Key Informant Perspectives on 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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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 and often not well defined or understood. This study sought to understand how CCA operationalizes integrated care by investigating CCA's model of care and its components, identifying factors influencing plan operations, and highlighting 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 to assess plan financial and service utilization performance by longitudinally analyzing claims costs for people of similar characteristics who are enrolled and not enrolled in CCA. 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 February to August 2024.

Using purposive sampling to identify participants with expertise relevant to our research questions, we conducted key informant interviews with 22 individuals. Interviewees 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. The present report focuses on findings specific to the plan's approach to integrated care and the mechanisms it uses to operationalize it.

Report Overview

In this report, we provide background and context regarding CCA's development as a health plan, then present our findings. The latter includes themes arising out of the research. The first theme reflects what study participants identified as important contextual factors influencing CCA's performance as an organization. The second theme arose from participants' statements about CCA's organizational culture and overall approach to care, while the third theme describes the key role that CCA's interdisciplinary teams play and how various team members function within those teams. CCA's approach to integrating behavioral health (BH) comprised the fourth theme, while the fifth theme concerned provider relationships; it details the variety

of ways CCA works with a range of community-based providers, hospitals (to ease transitions), and mobile integrated health (to minimize emergency department [ED] visits). The sixth and final theme consolidates respondent concerns about challenges facing CCA. The report concludes by discussing the study's implications.

CCA background and history

CCA was founded in 2003 as part of an integrated care demonstration serving dually eligible individuals aged 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 (SDOH) 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. The Demonstration aimed to test integrated care and financing models for younger Medicare-Medicaid enrollees. The Massachusetts FAI demonstration model, called One Care, was unique in focusing on the younger dually eligible population. Under the FAI, which expires at the end of 2025, CCA was able to undertake activities not typical of integrated care plans: first, it could offer certain flexible benefits, discussed below, and second, members were "passively enrolled" (i.e., automatically enrolled in the plan). At the time, CCA was one of the few plans with sufficient capacity and ability to serve this population; consequently, most One Care members were assigned to CCA. Passive enrollment freed CCA from the need to market One Care.

CCA enrolls a highly vulnerable population: about 16,000 in the SCO plan, and 32,000 in One Care. Table 1 shows that the 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 disorder (SUD) (35%). Additionally, approximately 57% of One Care members and 70% of SCO members with SPMI have complex medical conditions.

Table 1: Member demographics 2023

	SCO	*One Care*
Enrollment	31838	15862
Age (average)	75	52
English speakers	47%	89%
Race		
White	70%	78%
Black	18%	14%
Ethnicity		
Hispanic	48%	23%
Non-Hispanic	46%	70%
Chronic conditions		
Asthma	35%	36%
CHF	18%	8%
COPD	25%	20%
Dementia	15%	2%
Depression	58%	47%
Diabetes	50%	31%
SPMI	19%	52%
SUD	15%	35%
Comorbidities (number)		
0	19%	36%
1-2	42%	42%
3+	39%	10%

Source: CCA data. SPMI = Severe and persistent mental illness. SUD = Substance use disorder. The comorbidity count includes conditions not listed, such as liver disease or cancer.

Findings

The major themes presented below include: the factors shaping CCA development (*Theme 1*), how CCA approaches care (*Theme 2*), the use of teams in care provision (*Theme 3*), how BH is integrated into care (*Theme 4*), the nature of provider relationships (*Theme 5*), and challenges for ongoing operations/service provision (*Theme 6*).

Theme 1: Factors shaping CCA development

Study participants stressed the importance of understanding the contextual factors that shape CCA's current operations, frequently referencing how these contextual factors influenced its organizational culture. The most significant of these factors is CCA's genesis as a provider-led organization, developed in close collaboration with advocates. Another important factor is the Massachusetts policy context, which broadly supports innovation in healthcare.

Theme 1.1 Impact of CCA's history on plan development

CCA grew out of a Massachusetts-based community health movement that started in the 1970s, which involved collaborations between consumer advocacy groups and certain primary care provider (PCP) groups. These provider groups were unusual in focusing on the care of people with complex care needs, such as low-income individuals with severe physical disabilities and frail older people. Understanding that these individuals required an approach to care that was different from the status quo, the organizers sought to use integrated payment systems to better coordinate the multiple providers and services these people need, using provider-led interdisciplinary care teams (Black, n.d.; Master et al., 2003; Meyer, 2011). As one observer said,

> *Well, I think early on, the thing that made them unique was that they offered primary [care], they offered care coordination through nurse practitioners, advanced practice clinicians, you know, through nurse care managers who were experts in their field (Policymaker).*

This background means that CCA's founding by providers and advocates, rather than by an insurance plan, had an influence that persists to this day (Master et al., 2003). The observer noted,

> *CCA… primary care has evolved over time. They're trying to expand it to all of their population and just not focus solely on the population with physical disabilities and rare diseases. They're trying to make it a model of primary care that is accessible for their entire population (Policymaker).*

Respondents also discussed how the plan has had to shift over time toward being more of a traditional health insurance plan. A contrast between insurance plan practices and member-focused approaches was frequently made in the conversations. For example, a Board member said, "We try to behave more insurance company-like...but [CCA's] DNA at the core is taking

care of other people," indicating a perceived tension between these two things. Another key informant told this story:

> *They came in and did an audit... She just came in and looked at [the care plan] and said, this person's got diabetes and that's nowhere on the care plan. And our response honestly was, well, the member didn't wanna work on that. They wanted to work on getting transportation to go to church or whatever. Yeah, that's still got to be on your care plan. And that just was not part of how we did it. Our care plans were not medically focused (Management, Clinical 2).*

This quote demonstrates the extent to which the plan historically focused on member-defined goals and the shift it had to undertake to adapt to standard health insurance practices. As another participant said, "early CCA was like, utilization management, who needs it, right? ... early on [they] were really like, tell us what you need and we'll help you get it. If it's something that Medicaid and Medicare will pay for, you should be getting it" (Policymaker).

The role of advocates in founding both the SCO program and One Care has also had a long-term impact. CCA's commitment to promoting member influence within the plan is demonstrated by the range of mechanisms it uses to encourage consumer involvement. This occurs at multiple levels: in care planning, in soliciting member feedback, and in plan governance, a commitment which CCA continues to uphold. As one key informant said,

> *One of the things that's always so unique [is]… in the way that we utilize advocates, both true advocates and then the consumers... We've created different forums over time where we have standing engagements with individual advocates, advocates as a group, advocates that are sitting on the OneCare Implementation Council[1], and then individual consumers because we're always wanting to pressure test where are we getting it right from their perspective, and where do we need to improve, right? What are they seeing and feeling on the ground that we may not be recognizing is critical, and what can we do to make it better? (Executive, Policy 2).*

These practices were established well in advance of federal requirements regarding member involvement in plan operations. Federal requirements, promulgated in 2023, require dual eligible special needs plans (D-SNPs) to set up and maintain member advisory committees (Resources for Integrated Care, 2023). CCA was well ahead of the curve in underscoring the importance of consumer involvement.

Theme 1.2: The Commonwealth's commitment to integrated care

An important contextual factor shaping CCA is its position within the Massachusetts policy environment. Most importantly, CCA has benefited from Massachusetts' consistent support

[1] The One Care Implementation Council is a state-wide consumer council that plays a key role in monitoring member healthcare access and plan compliance with the Americans with Disabilities Act (ADA), tracking quality of services, providing support and input to state agencies, decreasing health disparities, and promoting accountability and transparency.

for integrated care. By launching the SCO program in close collaboration with CCA back in 2003, Massachusetts established itself as one of integrated care's early adopters. Its development of the One Care program has been described as "open-minded, participatory, and transparent" (Barry et al., 2015). Respondents consistently voiced appreciation for the state's support. Key informants noted several ways that CCA has benefited, including its approach to regulation of integrated care specifically and healthcare more generally. For example, one talked about the state's

> *openness and regulations to getting things done. I think Mass is a really forward-thinking community in terms of Medicaid in particular. And I think a lot of things...infrastructure policies… have been really well thought out and really innovative, comparatively to other markets (Executive, Provider Network 1).*

This key informant further pointed out that

> *Mass generally is pro-provider in a way that is really helpful. So that, first and foremost, they are continually trying to put things in place that...help the providers and certainly help those providers that are more community-based and so I look specifically at [BH] providers, LTSS community providers, and skilled nursing facilities. Massachusetts has built a general framework around supporting those providers that is incredibly helpful and that includes payment policies as well as regulation policies (Executive, Provider Network 1).*

The state also has a collaborative approach to quality improvement. For example, it draws on Medicare quality improvement resources to develop specific performance improvement projects (PIPs) for individual plans. One key informant said that the state has more recently become

> *[a] little bit more prescriptive, not necessarily with the exact topics [covered by the PIPs], but simply with the overarching suggestions for topic areas that they would like to see, and then they leave it to the plans to figure out what would work best for them in light of their membership and their membership needs (Executive, Operations 2).*

This respondent said this approach was

> *very beneficial for our members, especially because our members have such high need. And in the years when we were allowed to select our own topics, we really zeroed in on some very unusual topics, not your standard CHF [congestive heart failure] or diabetes or COPD [chronic obstructive pulmonary disease]. And we really got some very, very good results, both from the member perspective and also from the data perspective when we had those in place (Executive, Operations 2).*

In addition to Massachusetts' general support of innovation in serving vulnerable populations – and integrated care more specifically – respondents reported the sense that CCA, as an organization, was supported by the state. One said, "Massachusetts is gonna work with us even if we screw up. That doesn't mean we're not gonna try hard. We'll try really hard... I worry..., but then I come back to... [the fact that] senior officials and government believe in us" (Board Member 1).

Massachusetts' commitment to consumer involvement was also singled out:

> *I think their involvement with the actual beneficiaries, families, advocates is... leaps and bounds ahead of most states. The Implementation Council is still up and running for One Care – that's a hugely important body. They had, during the first few years of implementation... an Early Indicators Program... it was basically like a committee that included several members, advocates, family members, and other stakeholders that defined what success meant to them with the demonstration around quality and satisfaction (Executive, Policy 1).*

However, one area of state responsibility was reported to pose problems: some respondents felt that the state's health information infrastructure could be improved. As one said, "there's a lot of work at the state level to really kind of promote Mass HIway [the state health insurance information exchange] ..., but it's still not, I think, where anybody wants it to be. And so that's definitely an inhibiting factor" (Management, Clinical 3).

In sum, it was clear that CCA benefited from Massachusetts' openness to innovation and its commitment to serving vulnerable dually eligible residents, but was impeded, in part, by the state's health information infrastructure.

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 desire to avoid institutionalization, the plan must use creativity and innovation with products and services. Such creativity is enabled by the ability to provide flexible benefits under the integrated care model. The plan also focuses on addressing SDOH needs – food, housing, and transportation – by enabling members to access community resources and the benefits to which they are entitled. Addressing these SDOH needs is critical to this vulnerable population, who cannot stay healthy if these needs are ignored. In addition, a critical part of centering member needs and responding to the plan's history of working with consumers is member engagement at the individual, systematic, and governance levels.

Theme 2.1: Organizational culture

Key informants noted how the organization's history of serving the CCA population has created a unique organizational culture, characterized by the plan's commitment to its member population. This commitment is reflected in how the organization hires and trains

staff, ensures that member goals are met, and prioritizes connecting with member communities. It is also reflected in how it creatively utilizes available resources – and sometimes, when necessary, develops resources that are otherwise unavailable.
This culture permeates all levels of the organization, including leadership. The organizational culture, one key informant said, "starts at the top. And when I say the top, I mean like the very, very top. So, for instance, when I look at our board, it's the most impressive board in terms of pedigree that I've ever seen in a health plan" (Executive, Policy 2). Several respondents noted the importance of this widespread organizational commitment. One said,

> *Because of how we grew up as an organization, starting out as a primary care entity supporting people with disabilities, it is a place that has reputationally drawn people to that mission. And I think good people create good culture, right? And we have, at the leadership across the organization, a ton of highly committed individuals (Executive, Policy 2).*

Another key informant described how this culture is promulgated among new staff, and the importance of

> *being supportive, having leaders who are invested in trying to help staff when they come up against issues, also creating a culture where people lean on each other and have a buddy sort of support system... So, trying to help when we're onboarding people, give them somebody who's an experienced person to be their buddy, not just their manager (Management, Clinical 1).*

To sustain this culture, CCA needs staff who understand and are committed to the member population. As one manager said,

> *Having worked in other places, our population is really more complex than some of the others. And I think that if you don't have the mindset to really be willing to work with members who are this difficult, you're not gonna survive (Management, Clinical 1).*

An important part of this understanding and commitment is ensuring cultural competence among staff. One respondent said,

> *We intentionally try to hire people that look like the people we serve, right? ... So our team, we have one of our other staff members that's Hispanic, one is Portuguese, and then we tapped a Vietnamese colleague who is a community health worker that's helping us. And so we try to respect the culture and backgrounds that people come to the table with (Management, Engagement 2).*

Another important component of the CCA organizational culture is the emphasis on responding to member needs through creative use of resources and innovation. One key

informant said, "CCA has impressed me from the start about how innovative it is. And I, in my experience in other health plans, haven't seen that much innovation" (Executive, Operations 2). Another key informant described this openness to creativity by saying that, "CCA is a little bit more of a scrappy can-do company, right? It got into insurance by rolling up its sleeves because it really believed in the good of the people" (Executive, Operations 4). This environment of creativity and innovation is possible because of an overarching commitment across employee levels to think outside the box when it comes to member needs.

In some cases, CCA's innovations have been adopted by other managed care organizations. One observer remarked, "So they're kind of building these innovative pieces that kind of have evolved and other plans are taking notice and be like, 'oh, that's a really great thing. Let's build off of that model and think of it in different ways'" (Policymaker). Thus, CCA is not only flexible in the benefits provided to members (discussed below), but also in being open to innovation and most importantly, experimentation – likely due to its focus on meeting member needs through person-centered care.

Theme 2.2: Centering member needs through person-centered care

An important part of CCA's organizational culture is engaging with individual members and meeting their needs. Person-centered care accomplishes this by using a holistic approach that prioritizes respecting an individual's goals, values, and preferences. This perspective is integrated into CCA's approach to care planning. A respondent said, "I think the secret sauce is making sure that the member knows that they're not alone, that there's someone here that's going to fight for them, that they're going to be an advocate for them" (Management, Engagement 1). Another key informant described it like this:

> *The member is in the center of every decision that we make 100% of the time. And what can you do to remove the barriers for the member so that they can be successful in their goals and where they want to live and what they want to achieve. It's even at our leadership meetings, and... also from our CEO [chief executive officer] – 100% you don't make a decision without thinking how it's going to impact the member. And I firmly believe that we do that. I think that's a part of our mission that we live every single day (Management, Clinical 2).*

This theme arose in many other key informant responses. Another said,

> *And I think that that is part of the culture that... our teams recognize the members' needs come first. Yes, there's a lot of swirl, there's model care changes, there's re-procurement, but the emphasis is really on, is the member's need being met? Are we doing what we can to meet the member's need? (Management, Community Services 1).*

And yet another respondent indicated that,

> *It's always quality, the quality and member at the forefront of everything we do. We're not making decisions that are explicitly driven by how do we reduce utilization or medical expense. What we're looking at is... where is the most appropriate place for the person to have care? And then what is the set of services that they need wrapped around them, that fit most effectively and not even most appropriate? It's, in many instances, where does the member want to receive their care? (Executive, Provider Network 1).*

A central part of this commitment is enabling members to remain in their preferred living environment – in most cases, in the community. As one key informant said,

> *There's a lot of supports and systems that we offer these members specifically because that is our goal. Keep them out of the skilled nursing facilities as long as possible, keep them in their homes, assuming that's where they wanna be. Providing the services they need to stay out. That's our whole reason for being (Executive, Operations 2).*

Respondents consistently echoed this perspective in their comments; it was clear that there was a deep commitment to centering members' needs through the organization's policies and practices.

Theme 2.3: Flexible benefits

A critical aspect of person-centered care for dually eligible individuals is the need for non-medical supports that enable them to remain in their homes. Key informants expressed a belief that investments that support a broader definition of health not only meet members' immediate needs but will ultimately result in better longer-term health outcomes. Under the FAI, One Care plans were authorized to deliver these less traditional services as "flexible benefits." These could include air conditioning, microwaves, wheelchair ramps, and meals. One key informant said,

> *The other part of the model I really love is One Care and the flexibilities... We just had a case recently where an individual was very overweight, mostly living in a wheelchair. Starting to get to the point where they couldn't get through their doorways in their home. They couldn't transport. So we were able to go in and open the doorways. We were able to go in and actually take the bathroom out... Where else can you do these things that allow people to stay independent in their home? It's pretty special (Executive, Policy 2).*

Another key informant said,

> *We think about it in terms of what does this member need to remain safe in the community, to function in the community? And without this service, would they require an institution? Would they decompensate? Would they have a hard time navigating their day-to-day lives in the community? (Executive, Operations 3).*

While flexible benefits are advantageous for members, they can be expensive for CCA to cover, so staff must be creative with how they provide the best quality care as efficiently as possible. This creativity is reflected in the observations of one key informant:

> *We had a member on hospice and there was something that wasn't covered under the hospice benefit…We covered that...And we will look at how can we use their benefit structure to give them what they need so they can stay in their home. We've done stuff to keep people in their home that most people wouldn't do. It's expensive (Management, Clinical 2).*

One flexible benefit made possible by the FAI is the expansion of the personal care benefit to include cueing and monitoring:

> *Similarly, in the OneCare space, through the demonstration, we've been able to provide an expanded version of PCA [personal care attendance]. Just not people who need support with their ADLs [activities of daily living], but also offering people support who need just cueing and supervision or cueing and monitoring. So through that demonstration, we're able to say, if you are someone who is on the autism spectrum disorder, or has a serious and persistent mental illness, and all you need is someone coming in and reminding you to do things like take a shower, pay your bills, do your laundry. You can physically do all those things on your own, but you have that barrier (Policymaker).*

Notably, though the FAI enabled One Care members to receive expanded flexible benefits, SCO members have access to a more limited set of benefits. One popular benefit is the OTC (over the counter) card, which provides a quarterly amount of $425 that can be spent on food and health-related products without having to seek official approval through health plan channels. One respondent said that it's popular "Because it's free money.... And they can use that for Band-Aids, for Tylenol, for anything over the counter. Yeah, if they're eligible, if they have a chronic condition, they can also use it for food and utilities" (Management, Engagement 1).

The ability to provide flexible benefits is determined by state and federal regulation and reimbursement policies; however, a plan may choose whether and how much to utilize this flexibility. Study participants clearly indicated that CCA has taken advantage of this opportunity to creatively support members.

Theme 2.4: Focus on the Social Determinants of Health

The CCA model emphasizes SDOH – specifically, food, housing, and transportation (including social transportation). These are identified via the annual assessment and used in care planning. Once needs are identified, members are referred to community health workers (CHWs), trained non-medical support workers living in the same community. Their primary role is to link members with community resources. In addition, they help members navigate access to benefits and resources.

Respondents repeatedly emphasized the extent to which SDOH are critical to supporting the holistic health of CCA members. One argued,

> *If you're working with somebody who needs a CPAP [continuous positive airway pressure] machine and they're unhoused, how are they supposed to plug their CPAP machine in at night? Right. Like, so their apnea is not going to be treated because they're not housed. So it helps us kind of really understand [the need for] a safe place to go and things can build from there (Management, Community Services 1).*

This same respondent went on to say,

> *A lot of those [SDOH] impact engagement and access, right? So, I mean, we're lucky... we have transportation benefits… that's a huge thing. It's great if you have a really good provider network, but if you can't actually get to see the provider, it doesn't really do you much good, right?... We can make sure that our members can get to and from their appointments. They can also use that transportation for social things. They can go to church with it. They can go do their grocery shopping with it. They can go see their friend or family because we know that social isolation is a determinant as well. And if they're socially engaged, they're less likely to be depressed or to have poor health outcomes (Management, Community Services 1).*

This respondent also stressed the importance of help with accessing and maintaining benefits, noting that,

> *We're pretty successful with things like benefit maintenance, right? So making sure that folks know how to maximize their food, right? So a lot of our folks use SNAP [supplemental nutrition assistance program] benefits but not many of them are aware that they also have HIP benefits, the healthy incentives program, to get fresh produce... We want you to know what those resources are and to be happy to use them. Housing is always going to be the sticking point. We have a hard time with that.... It's not just apply for housing, check the box. It's get those documents, it's do the applications, keep on top of things, right? (Management, Community Services 1).*

Theme 2.5: Member engagement

Because CCA was founded in collaboration with consumer advocates, it is committed to meaningful consumer involvement. To do so, it uses several mechanisms. First, member communication with care partners and clinicians is facilitated by the care planning process and interdisciplinary care teams. Second, structured member feedback is obtained via the formal grievance process, surveys, and focus groups. Third, member committees are convened to discuss plan issues, which in turn inform plan governance.

Key informants discussed the importance of member engagement:

> *There's a huge effort that's made to create engagement and affinity. It's a trust-based relationship. It's almost like a good family member... And once you establish that level of trust, you have a lot of influence over what that patient does... it's a cultural dimension. It happens, I think, in the nature of the people that we hire, it happens to some degree in the self-selection, and it happens to some degree in the training programs (Board Member 1).*

Individual-level engagement is supported through the assessment and care planning process, where member needs and goals are identified. One key informant discussed the development of the assessment tool used by CCA:

> *When we put together this assessment that we're using currently, it was after a two-year pilot program. And... we interviewed members and said, how is this for you? Do you like it when we ask you about these things? And the feedback was overwhelmingly positive because people said, 'it makes me feel like you care about me'... it's really driven by the member's needs (Management, Community Services 1).*

These needs and goals are also communicated through member participation in the interdisciplinary care team, which provides members with access to a range of expertise.

In addition to individual-level engagement, CCA obtains systematic feedback on member experiences through the complaints they make, the formal grievances they lodge, and the reasons they give for leaving the health plan, all of which are tracked. However, the use of the grievance process, along with data from grievances, is only meaningful if members are aware of their right to lodge formal grievances (which, once lodged, are handled under requirements set by CMS and the Commonwealth). One key informant described efforts to inform members:

> *In our call center, our reps are actually trained. [So if] someone is complaining, you do offer them the opportunity to file a report. So that we can more formally track and document these types of things... It's [the member's] discretion if they want to move forward with the full filing of that complaint, that becomes the grievance... The rep, in turn, is encouraged to actually initiate the grievance process (Management, Engagement 2).*

Key informants also mentioned periodic member surveys, some of which are mandated by CMS, such as the yearly Consumer Assessment of Health Plan Survey. In other cases, surveys and focus groups assessed member responses to specific CCA initiatives or sought to identify issues that the plan needs to address or to understand the reasons for disenrollment.

Member involvement in plan governance is another core CCA value. As one respondent remarked,

> *We're trying to [make sure] that we have the appropriate mechanisms in place to have that feedback loop for the input that members are sharing, getting it to the appropriate places, and also communicating back to those members about, hey, this is what your input's done into the changes (Management, Engagement 2).*

CCA further engages with its members and member advocates in several ways. First is the Member Voices Program, a voluntary forum consisting of 100 CCA members and/or their family caregivers. The program aims to inform the ongoing development of CCA programs and services, and functions as a mechanism to incorporate member needs, preferences, and feedback into CCA's decision-making process. To do so, it hosts two types of meetings: forums focusing on specific topics, such as changes to CCA's care model, and consumer advisory boards that operate across CCA's 12 different regions, convening once a quarter to provide general feedback on the plan. In addition, a Consumer Voice Advisory Council serves as a subcommittee of the board and includes both provider representatives and consumer advocates.

Theme 3: Teamwork approach/flexible teams

The interdisciplinary care team is a key part of the CCA model. Team composition is tailored to members' needs: a team always includes a care partner (also called a care coordinator or advisor), who is typically a clinician. In addition, it may include a BH Specialist, who may act as the care partner or fill a consultative role. The care team may also include an independent coordinator of LTSS, known as the Long Term Services Coordinator (LTSC) for One Care members and the Geriatric Service Support Coordinator (GSSC) for SCO members. Another crucial part of the care team is the CHW, who attends to a member's social needs. Finally, the member may involve others (family members, trusted friends) as part of the team.

Theme 3.1: Interdisciplinary care teams

The responsibility for translating CCA's approach to care into practice lies with interdisciplinary care teams. Responsible for developing a member's care plan and coordinating care, teams meet regularly to ensure that members' medical, behavioral, and social needs are met. As one key informant described,

> *I think our unique model of care and the way our clinician care is formatted to benefit our members is very advantageous as well – they have clinical care partners and then they also have folks who are designated to provide the non-clinical portions of their care that they need. This could be someone who steps in... and helps them with transportation or assist with getting their caregiver to go on doctor's visits, etc. with them (Management, Clinical 2).*

The makeup of the team varies according to a member's individual care needs. Teams typically include a combination of care coordinators, PCPs, nurses, specialists, and others that members wish to include, such as peer support/counselors or family members, and are led by one individual from the team (the care partner). Team members may rotate on and off the care team as member needs evolve (Anthony et al., 2021). This same key informant remarked,

> *The member is asked who they want on their care team... Sometimes it's their PCA [personal care attendant], sometimes it's, you know, a daughter or granddaughter or whatever... Yeah, there's a gentleman that I've worked with who had a really hard time with executive functioning and he delegated, please just talk to my PCA. I mean, she couldn't make the medical decisions, but she could help us schedule appointments and do all this stuff (Management, Clinical 2).*

The team includes both clinical and non-clinical members. As one key informant said,

> *One thing that works really well is having our community health workers embedded on our care teams. I feel like that's kind of unique... You're talking about medical issues, but there's always other things that come up, right? Yeah, you know, that housing issue or the stairs or some type of accessibility or barrier. And it really helps us kind of get in there right at the root of issues to help resolve things before they get to catastrophe (Management, Community Services 1).*

The clinical care team works closely together, often consulting with other care team members. A key informant reports, "they have this daily huddle... They also have team meetings on a regular basis. I think that having that structure brings them together as a team of a variety of disciplines where they really lean on each other" (Management, Clinical 1).

Information-sharing among team members is facilitated via a dashboard. A key informant explained,

> *We have a really robust dashboarding system... It's very robust. And it gives us individual level dashboards so that I can reach in as a care manager and say, oh, so-and-so went to the hospital yesterday, or so-and-so went to the emergency department, that comes over through [XXX]. I could see who's got DME [durable medical equipment] that's expiring, who's got home and community-based services either expiring or have been approved, who's got care plans that are expiring, so I can look at that. And then I can go on a member-level data and it'll tell me when they last saw their PCP, when they last filled all their medications, when the last time was they were touched by a member of the care team (Management, Clinical 2).*

Theme 3.2: Care partners

A critical member of the team is the "care partner," whose role is analogous to that of care coordinator in other plans. The CCA model, however, stresses the need for clinical expertise. The care partner is the member's main point of contact, responsible for working with the member and the care team to develop an individualized care plan, ensuring the member can access care, and arranging for any other needed services; every member is assigned a care partner.

Although the discipline and precise role of the care partner may vary, they are typically clinicians (often registered nurses [RNs] and sometimes advanced practice nurses [APNs]) with expertise in a member's specific issues. Such a focus ensures that members are working with individuals who understand their often-complex needs. In the SCO, the care partner may be the member's PCP (Anthony et al., 2021). This centering of PCPs in care management illustrates CCA's "primary care-driven" approach. As one respondent remarked, "having individuals who understand the population, who are clinically trained in serving the population that are in the communities that we're serving in is unique" (Executive, Provider Network 1). Another said, "The thing that made them unique was that they offered primary, they offered care coordination through nurse practitioners, advanced practice clinicians through nurse care managers who were experts in their field" (Policymaker).

Respondents noted that CCA is shifting away from its heavy reliance on nurses for care coordination, due to the inefficiency of this use of an expensive resource, and toward otherwise allocating non-clinical coordination tasks. As one said, "when we look at the work, and we have years of having this RN care partner model, we see the amount of time – it's really expensive, but also again, the tasks that they are doing, you do not need someone with an RN degree to do that work" (Management, Clinical 3).

Theme 3.3: Behavioral health specialists

Members with significant BH needs can be assigned a BH Specialist as their care partner; roughly half of all members with an SPMI diagnosis have a BH Specialist care partner. Other members with BH needs will likely have a BH Specialist as part of their care team, acting in an advisory capacity. One respondent described how this works:

> *Over the course of kind of getting to know the member... [and] their behavioral health diagnoses, we really try to have their care partner...be a behavioral health 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 behavioral health, in which case that's also why as part of our care team structure, there's always a behavioral health specialist who is assigned to that clinical group...to provide consultative support (Management, Clinical 3).*

Another said,

> *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 development of this BH Specialist role was an important way for CCA to respond to the high level of need when the One Care program was launched in 2013. Figures at the time set the proportion of newly enrolled members with SPMI at 70% (Black, n.d.), although the 2023 figure was around 52%; the figure is around 19% for SCO members.

To respond to this level of need, BH expertise is necessary. Consequently, BH Specialists are "all… either independently licensed social workers or licensed mental health counselors" (Management, Clinical 1). For members whose BH issues are significant, "we really try to have their care partner...be a behavioral health specialist" (Management, Clinical 3). An estimated 20% of care partners are BH specialists (Management, Clinical 2).

Their expertise in dealing with this population helps members receive appropriate treatment and improves the quality of communication between the plan and its members.

> *Instead of having the RN call [members], 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 finding that people are engaging differently (Management, Clinical 1).*

Theme 3.4: Community Health Workers

For members with social needs, a CHW may play an important role in the care team; they are assigned when an assessment determines a social need. In contrast to most managed care organizations, CHWs are on staff (rather than contracted). Typically, managed care organizations that hire CHWs use them to support members with specific high-cost conditions, while contracted CHWs tend to take a broader view of the SDOH and work in closer partnership with communities (Wennerstrom et al., 2022). Thus, CCA's deployment of its CHW staff appears to be atypical. Not only are they trained in CCA's model of care, but they are also embedded in care teams. As one key informant said,

I really do think our CHWs as part of the care teams is like [our] secret sauce, special sauce. We've presented on our social determinants work... A lot of the folks that come up to us after we share our work are like, 'oh, that's interesting, we don't have CHWs that way.' Or, 'the only CHWs we have are out in the community, they're not within the plan.' And I think it really enables us to kind of collaborate from inside the house, right? It means that not only are we able to look at coordination of benefits with social needs, but it helps us act as a go-between between us and those community resources and providers as well (Management, Community Services 1).

The role of CHWS is to connect members with community resources that support SDOH. The process was described like this:

Annually, everybody gets those three questions about food, housing, and transportation, even if they say no to those things but they have other needs, or if they say yes to those things and want to, it's going to trigger a referral to the community health worker team. And once the CHW gets that referral, they're going to do a chart review, make sure they have as much information as possible, make an outreach to the member, and they're going to confirm, 'I received a referral.' Your provider said you consented to this. Are you still interested? (Management, Community Services 1).

As one manager said, CHWs

do most of our social determinants work. So they will help with food insecurity. They will help if they're at risk for losing housing. They'll go to housing court with them if they need to do that. They were very active in the last 18 months with the MassHealth redetermination, helping people fill out the paperwork. They will help them find housing if they don't have housing. They'll help them find community organizations who could help them with their electric bill if they're having problems with that, connecting them with the cell phones if they're not able to have access to that (Management, Clinical 2).

CHW jobs are typically entry-level positions for people with human services backgrounds, such as a bachelor's degree in social work; most of whom are certified by the Massachusetts Department of Public Health. Importantly, CCA seeks to ensure that CHWs originate from the communities they serve and share similar lived experiences. One respondent said,

They're very representative of the population. Many of them live in the same communities in which they work. Many are bilingual, bicultural, so there's also a huge trust factor there that they can build very quickly (Management, Community Services 1).

In addition to their primary role of supporting SDOH, CHWs may play other roles. Some CHWs may focus on engagement and outreach, while others work in CCA clinical groups. Additionally, a team of CCA CHWs works with the Hospital to Home program at four Boston-area hospitals. Embedded in the Emergency Department (ED), they can provide same-day assessments and approve services to support transitions.

Moreover, CHWs represent a careful use of resources by CCA. One respondent remarked on how the plan is increasingly utilizing CHWs to free up clinical staff. They said,

> *But even for your most complex folks, there's still a tremendous amount of time that is more administrative and helping that person navigate the system. And so in terms of being able to be both effective and efficient, we really shouldn't have nurses or clinicians spending [time] doing pretty administrative types of tasks (Management, Clinical 3).*

Theme 3.5: Independent coordination of long-term services and supports

A unique feature of both the One Care and SCO programs in Massachusetts is a requirement embedded in all managed care organization contracts: that the plans contract with independent organizations for coordination of LTSS. As described above, the person who does this is a GSSC for SCO members and a LTSC for One Care members. While all SCO members are assigned a GSSC, having an LTSC is an option for One Care members because not all One Care members have LTSS needs, though approximately 40% do.

The independence of the GSSC and LTSC role is meant to eliminate any conflicts of interest in service authorization, given that LTSC/GSSCs' organizations experience no financial benefit from such authorizations. More importantly, independence is meant to ensure that the members' interests are protected. Thus, both GSSCs and LTSCs are employed by independent community-based organizations, which may include Aging Services Access Points (Massachusetts' Area Agencies on Aging), Independent Living Centers, and Recovery Learning Communities (peer-run networks of self-help/peer support, information and referral, advocacy, and training activities for people with behavioral health needs). The commonality amongst these organizations is their experience in representing consumer interests rather than their role as providers.

GSSCs/LTSCs play an important role in the care teams. One key informant described it as follows:

> *The way that I see it is they are oftentimes the eyes and the ears on the ground. They are that person that's going into the home on a regular routine basis every six months. So the home visits that they do are incredibly important and help to level set for the whole care team (Management, Clinical 3).*

This respondent added that this role is

> *such an integral part of the model...having GSSCs as part of our kind of care model and care team structure is what keeps CCA as local as it can be…The GSSC who is in and from their community, who's really going to kind of get to know what are some of their in-home needs and kind of like also have eyes and ears and be a resource... That GSSC, because they're from that same community, is going to be able to give input that's really specific to them (Management, Clinical 3).*

Respondents from an independent community-based organizations managing GSSCs and LTSCs agreed with this perspective. One said, "they do advocate for the members because they are seeing the members. They actually go to the members' home more frequently than the nurses. So they usually have a better understanding about what the member actually needs" (Management, Community-Based Organization 1). However, another respondent added nuance to this picture, saying that,

> *Yes, we do advocate for members, but we're kind of like a middle person. So it's like a balance. We want to educate members about their rights and what they do have access to. But we also want to support the care partners with communicating with members. So it's definitely like a fine line (Management, Community-Based Organization 3).*

In some cases, respondents reported that members developed close relationships with their GSSCs or LTSCs. Consequently, GSSCs or LTSCS may be asked to perform tasks that might otherwise fall into the purview of the care partner or CHW. One key informant explained,

> *Because the GSSCs have developed such a strong relationship with a lot of those members, usually the members, if they have any issues or any help that they may need, the first person that they think about calling is our case managers, the GSSCs, because if, let's say, they're trying to get in touch with a doctor to schedule an appointment and that person's not responding, then they may end up calling the GSSC and say, 'Hey, I'm trying to schedule this appointment. Can you help with that?' So the GSSC may help them reach that doctor's office. Transportation is also something that they do as well (Management, Community-Based Organization 1).*

While the willingness of the GSSC/LTSC to perform tasks such as these may lead to member confusion regarding who they should turn to for help, it also makes it more likely that members receive the support they need from the person they most connect with.

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's relationships with an array of community-based organizations that work closely with this population – particularly health homes and crisis stabilization units (CSUs) – are other important features. As one key informant said, "CCA has this more integrated, robust component around behavioral health and community health workers" (Management, Clinical 1). The BH Specialist role, discussed previously, is a critical part of this.

The focus on BH is likely related to the BH expertise that is intentionally integrated at all levels of the plan. For example, one key informant noted that when first hired by CCA, they were "actually part of our primary care leg… I'm a licensed behavioral health clinician by training, an LICSW" (Management, Community Services 1). They were then switched to a management position. Another respondent reported being hired specifically to expand the plan's BH capacity.

At another level, public-facing staff have been trained in BH, including, for example, the customer service team:

> *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, as well as their knowledge of the community resources and systems that they and our members... need (Management, Community Services 1).*

Another aspect of BH integration is the range of BH providers that CCA works with and the nature of those relationships. This is discussed in more detail below. In one particular area, however, CCA had to develop its own capacity to meet member needs, by establishing the CSUs referred to previously. These facilities provide short-term residential care for high-need patients who are in crisis due to BH challenges, with a goal of avoiding psychiatric hospitalizations. Initially, CCA established two CSUs. One, however, was based in a hospital that closed down, leaving the plan with a single CSU – making the resource inaccessible for members outside its geographic reach.

The plan has published data on the efficacy of CSUs, presenting figures that indicate a 33% savings in average per diem cost for CSU admissions ($718 versus average inpatient admission costs of $1,071 per day in 2021), along with data indicating high member satisfaction (with 90% of members rating it at "good" or "excellent) (CCA, 2021). An independent study found, based on preliminary findings, that the CCA CSUs may have contributed to decreased inpatient facility stays, ED admissions, and per-member per-month costs (Lester & Verdier, 2016), although these findings were inconclusive. Overall, the efficacy of CSUs remains unclear.

An additional factor raised by key informants was how CCA and its members benefit from Massachusetts' relatively robust BH provider network. One respondent noted that "Massachusetts has more, particularly in behavioral health... So, we have a very vast continuum of services that have been built out, that are supported, that the Commonwealth encourages" (Management, Clinical 1).

Theme 5: Provider Relationships

A key challenge for managed care organizations is maintaining a sufficient and high-quality provider network. The Medicare program sets strict requirements for plans regarding member access to different types of providers. In addition, CCA aims to work with a range of community-based organizations that have existing relationships with members, supplementing traditional providers such as large hospital groups and primary care practices. As one key informant said, "there's a number of kind of interesting relationship structures or programs or partnerships that we've rolled out with hospitals, with primary care entities, and with behavioral health and care management organizations over the years" (Executive, Operations 1).

Theme 5.1: Partnerships as an exchange of expertise

Key informants described relationships with providers as a way to exchange expertise. Community-based organizations may be focused on delivering a specific service, such as nutrition support, and often lack experience working with managed care organizations; thus, establishing good working relationships requires outreach and education by CCA. One key informant described it this way:

> *Everything we do in the community is a partnership... We're both trying to serve populations that generally are underserved. And we're trying to do it in a way that is most effective on behalf of the population... [Providers] have the skillset, they've been trained to do it. I don't know that they have the bandwidth to always execute... We usually come at it and approach it from a perspective of, there are things that you're gonna do really well, there are things that we can complement and add to, and if we put those things together the right way, the experience that the members are gonna get is much different than if we try to do it separately (Executive, Provider Network 1).*

This individual continued:

> *And that's where I think CCA stands out... [is] really knitting together those services that exist in that community to make them show up for that consumer as cleanly and as effectively as possible and because we're doing it for a population that has such high needs that that becomes even more complex (Executive, Provider Network 1).*

In addition to social service and other community-based entities, this theme of supporting community-based organizations in serving CCA's challenging population extends to more clinically oriented providers as well. Another key informant describes working with these providers as

> *A combination of creative partnership and relationship structures along with our clinical capabilities and reputation... It's more of the reputation of what we do clinically and our willingness to show up as a partner to the provider and say, 'this is a population that's challenging for you to manage and we can help you manage it effectively in a clinical and mission-driven way' (Executive, Operations 1).*

This requires that participating providers

> *be trained and attest to the fact that they've read the model of care, they've been trained on it, they understand it... Regardless of the provider that you're going to, you're getting the same model of care, the same services, the same delivery of services...It's a challenge to manage though, and keep that (Executive, Provider Network 1).*

By working with these providers, CCA helps ensure continuity of care for members:

> *What's distinctive is that [CCA is] 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,' as opposed to like, 'thanks, they're ours now, we'll figure it out.' I think that they're really more about how do we support them where they are, and how do we help them to grow? And that I think is [what's] distinctly different [about CCA] (Policymaker).*

Theme 5.2: The delegated model

While the care of most CCA members is managed directly by CCA staff, about 25% of members are managed through delegated models. In SCO, this means that a primary care practice, typically located in a federally qualified health center (FQHC), is wholly responsible for care management (including assessments and care planning) and utilization management. These partnerships operate under value-based payment arrangements with dedicated staff coordinating with the range of providers and care team members working for or contracting with CCA, including GSSCs.

Through this model, CCA enables members to retain relationships with community providers while at the same time expanding its provider network in a way that is consistent with its organizational mission. One key informant said, "in Massachusetts, [delegation is] very much mission-driven with the financial piece of it. Elsewhere in the country, there are organizations where they basically said, delegation is our business model" (Executive, Operations 1).

When asked about the difference between being a delegated site for CCA as compared to the organization's more typical role in contracting with other integrated care plans in the area, one key informant said,

> *For the delegated site, we have a very close relationship [with CCA]... It's the fact that we are hands-on. We are connected with the clinical team. And as I stated before, the fact that we meet on a regular basis to address issues, concerns that the member might have, or any shortage in services, any... for example, if a member ended up having issues with housing, so we know all the details, everything that's taking place on a day-to-day basis for the member, those things are actually part of the agenda of discussion where we actually come up with a plan to support that specific member. I know that for the non-delegated, it's kind of different (Management, Community-Based Organization 2).*

To make these relationships work, CCA is significantly involved in helping delegated organizations meet the regulatory and other requirements associated with serving its members. One key informant reported that,

> *They use our systems. And...there's a team that oversees and manages that. We may come into play and have a relationship in terms of training, sharing of policies, and making sure that they're following our processes (Executive, Operations 3).*

Another advantage for delegated providers is that CCA may pay for the organization to hire staff dedicated to serving CCA members. CCA provides other benefits as well. Another respondent noted that

> *They're getting extra funding to do care management, but they're also getting all sorts of access to health plan type functions, right from us. So they're getting health plan cost and utilization reports. They're getting access to... a hospital's EMR [electronic medical records] to get transition to care data (Executive, Operations 1).*

In short, CCA presents the case for serving as a delegated provider like this:

> *This is a population that's challenging for you to manage and we can help you manage it effectively in a clinical and mission-driven way because you're getting access to clinical programs and partnerships like getting people into the home through the health plan, getting people to help with hospital discharge (Executive, Operations 1).*

This key informant noted that despite the advantages, there are some disadvantages for serving as a delegated provider, particularly administratively:

> *From a legal and compliance perspective... we hold them to the same standards, frankly, sometimes higher... But there's a lot of oversight and frankly, when you're having a conversation with a provider, it's like, they say, 'oh, we want to be delegated.' And then we say, like, here's all the requirements. And they go, 'oh, never mind.' So it's a lot of work administratively for the provider to take this on (Executive, Operations 1).*

Theme 5.3: Health Homes

A model related to, but distinct from, the delegated model is CCA's use of health homes in the One Care program. As noted, CCA aims to integrate BH into its model of care through, for example, the BH Specialist role, described previously. Another component of this integrated approach is the plan's close relationships with community-based mental health providers, which include state mental health programs and social service agencies serving people with SPMI/SUDs. In addition, for roughly 25% of One Care members, some of these entities act as health homes. As defined by CMS, the goal of a health home is to integrate physical and BH care (both mental health and substance use) and LTSS for high-need, high-cost Medicaid populations (CMS, 2024). Health homes accomplish this by identifying "designated providers." In the case of CCA, it designates a community-based mental health provider as the care coordinator for members with BH needs.

Under this arrangement, the health home is responsible for care coordination, working closely with the broader interdisciplinary team. Unlike the delegated model used in the SCO program, health homes are not responsible for utilization management or other health plan functions and are not at financial risk, although they may experience financial rewards for good management. This arrangement was described as unique to CCA, as compared to the other integrated care plans for dually eligible individuals 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 SUD or mental health diagnoses. You've been working with them [historically]. And you know them, you have that expertise. So when they join our OneCare 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, however, 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 [for] the health homes... the care manager assigned to the member is not a CCA employee. It's the provider partner that's doing it (Executive, Operations 1).*

This arrangement benefits members by supporting their existing relationships with providers. Moreover, the arrangement enables health homes to better serve members by expanding their ability to manage members' care.

Theme 5.4: Mobile integrated health: the InstED program

One of CCA's important innovations is its community paramedicine service, known as InstED, which is part of the mobile integrated health movement (Choi et al., 2016). Due to their limited scope of practice, typical emergency medical responders are unable to provide urgent care, resulting in preventable ED admissions (Gregg et al., 2019). In contrast, InstED, which was launched in 2014, 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. An observer remarked,

> *They were one of our first plans to really think about 'How do we utilize paramedics and other professionals with the InstED program?' And… virtual urgent care and mobile integrated health care has expanded to other plans, but they were really at the forefront... InstED I think is a really good example where they were one of the first people to say, 'we have members who have really unique needs.' And one of our marching orders in OneCare and in SCO is reducing ED utilization. And one of the best ways to do that is go to our members' homes when they have an urgent issue and can we actually resolve things in their home (Policymaker).*

Due to the innovative nature of InstED, it has been discussed in a few academic articles (Dorner et al., 2022; Maxwell et al., 2016; Romm et al., 2017), which were mainly descriptive. One study did, however, evaluate patient perspectives on the service, finding high satisfaction and positive user evaluations of quality (Dorner et al., 2022).

Theme 5.5: Hospital Transitions

Recognizing that discharges from hospitals can be a challenge, CCA has several strategies for managing these transitions. One is a CCA program known as Hospital to Home, where CHWs are embedded in four hospital EDs. These each

> *have their own CHW team and... it's like a relay. So they'll work with a member in the emergency department and then they pass the baton over to the CHW that covers their geographic catchment so that we pick up where they left off (Management, Community Services 1).*

A key role played by these CHWs is to ensure that, in addition to the health-related services that a member may receive on returning home, their other needs are addressed. As one key informant described, the embedded CHWs are

> *really unique in terms of the value that brings... The natural reaction for most ER [emergency room] clinicians is this person is... really complex. They also likely come in with a set of community needs that we don't know, whether they're being attended to in the community and if we send them home tonight, or today, whether they would get access to those community services to be able to stay safe back in the community. And so many times those individuals do get readmitted into the hospital just because that is the natural path. And so with that [CHW] in the emergency room, they're able to avoid that (Executive, Provider Network 1).*

In addition to the Hospital to Home program, study participants discussed other mechanisms for managing transitions. They stressed the focus on ensuring that members are followed closely and the need for systems that enable that. For example, one key informant said, "It's a struggle getting the discharge summaries from all the facilities. We've spent a lot of time trying to improve that" (Management, Clinical 2). This respondent further described:

> *We have a transition of care team. We have one that does the acute hospital, and then one that does skilled nursing facilities… They work closely with the care manager in the hospital to help them find out, 'hey, these are the services the member has at home, these are the risks when they're at home, and this is what we need to do to return them to the community' (Management, Clinical 2).*

This key informant went on to say,

> *We have a hospital utilization reduction initiative. So when someone comes out of the hospital, they're expected within X amount of time to be called to have a med rec. We follow up to make sure they go to their doctor's appointment. We found it hasn't done a lot on our 30-day readmissions. It's done a lot on our 60 to 90-day readmissions. So they may get one readmission, but they're not getting multiple readmissions. So now we're trying to fine-tune that a little to see, ok, how can we actually make that better? And then the same thing with the emergency room (Management, Clinical 2).*

As part of this, for planned procedures, "we have prior authorized six weeks of personal care and homemaking for them before they even go into the hospital so that it's ready when they come home" (Management, Clinical 2).

Theme 6: Challenges

Throughout the key informant interviews, respondents noted significant challenges that CCA faces. Those mentioned most frequently were challenges of scale and limited resources; relatedly, they noted challenges with the information technology (IT) needed to efficiently run the One Care and SCO programs. Key informants also mentioned the uncertainty associated

with the transition out of the FAI and the need to adapt the care coordination model to clarify roles and operate more efficiently.

Theme 6.1: Challenges of scale

A key theme was the challenges arising out of CCA's small size and its lack of resources more typical of large commercial insurers, which reduce the plan's ability to adapt quickly to regulatory and other changes and to absorb risk. This was attributed, in part, to its origin as a provider-led organization rather than an insurance company. As one respondent said,

> *When you start out not having traditional healthcare plan knowledge and you have to build the plane as you're flying it, you often see good intentions dragging out for years, systems needing a lot of tweaking before they work the way that CCA wants them to (Policymaker).*

Key informants noted the challenges CCA faced as it grew, and the need to adopt processes and practices more typical of other managed care organizations. One observed,

> *I remember early CCA was like, utilization management, who needs it, right? Like, we don't want to ascribe to these, you know, processes that are... making it more difficult for our members to get the things that they need... Over time as they've grown and as they've expanded... they have needed to become more of a quote-unquote traditional health plan. But I think they always try to look at it from that perspective of what is it that our members need? And how do we try to get to 'yes' in the least restrictive way? (Policymaker).*

Key informants acknowledged the limitations of CCA's lack of scale. One respondent noted the disadvantage the plan faces when negotiating with providers:

> *Maybe CCA isn't quite as [technologically] sophisticated as our big industry competitors… I think part of the objective value of that type of partnership is the ability... to give [providers] access to better information than they have, to improve what they're doing today and see a value add in the relationship there. That's a little bit harder for us to show with providers that are more used to getting that support from bigger payers (Executive, Operations 1).*

A further issue noted by some respondents was the greater risk associated with a smaller financial base, noting that one large national health plan

> *can handle if you all of a sudden had a really couple expensive cases or if your admissions were up a little, where we don't have that same cushion... So if there's a change in reimbursement for one from MassHealth, that's going to hit us harder than it's going to hit [the other health plan] overall, because they're more generalized with their commercial business (Management, Clinical 2).*

Another respondent added,

> *We are up against large for-profit entities with a lot of capital and deep pockets, and the ability to market, and have innovation and adapt [to] technology. And we just don't have those deep pockets. And so, I mean, that's a real cause for concern (Board Member 2).*

One respondent expanded on this theme of limited ability to absorb risk, but linked it with reimbursement policies:

> *We don't think that the growth factor that CMS estimated includes everything it should. We don't think it's an accurate description. And again, we just don't have margins to absorb that. We're not a multi-product. We don't have healthy Medicare Advantage products to offset the risk of this (Executive, Policy 1).*

This respondent felt that "The credits for serving a higher need population, it's not risk adjusted enough. The quality measurement doesn't reflect our population." Another key informant said,

> *The biggest issue from my vantage point is we're taking care of a very high need, high cost population. And we're doing it with public payers. And the rates keep being adjusted usually downward. And they're not always predictable. So the issue for us, the biggest challenge is how do you make this model affordable? (Board Member 2).*

Theme 6.2: Information technology challenges

An issue arising out of CCA's lack of "deep pockets" was also the most frequently mentioned challenge: the plan's IT infrastructure. One key informant described that in the early days, "We first started up our insurance plan practically in Excel, basically" (Executive, Operations 4). They continued, "We certainly didn't get it right out of the gate." As they described, "we [had] different parts of the care team working in two systems... which is just not sustainable."

This issue is ongoing. As one respondent said, "in that respect, we don't have all the tools we need to be as efficient as we can be. And to also scale, right? Because you can't scale when you're relying on hundreds of people at all times" (Executive, Operations 3). Some key informants noted how the system prevented managers from efficient oversight and quality management. As one said,

> *It's process and IT. So, part of it is we didn't have the workflows in place... And then the IT piece is, well, how the heck do we get our system to spit that data out for me? Because right now, if I wanted to collect that information, I would have to manually review text boxes from thousands of notes... What we're trying to do is, how do I make this data usable? (Management, Community Services 1).*

A key informant discussed how the infrastructure varied from that of other plans they had worked with:

> *We don't have kind of some of the standard grouper software logic that I'm used to having elsewhere. We develop our own predictive models for inpatient admission. But on the other hand, it is such a unique population that I'm not certain that off-the-shelf predictive models would be accurate (Executive, Operations 4).*

Another key informant, who had also worked for other insurance plans, identified IT as the biggest challenge. They noted that CCA processes were

> *highly manual... They're not as technologically advanced as I'm used to. So that does hamper or slow down processes... And the reporting can be a little bit more challenging because, of course, when your people are manually doing everything, it introduces a lot of error and sometimes bias, so you have to train them (Executive, Operations 3).*

Several commentors mentioned the problems that IT shortfalls created for providers. One said, "currently we don't have self-service options for providers... So they can't go in and query a system and see" (Executive, Operations 3). One partner organization backed up that statement, saying, "one of the challenges that we have faced with CCA for a pretty long time now is.. It's the data reporting that we get from them... that had caused a lot of issues" (Management, Community-Based Organization 1).

Key informants identified the range of issues around IT as a major challenge for operational efficiency, and as a drawback resulting from the plan's genesis as a provider organization and its limited financial base. Because it is a smaller, independent organization, CCA has lacked the ability to invest in the kind of infrastructure typical of larger commercial plans.

Theme 6.3: Challenges looking ahead

During the time of the study, respondents mentioned a range of other challenges faced by CCA, many of which concerned its future. These included the big picture changes associated with the end of the FAI, such as the loss of flexible benefits. There was also concern about the likely increased need for marketing in the One Care program due to the end of passive enrollment (another consequence of the FAI's termination) and consequent increase in competition for members.

Key informants also mentioned the need to revise and update the care team model. As noted, it was recognized that having a clinician as the care partner for every member might not be cost effective – nor feasible, given staffing shortages. One said that, "as they've expanded, they can't just hire all the nurses who have expertise in diabetes management, because... there's not enough nurses in Massachusetts and... everyone's competing for [them]" (Policymaker). CCA, like all healthcare organizations, was experiencing difficulty in recruiting and retaining appropriate staff, an issue that is especially acute when seeking to hire staff both willing and able to work with the population served by CCA.

Key informants also mentioned the possibility of more targeted care management strategies, wherein care management levels might be titrated to member need – although such changes were only under discussion during the study. Some observers also raised concerns about rate-setting for plans such as CCA, arguing that the methodology did not appropriately reflect the complexity of the enrolled population (a view shared by others – see, for example, Maxwell et al., 2016).

Implications for policy and practice

CCA's care model contains many of the elements identified as being effective in supporting the complex dual eligible population (Bella et al., 2024; Feldman, 2014; McCarthy et al., 2015). For example, there is consensus that care coordination utilizing interdisciplinary care teams tailored to member needs is a best practice for plans serving complex populations (Barth et al., 2019; Feldman, 2014; Kirst et al., 2017; McCarthy et al., 2015). In addition, CCA's model includes elements unique to CCA. For example, CCA expands on the interdisciplinary care team model by utilizing clinicians as care partners, consistent with evidence supporting the value of specialized care management. Moreover, it puts primary care in the center of care management (Feldman, 2014; McCarthy et al., 2015). Most notably, CCA supplements teams with BH expertise in response to member needs. While integration of BH has recently become recognized as desirable, there are as yet few models (to our knowledge) that have implemented it to the extent that CCA has.

It has long been evident that care coordination alone is insufficient for guaranteeing integrated, high-quality care: hence the focus on SDOH (or alternatively, health-related social needs) (National Academies of Sciences, Engineering, and Medicine, 2019). This is a critical part of the CCA model and, increasingly, other models serving high-cost, vulnerable populations (Sorbero et al., 2018). CCA is committed to ensuring that members have the food, housing, and transportation they need to be healthy. To further access these and other resources, the plan utilizes CHWs, a role that evidence has shown to be effective in improving various health and health-related outcomes in marginalized communities (Gibbons & Tyus, 2007; Kim et al., 2016; Sokol & Fisher, 2016), although some find the evidence mixed (Mistry et al., 2021) or of poor quality (Kennedy-Hendricks et al., 2021).

Another critical element is CCA's use of flexible benefits, which is particularly important for people with LTSS needs. The plan has always been committed to the creative use of services to support members' ability to remain in the community. While, for the One Care population, the use of flexible benefits is made possible by its participation in the FAI, CCA's ability to offer flexibility is also impacted by Commonwealth reimbursement policies; thus, its continuing ability to offer these types of flexibilities is questionable in light of the sunsetting of the FAI (which ends in 2025) and potential Medicaid cuts. Although there is limited evidence specifically addressing the use of flexible benefits for people needing LTSS, it is notable that these are a critical component of many programs serving the dually eligible population, such as many participant-directed LTSS programs (Sciegaj et al., 2017) and initiatives such as CAPABLE (Community Aging in Place Advancing Better Living for Elders) (Rosenblum & Rizer, 2023), indicating consensus on their value in the health policy community.

A further key element of the CCA model is the plan's close relationships with the communities in which their members live. In some cases, this means delegating responsibility for members to community-based providers (in addition to the state-mandated delegation of LTSS coordination to independent agencies). These arrangements build trust by enabling members to continue relationships with the providers who know them best.

From a policy perspective, CCA's close ties with community providers have the benefit of strengthening the organizational capacity of community-based organizations through enhanced reimbursement and staffing. In addition, because CHWs typically live and work in the communities they serve, their role exemplifies the plan's deep community connections and strengthens its ability to engage with diverse members. Given the passage of a federal budget that severely cuts the Medicaid program, however, it is likely that states such as Massachusetts with traditionally generous Medicaid programs will need to cut back. This retrenchment will likely reduce support for community-based organizations that rely on this funding for their operations, and for roles such as those of CHWs.

One of the more notable aspects of CCA is its integration of BH. This occurs at all levels of the plan, including the management level. A key mechanism is the use of BH clinicians to act as care partners for members with SPMI and/or SUDs; such clinicians may also act in a consultative role on care teams. Moreover, for some members, CCA delegates care management responsibility to provider groups with BH expertise, consistent with the health home model promulgated by CMS (CMS, 2024). All of these features are innovations deserving of further study, with implications for other managed care organizations aiming to better serve people with BH challenges.

These innovations respond to the high level of need among CCA's younger dually eligible population (while also benefiting the nearly 20% of SCO members with BH issues). Because this high level of BH need is not unique to Massachusetts, these mechanisms may be suggestive for other organizations aiming to integrate BH; however, this innovation requires further study. There appears to be very little data about the extent of BH integration within the Medicare Advantage program, much less any hypothesized outcomes associated with it. Moreover, to the extent that such integration relies on community-based provider groups (such as community mental health clinics that depend on Medicaid reimbursement), the ability to implement BH integration may be limited by provider shortages and clinic closures.

And lastly, while it is difficult to measure the impact of organizational culture, it is clear that CCA benefits from staff, management, and providers who are deeply committed to their mission of serving the complex members who enroll in the plan – and who, moreover, have appreciation for and expertise in working with these members.

CCA is facing significant challenges as it moves forward: respondents discussed a range of issues, from its need to improve its IT capabilities, to the implications of the end of the FAI, to the challenges associated with its small, non-profit status. A range of contextual factors also pose challenges, such as workforce shortages, the overall policy environment, and severe cuts to the Medicaid program. With these factors in mind, it is unclear whether some elements of the model that members currently enjoy, such as the flexible benefits and support for SDOH, will continue to be available in the near future.

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 practices in integrated care for complex member populations. For example, its patient-centered focus, use of interdisciplinary care teams, respect for specialized expertise, focus on transitions, and attention to SDOH needs. However, it also includes elements that are less typical: for example, the plan's integration of BH; its relationships with community-based providers; and its use of mobile integrated health. It was clear that the plan is deeply committed to its member populations, and that its organizational culture and procedures are centered around member needs. Overall, CCA displays an impressive record of innovation in its efforts to support the needs of its dually eligible members. While these innovative approaches have been historically critical to CCA's model of care, it remains to be seen whether these approaches can be sustainable in our rapidly evolving healthcare environment.

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