



# EXECUTIVE SUMMARY

## Member Experience in Commonwealth Care Alliance's Senior Care Options and One Care Plans

*Prepared for Arnold Ventures*

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*Research bridging policy and practice*



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## TABLE OF CONTENTS

Introduction.....	3
Method.....	3
Background.....	3
Findings.....	4
• Theme 1: High satisfaction with medical care .....	4
• Theme 2: Appreciation of non-medical benefits.....	4
• Theme 3: Relationship with care partners varied widely.....	4
• Theme 4: Overall appreciation for behavioral health supports.....	5
• Theme 5: Communication issues were key to member experience.....	5
• Theme 6: Members said they would not switch plans .....	6
Conclusion.....	6

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## Introduction

This report examines member satisfaction in Commonwealth Care Alliance's (CCA's) integrated care plans, which serve about 48,000 highly vulnerable individuals enrolled in both the Medicare and Medicaid programs (known as dual eligibles). The two plans are CCA's One Care plan, which serves members aged 21-64 years, and its Senior Care Options (SCO) program, which serves members aged 65 years and older. Dual eligibles are costly to Medicare and Medicaid due to their high levels of care need, thus motivating policymakers to encourage mechanisms, such as integrated care, to lower costs and improve outcomes. One of the most important outcomes is member satisfaction.

## Method

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

## Background

CCA is a health plan with a mission fundamentally shaped by its founders, clinicians who wanted to improve the lives of medically complex and highly vulnerable people. To do so, they aimed to center the plan around the needs of its members and provide the supports that enable members to live in their preferred environments.

CCA is committed to meaningful consumer involvement. It uses several mechanisms to ensure member engagement: first, through member communication with care partners and clinicians, facilitated by the care planning process; second, through structured member feedback via the formal grievance process, surveys, and focus groups; and third, through several member committees that meet to discuss plan issues, which then inform plan governance.

# Findings

Based on data from member focus groups, CCA members appear to be highly satisfied with the plan. Our research identified several key themes and subthemes.



## **Theme 1: High satisfaction with medical care**

Overall, members expressed high satisfaction with their medical care. Specifically, they were satisfied with *access to and quality of medical care* (1.1). Members appreciated the high quality of care and reported little difficulty obtaining access to specialists or services, specifically mentioning continuity of care as a plus. They also highlighted *appreciation for support in transitioning home* (1.2). Focus group participants noted how proactive the plan was in reaching out to them following a hospital stay or emergency department (ED) visit, making sure that members had the services and supports needed to stay home safely. Another aspect of the plan that members had nothing but praise for was *Mobile Integrated Health – the InstED program* (1.3). The InstED mobile integrated health program, which was launched by and is wholly owned by CCA, uses paramedics to provide urgent care in members' homes, under the medical direction of CCA primary care teams. Members who had used this service strongly agreed on its value.



## **Theme 2: Appreciation of non-medical benefits**

CCA members reported *appreciation of flexible benefits* (2.1). CCA provides a range of benefits that enable members to stay at home safely, which members valued. These include home modifications, durable medical equipment (DME), nonmedical transportation, and in-home behavioral health (BH) supports. SCO members receive an over-the-counter (OTC) card they can use toward the cost of medications or food. Members also appreciated *attention to social determinants of health (SDOH)* (2.2), including help with housing, food, and transportation needs. While transportation attracted considerable negative comments due to bad experiences with vendors, the availability of social transportation, such as trips to church or senior centers, was greatly appreciated by members.

Members also discussed *long term services and supports (LTSS)* (2.3). Members were generally happy with the in-home LTSS they received, and reported feeling that services were available if needed. However, they voiced confusion over the roles of the independent advocates who are meant to help them access LTSS. For SCO members, this is the Geriatric Services Support Coordinator, and for One Care members, the Long-Term Services Coordinator. Members also expressed a *desire for social connections* (2.4), reporting appreciation for the opportunities that were made available to them through the plan and talking nostalgically about pre-COVID opportunities.



## **Theme 3: Relationship with care partners varied widely**

Members are assigned a care partner, who is the member's primary point of contact, responsible for working with the member and the member's interdisciplinary care team to develop an individualized care plan, ensuring access to care, and arranging for necessary services. While these are mostly Registered Nurses and sometimes Advanced Practice Registered Nurses, members with significant behavioral health needs may be assigned a BH specialist (a clinician) as their care partner.

We found that although *many members had positive and close relationships with their care partners (3.1)*, some members reported *negative care partner experiences, typically due to not feeling heard, high turnover, or confusion about roles (3.2)*. Members with good relationships with their care partners were very positive about their experiences. Often, these same members reported that these positive care partner relationships had evolved over time. In contrast, members with negative experiences reported frequent turnover among care partners. Those with negative experiences also reported poor communication, with the care partners not demonstrating knowledge of their needs. Several said they did not know the names of their care partners.



#### **Theme 4: Overall appreciation for behavioral health supports**

Focus group participants were open in discussing their BH challenges and expressed *overall satisfaction with BH services (4.1)*, along with appreciation for their individual therapists. They specifically mentioned how well-connected their BH specialists were with their other service providers. Members felt their goals of *avoiding psychiatric hospitalizations were supported (4.2)* through therapy and through the availability of CCA's crisis stabilization capacity. Some members complained, however, about *high turnover among therapists (4.3)*.



#### **Theme 5: Communication issues were key to member experience**

One of the focus groups' dominant themes concerned communication issues. On a positive note, participants reported *good communication among providers and care team members (5.1)*. Many participants reported being impressed with how well the different parties involved in their care shared information. However, the theme of *communication between members and care partners being inconsistent (5.2)* also emerged. While some focus group participants praised how responsive their care partners were, others had difficulty getting in touch with them, which caused frustration. We found that members often referred to care partners as their care coordinators or advisors and demonstrated little understanding of care partner roles. However, it was evident that *language and cultural differences did not pose problems (5.3)*. Focus group participants from a range of communities reported satisfaction with CCA's ability to work with them in culturally and linguistically appropriate ways.

Despite positive elements, we found that *participants generally felt poorly informed on certain issues (5.4)*. Participants reported a poor understanding of plan benefits and provided varying reports of the information they received upon enrollment and thereafter. Some discussed the plan's online portal, with some liking it and others not. Participants also discussed *grievances (5.5)* reporting that plan responsiveness to complaints varied. Some were able to have situations resolved in good time, while others struggled. Only a few reported utilizing the formal grievance process, in part because other circumstances, such as health crises, prevented members from pursuing grievances. One focus group agreed that CCA consistently solicited member feedback at a governance level.



### **Theme 6: Members said they would not switch plans**

Although focus group participants raised various issues about CCA, when asked whether they would switch out of the plan, they nearly unanimously said they would not. Reasons for this varied: some said it was the people, others said they felt heard, some mentioned the broad benefits they received, and others voiced appreciation for their medical care. Some also expressed a sense of trust that CCA would enable them to get what they need.

## **Conclusion**

Based on data from focus groups, CCA members communicated broad satisfaction with the plan, with nearly all saying that they would remain with CCA if given the opportunity to switch plans. This suggests that CCA's efforts to engage members are, by and large, successful, and that the plan is responsive to members at both the individual and systemic level. Members are also highly satisfied with their medical services, specifically mentioning their primary care providers and the range of specialists to which they have access.

To some extent, member satisfaction is due to a variety of structural features made possible by the regulations surrounding integrated care in Massachusetts, which impact CCA's One Care and SCO plans' ability to offer a range of flexible benefits which CCA fully utilize. These benefits – including help with SDOH and BH needs– are critically important to and appreciated by this population.

The plan's ability to improve member experience is clearly impacted by the staffing shortages currently plaguing the healthcare system: members discussed turnover among care partners, BH providers, and LTSS staff. These day-to-day relationships have a significant impact on member experience. However, other areas of member dissatisfaction include organizational features that could be addressed, such as the plan's communication mechanisms and member confusion regarding staff roles.

Member satisfaction is bolstered by specific CCA innovations, as well as CCA's focus on certain aspects of the health care puzzle. One area of focus, for example, is on transitions from hospital to home, with which members were unanimously satisfied. Another innovation is CCA's InstED mobile integrated health service, which members also very much appreciated. In addition, CCA creatively deploys community health workers (CHWs), which impact both the quality of transitions (CHWs are embedded in certain hospitals' EDs) and the cultural competence of the plan. The most significant innovation, however, may be its integration of BH services, exemplified by the BH Specialist role, plan relationships with community-based providers, and the availability of its crisis stabilization unit, all of which members spoke highly.



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