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

Report Prepared for Arnold Ventures

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Research bridging policy and practice

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Background

The need to address behavioral health (BH) needs among individuals dually eligible for Medicare and Medicaid (i.e., the dually eligible population) is becoming increasingly recognized, due to their high rates of severe and persistent mental illness (SPMI) and substance use disorders (SUDs), particularly among younger dual eligibles. Thus, there have been calls for greater integration of behavioral health into the managed care organizations serving them (Bipartisan Policy Center, 2016; MACPAC, 2021; Soper, 2016).

The BH population is complicated and expensive to treat: most dual eligibles with BH issues experience other health challenges too. Nationally, dual eligibles with BH needs have an average of 3.43 chronic conditions, compared to 2.19 among dual eligibles without BH needs (ATI Advisory, 2024). Accordingly, a SPMI diagnosis has been associated with significantly higher costs among Medicare beneficiaries (Figueroa et al., 2020). The dually eligible population with BH needs report more adverse events than duals without such needs and even Medicare-only beneficiaries with BH needs (ATI Advisory, 2024).

Behavioral and physical health services have traditionally been delivered through separate systems, with minimal coordination between the two (Institute of Medicine, 2006). Under managed care, either the payer (for example, Medicaid or an employer) typically contracts with two entities (a managed care plan and a BH plan) or a managed care plan is responsible for subcontracting the delivery of BH to a separate BH plan. Increasing evidence suggests that this model presents barriers to the integration of physical and mental health care (Ashcroft et al., 2014). Conversely, financial integration of multiple funding streams contributes to better care (Charlesworth et al., 2021), although its success depends considerably on how integration is implemented (McConnell et al., 2023). This report describes how one plan serving dually eligible individuals, Commonwealth Care Alliance (CCA), has approached the provision and integration of BH services into its complete package of healthcare services to members.

Commonwealth Care Alliance

CCA was founded in 2003 as part of an integrated care demonstration serving dually eligible individuals 65 years and older. Under Massachusetts' Senior Care Options (SCO) program, Massachusetts Medicaid (MassHealth) and the federal Centers for Medicare & Medicaid Services (CMS) jointly contract with qualified managed care plans (the SCOs) to provide the full range of Medicaid and Medicare services for enrollees – including long-term services and supports (LTSS) and BH services, as well as services for social determinants of health needs (SDOH).

In 2013 – under the federal Financial Alignment Initiative (FAI) Demonstration – CCA began serving dually eligible individuals aged 21-64 years (known as younger dual eligibles). The Demonstration aimed to test integrated care and financing models for Medicare-Medicaid enrollees. The Massachusetts FAI model, called One Care, was unique in focusing on the

younger dually eligible population.

In both plans, how to provide BH services is of particular importance, 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 (CCA data, 2023). The focus of this report is on CCA's approach to integrating behavioral and physical healthcare, both of which are critically important to the overall well-being of the members they serve.

What we did

This qualitative report is one piece of a two-part evaluation strategy of CCA's experience; the other component uses quantitative methods based on a longitudinal analysis of claims costs to assess plan financial and service utilization performance. Drawing on interviews with CCA staff and others, along with a review of plan documents and other publicly available information, we sought to understand the plan's operations and the factors that influence them; data collection took place from March 2024 to March 2025. Using purposive sampling to identify participants with expertise relevant to our research questions, we conducted key informant interviews with 22 individuals who held roles in operating and managing CCA, as well as external observers. Key informants represented different aspects of plan management, such as external relationships, clinical operations, plan operations, and member engagement; we also interviewed three knowledgeable individuals external to the plan (two Board members and a Massachusetts policymaker). Interview protocols were tailored to the specific roles of the interviewees, drawing on a standard research protocol. We conducted focus groups to investigate the member experience; in all, we held 10 focus groups (two Spanish-language) with 41 individuals, referred to using pseudonyms in this report. A more complete description of the research methods is included in a separate Methods Report. This report focuses on findings specific to issues around the organization, delivery, and experience of those receiving BH services. Findings derive not only from the key informant interviews but also from member focus groups.

Findings

Overall, we found significant levels of BH integration, due in large part to the presence of BH expertise within management, within care teams, and among care coordinators for members with BH needs. The plan's efforts to establish strong relationships with providers willing to integrate BH into their standard practice and with an array of BH providers assured that BH integration was successful. The latter notably include community-based organizations, most importantly health homes and crisis stabilization units (CSUs). Additionally, our conversations with members receiving BH services found them to be largely satisfied with their services.

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

CCA recognizes that the intertwined nature of physical and BH requires an integrated approach and, over time, has developed various strategies to achieve it. Key informants discussed several dimensions of this integration, including the integration of BH expertise throughout CCA, the role of the BH Specialist, and the plan's relationships with key BH providers in Massachusetts. Some innovative features include utilization of CSUs as an alternative to admissions to psychiatric hospitals, and CCA's use of health homes, where the management of people with BH needs is delegated to community organizations that specialize in BH management.

Theme 1.1: Behavioral health expertise is woven throughout the organization.

Consistent with CCA's organizational culture of focusing on individual member needs, the plan has treated BH as part of the spectrum of member needs, one that requires special attention and creative thinking. A Board member noted that CCA's focus on personalized care is consistent with the effort, at a high level, to integrate BH. She said, "We have tried to integrate behavioral health. I don't think we're at our destination yet, but we're on the road" (Board Member 2).

Another key informant said, "All members are created equal and…all members have access to behavioral health clinicians. And I do think that is unique" among managed care plans (Management, Clinical 1). Still another respondent observed,

> *The traditional way of thinking is that every single member can fit into primary care and primary care is the right setting of care for everyone… [Instead]…we've got to be thinking about other parts of the health care system for individuals with different needs…if you're primarily dealing with a BH need or an SUD need, your specialist is probably your point of care. That person is probably responsible for delivering most of your care as opposed to the primary care physician. And so rethinking and reframing the way that maybe care needs to show up or the way we even think or incentivize it probably will start to change (Executive, Provider Network 1).*

Respondents emphasized the need to span the divide between physical and mental health. One manager described "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).

This focus on BH likely results from the integration of BH expertise throughout the plan. For example, one manager described her promotion to management even though, when first hired by CCA, she "was actually part of our primary care leg... I'm a licensed behavioral health clinician by training, a LICSW [Licensed Independent Clinical Social Worker]" (Management, Community Services 1). At another level, the full range of public-facing staff have some training in BH, including the customer service team.

Because you are hearing difficult things from members sometimes. And you have some joy and empathy training that we try to pass out to the team so that they have some of that behavioral health knowledge before they start making the call (Management, Engagement 1).

Another said,

The folks that we serve in our duals programs are pretty complex…we just really want to make sure that our [customer service] staff understand that it's not going to be a simple fix. And that it's really gonna require, you know, using those motivational interviewing skills, customer service skills, and empathy (Management, Community Services 1).

This emphasis on weaving BH into the plan's operations was evident in many responses.

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, who are "all independently licensed, so they're either independently licensed social workers or licensed mental health counselors" (Management, Clinical 1). BH Specialists are assigned as care partners (the CCA care coordination role) to members with a SPMI and/or SUD diagnosis. An estimated 20% of care partners are BH Specialists (Management, Clinical 2).

Over the course of kind of getting to know the member… [and] their BH diagnoses, we really try to have their care partner…be a BH specialist. Now, a lot of our members also have a lot of co-occurring conditions, right? Like some pretty significant clinical, complex clinical needs mixed with BH, in which case that's also why as part of our care team structure, there's always a BH specialist who is assigned to that clinical group…to provide consultative support (Management, Clinical 3).

In this consultative role, BH Specialists advise care teams, in addition to supporting members.

Our behavioral health clinicians are here to provide consultation to a member or consultation to our internal staff, but they're also here to try and help our members navigate the wild world of behavioral health and how do they get access to the right level of care and the right services (Management, Clinical 1).

The expertise of BH Specialists helps ensure that members receive appropriate treatment, both by acting as care partners and by educating and supporting care team members. It also improves the quality of communication between the plan and its members.

Instead of having the RN [Registered Nurse] call [the member], we have a behavioral health clinician call them…if you have the care manager call and then say, hey, I'd really love for you to speak to our behavioral health clinician, usually the answer is, yeah, no. But the behavioral health clinician calls and either identifies or maybe doesn't identify immediately, but kind of finesses the conversation because that's how we're trained. We're trained very differently than nurses. We're finding that people are engaging differently (Management, Clinical 1).

Theme 1.3: The plan fosters relationships with behavioral health providers

Another key feature is the extent to which CCA invests in developing strong relationships with many of the BH providers in Massachusetts. The plan has actively worked to integrate them into their provider network:

And so one of the gaps that I identified was that there was a small team within CCA that was talking to some medical providers, but no one was really talking to the behavioral health providers in the community… And so that was a huge gap in behavioral health. And so I actually created a team called Behavioral Health Provider Engagement. Where we specifically focus on that provider relationship (Management, Clinical 1).

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). They stressed the importance of CCA's ability to hire or contract directly with them. One said, "The combination of having our own behavioral health clinicians to do things… that is one piece of the pie or puzzle. We own the behavioral health network; it's not carved out" (Executive, Operations 1).

Due to the high proportion of members with both BH and complex care needs, CCA strives to work with providers that have both kinds of expertise. However, this can be difficult, given the traditional separation between these two types of care. As one key informant said,

So an independent behavioral health provider [may say], I can work with Medicare or Medicaid members whose primary issue is behavioral health, but your members have more medical complexities that impact their behavioral health, and I may not be educated enough to do that (Management, Clinical 1).

CCA must then compensate for this lack of expertise (and sometimes, lack of willingness) in jointly managing BH and complex care needs. However, the same respondent went on to note that, on average, "Our behavioral health clinicians know an awful lot about medical, more so than any average behavioral health clinician ever would" (Management, Clinical 1).

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 SUD.

> *And if we see that they're working with an agency, we can work with them. We get files from [the agencies]. So if they're working with [the agencies], we can work with those caseworkers to help us (Management, Engagement 1).*

These close relationships include the "health home model," where responsibility for members with BH needs is delegated to and 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:

> *[CCA is] contracted with a variety of social service organizations to be their health homes… And in this space, they basically say you are already working with this individual who is disabled because of an SUD or mental health diagnoses. You've been working with them either historically through [various programs]. And you know them, you have that expertise. So when they join our One Care plan, if they want to stay with you as their designated health home care coordination agency, we will assign them to you (Policymaker).*

In these health homes, the care partner is not a CCA employee.

> *So for both programs [One Care and SCO], you're required to have a care manager assigned to every member. That's the health plan contract requirement. And so… the care manager assigned to the member is not a CCA employee. It's the provider partner that's doing it (Executive, Operations 1).*

Another observer said,

> *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).*

These quotes illustrate CCA's utilization of existing community expertise and its commitment to continuity of care for members, even when it means foregoing "exclusive" ownership over the direction of care for the individual. In addition, these relationships recognize that some BH providers need sustainable financing, which in some cases means that CCA will help fund staff positions within the organization to ensure that CCA members are properly served.

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 network of CSUs. These provide 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. A second CSU was based in a hospital that subsequently closed down, limiting access for CCA members. One key informant described that,

> *Especially with the unreachable population, it's more about making sure that they're stable, they have what they need, and trying to keep them engaged so that they know where they can come to. So that's the thing that we're working on right now is trying to build that playbook. We…see a lot of our behavioral health patients in the CSU (Management, Engagement 1).*

This focus was developed in response to a dearth of community options for providing services to support sobriety or members experiencing exacerbations of mental illness; indeed, previous research reported such issues:

> *In some locations, outpatient providers have been unwilling to see One Care enrollees or have set visit limits… CCA also has had difficulty finding facilities that can provide detox or step-down services to support sobriety. To address these gaps, CCA has created two CSUs that provide short-term acute psychiatric care, including detox services. They also have partnered with …a nonprofit social service agency to provide treatment and care transition services (Klein et al., 2016).*

Members themselves spoke positively of their experiences with these CSUs, in contrast with their mostly negative reports of psychiatric hospitals:

> *Basically, it's a secure place where you're secure. And surprisingly, the door, even though it's a volunteer, you can leave. They emphasize that by letting you know the door swings both ways, but when you're in here, they're going to try to do what you need, crisis stabilization (Ernest, One Care).*

Thus, it appears that CSUs comprise an important part of CCA's provider network, potentially reducing utilization of psychiatric hospitals. Unfortunately, access to this resource is limited.

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

In our focus groups, members (who are quoted in this report using pseudonyms) were open while discussing their BH challenges. Overall, they expressed satisfaction with BH services.

2.1: Participants were satisfied with their behavioral health services

As one said, "I get counseling. I do therapy. They're good, they're real good with me" (Jill, One Care). They were also grateful for their ability to access BH and other services easily: "I do take therapy. I've done that in the past…. And… they're right on board when I need it. So they'll refer me to whatever I need to be referred to" (Gabriel, One Care). One participant had high praise for her BH Specialist:

> *I see a counselor and she helps me out a lot. She's actually helping me get a psychiatrist and she's actually gonna be going to my first couple appointments with me. Which is amazing. My counselor goes above and beyond to always make sure that I feel okay and feel safe doing things…. Oh my god. She's so amazing and the funny thing is I was tricked into meeting her at my doctor's office (Serafina, One Care).*

One member highlighted how well her mental health services are coordinated with her other health services, saying, "I have a therapist, and… she calls me. I have a treatment plan and everything. And she communicates with my doctors" (Claire, SCO).

Another member was especially grateful for the ability to obtain a therapist consistent with her values. This Hispanic respondent said,

> *I didn't know Commonwealth Care Alliance very well. But when they gave me the names, I was looking for a Christian therapist…. So, the first three numbers they sent me, the second one was a Christian therapist and from that point on I was very happy and very joyful…That was the most important thing I was looking for (Amelia, One Care).*

2.2: Participants valued the opportunity to utilize therapy and crisis stabilization units in order to avoid hospitalization

Avoiding hospitalization was a priority for members with BH needs, due to negative experiences with psychiatric hospitals. They consequently recognized the importance of regular therapy and CCA's CSU:

> *Right now, I'm avoiding any hospitalization. I utilized my groups, my therapy because I don't like being in that…and I used to go to the CSU in Quincy all the time…. I never want to go in a hospital again. Never ever. That was what got me going [to therapy] (Delia, One Care).*

2.3 Provider turnover was seen as an issue

Negative comments largely focused on turnover among BH providers. As one focus group participant said,

> *My therapist just left me again. So, now, I had to start a new therapist. So I had to start talking about my whole situation again. I get aggravated with that… But my new therapist, she's nice so far, but I keep watching - but, are you gonna leave me again? (Ben, One Care)*

Another focus group participant reacted to this comment by saying, "I'm in the same situation...My therapist, her name was [XXX]. I've been seeing her for almost a year, so she just left last week, so I have a replacement now" (Samuel, One Care).

Overall, focus group participants who discussed their BH needs were grateful for and satisfied with the services they received. As described above, many talked about their good relationships with therapists, and their feelings of trust that help would be available if needed.

Conclusion

The goal of this research was 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 and that has BH issues. In conducting this research, it became clear that CCA, which had historically focused 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 also 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 for their primary contact to be a clinician specializing in BH. Behavioral health awareness was critical across the provider network: 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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