EXECUTIVE SUMMARY

Key Informant Perspectives on 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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Introduction

This report examines Commonwealth Care Alliance's (CCA's) integrated care plans in Massachusetts, which serve the highly vulnerable population enrolled in both the Medicare and Medicaid programs (known as dual eligibles). Dual eligibles are costly to these programs due to their high levels of care need, thus motivating policymakers to encourage mechanisms, such as integrated care, to lower costs and improve outcomes. "Integrated care," however, is a broad term. This study sought to understand how CCA operationalizes integrated care by investigating CCA's model of care and its components, factors that influence plan operations, and its other strategies for serving members.

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. Using purposive sampling to identify participants with expertise relevant to our research questions, we conducted key informant interviews with 22 individuals. They 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 also conducted focus groups to investigate member experiences. A more complete description of the research methods is included in a separate Methods Report.

CCA background and history

CCA was founded in 2003 as part of an integrated care demonstration in Massachusetts serving dually eligible individuals 65 years and older. Under the state's Senior Care Options (SCO) program, Massachusetts Medicaid (MassHealth) and the federal Centers for Medicare & Medicaid (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 behavioral health (BH) services, as well as social determinants of health needs, such as housing, food, and transportation. In 2013 – under the federal Financial Alignment Initiative (FAI) Demonstration – CCA began serving dually eligible individuals aged 21-64 years of age. The Demonstration aimed to test integrated care and financing models for Medicare-Medicaid enrollees. The Massachusetts FAI demonstration model, called One Care, was unique in focusing on the younger dually eligible population.

CCA enrolls a highly vulnerable population: about 16,000 in the SCO plan and 32,000 in One Care. Member populations are highly diverse: 30% have a primary language other than English and a quarter are non-white. SCO members have high rates of complex medical conditions, with 39% having three or more major medical conditions, such as diabetes, dementia, or congestive heart failure. In contrast, One Care members have high rates of severe and persistent mental illness (SPMI) (52%) and substance use disorders (SUDs) (35%). More than half (57%) of One Care members with SPMI also have complex physical health conditions.

Themes arising out of the research

Theme 1: Factors shaping CCA development

In understanding CCA, it is important to appreciate the contextual factors that shape its current operation. The most significant of these is *the impact of CC's history on plan development* – that is, its genesis as a provider-led organization, developed in close collaboration with advocates. This history explains its clinician-led care model and its commitment to member engagement and person-centered care. Another important factor is the *Commonwealth's commitment to integrated care*. Respondents noted the extent to which CCA benefited from the Massachusetts policy context, which broadly supports innovation in healthcare and generous social benefits.

Theme 2: The CCA approach to care

CCA's *organizational culture* is informed by both its history and its commitment to *centering member needs through person-centered care*. Leadership, staff, and others involved in care delivery are committed to serving the plan's complex population and keeping them in the community. To support members' unique needs and ability to avoid institutionalization, the plan must be creative with products and services. Such creativity is enabled by the ability to provide *flexible benefits* under the integrated care model. Linked to flexible benefits is the plan's *focus on SDOH* (food, housing, and transportation), without which this vulnerable population cannot access healthcare or sustain healthy behaviors.

An important part of centering member needs is *member engagement*, which is consistent with the plan's history of working closely with consumers. This operates at multiple levels. At the individual level, the plan engages members in their own care and care planning; at the systematic level, it obtains feedback through surveys and focus groups; and at the governance level, it involves members in committees that contribute to CCA decision-making.

Theme 3: Teamwork approach/flexible teams

The *interdisciplinary care teams* are a key part of the CCA model. Team composition is tailored to members' needs: a team always includes a *care partner* (i.e., care coordinator or care advisor), typically a clinician, who is the member's main point of contact and helps develop and operationalize the care plan. The member may also involve others (family members, trusted friends) as part of the team. In addition, it may include a *behavioral health (BH) specialist*, who may act as the care partner or fill a consultative role providing BH

expertise and a *community health worker* (CHW), who attends to members' individual social needs. Teams may also include an *independent coordinator of LTSS*, known as the Long Term Services Coordinator (LTSC) for One Care members and the Geriatric Services Support Coordinator (GSSC) for SCO members, who is responsible for ensuring that members get the home-based supports they need.

Theme 4: Integration of behavioral health

One of CCA's notable features is its integration of BH. This is driven by the utilization of BH expertise within management, within care teams, and as care coordinators and consultants for members with BH needs. The plan also has strong relationships with an array of community-based organizations (CBOs) that work closely with members with SPMI and/or SUDs. Of particular note are health homes, described below, and crisis stabilization units – short-term residential placements that respond to member crises, helping them to avoid psychiatric hospitalizations.

Theme 5: Provider Relationships

A key challenge for managed care organizations is maintaining a sufficient and high-quality provider network. In addition to CCA's need to meet Medicare's requirements regarding member access to different provider types, CCA aims to work with a range of CBOs. Such providers have existing relationships with members, supplementing traditional providers such as large hospital groups and primary care practices. Such partnerships were seen *as an exchange of expertise*, where the CBOs offer community connections and expertise and CCA offers organizational resources associated with a managed care plan as well as connections with other service providers. For more traditional service providers, CCA offers expertise in the member population.

For 25% of members, services are managed through *the delegated model*. Under this model, a primary care practice, typically located in a federally qualified health center (FQHC), is wholly responsible for SCO members' care management (including assessments and care planning) and utilization management. Under the *health home model*, a similar arrangement delegates care management (but not utilization management) to community-based mental health providers, which include state mental health programs and social service agencies serving people with SPMI/SUDs. Roughly 25% of One Care members are supported through health homes.

CCA also maintains relationships with hospitals to facilitate *transitions*, most notably through its Hospital to Home program, which embeds CHWs in the emergency departments of four hospitals. These staff work to ensure that members have what they need when they return home. Another CCA resource is its community paramedicine service, *InstED*. This service (also known as "mobile integrated health") uses paramedics employed by an ambulance company to provide members with urgent care in their homes, under the medical direction of CCA primary care teams.

Theme 6: Challenges

Throughout the key informant interviews, respondents noted challenges faced by CCA. Those mentioned most frequently were *challenges of scale* and, relatedly, *challenges with the information technology (IT)* needed to efficiently run the One Care and SCO programs. As a small, independent organization, CCA lacks the resources and "deep pockets" associated with commercial health plans with more diverse product lines; without such resources, CCA is constrained in its ability to adapt to change. Similarly, building an IT infrastructure has proved challenging. Key informants also mentioned *challenges looking ahead*: the uncertainty associated with the transition out of the FAI and the need to adapt the care coordination model to clarify roles of members of the care team in order to operate more efficiently.

Conclusion

This research aimed to understand the mechanisms used to integrate care for the highly complex, highly vulnerable dually eligible populations served by CCA, an integrated health plan with deep experience serving this population. In many ways, the plan conforms to best practice in integrated care for complex member populations. For example, in its person-centered focus, use of interdisciplinary care teams, respect for specialized expertise, focus on transitions, and attention to SDOH. However, it also includes elements that are less typical: for example, the plan's integration of BH; its relationships with community-based mental health providers; and its use of mobile integrated health. It is clear that the plan is deeply committed to its member populations, and that its organizational culture and procedures are centered on member needs. Overall, CCA displays an impressive record of innovation in supporting the needs of its dually eligible members.

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