EXECUTIVE SUMMARY

Behavioral Health in Commonwealth Care Alliance's Senior Care Options and One Care Plans

Prepared for Arnold Ventures

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Research bridging policy and practice

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Background

The growing imperative to address behavioral health (BH) needs among the population dually eligible for Medicare and Medicaid is becoming increasingly recognized, due to their high rates of serious and persistent mental illness (SPMI) and substance use disorders (SUDs). However, behavioral and physical health services have traditionally been delivered through separate systems, with minimal coordination between the two. Increasing evidence finds that this model presents barriers to optimal care, and that financial and operational integration contributes to better care. This report describes how one plan serving dually eligible individuals, Commonwealth Care Alliance (CCA), has done so.

Commonwealth Care Alliance

Commonwealth Care Alliance was founded in 2003 under Massachusetts' Senior Care Options (SCO) program, an integrated care demonstration serving dually eligible individuals 65 years and older. In 2013, CCA helped launch Massachusetts' One Care program, which was unique among integrated plans in serving only those dually eligible individuals aged 21-64 years. In both plans, CCA provides the full range of Medicaid and Medicare services for enrollees – these include long-term services and supports (LTSS), BH services, and flexible benefits including social determinants of health (SDOH) needs.

In both plans, BH is a concern, although more so in CCA's One Care program, where 52% of members have a SPMI diagnosis and 35% have a SUD. In the SCO program, a still substantial 19% have a SPMI diagnosis and 13% have a SUD. Thus, this report focuses on CCA's approach to integrating behavioral and physical healthcare, given its importance to the members they serve.

What we did

This executive summary draws on data from the qualitative portion of a two-part evaluation of CCA; the other component uses quantitative methods to assess plan performance. Interviews with CCA staff and others, along with plan documents and other publicly available information, were used to understand the plan's operations and the factors that influence them; data collection took place from March 2024 to March 2025. Overall, we conducted key informant interviews with 22 individuals with roles operating and managing CCA. In addition, we conducted 10 focus groups, including two Spanish-language groups, with 41 individuals to investigate member experience. This report focuses on findings specific to BH, mainly from the key informant interviews but also the focus groups with members.

Findings

Overall, we found significant levels of BH integration, driven by the utilization of BH expertise within management, within care teams, and as care coordinators for members with BH needs. The plan's relationships with providers were another important feature: these included relationships with both health care providers willing to integrate BH into their standard practice and with an array of BH providers. The latter notably include community-based organizations, most importantly health homes and crisis stabilization units (CSUs). Additionally, our conversations with members found them to be largely satisfied with their BH services.

Theme 1: Commonwealth Care Alliance employs a variety of techniques to integrate behavioral health

CCA recognizes that the intertwined nature of physical and behavioral health requires an integrated approach and, over time, has developed various strategies to achieve it. Key informants discussed several dimensions of this integration.

Theme 1.1: Behavioral health is woven throughout the organization.

Consistent with the CCA's organizational culture of focusing on individual member needs, the plan has treated behavioral health as part of the spectrum of member needs, one that requires special attention and creative thinking. Key informants emphasized the need to bridge the divide between physical and mental health. This focus on BH may result from the integration of BH expertise woven throughout CCA. Some managers, for example, have a BH background. At another level, the full range of public-facing staff have some training in BH, including the customer service team. Most importantly, interdisciplinary care teams add BH expertise where needed.

> *The plan is always "looking for those opportunities to help be more of a bridge across the different parts of the health system that oftentimes are not as connected as we ideally want them to be" (Management, Clinical 3).*

Theme 1.2: The behavioral health specialist role helps ensure appropriate management of members with severe and persistent mental illness and/or substance use disorders.

One of CCA's important innovations is its use of the BH Specialist role. These staff are typically independently licensed social workers or licensed mental health counselors who are assigned as care partners (CCA's care coordination role) to members with a SPMI and/or SUD diagnosis. An estimated 20% of care partners are BH Specialists. BH Specialists may also play a supportive role in advising care teams; key informants noted that their expertise helps ensure that members receive appropriate treatment. Consultation with BH Specialists also improves the quality of communication between the plan and its members.

Theme 1.3: The plan fosters relationships with the full range of behavioral health providers

Another key feature is CCA's relationship with many of the BH providers in Massachusetts. The plan has actively worked to integrate them into their provider network. Key informants acknowledged that the plan benefits from Massachusetts' relatively robust supply of BH providers (compared to other states, although this was seen as less true in Western Massachusetts).

Due to the high proportion of members with both behavioral health and complex care needs, CCA strives to use providers with both kinds of expertise. However, this can be difficult, given the traditional separation between these two types of care; consequently, providers may lack the understanding needed to accommodate both types of needs. CCA must then compensate for this lack of expertise (and sometimes, lack of willingness) through education and outreach.

Theme 1.4: The plan uses the health home model to provide behavioral health to members in the community

Respondents noted that the ability to serve members with BH needs well depends on close relationships between the plan and the community partners who have traditionally worked with this population. These include state mental health programs and social service agencies serving people with SPMI and SUDs.

These close relationships include the "health home model," where a member with BH needs is managed by a community-based organization specializing in BH. One observer identified this model as unique to CCA, as compared to the other dual eligible plans in Massachusetts.

In these health homes, the member's care partner is not a CCA employee. Rather, the provider partner is responsible for managing members. Such an arrangement enables members to continue working with trusted community providers and programs.

> *What's distinctive is that they [CCA] are not removing members from a relationship that they have currently with a community-based organization or a social service organization. Instead, they're saying, "Let's work with you." Let's keep members where they're safe, where they're known, where they have relationships built already (Policymaker).*

Theme 1.5: The plan integrates Crisis Stabilization Units into the behavioral health provider network

Another important resource for members with SPMI and SUDs is CCA's CSU, which provides short-term crisis stabilization for members with acute BH and/or SUD needs as an alternative to hospitalization. CCA's commitment to this model is long-standing; it launched its own CSU, Marie's Place, in 2015. The focus on CSUs developed in response to a dearth of community options that support sobriety for members with SUD or members experiencing exacerbations of mental illness.

Members themselves spoke positively of their experiences with CSUs, in contrast with their mostly negative reports of psychiatric hospitals. They particularly appreciated the CSU's role in helping them avoid hospitalizations. Thus, it appears that CSUs comprise an important part of CCA's provider network, potentially reducing utilization of psychiatric hospitals.

Theme 2: Members expressed satisfaction with their behavioral health services.

In our focus groups, members were open while discussing their BH challenges. Overall, they expressed satisfaction with BH services, noting that they have access to the services they need. Members also expressed appreciation for their therapists, with some highlighting how well coordinated mental health services were with other health services.

Negative comments largely focused on turnover among BH providers; a concern echoed by several focus group participants. Overall, focus group participants who discussed their BH needs were grateful for and satisfied with the services they received. Many talked about their good relationships with therapists, and their feelings of trust that help would be available if needed.

Conclusion

This research aimed to shed light on the inner workings of an integrated care plan serving the highly vulnerable population that is dually eligible for Medicare and Medicaid. In conducting this research, it became clear that CCA, which had historically focused more on an older population with complex care needs, had adapted to serve the large proportion of younger individuals with significant BH needs through its One Care plan. Broadening their population also benefited the smaller set of SCO members with BH needs; additionally, it introduced BH innovations that address individuals' issues and concerns. These innovations are of broader interest to the wider healthcare community that sees the integration of BH as a priority.

The study found that, for CCA, integrating BH went well beyond contracting with appropriate providers. It also involved integrating BH expertise into the management and operation of the health plan. Moreover, the plan recognized that, for certain members, it made sense to have their primary contact be a clinician specializing in BH. The provider network was also critical: providers needed to understand both patients' physical and mental health challenges, which sometimes involved provider education. Moreover, the plan saw the value of establishing relationships with providers that had historically worked with the member population. In some cases, this meant delegating management of these members to such organizations, establishing them as health homes.

These findings can inform efforts to better integrate BH into healthcare more generally.

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