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

Report Prepared for Arnold Ventures

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Research bridging policy and practice

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Introduction

This report examines the member experience in 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 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. In addition to improving health outcomes, it has been a priority to improve the satisfaction and well-being of people enrolled in integrated care programs – not least because people who are satisfied and engaged with their own care tend to have better outcomes more generally (Marzban et al., 2022).

What we did

This qualitative report is one piece of a two-part evaluation strategy of CCA's experience; the other component uses quantitative methods based on a longitudinal analysis of claims costs to assess plan financial and service utilization performance. Drawing on interviews with CCA staff and others, along with a review of plan documents and other publicly available information, we sought to understand the plan's operations and the factors that influence them; data collection took place from March 2024 to March 2025. Using purposive sampling to identify participants with expertise relevant to our research questions, we conducted key informant interviews with 22 individuals. They represented different aspects of plan management, such as external relationships, clinical operations, plan operations, and member engagement; we also interviewed three knowledgeable individuals external to the plan (two Board members and a Massachusetts policymaker). Interview protocols were tailored to the specific roles of the interviewees, drawing on a standard research protocol. We conducted focus groups to investigate the member experience; in all, we held 10 focus groups, one in Spanish, with 41 individuals, referred to using pseudonyms in this report and identified by plan. A more complete description of the research methods is included in a separate Methods Report. This report focuses on findings specific to member experience, mainly from the focus groups with members but also the key informant interviews. First, however, we provide background on CCA's approach to member engagement.

Background: The CCA approach to member engagement

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

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 Medicare-Medicaid enrollees. The Massachusetts FAI demonstration model, called One Care, was unique in focusing on the younger dually eligible population.

CCA enrolls a highly vulnerable population: about 16,000 in the SCO plan, and 32,000 in One Care. The populations are highly diverse: 30% have a language other than English as their primary language and a quarter are non-white. SCOs 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 serious and persistent mental illness (52%) and substance use disorders (35%).

CCA's founder, Dr. Robert Master, believed deeply in the need for "meaningful consumer involvement in all policy and operational levels" (Master et al., 2003). This meant a focus on engaging members at three levels: in their individual care, by setting out personal goals and participating as equal members of their care team; developing mechanisms for member feedback; and involving members in plan governance. This commitment persists to this day. Key informants described the plan's mechanisms for member engagement, frequently emphasizing that member buy-in is critical to health maintenance.

While CCA sees satisfying its members as a core goal, the emphasis on member experience also results from pressures external to the plan. Both the state and the Centers for Medicare & Medicaid Services (CMS) mandate various mechanisms to ensure plan responsiveness to member perspectives. Most importantly, plans are required to conduct a yearly Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which ultimately feeds into the plan's star rating[1] and may also affect plan reimbursement.

Ensuring individual engagement

Individual-level engagement functions primarily through member communications with care partners and clinicians, facilitated by the care planning process. A key informant described the welcome (intake) call to new members:

> *We've also revamped the welcome call in the last year to, instead of it just being an interview or feeling like an interview, moved the questions around and reworded the questions to make it feel more member-centric, so it's conversational… and they feel like they're not just being drilled, but they're having a conversation about their needs (Management, Engagement 1).*

[1] The star ratings system was developed by CMS. It rates Medicare managed care and prescription drug plans on a 5-star scale, with 1 being the lowest score and 5 being the highest score. Ratings focus on health plan quality based on measurements of customer satisfaction and the quality of care a plan delivers. Plans that perform well may get a 5% quality bonus adjustment payments and benchmark reimbursement increases.

This welcome call is for "making sure that [members] understand their benefits, making sure that they know where to call when they need something, that CCA is here to provide anything that they need, that we're not just your health plan, but we're also here to help you" (Management, Engagement 1).

The welcome call is then followed by a full assessment used for care planning. The script for this was piloted with members:

> *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 members' needs (Management, Community Services 1).*

When discussing the extent to which CCA has traditionally been led by member needs, one key informant told this story:

> *[The state] came in and did an audit and CCA routinely use their care plans as a care management focus, meaning the goals and opportunities that were listed were around managing care. It may not have touched their diabetes. It may not have touched that they've got heart failure. She [state auditor] just came in and looked at it 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 (Management, Clinical 2).*

Systematic mechanisms for feedback

Critical sources of information on member experiences include the complaints they make, the formal grievances they lodge, and the reasons they give for leaving the health plan, all of which are tracked by CCA. A key part of this is ensuring that members are aware of their right to lodge formal grievances. One key informant described efforts to inform members:

> *In our call center, our reps are actually trained. If someone is complaining, you do offer them the opportunity to file a report, right? So that we can more formally track and document these types of things. Although the customer service rep is going to document what you were saying, and then it's up to the member, it's their 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).*

Once a formal complaint is lodged, the process is highly regulated. Complaints about denials of Medicare benefits, for example, are handled under regulations and within time frames set by CMS, while LTSS appeals are handled by MassHealth in a similarly proscribed way. Data on complaints and grievances are collected and often discussed in the member councils discussed below.

Key informants also mentioned periodic member surveys, some of which are mandated by CMS, such as the yearly CAHPS survey. In other cases, the surveys assessed member responses to specific tools used by the plan, such as the welcome script for new members, to identify issues that the plan needs to address or to understand reasons for disenrollment. One key information said,

> *What we're relying on now… is working in conjunction with our member voices team, and they will do interviews with members. They do it as part of the member journey mapping process, but it's really like a survey. It's qualitative to figure out, are you feeling like your needs are being met? (Management, Community Services 1).*

To some extent, member engagement is propelled by regulatory pressures from the state or CMS. As one key informant said, "There was a project that we did around care planning and the assessment that went into that. That was driven primarily by the state, because they've gotten a lot of feedback from members about the care planning process" (Management, Engagement 2).

Key informants also mentioned focus groups conducted to gather feedback on specific topics, including obtaining data to elaborate on results from the CAHPS survey or in response to issues identified by the state. They also aimed to clarify quantitative findings detected by CCA analysts, such as underutilization of specific benefits.

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

> *I know we are the experts -- so we think -- but have we allowed members to have input? So 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 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.

A key informant described the Member Voices Program as follows:

> *Our process is set up to make sure that the council and their feedback have this loop with kind of key businesses that we identify -- bills and grievance being one, clinical being one… So we only meet the councils quarterly, so four times a year. So one quarter, we might be looking at appeals data or grievance data, trend data from clinic. Maybe there's something a lot of people are asking for authorization about. Or they also use those opportunities when they want to get input about changes to benefits or underutilization of certain benefits. The business will come back and say, hey, can we talk to members about why they're not using this benefit? (Management, Engagement 2).*

Additionally, two committees facilitate the plan's engagement with advocates and the members they represent. The first, the Advocate Advisory Committee, meets monthly to gather feedback from advocacy organizations that represent CCA members. Meetings are topic-specific and more policy-oriented than Member Voices Program discussions. The second committee is the Consumer Voice Advisory Council, which serves as a subcommittee of the board and includes both provider representatives and consumer advocates. Its role is to advise the board on specific activities.

As one key informant said, "Members are going to be your canary in the coal mine, right? They're going to be the first ones to signal that something is not what we think it is" (Management, Engagement 2). However, it was acknowledged that participation has not been evenly distributed across CCA populations: securing representation from SCO and people with serious and persistent mental illness and substance abuse disorders has been challenging. The same respondent added "there's a lot to prioritize, but I think we do a good job of getting members' input into almost any and everything" (Management, Engagement 2).

Member perspectives

The mechanisms for member engagement described above are only part of what CCA does to serve its members: these mechanisms aim to support its primary function of delivering quality care, ultimately resulting in member satisfaction. This study finds that overall, focus group participants (referred to below using pseudonyms and identified by the plan in which they are enrolled) were highly satisfied with the medical care they received (*Theme 1*). Participants also appreciate the range of non-medical benefits they receive through the plan, including flexible benefits, help with SDOH needs, and LTSS needs (*Theme 2*). One of the key strategies for supporting members is the role of the care partner (i.e., care coordinator, advisor). However, participants reported varying experiences with their care partners (*Theme 3*), in some cases finding them to be knowledgeable and supportive, in other cases being frustrated by care partners who were unresponsive to their needs.

Other aspects of care were also appreciated by respondents. Members with BH needs reported being highly satisfied with the help they received (*Theme 4*), although turnover among providers was reported as common. Regarding communication, participants were impressed by communication among providers and care team members; however,

communication between care partners and members was inconsistent (*Theme 5*), with some participants reporting good communication while others found communication frustrating. Overall, members said they were satisfied with CCA, saying that they would not switch plans if given the option (*Theme 6*).

Theme 1: High satisfaction with medical care

Overall, members reported high satisfaction with their medical care, mentioning the full range of medical providers, including specialists and hospitals. Members expressed appreciation for both their ability to access care and the quality of services received. One said, "I just feel confident with them, as far as my choices of doctors and other medical providers" (Eleanor, One Care). Participants particularly valued the support they received when transitioning from hospital to home.

1.1: Access to and quality of medical care

Overall, focus group participants had high praise for their medical providers, both in terms of provider quality and access: few respondents mentioned problems with providers being out of network or being denied authorization for physician referrals. One said, "Nephrologist. Amazing. Oncologist. Amazing. Dermatology. Three specialties. Amazing, amazing, amazing" (Sofia, One Care). In some cases, members explicitly attributed this to the continuity of care that CCA seeks to ensure through its contracting practices. One said,

> *I've been going basically more than half my life at that same doctor's. I mean, they've moved a few times, but I got to stay with the same doctor and everything like that. All my specialists, they're all amazing. And they all jump through hoops to make sure I got what I need (Serafina, One Care).*

Another commented that the plan's provider network did not appear to restrict the providers they could see:

> *I had no problem with anybody saying, "Oh, you know, we don't take CCA for hospital," or of course I'd take it because I have Medicare. But my primary stayed the same, and some of the other specialists stayed the same. So, there was really no problem (Leslie, One Care).*

Nor did authorization requirements typical of managed care plans appear to restrict access to services, according to another participant:

> *I can honestly say that any dental work that I've had to have has been submitted and approved. I've never had issues with anything. I've never been denied for anything that any specialist recommends, or just [a] regular doctor has recommended as a procedure (Miles, One Care).*

One participant specifically mentioned the high level of expertise with complex care exhibited by providers.

> *I guess there's, like, because they're so familiar with people with disabilities, there's less of a need to almost justify certain things. I feel like they understand certain things…. For the most part, that feeling of they kind of get where I'm coming from (Gabriel, One Care).*

Participants also spoke highly of the plan's generous benefits coverage. One said, "I noticed they do offer more things than what I had before" (Serafina, One Care). Another said, "I'm overwhelmed by what they cover. And the fact that there were no co-pays and the meds that I'm on are all covered 100%" (Miles, One Care).

1.2: Appreciation for support in transitioning home

After a hospital stay or emergency department visit, the transition home is a crucial period for patients; inadequate support can mean another hospital visit. CCA members appreciated the plan's organization and attention to detail in supporting these transitions. They felt prioritized and assured that CCA would be there for them. One explained,

> *It was really good. You know, I was seen, and they called me, I think, within 24 hours and asked if I needed to go see my primary or if I needed to see a specialist and it was fine… anytime that my head or neck is involved, um, I always go to the ER [Emergency Room] because… before I didn't do that, then I ended up with a brain injury. So yeah, they were great. They called me right away. Is everything okay? Do you need anything? … So that was like, wow. That was great (Leslie, One Care).*

Another member shared,

> *So, you know, I had the hernia operation last spring, and she called me like two days after the surgery to ask me how I was. And I was a little dumbfounded… she was right on top of it, you know, making sure that the procedure went well, and I was doing well. And if there was anything that was needed by me, you know. All in all, it was just another feather in the hat of being very pleased with their overall performance (Miles, One Care).*

That same member said that CCA providers were "like a family" because they "like to see how you're doing and make sure that you're doing well both physically and mentally."

1.3 Mobile Integrated Health – the InstED program

Another service CCA offers is InstED, a mobile integrated health program. Launched in 2014 and wholly owned by CCA, it uses paramedics to provide members with urgent care in their homes, under the medical direction of CCA primary care teams. Members reported appreciation for the care received through this service. One focus group participant brought this up unprompted, stressing how glad she was to avoid a trip to the emergency department:

I wanted to make a comment, that CCA has something called the InstED Department… They have their own department with virtual emergency doctors. Like telehealth, you know? It's not like you're going to physically go to them…. But there are doctors there, doctors trained to work in the ER department, who do it virtually… I've called them like three times to see me when I don't want to sit in a hospital and wait in the ER for four days to be seen. The first time when I told them that I had fallen, I fell two more times… and they came, they even brought the EKG [electrocardiogram] machine, to do an EKG on me at home (Aria, One Care).

This story prompted others to speak up. One added, "One night I was in pain, and I was really worried about this problem. They came to my house, and they really helped me" (Leo, SCO). Another said, "Yes, yes – I've used it quite a bit. I got, what's it called? I got dizzy, so they came to my house, gave me oxygen" (Ava, SCO).

Members who had used this service strongly agreed on its value. As one said, "Yes, excellent, excellent!" (Claire, SCO). In response to this, another focus group participant said, "Why do I want to go to an emergency room? Let them come to me!" (Priscilla, SCO).

Theme 2: Appreciation of non-medical benefits

The medically complex and vulnerable population enrolled in CCA needs not only excellent medical care, but also a range of non-medical services and benefits to enable them to live safely in the community. These services include flexible benefits such as air conditioners to maintain safe body temperatures, as well as help with SDOH needs such as food, housing, and transportation. In addition, many members need help with basic activities of daily living, such as eating, bathing, and dressing.

2.1 Appreciation of flexible benefits

Under the FAI demonstration, One Care members have access to flexible benefits not otherwise available through the state's Medicaid program. These include home modifications, durable medical equipment (DME), non-medical transportation, in-home BH supports, and BH diversionary services (Justice in Aging, 2023). The benefits are greatly appreciated by members. One said,

CCA does support a lot of like out of the box type of things. So, I got acupuncture before and I don't think that's something that everybody is supporting of. I've had nutrition help, which I'm sure that's supported other places. But I just feel that they're on board with certain things that other places may not be (Eleanor, One Care).

SCOs also have access to flexible benefits. As one member said,

I have COPD [chronic obstructive pulmonary disease], and they've supplied me with a nebulizer, they've supplied me with air conditioning… oxygen in the house and portable oxygen, for when I leave the house and in my vehicle. Like I've said, they've been very good. I can't say enough about them (Perry, SCO).

One especially popular benefit for SCOs is the over-the-counter (OTC) card, which provides members with a fixed amount every quarter ($425) to purchase food and medicine. One respondent commented that,

> *The OTC is a great help. Because not everybody has food stamps. So, OTC comes right back, helps you with food… So, even though we take medication if you don't have food, it's a problem… And then not everybody can have a food stamp (Alex, SCO).*

2.2: Attention to social determinants of health

This flexible approach aligns with the plan's focus on addressing SDOH needs, which CCA considers critical to maintaining members' health. For example, one CCA manager talked about the importance of transportation, saying that it:

> *Impact(s) engagement and access, right?... 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... 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).*

Similarly, key informants emphasized the importance of stable housing in maintaining health, as well as access to food via the Supplemental Nutrition Assistance Program (SNAP) or referrals to community food pantries. The same key informant went on:

> *What resources are available? Let's educate you on that so that you can choose what works best for you. And supplementing it with other resources in the community… We want you to know what those resources are and to be happy to use them (Management, Community Services 1).*

This stress on SDOH was appreciated by members. For example, in one focus group, participants agreed that CCA had checked on whether they had the food they needed; those who mentioned a need reported receiving help in applying for SNAP and/or were referred to community resources. One participant said,

> *They would ask me, you know, do you need this? Do you do that? They would just make sure that I knew all the things that were available to me at the time. And so yeah, they helped me get the food stamps. They helped me just do the applications (Gabriel, One Care).*

Another commented that the plan was

> *Comprehensive in the sense that they care about the person as a whole. Your life as a whole – not just your medical appointments or if you're seeing doctors and if the doctors are covering you – medical transportation, and social transportation. They care about everything. For example, here at [CCA's primary care health] Center, the administrator here cares if you need help with apartment applications, applications for any resource, or anything (Adriana, SCO).*

While most respondents indicated that the topic of food access had been discussed, not all recalled being offered help with housing. However, some noted that any such offer would be irrelevant because they were appropriately housed.

Transportation was a SDOH need that focus group participants discussed the most, and the one that attracted the greatest volume of negative comments. Indeed, one commented that his problems with transportation were what prompted him to participate in the Member Voices Program: "I was having issues with transportation. And a lot of people were having issues with transportation, and that was what the impetus for the entire thing was" (Christian, SCO).

These negative comments primarily focused on the transportation vendors with which CCA contracts. However, several respondents noted that transportation issues are "not really CCA's fault. It's an outside transportation company" (Eleanor, One Care). This participant added, "Sometimes it's great, but sometimes… I would hope they could vet those contractors… Vet them a little bit stronger. Because [for] some of them, it's a scary ride." Another participant went on to say, "I've had two really concerning one[s] where my driver was falling asleep" (Gabriel, One Care).

The biggest complaint centered on the unpredictable timing of pickups and drop-offs. One focus group participant recalled,

> *And they never showed up… I was having some dental work done… And I call them when I came out. "Oh, we'll be there in 10 min." 10 min come and go, and then it was an hour, and then it was two hours, and I say, "Well, where were you?" "Oh, it was traffic." Two hours in traffic? Really? (Christian, SCO).*

However, participants also noted that CCA was responsive to complaints about vendors, reporting that vendors were changed on request. One commented, "I have never really had any problems except for the RIDE [Boston's paratransit service] and they fixed it for me" (Amelia, One Care).

Many participants also expressed gratitude for the availability of transportation and were pleased with the service. One said, "I use their service, too, for my appointments. They're pretty good" (Jill, One Care). Another agreed, saying, "I get all my rides to my doctors and they're fantastic" (Bruce, One Care). One was happy she could access Spanish-speaking

drivers (Aria, One Care). And yet another said, regarding CCA more generally,

> *I'm thoroughly happy and the extra things that are offered that I've taken advantage of, a couple of which, as an example, rides to doctor appointments if you're unable to drive yourself, or like if I had a colonoscopy and I wasn't able to drive. It's a lot easier to hook up with a CCA ride share than have to depend on someone to take a day off from work and be there for you. So that's a strong plus as well (Miles, One Care).*

One respondent said that the availability of social transportation is what convinced her to join CCA:

> *I had insurance that covered everything, my medical transportation, but I'd never had social transportation. And so, like my family, everyone was working, I lived alone… I had never heard of the company, or asked or anything. [A CCA sales agent] called me and said, do you want to change?… I told him, tell me everything you have, and as soon as he told me we provide social transportation, I said, "I'm going with you" (Aria, One Care).*

Overall, focus group participants appreciated their access to both medical and social transportation benefits.

2.3 Long term services and supports

A high proportion of CCA members have significant LTSS needs, which include help with activities of daily living such as eating, bathing, and mobility, as well as help with instrumental activities of daily living such as help with finances or shopping. In addition to the more typical LTSS, the One Care program includes coverage for cueing [reminders] and supervision for certain members, a benefit that is particularly valuable for people with BH needs and is not typically available under Medicaid. A key informant described this benefit:

> *Through the [One Care] demonstration, we've been able to provide an expanded version of [the] Personal Care Attendant (PCA)… offering people support who need just cueing and supervision or cueing and monitoring…. 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 (Policymaker).*

Many respondents reported their gratitude for the in-home services they received. One said,

> *I have two PCAs in my house. They got all of this for me. It's terrible, if I didn't have that help from the PCA, I don't know what... Maybe I'd be alive, but I'd be going through a difficult time (Leo, SCO).*

Another said, "They have good home care too. It's fantastic" (Bruce, One Care). One participant said, "She's my support, she's my – everything, she does everything for me" (Nadine, SCO).

Some, however, noted problems with finding the right person and high turnover among home care staff:

> *I had to go through a few companies and girls before I finally found one that was good at what she does. And you know. I have them for about a year and a half, and then they move on, and then the look starts again (Priscilla, SCO).*

Others reported awareness that services are available if needed. One said, "The offer is always there. I'm probably more thick-headed than most. So I opt out of any in-home care but the offer is always there" (Miles, One Care).

To ensure that members have access to appropriate in-home supports, all One Care and SCO plans in Massachusetts are required to contract with independent organizations – typically Aging Service Access Points (ASAPS)[2] or Independent Living Centers (ILCs)[3] – for coordinating LTSS. Those enrolled in SCOs are assigned a Geriatric Services Support Coordinator (GSSC), while One Care members are offered a Long-Term Services Coordinator (LTSC). Respondents reported confusion when asked to identify their GSC or LTSC and appeared to have limited understanding of the role. While some participants clearly worked with a GSSC or LTSC, few were able to articulate what they were responsible for or how they fit into the care team. The following exchange was typical:

> ***Interviewer:*** *So that person is responsible for figuring out who's coming into your house and helping you with [in-home care]. Is that the person you're talking about?*
>
> ***Gabriel (One Care):*** *Yes, I'm talking to her on a regular basis.*
>
> ***Interviewer:*** *Is she attached to a center for independent living or something like that?*
>
> ***Gabriel (One Care):*** *Good question... I'm not absolutely sure, but yeah, I apologize. Yeah, I should --*
>
> ***Interviewer:*** *So she helps you get all the support you need?*
>
> ***Gabriel (One Care):*** *Correct… I do my LTSS with [my local ASAP], and then CCA chimes in.*
>
> ***Interviewer:*** *What about your medical needs? So when you talk to your care partner, you know, you need help with seeing a doctor, getting a test or getting a bill?*
>
> ***Gabriel (One Care):*** *It is still her. So maybe she is my care partner. Maybe I just don't know that that's her title. It's possible… Because I know she works for CCA.*

[2] Massachusetts operates 24 regional Aging Services Access Points (ASAPs) that coordinate services such as in-home assessments, care plan development, home care services, caregiver support, and provide free information and referral services. ASAPs are private, non-profit agencies contracted by the state to deliver services to residents.

[3] In Massachusetts, Independent Living Centers (ILCs) offer information and referral services, peer supports, skills training, advocacy, and help consumers access to the state Personal Care Attendant program, as well as other in-home services. ILCs are community-based non-profit organizations run by people with disabilities.

It was evident that members had little understanding of the GSSC or LTSC roles.

2.4 Desire for social connections

Although this topic was not included among the standard questions asked of participants, some raised the issue of social isolation and their need for structured forms of socialization. In one focus group, participants recalled different social groups they had participated in pre-COVID -- in particular, a nutrition class that they had enjoyed. One said, "So I used to actually go to a nutrition class at the CCA building" (Eleanor, One Care). Another said, "Yes, I remember that" (Gabriel, One Care). The first person continued:

> *That was nice to kind of get out and socialize. And learn more about things, you know, with my health… We'd work in groups. We'd create meals, like a meal idea, like healthy meals, and just a lot of different discussions.*

One existing mechanism for socialization is the plan's Member Experience Centers, which are located in Boston and Springfield and house CCA primary care practices, offering space for consultations and group activities. One participant discussed how much he enjoyed an activity hosted in the Boston Center:

> *[My case manager] interviewed me before I came here. I said to her, I like to draw, sketch pictures, and she said there's an art therapy every Thursday, so I used to come here just once a week on Thursdays for art therapy. So, [XXX] said, we opened five days a week…. So, now, I come here three days a week… I have no issue with this place. I'd rather come here than go to [another center] (Samuel, One Care).*

Others joined in, mentioning how much they enjoyed holiday celebrations and other activities hosted by the Center. Other focus group participants mentioned that they would welcome group therapy meetings for members.

In another focus group, a participant raised the idea of peer supports among CCA members:

> *I think there should be also scheduled calls, group meetings for this stuff, you know, to go over, especially with people with disabilities. The gentleman [another focus group participant] that's on the phone with us, I got like 15 things that I can help him with (Bruce, One Care).*

Overall, it appeared that members desired opportunities for social connections.

Theme 3: Relationship with care partners varied widely

A critical member of the team is the "care partner," whose role is analogous to that of a care coordinator in other plans, although the role differs in important respects. The care partner is the member's 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 necessary services. Every member is assigned a care partner.

Although the discipline and precise role of care partners vary, they are typically clinicians (often Registered Nurses and sometimes Advanced Practice Registered Nurses) with expertise in a member's specific issues. When BH is a member's primary issue, they are assigned a BH specialist (a clinician) as their care partner.

A focus on connecting members with clinicians with expertise in specific issues ensures that members work with individuals who understand their often-complex care needs. In the SCO program, the care partner may be the member's primary care provider (PCP). This centering of PCPs in care management is a clear illustration of CCA's "primary care-driven" approach. Members often referred to care partners as their care coordinators or advisors but demonstrated little understanding of care partner roles. Moreover, relationships with care partners varied widely.

3.1 Many members had positive and close relationships with their care partners

Many respondents expressed satisfaction with their care partners, reporting that the care partners understood their needs, listened to their concerns, were responsive, and proactively addressed any issues. These positive experiences foster trust between members and their care partners, which one member appreciated.

> *She's really good. She hugs me...she comes and talks to me…I tell her if I need things and so on. Really good people. They trust me, and I trust her (Ava, SCO).*

Participants shared how knowledgeable their care partners were in addressing their health issues, as was the case for one member.

> *They familiarize themselves with you. And you know, what things you've gone through or what you need. You know I mean, like, I've been pretty bad[ly] beaten up. But they're good…they have a better understanding when they talk to you (Perry, SCO).*

Many reported feeling that their care partner understood their needs, a process that was facilitated by the initial assessment, where member needs and goals are determined. When asked whether she felt her care partner understood her needs, one said, "Yes, she did. She did a good job of it. She asked me a lot of questions" (David, One Care).

Similarly, another participant appreciated how proactive his care partner was in addressing his vision issues.

> *My coordinator… she's fantastic. Right off the bat, we started talking about my disability, my vision...We didn't even get to have our first meeting. We just talked over the phone via voicemail before our first call, and she already gave me a list of eye doctors… that was very proactive and nice of her. That was fantastic (Bruce, One Care).*

A key factor that appeared to influence member satisfaction was the stability of the care partner relationship.

> *She's been with CCA for quite a while. So, it's not like I get a different person every six months. So that speaks volumes as far as the company itself… And when she's talking to me, it's like I'm her only patient. And that's very comforting. And anytime I've had any specific issues, she immediately goes to bat for me. I had a problem last fall... [and] she really went above and beyond (Leslie, One Care).*

Another mentioned, "since I've been at this apartment, I've had the same care partner. It's just really helpful because sometimes I lose track of things, and she already knows" (Eleanor, One Care). This trusted relationship enabled Eleanor to work on goals important to her:

> *Every six months or something… we go over my goals, like what I want to see with my health… [This year] I've been working on regulating my blood sugar. That's the goal and she's been helping me with that. With my doctor and everything so it's been good.*

Care partners are responsible for the assessment and care planning process, which members felt facilitated mutual understanding:

> *I thought it was really good. I thought it was a little bit intrusive, some of the questions... And I kind of got over it. And I knew that their intention was good, like their intention was to make sure I was getting all the help I need.… when I sat down and thought about it, I'm like, wow, plus I got a care plan, which was really cool. So, I'm very, very impressed with CCA (Leslie, One Care).*

Similarly, another member shared how he felt listened to by his care partner when it came to his health, which was not always his experience with other healthcare workers.

> *I've never really had a relationship with people who I consider in the medical field or with my health [until CCA]. I've always felt like I kind of just listened to what they said and then went back home, and then [they] didn't talk to me until my next annual physical....I just texted [my care partner] two days ago...and she got back to me about my annual (Gabriel, One Care).*

3.2 Some members reported negative care partner experiences, typically due to not feeling heard, high turnover, or confusion about roles

Conversely, some members reported negative relationships with care partners. They felt care partners were sometimes unresponsive, didn't listen to them, or didn't know them due to high turnover rates. Some also reported not understanding the role of a care partner.

One member reported that she did not feel listened to by her care partner.

> *She doesn't check in with me and then when I reach out to her, she's always like, oh, do this yourself. I'm like, I'm reaching out to you cause I don't know how to do it or I need help…. Like I understand I'm an adult and I should know this, but I have a learning disability. I don't know, I have trouble understanding certain things and she won't help me (Serafina, One Care).*

Another said, "I thought [the plan of care] was sent to me by mistake… the only thing on it was transportation, which we didn't talk about at all. I have a car. I don't need transportation" (Sofia, One Care).

A topic that attracted many negative comments across focus groups was the high turnover among care partners. As one member shared:

> *I had...four care partners. The second one, I was having problems with my dentist, and I asked her to help me, and she said she could not help me, and I had to deal with it myself. And then I had my third care partner, and I mentioned that and a couple other issues. And she said she would look into it. And a couple months later, I heard from her to tell me that due to a change in personnel, she would no longer be my care partner, so I had a new one (Simon, One Care).*

Another said,

> *I think that they're burnt out, and they stretched them. They got a heavy caseload. And they need more where they can accommodate the heavy load of clients. You know it's like you can't be everywhere and everything to everybody. So somebody's falling through the cracks (Claire, SCO).*

This frequent turnover meant that members were sometimes unsure who their care partner was.

> *I get a lot of phone calls that they keep saying, I'm your advocate or caseworker, but I get like, ten of them, they keep switching. They keep changing...So I don't know who it is now, they keep changing representatives (Ernest, One Care).*

In one focus group, which comprised members with severe and persistent mental illness and substance use disorders, nearly all reported not knowing who their care partners were (based on a show of hands). Participants also expressed confusion around the role of care partners. As one participant from this focus group said,

> *The only thing I know is her name. I haven't seen her, I've never met her in person. Like what? What is that supposed to do? I don't know who I'm speaking to. I don't know what she looked like, I don't know anything except her name (Melody, SCO).*

It was evident that CCA's contractual relationships with different providers sometimes led to confusion. One participant said that his care coordinator was through the Behavioral Health Network (BHN). He said,

> *BHN is [the] Behavioral Health Network. They're located all throughout and there's a partnership between the two, CCA and BHN. That's, I think, where confusion is with these coordinators because they actually work for BHN and not CCA, which is, I still don't even understand how that works, but it is what it is (Bruce, One Care).*

Theme 4: Overall appreciation for behavioral health supports

Given the high proportion of One Care members with BH concerns (and the smaller but still significant proportion of SCO members with such concerns), integration of BH services is critical. Focus group participants were open while discussing their BH challenges and overall expressed satisfaction with BH services.

4.1: Participants were satisfied with their behavioral health services

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

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

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

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

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

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

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

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

4.3 Behavioral health provider turnover was seen as an issue

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

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

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

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

Theme 5: Communication issues were key

5.1 Good communication between providers and care team members

Many participants reported being impressed with how well the different parties involved in their care shared information. One said, "I never have to update my PCP or anything like that, seems like everything just is connected" (Eleanor, One Care). She continued,

> *I just feel like there's so much CCA has done to kind of make communication a lot easier. So, like with my doctor… somehow he's always caught up to date [with] my PCP… So, as far as, like, how it's all connected, I'm not really sure (Eleanor, One Care).*

Another member said, "All my specialists and my counselor, everything, they all communicate with each other. Everybody knows what's going on" (Serafina, One Care).

5.2 Communication between members and care partners being inconsistent

While some members praised how responsive their care partners were, others had difficulty getting in touch with them. One said, for example, "Most of the time you have to leave a message for the care partner… They don't call you back, you see. So that's the problem with the care partners" (Alex, SCO).

One member described his frustration:

> *I got a letter saying they're trying to contact me, CCA. There are no missed phone calls on my phone and no voicemails. Yet they say they're trying to contact me. I don't know how they're trying to contact me, but like I said, no voicemails. And no missed calls. And I tell them it's a landline. So I can't accept texts. And I do not text anyways. I've been through this countless times (Robert, SCO).*

This member also complained that "I'm hard of hearing. I use hearing aids and all I could make out of the entire message was 'all'… And I told her, you're very soft spoken… I can't hear your voicemails" (Robert, SCO).

Another complained, "Well, she seems like she doesn't listen, you know? I mean, I need to be heard… my care partner… [would] keep talking more than me, you know? I don't like her. I never call her" (Ernest, One Care).

Several participants reported workarounds. As one said, "I don't want my care partner. I avoid her, just like I avoid the hospital. But I use the other services, I talk to [XXX], I talk to my therapist" (Delia, One Care), indicating that members have other avenues of communication.

Another recounted,

> *Well, the care partner. If you can find the care partner, and if she answers. That's one thing, but my care partner has changed a few times. And I think it was [XXX] -- I'm not sure. I haven't talked to her for a while. Because usually I kind of go in the back door, and I talk to whatever. I want transportation, I call transportation. I'd want somebody else. I call somebody else; you know. That type of thing. I don't often go to the care partner as such, because like I say, it's difficult to leave a message. And hopefully, we'll call you back in the next 48 hours, or whatever (Christian, SCO).*

Conversely, some focus group participants reported no communication issues. One said, "Yeah, if I call and I can't remember, I just call the number and then it says, oh, your liaison or your caseworker, I think they call a caseworker or whatever, and I'm switched right to her. So, I've never had any issues whatsoever" (Leslie, One Care). Another said it was easy:

> *I schedule a time with mine. We already worked that out… if we need something, we call each other. That's the way it should be. You know, reach out if you got an issue. They're going to be there for you (Bruce, One Care).*

Respondents particularly appreciated regular check-ins. One noted, "They always call and ask if I need anything" (Tobias, One Care). Another wanted more frequent contact: when asked what CCA could do better, he replied, "Call us more often. I get calls maybe once a month to check up on us. I should get more calls than that" (David, One Care).

5.3 Language and cultural differences did not pose problems

Focus group participants from a range of communities reported satisfaction with CCA's ability to work with them in culturally and linguistically appropriate ways. For example, when a Haitian participant was asked whether he and his wife (also a member) were able to find doctors who understood their background and culture, he responded positively:

> *Sometimes they want to communicate directly with her [rather than use him as a translator]. You see, so they use their own [translator]... So, it's not a problem. Sometimes, when they want to communicate with her.… they also send [a] nurse. Some nurse speaks the same language, like a French Creole. And this is not a real issue" (Alex, SCO).*

The cultural competence of the plan was evident during the Spanish-language focus group, where it was notable how intertwined the plan was with community members. While one mentioned a community member (a community health worker) introduced them to the plan, another said:

> *Yes, my daughter told me, my daughter who was already enrolled in the program, and she said, Mommy, sign up for CCA, it's a really good insurance. So, then my other daughter, who works with doctors, told me too. And then I talked to my brother, who was in before me, and he said, that insurance is really good. And my nephew, so my niece... She was the one who did the intake for me; just like with him, she did the intake for him too. She works for CCA too (Adriana, SCO).*

In other words, the participant's niece was a CCA care partner. Another (Aria, One Care) commented that cultural competence extended even to transportation services, as she was able to request Puerto Rican drivers.

5.4 Participants generally felt poorly informed

Participants reported a poor understanding of plan benefits. When asked what information they received, upon enrollment and thereafter, one said,

> *To tell you the truth, that's one thing they didn't give me. I had to inquire myself. I didn't get the full information, I didn't get to sit down, and [the] individual attention that's indicative of a new health insurance thing. Yeah, because I was going through some traumatic stuff, cancer… I just recently heard about [a community food pantry] … but I'm saying, I didn't get that information until my fifth year almost. And I'm thinking, you know, people should have put that out first and foremost (Ernest, One Care).*

When asked about the initial assessment, one said she wasn't asked about her needs or informed about benefits. She said, "This is what you're going to be having and that's it. I found out more about my dental benefits when I was in my dentist's office waiting room one time" (Sofia, One Care).

Some members of one focus group liked the idea of a pamphlet containing important information. "I think it would be great if CCA generated a pamphlet telling exactly what they do and don't do" (Simon, One Care). Another built on this, saying, "A pamphlet would be nice" (Melody, SCO).

In a different focus group, a participant said, "No, so they never came out and talked to me, but my dad's girlfriend's on [CCA], and they came out and talked to her. I went to her house at the end of the meeting, and I learned a little bit" (Serafina, One Care). Another said,

> *CCA sends us a letter. So, I've read that, and they give you a list…, but that's just information about your cost and what they're serving you, what you're entitled to. It doesn't tell me about [One Care] and all the other stuff (Delia, One Care).*

Meanwhile, another complained "so much paper [is] sent to me that I don't even need to know about" (Sofia, One Care). In one focus group, a newsletter was mentioned, but not all participants remembered receiving it.

Several commented specifically on the plan's online portal. Some liked the convenience:

> *That's like their own personal email sort of. And it goes right to member services, and whenever I can't get a hold of somebody, or I need advice, I am on that portal. I'm not gonna wait for somebody to pick up the phone and blow me off. I'm on the portal…. Then I have a paper trail. I like having a paper trail (Priscilla, SCO).*

While another participant thought the portal could be more useful:

> *I would like to see… a better portal in terms of where we get information. They have a CCA portal that I use, not frequently, but I can see all my connections in terms of LTSS…. But if they had a better portal where we could put information in and use it on a daily basis. Sort of like the MyChart [XXX] had mentioned earlier, and see our appointments and see just another way just to organize things. That would be awesome (Gabriel, One Care).*

Overall, respondents mentioned frustration in communicating with the plan and understanding the benefits they were entitled to.

5.5 Grievances

Participants reported that plan responsiveness to complaints varied. Some were able to have situations resolved in good time, while others struggled. For example, complaints about transportation received appropriate action, according to one respondent. When asked whether CCA was responsive to complaints, one participant answered,

> *Absolutely, but I'm not sure what they did in terms of the first situation. But the second situation, they did remove that vendor from my file so that I would never work [with them] (Gabriel, One Care).*

Billing issues seemed the hardest to get resolved. One participant told a story of trying to get a bill paid:

> *So this went back and forth. I would call CCA and I would explain the situation… and they're, oh my gosh, that was approved, blah blah, then it should have been paid. I'll make a note. They're all set. Thanks. Two weeks later, I get a bill. I'm like, oh, come on. I mean, it got to the point, I went through this at least six months, if not more (Sofia, One Care).*

Only a few participants said they had utilized CCA's formal grievance process, although one (Claire, SCO) said she had used it "over 50 times." When asked whether the situations were resolved, she said, "It just doesn't happen again. But, you know, it is what it is. I am so happy that I get what I get. Just like, don't rock the boat."

Participants highlighted that they sometimes didn't feel like complaining, given their health or other situations. As one said,

> *I was just really too stressed out to complain about it. And now it's been so long that, I mean, I complained to the staff that was there at the facility, but I never really did anything afterwards (Eleanor, One Care).*

However, one focus group participant agreed that CCA was the better insurance plan because "they ask for our input. Like other insurance don't even care what we think. They're gonna do it their way. And you either deal with it or kick rocks" (Claire, SCO).

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. Indeed, several reported recommending CCA to others. As one said, "As a whole. I'm satisfied [with] it. And my wife also. We both are in CCA at the same time. I even recommend CCA to others, to my children. They give good service" (Alex, SCO).

Reasons for wanting to stay with CCA varied, however. Reflecting frustrations with unresponsive care partners, one said,

> *I personally will stick with CCA. I mean, even though I have to kind of jump through hoops to get certain things, I noticed they do offer more things than what I had before…. I think once I get a new [care partner] ... I think I would stick with CCA (Serafina, One Care).*

Along the same lines, another commented,

> *Well, it's the people problem. You know, as far as being covered and seeing all my same doctors, nothing has changed. It's been very good. It's just the people problem (Robert, SCO).*

Conversely, other participants said that the people were one of the main reasons they would want to stay with CCA. One noted,

> *What makes me happy with CCA? Well, like I told you before, they're really nice people to work with…. And if you don't get what you want, all you do is tell them and they'll talk to you. Answer your question or they'll try to help you (Elijah, SCO).*

A long-time member went even further to say,

> *The quality hasn't gone down, if anything, it's increased…. It's more of a family now than it is an insurance patient-type situation or a client. So that's kind of, I feel very comfortable having them as my insurance company. It's just a step above anything I had years prior (Miles, One Care).*

Another said that the best thing about CCA for her was that "I definitely feel like I'm part of a team in terms of my own medical situation. So I feel like I'm being heard rather than talked to and told what to do in situations" (Eleanor, One Care).

Participants also mentioned that access to a broad array of benefits is a reason for wanting to stay with CCA.

> *They were very open and getting me a scooter… I'm a diabetic, so you know, my meds, and they sent a pharmacist out to my house so I can get them delivered. I mean, it was amazing, and they gave me this, but I had to be evaluated… The InstED team. They're amazing. I get IV a lot because I get dehydrated. They come right there, my house, do it right there… So I've loved this insurance. I have to be honest. I really, I love it...I love it (Delia, One Care).*

Discussion

CCA is a health plan founded by clinicians who wanted to improve the lives of medically complex and highly vulnerable people. To do so, they aimed to center the needs of plan members and provide the supports that enable them to live in their preferred environments. This study aimed to assess member perspectives on CCA, to understand what they think works and doesn't work, and their overall level of satisfaction with the plan. Consistent with other studies on CCA and the Federal Alignment Initiative demonstration (Gattine & Snow, 2023; Lipson & Chelminsky, 2024), this evaluation found members to be highly satisfied with the plan.

That is not to say that participants in our focus groups were uniformly positive about all aspects of the plan; indeed, certain aspects consistently attracted negative comments. The most significant of these concerned care partner relationships. Some members reported experiencing high turnover with their care partners or working with care partners who they perceived as unresponsive or uncaring about their individual circumstances and needs. However, other members reported high satisfaction with their care partners, characterizing the relationships as trusting and close and reporting that care partners go "above and beyond" in ensuring that members get what they need. These more positive relationships tended to be reported by focus group participants who had enduring relationships with their care partners. Clearly, care partner turnover has an impact on member satisfaction, an association reported in other research on integrated care plans (Lipson & Chelminsky, 2024).

Interestingly, even members who were not satisfied with their care partners reported good relationships with other CCA professionals, such as their BH provider or even their dentist (in one case). This is likely related to our findings of near-universal satisfaction with the medical care provided through CCA, both in terms of the quality of care and members' ability to access care. It is notable that service denials were rarely raised as a problem. It is also notable that every respondent who discussed a transition from a hospital or emergency department visit (in response to a standard question posed in every focus group) had high praise for the support received during and after this transition. Another highly valued service was the InstED mobile integrated health program, which members liked for its ability to reduce the likelihood of an emergency department visit.

Other stand-out aspects of the plan for participants were its flexible benefits, which were appreciated by members, bolstering their sense that services were aligned with their personal needs. SCO members in particular mentioned the OTC card, which allows members to supplement their food or pharmacy budget.

Participants' appreciation of flexible benefits was also tied to their appreciation of support with SDOH needs, particularly with accessing food and housing, along with other benefits. The SDOH need which attracted the most negative comments was the transportation benefit, largely due to the quality of transportation vendors and the erratic and inconvenient timing of pickups and drop-offs. Most participants who raised this issue felt that CCA handled complaints about transportation adequately, while a few felt that vendor oversight could be stronger. Some participants singled out the availability of social transportation as a big plus.

Members with BH needs also voiced appreciation for the services they received. Overall, they had high praise for their therapists, although again, turnover was reported as a significant problem. Members particularly valued CCA's CSU for its ability to prevent a psychiatric hospital stay, seeing the CSU as a positive resource in times of crisis.

Similarly, participants with LTSS needs reported that they received what they needed. Their primary concerns related to the quality of PCAs and their turnover rate. It was also evident that, although GSSCs and LTSCs are meant to serve as advocates in assisting members with LTSS, members had limited understanding of what those roles entail.

Overall, this kind of confusion was a recurring theme in the focus groups: participants displayed limited understanding of plan benefits or the roles of care team members. Those who had a trusted and consistent relationship with their care partners generally understood how to navigate the plan and reported few problems (if any), while those who did not reported considerable frustration in communicating with the plan or getting issues resolved.

This study was unable to determine whether the member engagement mechanisms employed by the plan were successful: only a few participants reported using the grievance process to resolve issues, although several reported resolving issues via other means. Several focus group participants were involved in the Member Voices Program, a structured opportunity for members to provide feedback to plan governance and reported generally positive experiences.

Ultimately, when asked whether they would switch plans, members nearly unanimously said they would stay with CCA. The high quality of care and the plan's generous benefits were the top reasons given. Many also mentioned positive relationships with care partners as reasons for their loyalty, while others identified care partners as a problem.

Conclusion

Based on data from these focus groups, CCA members appeared to be highly satisfied with their plans, 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 PCPs 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 regulatory category that the SCO and One Care plans fall into – that is, the FAI demonstration and Massachusetts's SCO program, which impact CCA's ability to offer a range of flexible benefits. 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 PCAs. Because these day-to-day relationships have a disproportionate impact on member experience, they are significant. 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 appreciated. CCA also creatively deploys community health workers (CHWs), which impact both the quality of transitions (CHWs are embedded in certain hospitals' emergency departments) 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 and the availability of its CSUs, both of which members spoke highly.

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