDE SNP



* States can include Medicaid risk sharing arrangements in their SMACs.

MASSHEALTH'S PLAN TO RETAIN KEY ONE CARE FEATURES IN THE TRANSITION TO A FIDE SNP

MassHealth submitted an Initial Transition Plan to CMS on One Care's transition from an MMP to a FIDE SNP in September 2022. The Transition Plan emphasizes MassHealth's commitment to preserve the advancements made in integrated care for the One Care population under the demonstration. It describes the process by which MassHealth will determine the structural, policy, and operational elements of the transition to FIDE SNPs. The Transition Plan highlights MassHealth's strategy to engage members and other key stakeholders throughout the planning and implementation phase of the transition.[g] Critically, the Transition Plan reflects a continued commitment to the goals and principles of One Care, including improving access to care, providing culturally competent care, promoting independence in the community, and maintaining strong member protections.

Two key elements of the MMP – strong program oversight and Medicare and Medicaid financial alignment – are features that MassHealth is particularly focused on retaining as much as possible under the FIDE SNP.

ENSURING STRONG PROGRAM OVERSIGHT

The shift from a single three-way contract to two two-way contracts creates two program oversight challenges for MassHealth.

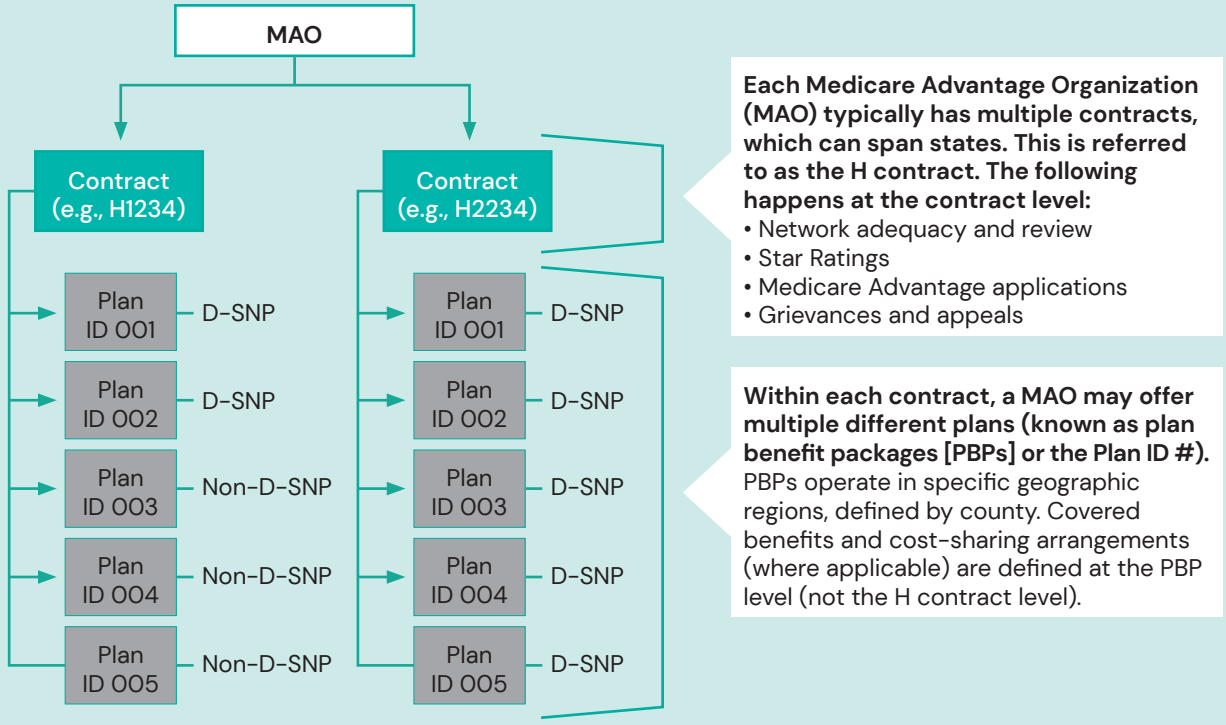
1. MassHealth will need to develop an approach for assessing the Medicare performance of the new One Care plans. Under the FIDE SNP model, MassHealth will no longer be able to influence the standards for assessing One Care plans' Medicare performance. For example, under the FIDE SNP model, MassHealth will no longer have a way to establish aligned Medicare and Medicaid network adequacy standards for One Care plans. MassHealth also cannot influence the quality measures that CMS uses to assess Medicare plans, as those are defined federally.

   While it cannot influence the quality measures plans report on, MassHealth intends to ensure it can continue to monitor One Care plans' comprehensive performance. To maintain oversight on both Medicaid and Medicare standards, MassHealth can leverage the SMAC to include provisions that require plans to report their Medicare quality measure performance to the Commonwealth.

   The way Medicare Advantage contracts are structured creates additional barriers to strong state program oversight. Typically, Medicare Advantage organizations offer many different plans, including both D-SNPs and non-special needs Medicare Advantage plans, within a single contract (see Figure 5). This Medicare Advantage contract can also cover plans operating in multiple states. This creates a challenge for the state to exercise proper oversight over the plan, since important oversight functions such as network adequacy reviews and quality measure reporting happen at the contract level, not the individual plan level. Broad-based Medicare Advantage contracts leave states (and CMS) with very limited insight into how specific D-SNPs are serving dual eligible members in specific states, since D-SNP performance is lumped in with the carrier's other Medicare Advantage products offered in that state (as well as some of their Medicare Advantage products offered in other states).

[g] MassHealth's Transition Plan notes several channels for stakeholder engagement to provide opportunities for feedback from diverse groups, on at least a quarterly basis. Examples of these communication and feedback channels include the Implementation Council, CMFI, public meetings, disability advocate meetings, stakeholder emails, the One Care website, health plan communications, transition meetings, work groups, and requests for information (RFIs).

FIGURE 5. OVERVIEW OF MEDICARE ADVANTAGE ORGANIZATION CONTRACT STRUCTURE



To mitigate these challenges, and create a more level field for assessing D-SNP quality between larger, national carriers with Medicare Advantage contracts spanning several states versus smaller, more localized carriers, states have the option to require that all One Care FIDE SNPs operate on state-specific D-SNP-only contracts. For example, contract H2234 in Figure 5 is an example of an H contract that is limited to D-SNPs (i.e., a D-SNP-only H contract). Contract H1234 is not a D-SNP-only H contract, and it includes Medicare Advantage products beyond D-SNPs. States can further limit D-SNP-only contracts so that they include only a single D-SNP. State specific D-SNP-only contracts allow, for example, plan administrators to review a D-SNP-specific provider network and share in joint oversight with CMS over how their plans meet network adequacy standards. State-specific D-SNP-only contracts also allow states and CMS to assess how a plan performs on quality measures specifically for the dual eligible individuals it serves.

In Massachusetts, MassHealth intends to require that all One Care FIDE SNPs operate on a state-specific D-SNP-only contract. Requiring use of this type of contract will mean that a health plan's One Care FIDE SNP will be the only plan within the organization's Medicare Advantage contract with CMS (and that this FIDE SNP will only operate in the Commonwealth). This enables the Commonwealth and CMS to assess plan performance and processes specific to MassHealth dual eligible individuals enrolled in One Care. All Massachusetts SCO plans have used D-SNP only contracts since 2022; 2024 Medicare Star Ratings for SCO contracts are specific to the organization's SCO product performance.

2. MassHealth will need to assume some new contract management and oversight responsibilities. Under the MMP, the three-way contract allows for joint CMS and MassHealth oversight over the entirety of the program, with CMS able to support the Commonwealth in managing the Medicare and Medicaid aspects of One Care. In the FIDE SNP model, CMS' role in direct management over the plan is less robust given the two-way contract between the state and health plan (SMAC) that governs the program. In addition, post-

transition, each One Care plan will be one of many D-SNPs, and one of even more Medicare Advantage plans, that CMS oversees. As a result, MassHealth will need to assume greater oversight of the plans. Assuming greater oversight of the plans may include, for example, ensuring that integrated member materials are compliant with Medicare requirements and any state-specific Medicaid member material and communication guidelines, or overseeing unified appeals and grievances processes to ensure compliance with Medicaid requirements.

While a joint contract management team (composed of both CMS and state staff) will no longer conduct oversight of One Care plans, both MassHealth and CMS intend to maintain access to CMS' Health Plan Management System (HPMS), an online platform that CMS uses to manage and oversee Medicare Advantage plans. While Medicare Advantage plans have always used HPMS to submit information like their bid and benefit packages and marketing materials for CMS review, CMS now allows state Medicaid agencies that oversee single D-SNP-only contracts with EAE, like MassHealth, to access HPMS as well. This allows for MassHealth to have shared transparency into plan material and benefit submissions, enabling MassHealth and CMS to continue to collaborate on joint oversight.

Through anticipated provisions in the SMAC, MassHealth will expect One Care FIDE SNPs to develop processes for providing MassHealth with timely documentation and analyses related to the plans' performance and compliance, including reporting quality measures. MassHealth will also require the plans to use performance and quality data to identify where their performance lags and to adjust policies and procedures to promote improved outcomes and member experience, and alignment with MassHealth's goals for One Care.[xxviii] The state will need to exercise strong program oversight to review the documentation and quality measures and to ensure plans are in full compliance with these requirements.

MassHealth acknowledges that its contract management responsibilities will need to compensate for the reduced CMS oversight, and the Commonwealth has focused on growing its oversight functions to enable a smooth transition to overseeing the One Care FIDE SNP program.

MAXIMIZING FINANCIAL ALIGNMENT BETWEEN MEDICARE AND MEDICAID

The MMP demonstration includes several tools that address the financial misalignment that can otherwise happen between Medicare and Medicaid – both at the federal and at the plan-level – and that allow for CMS and states to share in savings and losses. At the federal level, CMS and state Medicaid agencies collaborate to determine aligned financial terms and risk sharing (across Medicare and Medicaid) for dual eligible individuals. Through this process, CMS and states also establish program savings assumptions based on expected program administrative efficiencies (e.g., having a single set of member materials), improved care coordination, and improved health care utilization likely to result from financial alignment created by the MMP demonstration. Importantly, CMS and states receive the same percentage of program savings regardless of whether the savings come from Medicare services or Medicaid services.

As an example of Medicare-Medicaid financial alignment in the MMP demonstration at the plan level, a single MMP receives the Medicare and Medicaid capitation payments directly through one three-way contract structure. This alignment allows the plan to focus on prioritizing the right care for members, informed by one integrated set of financial incentives, regardless of whether members need services paid by Medicare or Medicaid.

This approach also makes it easier for CMS and states to hold MMPs accountable to a single, integrated medical loss ratio (MLR). The MLR reflects the portion of total Medicare or Medicaid payments made to the plan that is spent on member benefits/clinical services and quality improvement versus administrative costs and profits; under the demonstration, plans are expected to spend at least 85 percent of their Medicare and Medicaid payments on the former. Plans that do not spend a sufficient amount of their payments on benefits/clinical services and quality improvement activities must remit or return those payments to CMS and states. By being held accountable to one

MLR that combines both Medicare and Medicaid payments and expenses, One Care plans are incentivized to cover services based on members' needs regardless of whether the payment is from Medicare or Medicaid.

The FIDE SNP model does not have all of the financial flexibilities included in the MMP demonstration. For example, under the FIDE SNP model, CMS and states do not have the direct ability to share in program savings. And at the plan-level, FIDE SNP payments from Medicare and Medicaid include program-specific quality incentives and payments, with no aligned savings terms between payers. This results in a lack of alignment in financial incentives for the plan, potentially leading to cost shifting from one program to another.

MassHealth is exploring opportunities to promote and preserve Medicare-Medicaid financial alignment at the plan level, including tracking payer cost shifting over time and maximizing approaches to retain shared savings and losses. For example, MassHealth will retain the integrated MLR described above in the FIDE program to reflect holistic spending across Medicare and Medicaid. MassHealth also intends to leverage a risk corridor that accounts for combined Medicare and Medicaid profits and losses. A risk corridor is a tool that limits health plan financial risk and potential profits by allowing health plans and the state to "share" in program profits and losses. Combining Medicare and Medicaid profits and losses into a single, blended risk corridor should further encourage plans to provide appropriate services and care, regardless of where the payment is coming from.

Collectively, these approaches may help reduce cost shifting between Medicare and Medicaid at the plan level because they encourage FIDE SNPs to consider their costs and profits holistically.

RETAINING KEY ONE CARE FEATURES

In addition to MassHealth's approaches to retaining as much of the program oversight and financial alignment aspects of the MMP demonstration as possible, it also intends to carry over several additional core elements of the demonstration into the FIDE SNP model, particularly those features that are critical to the care model and member experience. As noted previously, MassHealth can leverage the SMAC and collaborate with CMS to retain many key One Care features. This approach is intended to provide as seamless a care transition for members as possible as the program shifts from one authority to another.

Some features of One Care – such as the key elements of the care model – can be easily retained using the SMAC. Other elements – such as the streamlined enrollment approach across Medicare and Medicaid – cannot be fully retained in the FIDE SNP model, though the Commonwealth is exploring options to retain as many consumer protections in those elements as possible. Figure 6 below specifies what is known as of the date of this publication about whether and how the Commonwealth intends to retain key elements of the One Care program in this transition.[h]

[h] The assessment of key attributes' status post-transition from MMP demonstration to FIDE SNP reflects a review of publicly available materials including: MassHealth's transition planning documents; materials from public meetings regarding the transition; Implementation Council meeting materials; an interview with MassHealth officials overseeing One Care and its transition; and the Commonwealth's recent request for responses (RFR) for the One Care and SCO programs, released by the Massachusetts Executive Office of Health and Human Services (EOHHS) on November 30, 2023. Additional insights are drawn from federal CMS requirements of all FIDE SNPs.

FIGURE 6. ANTICIPATED STATUS OF KEY ELEMENTS OF ONE CARE IN TRANSITION FROM MMP TO FIDE SNP

KEY ELEMENTS AND ATTRIBUTES OF ONE CARE	ANTICIPATED STATUS POST-TRANSITION FROM MMP TO FIDE SNP
PERSON-CENTERED CARE MODEL AND FLEXIBLE BENEFITS	
Person-Centric Interdisciplinary Care Team	**Retained post-transition.** The Commonwealth is retaining all key elements of One Care's person-centered care delivery model. While key elements will be retained, the Commonwealth intends to use the transition as an opportunity to look further into these roles and the person-centered care delivery model and utilize opportunities (through the SMAC, for example) to standardize and improve the model. For example, in response to feedback raised by stakeholders through the CMFI process, the Commonwealth intends to further standardize and clarify the roles of the care coordinator and the LTS Coordinator on the care teams.
Comprehensive Assessment	
Individualized Care Plan	
Long-Term Supports Coordinators (LTS Coordinators)	
Expanded Benefits	**Retained post-transition.** The Commonwealth is requiring that One Care FIDE SNPs include all "expanded benefits" currently covered in One Care under the standard MassHealth benefit package. Members will have access to the same comprehensive benefits that they are eligible for today in the One Care demonstration.[i]
Flexible Benefits	**Retained post-transition.** One Care FIDE SNPs will retain the ability to offer "flexible benefits" financed through their capitated Medicaid payments and/or Medicare supplemental benefits (see below). As in the One Care demonstration today, flexible benefits will be offered at the discretion of One Care FIDE SNPs, consistent with members' Individualized Care Plans (ICPs), and appropriate to address the members' needs. Many of the flexible benefits currently in One Care are possible through Medicare Advantage "supplemental benefits," which are similar to One Care's current flexible benefits. These benefits are typically offered at the plan's discretion and in accordance with member need. They can include in-home support services, home modifications, and home-delivered meals among other benefits similar to those available in One Care. The limitation of this approach is that Medicare Advantage plans can choose to offer supplemental benefits but must define these benefits when they submit their bids to CMS the year prior to implementation, whereas One Care's flexible benefits are not predefined, offering more flexibility for plans to offer any benefit that aligns with needs documented in the member's ICP. The Commonwealth will monitor One Care FIDE SNPs' continued provision of flexible benefits. The state will do so both by tracking the benefits provided through capitated Medicaid payments and by requiring through the SMAC that plans report to the state on their members' use of Medicare supplemental benefits.
MEANINGFUL MEMBER ENGAGEMENT	
One Care Implementation Council	**Retained post-transition.** The Commonwealth intends to preserve the Implementation Council's role in the next phase of One Care, and to continue engaging the council as an essential partner in policy and program change, monitoring, and oversight. CMS will remain connected to and engage with the council following One Care's transition from demonstration to FIDE SNP.

[i] Once One Care has been transitioned to a FIDE SNP, the core One Care benefit package will be composed of the standard Medicare benefit package plus the standard MassHealth benefit package (authorized through its State Plan and/or Section 1115 MassHealth demonstration).

Plan-Specific Member Advisory Board	**Retained post-transition.** CMS requires all Medicare Advantage D-SNPs to establish and maintain a "member advisory committee" reflective of the dual eligible individuals they serve; Medicaid managed care regulations also have a similar requirement. MassHealth intends to require that such committees meet both the Medicaid and the Medicare requirements. At minimum, CMS requires that these advisory committees must solicit input on ways to improve access to covered services, coordination of services, and health equity among underserved populations. The One Care RFR enumerates several requirements for the member advisory committees (which are referred to as "consumer advisory boards" in the One Care FIDE SNP program).[j] Such requirements include direction that consumer advisory boards must include members and family members and/or caregivers of members, reflecting the diversity of the One Care eligible population, including individuals with various disabilities and consideration for cultural, linguistic, racial, disability, sexual orientation, and other member identities.
ROBUST MEMBER PROTECTIONS	
My Ombudsman	**Retained post-transition.** The Commonwealth intends to retain continued access to robust ombuds services for One Care members, though the federal grant funding that currently supports these services will end with the demonstration. Absent these federal grant funds, states can still seek federal Medicaid administrative funding to continue supporting ombuds activities specific to dual eligible individuals. MassHealth intends to work with CMS to consider options for continued federal Medicaid administrative funding; MassHealth may also need to identify state funding sources to make up for the gap between the amount of federal grant funding it currently receives under the demonstration for these services and the amount it can obtain through federal Medicaid administrative funds after the transition.
Unified Appeals and Grievance Process	**Retained post-transition.** The Commonwealth intends to retain a single, unified appeals and grievance process with integrated benefit determinations. CMS requires D-SNPs operating with EAE – such as the One Care FIDE SNP – to operate a single, unified appeals and grievance process.

[j] One Care FIDE SNP "consumer advisory boards" must meet both Medicaid managed care requirements for a Member Advisory Committee as described at 42 CFR 438.110 and Medicare D-SNP requirements for an Enrollee Advisory Committee as described at 42 CFR 422.107(f).

Aligned Provider Network Adequacy Requirements and Oversight	**Changing post-transition.** Two elements of provider network adequacy are changing: (1) the standards plans are measured against, and (2) the role MassHealth can play in assessing Medicare plans' provider adequacy. After the transition to FIDE SNPs, One Care plans will be assessed using standard Medicare Advantage network adequacy standards, which were developed based on the needs of the broader Medicare population – not the specific needs of the One Care population. As a result, the network standards applied to One Care plans may not adequately reflect the diverse physical, behavioral, cognitive, or functional needs of dual eligible One Care members, the majority of whom are under age 65 and with different needs than the broader Medicare population. To mitigate some of these network adequacy limitations, the Commonwealth may seek approaches via the SMAC to ensure that One Care members are still able to access providers across their comprehensive set of needs. For example, states can apply more stringent Medicare network adequacy standards beyond those required by Medicare, as long as they do not conflict with and are more member-protective than the existing Medicare standards. This would require, however, that MassHealth be more proactive in influencing and overseeing those additional network adequacy standards, compared to the MMP, where states' role in assessing Medicare network adequacy was inherent. Additionally, in most instances, states have limited ability to influence CMS' automated review of Medicare Advantage D-SNP network adequacy. For example, D-SNPs may submit exception requests to CMS when they cannot meet network adequacy (due to, for example, unique patterns of care in the state or a particular region). In most instances, CMS will approve a D-SNP's exception request unbeknownst to the state in which the D-SNP operates, which further hinders states' abilities to truly understand how a D-SNP's provider network does or does not meet the needs of dual eligible individuals. CMS has indicated it will collaborate in Medicare Advantage network adequacy exception request reviews with states requiring D-SNPs to pursue state-specific D-SNP-only contracts, as the Commonwealth intends to do.
Continuity of Care Protections	**Retained post-transition.** Members transitioning from One Care demonstration plans to FIDE SNPs will similarly be afforded a 90-day period during which members will be expected to transition to providers in the plan's network. Additionally, to minimize the risk of members having to choose new providers in the transition to One Care FIDE SNPs, the Commonwealth has maintained all the robust continuity of care requirements existing in One Care today, including requirements for single-case out-of-network agreements.
UNIFIED MEMBER MATERIALS AND COMMUNICATIONS	
Integrated Member Materials	**Retained post-transition.** CMS requires that states pursuing D-SNP-only contracts, as the Commonwealth intends to, work with CMS to ensure that members receive, at minimum, the integrated summary of benefits, formulary, and combined provider and pharmacy directory. MassHealth has authority through the SMAC to require that One Care FIDE SNP plans integrate additional member materials, such as the member handbook (i.e., evidence of coverage), and intends to maintain requirements for integrated materials. Like the existing One Care member material review processes, MassHealth intends to continue working with CMS to jointly review and lead development on any required integrated member materials the Commonwealth pursues. The Commonwealth intends to engage key stakeholders regarding the development of any new member material templates, as it does currently in One Care and the SCO FIDE SNP.

Single Member Services Call Center	**Retained post-transition.** The Commonwealth intends to leverage the SMAC to require that One Care plans continue operating a single, toll-free call center post-transition for members to access information regarding their Medicare and Medicaid services and benefits.
STREAMLINED ENROLLMENT APPROACH	
Integrated and Streamlined Enrollment and Disenrollment Processes	**Changing post-transition.** Following the demonstration's end, members will experience plan enrollment and disenrollment differently. For example, One Care FIDE SNPs – rather than MassHealth – will coordinate all One Care enrollment and disenrollment processes, including issuing member notices. While process changes are expected, the Commonwealth remains committed to prioritizing strong member protections for enrollment and disenrollment. For example, while CMS delegates enrollment and disenrollment processing to Medicare Advantage plans, One Care FIDE SNPs will need to request approval from MassHealth before using independent agents and brokers (collectively referred to by MassHealth as "external brokers") to enroll members in One Care, and MassHealth will require enhanced oversight and reporting for all education, marketing, and enrollment activities.[xxix] New CMS rules will also help address misalignments that may come from Medicare and MassHealth having different enrollment periods. CMS recently created a monthly Special Enrollment Period that will enable dual eligible individuals to enroll in an integrated D-SNP – like a FIDE SNP – if they are already enrolled or are in the process of enrolling in the Medicaid managed care plan operated by the same parent organization as the integrated D-SNP. This new provision will help facilitate aligned enrollment.[xxx]
Passive/Facilitated Enrollment	**Will not exist post-transition.** The ability to passively enroll individuals into One Care plans will end with the demonstration. Members will enroll and disenroll directly (i.e., self-select) in and out of One Care FIDE SNP plans.
MAXIMALLY ALIGNED QUALITY MEASUREMENT	
Quality Measure Reporting	**Changing post-transition.** Following the demonstration's end, One Care plans' Medicare performance will primarily be assessed against Medicare quality measures, such as those in CMS' Medicare Advantage Star Ratings program. Medicare quality measures may not reflect the complexity of behavioral health, socioeconomic, or functional needs of dual eligible individuals, particularly dual eligible individuals under age 65 like those enrolled in One Care. MassHealth's pursuit of state-specific D-SNP-only contracts will at least provide MassHealth with One Care FIDE SNP Star Ratings – and any other Medicare quality data that the Commonwealth may require plans to report to the state, such as CAHPS and HEDIS results, exclusively reflecting the quality of care that plans are providing to One Care members. This will allow the Commonwealth to continue to monitor the Medicare performance of the D-SNPs operating in Massachusetts. MassHealth will also include quality metrics tied to Medicaid withholds and incentives for the One Care FIDE SNP plans.

TRANSITION PLAN TIMELINE

The Commonwealth has issued a procurement for health plans for One Care (and SCO) through an aligned Request for Responses (RFR) process; this process will result in contracts with the Medicare Advantage plans that will serve One Care members under the new FIDE SNP model beginning in 2026. Given the structure of FIDE SNPs, One Care plans will need to go through two procurement and implementation processes: one to contract with MassHealth and another to contract with Medicare. Figure 7 provides a summary of the One Care transition timeline, inclusive of both MassHealth and Medicare deadlines, and the box below describes how stakeholders will be engaged in the process.

FIGURE 7. ONE CARE TRANSITION TIMELINE

MassHealth released a Request for Responses (RFR), outlining program expectations and requirements, to competitively procure managed care plans for both the One Care and SCO programs.	November 30, 2023
Deadline for plans to submit their RFR responses to MassHealth.	April 5, 2024
MassHealth anticipated selection of One Care and SCO plans.	November 1, 2024
Deadline for plans to submit a Notice of Intent to Apply to Medicare indicating intention to apply for a D-SNP in 2025.	November 2024
MassHealth "Readiness Reviews."[k]	Begin early 2025
Deadline for plans to submit their applications for new D-SNP contracts to CMS.	February 2025
SMACs signed by One Care plans and MassHealth.	May 1, 2025
Deadline for plans to submit their actuarial pricing bids for approved D-SNP contracts to CMS.	June 2, 2025
SMACs due to CMS for review and approval.	July 2025
CMS Medicare contracts signed.	August 2025
Marketing and Medicare Open Enrollment.	October 15–December 7, 2025
First enrollments effective.	January 1, 2026

STAKEHOLDER ENGAGEMENT DURING RFR PROCESS

As part of the Commonwealth's procurement process for One Care, MassHealth solicited "Consumer Readers," or individuals who are enrolled in or have experience with One Care or SCO and will have a role in the health plan selection process by reviewing key sections of plan responses and engaging with MassHealth to discuss and share feedback. Consumer Readers were selected and began engagement with MassHealth in fall 2023.

[k] "Readiness reviews" ensure that selected health plans are ready to accept enrollment, protect and provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers most frequently utilized by the Medicare-Medicaid population, and fully meet the diverse needs of the Medicare-Medicaid population.

LOOKING AHEAD

One Care is a unique integrated care program for people who are dual eligible, and one of few in the country focused on providing comprehensive care to adults with disabilities under the age of 65. The core tenets of the program – person-centered care with a focus on independent living and recovery in the community – have shaped One Care's program features and are key principles that MassHealth has committed to prioritizing in the state's transition from the MMP demonstration to a FIDE SNP platform.

The FIDE SNP model has some limitations relative to the current MMP demonstration that may reduce some of the Medicare-Medicaid alignment achieved by the One Care program, particularly as it relates to financial alignment and program oversight. However, MassHealth has indicated a commitment to preserve key elements of the One Care program – including, critically, the care model – in this transition. As MassHealth moves forward with transitioning the program to a new authority in January 2026, it has demonstrated its intention to continue working collaboratively with key stakeholders and CMS to ensure the development of a program that preserves the vital, person-centered elements of One Care.

APPENDIX A : EVOLUTION OF ONE CARE

One Care launched with three MMPs (CCA, Tufts, and Fallon Total Care).	October 2013
One MMP (Fallon Total Care) left the demonstration; two remained (CCA and Tufts).	Late 2015
UnitedHealthcare joined One Care as an MMP, for a total of three MMPs (CCA, Tufts, UnitedHealthcare).	January 2022
MassHealth launched the Care Model Focus Initiative (CMFI)[1] to reassess, reclarify, and refocus on One Care's care model.	January 2022–July 2022
Increase in geographic coverage over time to include all mainland (non-island) counties in Massachusetts.	January 2022

[1] MassHealth launched the Care Model Focus Initiative (CMFI) in One Care's ninth year to identify steps to result in greater alignment, clearer expectations, and increased focus on performance around key aspects of the One Care model, including the member experience, service delivery, and program and plan accountability.

APPENDIX B: RESOURCES FOR MORE INFORMATION

For more information on the topics covered throughout this brief, please see the resources provided below.

ONE CARE RESOURCES

- For current One Care three-way contracts, please see MassHealth's Health Plan Contracts page.
- For more information on the performance of the One Care demonstration, please see the most recent evaluation report (April 2023).
- For more information on the available care models for dual eligible individuals in the Commonwealth including One Care, please see this Blue Cross Blue Shield of Massachusetts Foundation primer.
- For a quantitative analysis of the dual eligible population in the Commonwealth, please see this databook.
- For more information on risk adjustment for models serving dual eligible individuals in Massachusetts, please see this report.
- To read MassHealth's initial One Care Transition plan, please see this page.
- For information on One Care's transition from the MMP demonstration to a FIDE SNP, please see MassHealth's One Care Transition Planning page, or specifically their resources for stakeholder engagement efforts.
- For stakeholder information on the procurement for One Care plans, please see MassHealth's Procurement for One Care Plans and Senior Care Options (SCO) Plans for 2026 page, which includes the RFR and model contract documents for One Care FIDE SNPs. This information is also available on COMMBUYS, the Commonwealth's official procurement site.

MEDICARE AND MEDICAID INTEGRATION RESOURCES

- To learn more about dual eligible individuals and their coverage and care, please see "A Profile of Medicare-Medicaid Enrollees (Dual Eligibles)" from the Kaiser Family Foundation.
- For more information on the Financial Alignment Initiative and its demonstrations, please see the Medicaid and CHIP Payment and Access Commission (MACPAC) webpage.
- For information on integrated programs for people who are dual eligible, please see the Integrated Care Resource Center (ICRC) website.

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