



The One Care
Implementation Council
*Stakeholder Engagement
Within a Duals
Demonstration Initiative*

June 2018



Executive Summary

A One Care Implementation Council was established in 2013 to ensure stakeholders assume an active role in the implementation of Massachusetts' Financial Alignment Initiative known as "One Care: MassHealth plus Medicare (One Care)." The Council represents diverse stakeholder perspectives, including MassHealth members with disabilities, their family members and guardians, representatives from community-based organizations, advocacy organizations, unions and providers. Supported by the Executive Office of Health and Human Services (EOHHS), the Council is an innovative body that was the brainchild of Massachusetts disability advocates. It has been replicated in a number of other states that are participating in the Financial Alignment Initiative. The Council's impact is a notable example of effectively engaging consumers and their advocates in policy and program change – as this case study will illustrate.

Six interviews with seven total stakeholders, including enrollee, provider, advocate and state representation were conducted and supplemented with a comprehensive document review to inform the following case study issue brief. This issue brief is intended to be a resource for policymakers, health care leaders, advocates and program enrollees nationwide who want to develop or enhance similar Councils.

Council Formation and Management

The Implementation Council, formed through a Request for Response process, elected a chair who is a One Care enrollee (but also can be a family member) who then worked with co-chair(s) to develop agendas, facilitate meetings and oversee work plans and reporting activities. The Council hosted 44 meetings between February 2013 and November 2016. Each meeting lasted approximately two hours, with the last portion of each meeting typically dedicated to public questions and comments. The Council convened additional subcommittees and workgroups to address topical issues, including behavioral health integration, LTSS integration, quality measurement and data analysis. The University of Massachusetts (UMASS) Medical School assumed a project support role for the Council by producing meeting minutes, providing support for workgroups and broader community engagement activities.

The Council relied on motions as the primary method for decision making during its early years, but moved to more consensus-based decision making over time. While the Council is independent from EOHHS, it needed to work together with State partners to prioritize projects and work plans. Building trust – among Council members and with the State partners – was critical to ensuring effective interpersonal communication and Council progress. Trust was fostered in instances where people were forced to solve a time-sensitive problem, since all parties shared a common goal of supporting the immediate needs of enrollees. The Council meetings were scheduled to account for Council members' schedules and religious holidays, and Council members who could not make meetings in-person were provided with speakerphone access. Additional accommodations for Council members included access to American Sign Language interpreters and Communication Access Real-Time Translation (CART) providers, transportation, stipends, travel reimbursement and various material formats. Council members received training information through webinars, presentations, reports and guest speakers. UMASS Medical School staff supported Council members through one-on-one discussions, which occurred outside of formal Council meetings.

Council Representation, Skills and Characteristics

The Council is comprised of individuals diverse in experience, disability, race, ethnicity and geographic representation who are residents of Massachusetts and not employed by One Care. The original Council included 11 consumer representatives; six advocates and peers from community-based and consumer advocacy organizations; and four representatives from service providers, trade organizations and unions. One Care enrollees and providers were important to the Council because they contributed to discussions grounded in real-life experiences. State partners were also present during most Council meetings and shared information, actively participated in discussions and assisted to prioritize activities. Council members had a variety of skills and characteristics that were

beneficial to the Council process, including strong communication skills; effective conflict resolution skills; knowledge about the One Care model and the needs of enrollees; analytical skills to read tables, recognize trends and analyze data; and project management skills to monitor their own work plans, goals, timelines and deliverables. Council members also had to be strong advocates for the population they represented, as well as for other populations not formally represented within the Council.

Council Focus Areas and Impact

The Council addressed both Council process and One Care implementation. The majority of Council discussions focused on One Care implementation, including thoughtful rollout to allow new enrollees to acclimate to managed care; risks of passive enrollment; effective use of assessment tools and individualized care plans; effective care coordination strategies; use of peer supports; and health plan and provider training needs. The Council ensured One Care enrollees' voices informed implementation. For instance, public comment sessions took place during each Council meeting to shed light on challenges enrollees faced, and Council members also tapped their own communication networks to learn what was happening "on the ground" with One Care enrollees. The Council members collected insights that informed the improvement of One Care, including the development of quality measures and the implementation of the LTS Coordinator role. The Council also minimized enrollees' service disruptions by assisting in the transition process for enrollees after a One Care plan unexpectedly discontinued its participation in the program. Additionally, the Council addressed quality by working directly with State partners and UMASS Medical School to monitor and report on early indicators of One Care enrollees' experiences. The Council addressed One Care's financial sustainability by identifying cost drivers and communicating the importance of the One Care model to federal partners.

Lessons learned from the development and operation of the One Care Implementation Council, identified below, have salience for stakeholders nationwide who want to develop or enhance similar bodies.

- ❖ Council membership and structures should be formed in partnership with community leaders and be flexible enough to grow and change with the Council over time.
- ❖ Council members' training should include Medicaid, Medicare and managed care models as well as Council process and expectations.
- ❖ Training and communication strategies should be multi-faceted (e.g., in-person, web-based, phone) and flexible enough to meet the unique needs of each Council member.
- ❖ Slower facilitation, consistent following of agendas and the use of simplified language can support Councils to offer universal accessibility.
- ❖ Work directly with individual Council members to identify strategies to meet their unique engagement needs to avoid Council turnover resulting from accessibility obstacles.
- ❖ Meaningful engagement of 'hard to reach' enrollees and diverse geographic communities requires you to "go where the people live, work and play."
- ❖ Council members will have varying levels of relevant personal and policy experience; training, communication and facilitation strategies should account for these differences.
- ❖ Councils may benefit from identifying priority focus areas, but also anticipating and dedicating time on the agenda to urgent, unplanned topics.
- ❖ The public comment section of the Council meetings is an opportunity to hear directly from enrollees; the time allocated should be consistently upheld and systematically inform Council work.
- ❖ Council members' access to timely data (e.g., care coordination and service utilization data) allows Council members to assume a meaningful role in quality monitoring.

- ❖ Council support from a third party, such as an academic institution, can encourage group progress and communication among stakeholders.
- ❖ People with lived experience share valuable experience and should be compensated for their time invested, including smaller group activities, meeting preparation and follow up.
- ❖ Transparency and the building of trust over time can lead to improved communication and effective decision-making among Council members and with State partners.
- ❖ Councils will need to balance their own autonomy with the collaboration needed (e.g., with State partners and health plans) to inform program design and improvements.

The One Care Implementation Council

Stakeholder Engagement Within a Duals Demonstration Initiative

Authored By:

Erin McGaffigan, PhD and Danielle Skenadore Foster, MSW

Funded By:

The Center for Consumer Engagement in Health Innovation, Community Catalyst

The LeadingAge LTSS Center @UMass Boston

Background

The Massachusetts' Financial Alignment Initiative (FAI), "One Care: MassHealth plus Medicare" (One Care), was launched in October of 2013 and serves dual eligible adults with disabilities who are 21 through 64 years of age at the time of enrollment. FAIs, also known as the Duals Demonstrations, are part of a national effort led by the Centers for Medicare and Medicaid Services' (CMS) Medicare-Medicaid Coordination Office (MMCO) to improve care for individuals dually eligible for Medicare and Medicaid. Massachusetts is one of thirteen states with an FAI. The Massachusetts Executive Office of Health and Human Services (EOHHS) currently contracts with two health plans (Commonwealth Care Alliance and Tufts Health Plan) to implement the One Care Duals Demonstration, which now serves over 19,000 individuals through integrated physical and behavioral health and long-term services and supports (LTSS). The One Care Implementation Council (referred throughout this report as the Implementation Council or Council) was established in 2013 to ensure stakeholders inform the implementation of One Care. The Council was formed to represent diverse stakeholder perspectives, with the majority of representatives being One Care members with disabilities and their family members and guardians. The Council also includes representatives from community-based organizations, advocacy organizations, unions and providers. Supported by the Executive Office of Health and Human Services (EOHHS), the Council is an innovative body that was the brainchild of Massachusetts disability advocates. It has been replicated in a number of other states that are participating in the Financial Alignment Initiative. The Council's impact is a notable example of effectively engaging consumers and their advocates in policy and program change – as this case study will illustrate.

This issue brief provides a case study review of the Implementation Council. Utilizing key informant interviews and a web-based material review, this issue brief supplements Implementation Council findings documented in One Care's [Evaluation Reports](#) and is intended to be a resource for policymakers, health care leaders, advocates and program enrollees nationwide who want to develop or enhance similar Councils in their own states. The Center for [Consumer Engagement in Health Innovation \(CCEHI\)](#) and the [LeadingAge LTSS Center @UMass Boston](#), the funders of this issue brief, are appreciative of the time dedicated by Massachusetts stakeholders to share their lessons learned so that others may benefit.

Methodology

[Collective Insight](#), on behalf of CCEHI, conducted six interviews with seven total stakeholders. These interviews were guided by key informant questions, which were reviewed and improved upon by the Implementation Council

leadership. Each interview was recorded, with the subject’s written consent, and transcribed for analysis. NVivo qualitative analysis software was used to track key themes within and across the interviews. Interviewees represented a diverse range of Council stakeholders and partners, including enrollee, provider, advocate and state staff. Collective Insight received University of Massachusetts’ Institutional Review Board approval for interview methods, outreach approach, interview guides and consent forms prior to initiating this project. All interview subjects were offered accommodations to support their participation and had the opportunity to review and provide comments on this issue brief prior to its release. Collective Insight also analyzed, using NVivo, 43 monthly meeting minute documents and Approved Council Motions to understand the Council’s focus, organization and decision-making processes throughout the Council’s first procurement (2013-2016). Collective Insight supplemented this analysis with a high-level review and analysis of additional Council documents (e.g., subcommittee reports and formal presentation slides). All documents, which are referenced at the end of this issue brief, were located on the [One Care Implementation Council website](#), the [Duals Demonstration website](#), or directly provided by Council stakeholders.

Council Formation and Management

The Implementation Council was formed as an outgrowth of both informal and formal conversations held among the EOHHS representatives and enrollee advocates. Disability Advocates Advancing our Healthcare Rights (DAAHR), a cross-disability coalition comprised of disability, senior and health care advocates, identified a need for an ongoing consumer role that could inform strategic elements and implementation of One Care. Prior to One Care implementation, DAAHR partnered with the EOHHS and advocates to hold community forums to engage stakeholders. Through these forums, advocates and the EOHHS saw additional opportunities to inform the One Care

model, and as a result, formed the Council in February of 2013. The EOHHS and advocates agreed that the Council’s name must include the term, “implementation” to communicate the active, as opposed to purely advisory, role the Council would assume within the One Care model. This symbolism was the first of many steps in defining the Council’s role, meaning and ultimate impact. The EOHHS created an initial model for the Council in collaboration with DAAHR, but then allowed the Council the flexibility to define its own role, operations, priority areas and work plans over time.

Nomination and Selection Process. The EOHHS formed the Council through a Request for Responses (RFR) process, and interested individuals had to submit nomination forms and a reference to the EOHHS to apply. The EOHHS established selection criteria with a goal of creating a Council that represented the diverse Duals Demonstration populations.¹ The Council was intended to have 15 to 21 members with at least 51% being One Care enrollees with disabilities, their family members, or guardians. Initially a 21-member committee was established in 2013, but the Council membership decreased over time. Additional members were appointed through a supplemental procurement process once active Council members requested the EOHHS release non-active members. Council chairs assisted in the screening of replacement Council members during this supplemental procurement process, but final applicant decisions were made by the EOHHS.

“We don’t just want [an] advisory group [that has no] real impact on the development of this new healthcare delivery system.”

— One Care Interview

1. Representation for the Implementation Council was sought for adults with physical disabilities; intellectual/developmental disabilities; serious mental illness; substance use disorders; multiple chronic illnesses or functional and cognitive limitations; and individuals with disabilities who are homeless.

Charter and By-laws. Once the Implementation Council was formed, Council members appointed a Subcommittee to draft its [Charter](#) and [By-laws](#), which aligned directly with Council’s original RFR. The Charter describes the following Council responsibilities:

- Advise the EOHHS on issues brought to the Council
- Provide support and input to the EOHHS
- Solicit input from stakeholders regarding the Demonstration and its implementation
- Monitor access to health care and compliance with the Americans with Disabilities Act (ADA)
- Track quality of services
- Assist in shaping quality metrics to be used to measure Duals Demonstration outcomes
- Review issues raised through the grievances and appeals process and Ombudsperson reports
- Examine access to services (medical, behavioral health and LTSS)
- Promote accountability and transparency
- Participate in the development of public education and outreach campaigns, as appropriate

Council By-laws outline member responsibilities, which include attending meetings, participating in committee activities and preparing for and contributing during meetings.

Facilitation and Support. Council members elect a chair who is a One Care enrollee or family member of a One Care enrollee. The chair and co-chair(s)² develop agendas, facilitate meetings and oversee work plans and reporting activities. The University of Massachusetts (UMASS) Medical School assumes a project support role for the Council and its members. Some Council members refer to UMASS Medical School as a helpful “bringer” of communication among Council members, State partners and the broader community. More specifically, UMASS Medical School’s role includes:

- producing meeting minutes
- providing support for workgroups and broader community engagement activities, such as statewide town hall events
- supporting communication within the Council and external of the Council

Meeting Frequency and Agendas. The Council was required, during the first procurement, to host public meetings at least six times per year. Between February 2013 and November 2016, 44 formal meetings were held (averaging 11 meetings annually). Each meeting lasted approximately two hours, and the last portion of each meeting typically was dedicated to public questions and comments. The EOHHS and the Council regularly invited guest speakers to present and participate in meetings, including academic partners evaluating One Care, local community health partners, health plans and CMS regional partners. The Council convened additional subcommittees and workgroups to address topical issues, including behavioral health integration, LTSS integration, quality measurement and data analysis.

Council Representation, Skills and Characteristics

Representation. Council members are required, as written in the original RFR and Council By-laws, to possess analytic, critical reading, interpersonal and communication skills; be a resident of Massachusetts; and not be employed by one of the One Care health plans. The State and Council leadership also strived for the Council to be representative of individuals diverse in experience, disability, race, ethnicity and geographic representation. There is consensus, among Council members and State partners, that “real life” One Care enrollees, in addition to enrollee advocates and providers, are essential to ensure the Council is effective in its intended role. Appointing actual One

2. Council “co-chairs” are not required, but have been appointed to bring diversity in skills to the leadership of the Council and to share the leadership responsibilities.

Care enrollees to the Council allowed the Council to ground discussions in real life. Also, the public nature of Council meetings allowed stakeholders to hear updates on health plan operations and enrollment while also providing an outlet for stakeholders to engage with program leaders, voice concerns and ask questions. Even so, the restricted window of time dedicated to public comments (often at the end of meetings and shortened if other parts of the agenda went longer than expected) sometimes limited the engagement of One Care enrollees.

The original Council included 11 consumer representatives; six advocates and peers from community-based and consumer advocacy organizations; and four representatives from service providers, trade organizations and unions. Council members represented the physical disability, intellectual/developmental disability and behavioral health communities; various racial and ethnic communities; religious communities and the LGBTQ+ community. While the Council's original intention was to host meetings in diverse geographic locations, Council meetings were ultimately held in Boston, making it difficult for stakeholders representing the far ends of the Commonwealth to participate in-person. Efforts to expand geographic accessibility were made by allowing Council members to participate in Boston-based meetings by phone. Even so, some stakeholders believe that the inclusion of diverse geographic communities requires the Council to "go where the people live, work and play."

"You have members who are enrolled in One Care, you have providers... bringing all of those different skill sets together ... [it] took some time ... to understand who is at the table and why ..."

— One Care Stakeholder

Stakeholders recognized the providers' voice was, at times, a surprising asset within the Council since the providers could often validate the experience of enrollees. The Council membership does not formally include State partners (e.g., EOHHS staff and representatives from MassHealth). However, many saw the importance of having State partners engaged as well, especially State partners who value the work of the Council and have the authority to make decisions. State partners were present during nearly every Council meeting, shared information, actively participated in discussions; and assisted in prioritizing activities. Representatives from the MMCO also attended most of the Implementation Council meetings, which communicated the importance of Council activities as well.

In the current Council, representatives from the health plans, MMCO, Ombudsman program and EOHHS participate in Council meetings as non-voting individuals, although involvement in meetings is at the discretion of Council leadership. Health plan representatives, while not formally represented on the Council, attended meetings routinely to provide updates and to hear the opinions of the Council. Council stakeholders had differing opinions as to whether health plan representatives should be formally appointed to the Council. Some stakeholders believed that health plans would be more invested in the Council process if they were formally appointed, while others worried that health plan representation would make One Care enrollees less comfortable speaking their minds.

Underrepresented Groups. While Council members were proud of their diversity, many recognized that more inclusion was possible, specifically in the areas of race, ethnicity, disability and geographic location. Some believed that Council member racial and ethnic diversity could be expanded by partnering directly with local communities and their leaders to identify new members for the Council, which takes time and the building of trust. Some also recognized the Council should be more inclusive of people who have intellectual disabilities, who are deaf or hard of hearing, who are in recovery from addiction, who have a

"Buy-in has got to come from the top... We also need decision makers involved... the commitment has to be to real [State] participation at the meetings..."

— One Care Stakeholder

history of homelessness, who are visually impaired and who are assistive-technology-dependent. The Council also faced challenges engaging individuals who have disabilities, but do not personally identify as having a disability or as part of the disability community (e.g., people who don't even know One Care exists). While basic accommodations were provided for Council members (e.g., interpreters and physical support to turn pages, etc.), the Council was especially challenged with engaging Council members who required slower facilitation, consistent following of agendas and simplified language (e.g., individuals who are deaf or hard of hearing, speak languages other than English and/or have intellectual disabilities). Council members recognized that finding ways to improve engagement of these underrepresented communities would prepare the Council to better inform health plans of how to be more inclusive in their own enrollee and community engagement efforts.

COUNCIL MEMBERS' SKILLS AND CHARACTERISTICS. Council members held a variety of skills and characteristics that were beneficial to the work of the Council. The following is a review of the Council member characteristics that stakeholders found especially helpful to the engagement process.

Strong advocates. Council members must be willing to speak up when they foresee challenges associated with the model implementation. They also must balance being an advocate for the population they represent with supporting decisions that benefit the broader One Care membership. Council members need to be able to advocate for others who may struggle to be heard, such as individuals who use interpreters, who have intellectual disabilities and who are underrepresented within the process (e.g., homeless population, those who do not self-identify as having a disability, etc).

Strong communicators. Council members need to be able to listen to others, to advocate for a position and to minimize acronyms and technical jargon. Council members also need to communicate with the communities they represent and bring their ideas and concerns back to the Council for discussion. Council members benefit from having strong conflict resolution skills, transparent behavior, public speaking skills and basic reading and writing skills.

Knowledgeable. Council members needed to know about One Care (e.g., who is eligible, the benefit package and the care coordination model) and the needs and characteristics of the enrollees served. It is also beneficial for Council members to understand managed care given the technical nature of many conversations. Some One Care enrollees came with their own professional experience, which was found to be beneficial to the Council's work.

Analytical. Council members reviewed One Care data frequently, including tables with enrollment and financial data. This required Council members to be able to read tables, recognize trends and apply their personal experience to help determine what the data actually means.

Reliable and Invested. Council members need to invest significant time in Council activities to be successful in their roles. Council progress is limited if members do not attend consistently and work both inside and outside of meetings to

“Those of us who were true consumer representatives... were loud, brash and not afraid to say when something doesn't work.”

— One Care Stakeholder

“...we've been very lucky [with the] skill sets on the Council... extremely knowledgeable about Massachusetts law and huge on disability advocacy. I think that that has been really important... they have brought us to an understanding... that we may not have thought of, frankly.”

— One Care Stakeholder

ensure the Council’s progress (e.g., to share updates with stakeholders and to participate in Council subcommittees and workgroups).

Project Management Skills. The Council developed and monitored their own work plans and facilitated project-specific workgroups that had their own goals, timelines and deliverables. A basic level of project management skills and writing skills were beneficial to the Council process.

STATE PARTNERS’ SKILLS AND CHARACTERISTICS. Stakeholders also referenced State partners’ various skills and characteristics that were beneficial to the Council’s process. For instance, some discussed the importance of State partners being good listeners and transparent in their sharing of information and decision making. It was important for Council members to feel heard by State partners, regardless of a final decision and to hear the reasons for any decisions counter to a Council’s recommendation. It also was beneficial for the State partners to be well informed of the One Care model to support thoughtful Council discussions about One Care’s design. Some believed it was important that State partners were advocates in their own right, advocating internally for the Council and passionate about addressing the needs of One Care enrollees. State partners also needed to be patient with the process, have ‘thick skin’ when conversations felt combative and be committed to follow through when next steps were identified.

Council Focus Areas

Many stakeholders struggled with defining the Council’s scope of work and priorities, as well as with determining where they fit within the One Care decision-making process. The first year was recognized by some as a ‘role shaping’ year as Council members felt their way through how to meaningfully influence One Care. While acknowledging this may have been unavoidable, some felt that the heightened focus on Council process when the Council was new decreased enthusiasm and deterred some Council members from attending meetings. With time, trial and error, the purpose and scope of the Implementation Council has become clearer. Many see the Council as an opportunity to bring people with different lenses together to share a “wealth of information” since “each of us, in different ways, want One Care to be successful and to grow.” Stakeholders believe that the Council will be, as time progresses, a place that allows for a “deep dive” on various One Care topics to understand what is happening on the ground and to determine how to improve One Care practices.

“I think, over time, we figured out how to effectively work together to address the things that they wanted to address in a meaningful way.”

— One Care Stakeholder

While the Council’s focus was confusing to many who were engaged, the Council did address a wide range of One Care topics. Between 2013 and 2016, the majority of Council discussions focused on the following topics:

- thoughtful rollout to allow new enrollees to acclimate to managed care
- risks of passive enrollment (an approach many Council members opposed)
- effective use of assessment tools and individualized care plans
- access to covered benefits
- effective care coordination strategies and the Long-Term Supports (LTS) Coordinator function
- use of peer supports
- health plan and provider training needs

The Council also spent significant time discussing One Care communication strategies and the use of effective stakeholder engagement strategies. Quality measurement and improvement also was discussed by the Council, including measures that can act as ‘early indicators’ of program success (and the monitoring of abuse, neglect, grievances, network adequacy, enrollee satisfaction and provider satisfaction). The Council

addressed financial aspects of the One Care model as well, including capitation rates; pay for performance strategies; direct care worker wages; and program sustainability.

Council Impact

The Council ensured One Care enrollees' voices informed implementation. The Council collected and applied the voice of enrollees using multiple methods. First, the Council facilitated public comment sessions during each Council meeting to allow for enrollees' communication of their own personal obstacles. The time allocated to public comments was inconsistent given it was the last topic addressed during Council meetings (when some in attendance had already left). Council members also were challenged, at times, with how to apply enrollee experiences in a timely way to Council activities. Even so, the public commenting sessions shed light on challenges enrollees faced, such as with transportation, accessing interpreters and accessing LTS Coordinators. Now, non-Council participants often engage in Council discussions throughout the meeting, not just at the end. Council members also tapped their own communication networks to learn what was happening "on the ground" with One Care enrollees. For instance, Council members called upon their own advocacy networks to identify early implementation enrollment challenges. The Council also recently facilitated Town Halls, which were held virtually, using central and regional connection hubs. This process allowed the Council to connect with enrollees who were otherwise difficult to engage due to geographic distance and travel challenges. The Council members, through these various methods, collected insights that informed the improvement of One Care, including the development of quality measures and the implementation of the LTS Coordinator role. For instance, these engagement mechanisms shed light on the need for additional provider and enrollee education on the role of the LTS Coordinator and how to access this assistance, when needed.

"We vetted [transition] letters. We recommended language so that [enrollees] didn't freak... we wanted to make sure that we were heralding that the program itself is not ending... we offered a lot of advice for options counseling too, things that SHINE could say and do, things that MassHealth could say and do [to support a smooth transition]."

— One Care Stakeholder

The Council minimized enrollees' service disruptions. In the third year of implementation (2015), the unexpected departure of a One Care plan left both State agency and Council members concerned about transition needs for the health plan enrollees. Instead of a planned summer break, Council members met intensely over the summer with State partners, sometimes multiple times a week, to plan for transition obstacles and to develop enrollee materials that supported seamless transition. Council members not only assisted in the development of enrollees' letters, but also provided helpful talking points for various partners who would be responding to enrollees' concerns and questions.

The Council addressed quality. The Council worked directly with the EOHHS and UMASS Medical School to monitor and report on early indicators of One Care enrollees' experiences. Council members reviewed reports from multiple sources, including the Ombudsman Office, MassHealth, focus groups and member

"We were able to frame the questions and the survey tool in a way that... was meaningful to the members that were filling out the survey... [and we] wanted to make sure that the surveys were...representative of all groups and that the language... wouldn't fly over people's heads.."

— One Care Stakeholder

surveys, to interpret early implementation trends and obstacles from the enrollee perspective. Council members advocated for measures they felt were important and assisted in the development of new measures not otherwise collected. Council members also explored ways to increase survey and focus group response rates; reviewed measures and survey cover letters for simplicity and advocated for health plans' timely response to data findings.

The Council addressed One Care's financial sustainability. Council stakeholders recognized issues early on with One Care's design and the financial repercussions of these issues, which was putting the long-term sustainability of the model at risk. Council members became integral players, alongside their State partners, in the identification of cost drivers and the communication of the importance of the model to federal partners. Many point to a meeting held in Washington, DC, for which both State partners and Council leadership were in attendance, as critical to demonstrating the Commonwealth's commitment to the One Care model and the obtaining of more than \$43 million in sustaining funding.

Council Training and Communication Practices

Training Strategies. Council members received pertinent program information through webinars, presentations, reports and guest speakers. Many stakeholders discussed the role UMASS Medical School staff assumed in supporting Council members to learn about Council topics through one-on-one discussions, which occurred outside of formal Council meetings. PowerPoint presentations and other supportive materials were helpful learning tools for Council members, and some believe that having these materials prior to meetings could better support Council members' participation. While some trainings have been provided, Council members discussed the benefits of having a more formalized training and onboarding process to support the Council's work.

Trust and its Linkage to Communication. Building trust, among Council members and with the State partners, was critical to ensuring effective interpersonal communication and Council progress. Early in the process, Council members spent more time advocating for their constituency base than listening to others. Also, some Council members were concerned that the Council was not receiving the data needed (e.g., member service utilization data) to effectively perform its role. Communication improved over time, between Council members and State partners, as trust was built. Trust was fostered when people were forced to solve a time sensitive problem, such as the loss of a health plan, since all parties shared a common goal of supporting the immediate needs of enrollees.

Communication Strategies. The Council relied on multiple communication strategies and tools, which supported communication within the Council, with State partners and with broader communities. Stakeholders reported positive experiences using both email and phone to support communication for Council and workgroup meetings. The speakerphone was a useful tool, but monitoring phone etiquette was important (e.g., use of mute to minimize disruptions and ensuring the needs of people with hearing impairments were appropriately addressed). Stakeholders also felt that written materials, such as meeting notes and agendas, were helpful communication tools, both for Council members and the broader community. The Council relied on the One Care website and Council members' network communication chains to communicate the Council's progress to broader constituency groups.

Facilitation and Decision-Making Strategies

Council Decision Making. The Council mostly operates according to Robert's Rule of Order and utilizes a motion system to formally vote on Council actions. The Council relied on motions as the primary method for decision making during its early years, but moved to more consensus-based decision making over time (41% of the total motions were made in the Council's first year while only 16% occurred in 2016). During the Council's first term, the majority of completed motions were related to Council operations while far fewer completed motions were related to One Care model implementation. This finding may indicate that formal motions for which the Council has direct control (e.g., internal operations) may be appropriate, but collaborative decision making may be necessary when influencing One Care decisions.

Council Facilitation. The Council sometimes struggled adhering to set agendas since pressing topics would surface during the meetings, diverse stakeholder views needed to be heard and the learning needs of Council members varied. Engaging people with a wide range of policy experiences in one group required some flexibility in what was prioritized at meetings. There was a continuous need, among Council chairs, to balance the Council’s discussion of One Care enrollee experiences with broader program and policy obstacles their experiences were intended to inform. These challenges may have influenced the Council’s ability to address the motions made, especially more complex motions that required multiple steps and collaboration with outside parties.

Council Motions and Completion Rates	
98 Approved Motions (During Entire Council Term)	
61% of these Motions Addressed Internal Council Functions (e.g., work plans, annual reports and meeting minutes)	98% of Motions Completed
39% of these Motions Addressed the One Care Model (e.g., recommendations for program design and delivery; calls to establish workgroups; contracting decisions; and requests for information)	37% of Motions Completed

Prioritization of Work and Meeting Topics. The Council RFR established the Council as independent from EOHS. While this expectation aligns directly with Massachusetts’s rich history of member activism, it also created some challenges. For instance, the Council created work plans that required direct alignment, attention and support from their State agency counterparts to be effective. Over time, the Council and their State partners identified concrete ways to work together on the most pressing of issues, many of which were not even in the original work plans developed. Developing projects and work plans directly with State partners may have saved time and led to projects all stakeholders equally supported. meetings to

“Each year, we develop a work plan... if things are not done, we have to ... reprioritize things... we don’t like to leave any stones unturned, and we have a wonderful group with our host of expertise...”

— One Care Stakeholder

Council Accommodations

The State provided, with assistance from a federally-funded grant, accommodations for Implementation Council members, including access to American Sign Language interpreters and Communication Access Real-Time Translation (CART) providers; transportation coordination and payment; stipends and travel reimbursement; and various material formats (e.g., large print and electronic). Stipends and travel reimbursements were available to Council members who were categorized as consumer representatives (including family members and guardians); eligible Council members were offered \$50 per Council meeting (they were required to attend in person) and \$25 for pre-meeting work. Council members compensated by an organization were not eligible for stipends or reimbursements. The Council meetings were scheduled to account for Council members’ schedules and religious holidays, and Council members who could not make meetings in-person were provided with speakerphone access. Many believe that providing compensation for Council members (including work conducted outside of meetings) recognizes the skills they bring, the time they dedicate and the importance of their role.

The Council faced some challenges when making meetings accessible. For instance, the Council faced difficulties avoiding technical jargon and keeping with the planned agenda. These challenges made the meetings less accessible to individuals with cognitive disabilities, to those who used interpreters and those who had less policy experience. Reportedly, a Council member with an intellectual disability eventually left the Council given his/her frustration with not being able to participate meaningfully. Moving forward, Council members would like to slow down the meeting process, follow written agendas more closely and minimize the use of technical terms and acronyms to improve accessibility. Some Council members also want to spend more time understanding why an accommodation is requested so they can work diligently to provide meaningful accommodations.

“A lot of people are skilled, they may have acquired education, they may have had careers before they got sick ... and what happens a lot [is they] don’t get paid... it’s like taking money directly out of an individual’s pocket as well as taking their skills, knowledge and education...”

— One Care Interview

One Care Case Study Lessons Learned

This issue brief calls upon key informant interviews and a web-based material review to document One Care Implementation Council formation, representation, focus, impact and implementation practices. The One Care case study issue brief provides insight into how this Council, and similar Councils, can assume a meaningful role in the design and improvement of Dual Demonstrations. Council lessons learned, as described throughout this issue brief, are summarized below. These lessons learned can inform future Council improvements as well as the design of similar bodies across the nation.

- ❖ Council membership and structures should be formed in partnership with community leaders and be flexible enough to grow and change with the Council over time.
- ❖ Council members’ training should include Medicaid and managed care models as well as Council process and expectations.
- ❖ Training and communication strategies should be multi-faceted (e.g., in-person, web-based, phone) and flexible enough to meet the unique needs of each Council member.
- ❖ Slower facilitation, consistent following of agendas and the use of simplified language can support Councils to offer universal accessibility.
- ❖ Work directly with individual Council members to identify strategies to meet their unique engagement needs to avoid Council turnover resulting from accessibility obstacles.
- ❖ Meaningful engagement of ‘hard to reach’ enrollees and diverse geographic communities requires you to “go where the people live, work and play.”
- ❖ Council members will have varying levels of relevant personal and policy experience; training, communication and facilitation strategies should account for these differences.
- ❖ Councils may benefit from identifying priority focus areas, but also anticipating and dedicating time on the agenda to urgent, unplanned topics.
- ❖ The public comment section of the Council meetings is an opportunity to hear directly from enrollees; the time allocated should be consistently upheld and systematically inform Council work.
- ❖ Council members’ access to timely data (e.g., care coordination and service utilization data) allows Council members to assume a meaningful role in quality monitoring.

- ❖ Council support from a third party, such as an academic institution, can encourage group progress and communication among stakeholders.
- ❖ People with lived experience share valuable experience and should be compensated for their time invested, including smaller group activities, meeting preparation and follow up.
- ❖ Transparency and the building of trust over time can lead to improved communication and effective decision-making among Council members and with State partners.
- ❖ Councils will need to balance their own autonomy with the collaboration needed (e.g., with State partners and health plans) to inform program design and improvements.

References

1. Disability Advocates Advancing Healthcare Rights. (2011). Dual Eligible RFI Response.
2. Disability Advocates Advancing Healthcare Rights. (2012). Memorandum of Understanding Response.
3. Executive Office of Health and Human Services. (2013). One Care Implementation Council Members (2013-2015). Retrieved from <https://www.mass.gov/files/documents/2017/08/31/one-care-implementation-council-membership-2013-2015.pdf>
4. Executive Office of Health and Human Services. (2015). Implementation Council Frequently Asked Questions. Retrieved from <https://www.commbuys.com/bs0/external/bidDetail.sdo?docId=BD-15-1039-EHS01-EHS02-00000004378&external=true&parentUrl=bid>
5. Executive Office of Health and Human Services. (2015). Nomination Form. Retrieved from <https://www.commbuys.com/bs0/external/bidDetail.sdo?docId=BD-15-1039-EHS01-EHS02-00000004378&external=true&parentUrl=bid>
6. Executive Office of Health and Human Services. (2015). Notice of Opportunity to Participate. Retrieved from <https://www.commbuys.com/bs0/external/bidDetail.sdo?docId=BD-15-1039-EHS01-EHS02-00000004378&external=true&parentUrl=bid>
7. Executive Office of Health and Human Services. (2015). One Care Implementation Council Members (2015-2016). Retrieved from <https://www.mass.gov/files/documents/2017/08/31/one-care-implementation-council-membership-2015-2016.pdf>
8. Executive Office of Health and Human Services. (2018). One Care: January 2018 Enrollment Report. Retrieved from <https://www.mass.gov/files/documents/2018/02/07/January%202018%20One%20Care%20Enrollment%20Report%20FINAL.pdf>
9. One Care Implementation Council. (2013). Annual Report 2013. Retrieved from <https://www.mass.gov/files/documents/2017/10/31/140425-ic-annual-report-draft.pdf>
10. One Care Implementation Council. (2013). By -laws. *EOHHS*. Retrieved from <https://www.mass.gov/files/documents/2017/11/01/130510-by-laws.pdf>
11. One Care Implementation Council. (2013). Charter. *EOHHS*. Retrieved from <https://www.mass.gov/files/documents/2017/11/01/130510-charter.pdf>
12. One Care Implementation Council. (2013). Implementation Council Priorities Proposal. Retrieved from <https://www.mass.gov/files/documents/2017/11/01/130829-implementation-council-priorities.pdf>
13. One Care Implementation Council. (2013). Meeting Operating Guidelines. Retrieved from <https://www.mass.gov/service-details/2013-one-care-implementation-council-meeting-materials/resources?page=1>
14. One Care Implementation Council. (2013). Implementation Council Meeting Minutes from February 2013 – December 2013. Retrieved from <https://www.mass.gov/service-details/2013-one-care-implementation-council-meeting-materials/resources?page=0>

15. One Care Implementation Council. (2014). Annual Report. Retrieved from <https://www.mass.gov/files/documents/2017/10/30/150529-ic-annual-report-2014.pdf>
16. One Care Implementation Council. (2014). Implementation Council Meeting Minutes from January 2014 – December 2014. Retrieved from <https://www.mass.gov/service-details/2014-one-care-implementation-council-meeting-materials>
17. One Care Implementation Council. (2014). Council 2014 Work Plan. Retrieved from <https://www.mass.gov/files/documents/2017/10/31/140425-workplan-draft.pdf>
18. One Care Implementation Council. (2015). Implementation Council 2015-2016 Work Plan. Retrieved from <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/2015/150911-work-plan.pdf>
19. One Care Implementation Council. (2015). Implementation Council New Member Onboarding. Retrieved from <https://www.mass.gov/files/documents/2017/10/26/151211-onboarding-slides.pptx>
20. One Care Implementation Council. (2015). 2015 Year In Review. *January 2015 Implementation Council Meeting Minutes*. Retrieved from <https://www.mass.gov/files/documents/2017/10/30/150109-minutes.pdf>
21. One Care Implementation Council. (2015). Implementation Council Meeting Minutes from January 2015 – December 2015. Retrieved from <https://www.mass.gov/service-details/2015-one-care-implementation-council-meeting-materials>
22. One Care Implementation Council. (2016). Council, Stakeholder and Guest Speaker Presentations 2013-2016. Retrieved from: <https://www.mass.gov/service-details/one-care-implementation-council-0>
23. One Care Implementation Council. (2016). Implementation Council Meeting Minutes from January 2016 – November 2016. Retrieved from <https://www.mass.gov/service-details/2016-one-care-implementation-council-meeting-materials>
24. One Care Implementation Council. (2016). Implementation Council Subcommittee Meeting Minutes and Presentations 2013-2016. Retrieved from: <https://www.mass.gov/service-details/one-care-implementation-council-0>
25. One Care Implementation Council. (2016). Implementation Council Workgroup Meeting Minutes and Presentations 2013-2016. Retrieved from: <https://www.mass.gov/service-details/one-care-implementation-council-0>
26. One Care Implementation Council. (2016). Summary Document: Approved Motions February 2013 – October 2016. Retrieved from <https://www.mass.gov/files/documents/2017/10/16/161118-approved-motions.pdf>
27. Massachusetts Medicaid Policy Institute. (2014). Overview of the Massachusetts One Care Initiative for Non-Elderly Dual Eligibles. Retrieved from https://bluecrossmafoundation.org/sites/default/files/download/publication/OneCare_Report_FINAL.pdf
28. Walsh, E.G. (2016). Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare First Annual Report. *R7/ International*. Retrieved from: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MASSFirstAnnualEvalReport.pdf>

Appendix I: Implementation Council Focus Areas 2013-2016

Implementation Council Focus Areas 2013-2016

*Most Referenced Subjects within Topic Area

Council Operations	<ul style="list-style-type: none"> Charter and By-Laws Consumer Meetings Council Budget 	<ul style="list-style-type: none"> Council Members* Subcommittees* Work Groups*
Stakeholders	<ul style="list-style-type: none"> Consumers MassHealth* EOHHS Ombudsperson* ICOs (health plans)* 	<ul style="list-style-type: none"> Providers* Community Based Organizations DAAHR SHINE (Serving Health Insurance Needs of Elders)
One Care Design and Delivery	<ul style="list-style-type: none"> Assessment Tools Behavioral Health Benefits Care Coordination Community Health Workers Customer Service Dental Care Enrollment (Demographics, Auto-Assignment)* Individualized Care Plans 	<ul style="list-style-type: none"> Long Term Services and Supports* Long Term Supports Coordinators* Peer Supports* Pharmacy Program Implementation Service Accessibility and Accommodations* Support Service Providers Training Transportation
Communication	<ul style="list-style-type: none"> MassHealth Data and Information Sharing* Targeted Outreach* 	<ul style="list-style-type: none"> Ombudsperson Data and Information Sharing Stakeholder Communications*
Quality Monitoring	<ul style="list-style-type: none"> Abuse and Neglect Complaints and Grievances Consumer Satisfaction Encounter Data Early Indicators* Health Outcomes ICO Reporting* LTSS Surveys 	<ul style="list-style-type: none"> Network Adequacy Provider Satisfaction Quality Withholds Readiness Reviews* Risk Adjustments Service Utilization Stakeholder Engagement*
Finance	<ul style="list-style-type: none"> Capitation Direct Care Worker Wages Payment Rates* 	<ul style="list-style-type: none"> State Budget Implications One Care Sustainability* Pay for Success



@CCEHI

healthinnovation.org

COMMUNITY CATALYST
ONE FEDERAL STREET, 5TH FLOOR
BOSTON, MA 02110
617.338.6035