

## CASE STUDY

# CARE MODELS FOR HIGH-NEED, HIGH-COST PATIENTS

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## The “One Care” Program at Commonwealth Care Alliance: Partnering with Medicare and Medicaid to Improve Care for Nonelderly Dual Eligibles

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This case study is one in an ongoing series examining programs that aim to improve outcomes and reduce costs of care for patients with complex needs, who account for a large share of U.S. health care spending.

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### PROGRAM AT A GLANCE

**KEY FEATURE** Interprofessional care teams provide integrated, high-touch care to patients in homes, primary care practices, and community settings, using flexible benefits that cover services not traditionally reimbursed by Medicare or Medicaid.

**TARGET POPULATION** Low-income adults under age 65 who are enrolled in both Medicare and Medicaid.

**WHY IT'S IMPORTANT** One Care: MassHealth plus Medicare is one of a few programs in the United States that seek to integrate medical, behavioral health, and social services for patients with serious mental illnesses, substance abuse problems, or debilitating disabilities.

**BENEFITS** After 12 months, Commonwealth Care Alliance health plan members enrolled in the One Care demonstration had 7.5 percent fewer hospital admissions and 6.4 percent fewer emergency department visits compared with the prior 12 months, and made greater use of long-term services and supports.

**CHALLENGES** Ensuring lump-sum payments from Medicare and Medicaid are adequate for meeting medical and nonmedical needs. Establishing community-based service networks to fill gaps in the care continuum.

### INTRODUCTION

Soon after completing their prison sentences for drug violations, Diane R. and Melissa H. moved into a rundown apartment in an old Massachusetts manufacturing town. There, they went back to using heroin, despite life-threatening illnesses—end-stage liver disease for Diane and HIV for Melissa. Because both women were dually eligible for Medicare and Medicaid benefits, they were able to enroll in an experimental program that allows health insurance plans to combine the capitated payments they receive from both programs to pay for a wider array of services, including substance abuse treatment. The goal of the program, called One Care: MassHealth plus Medicare, is to see whether providing comprehensive, well-coordinated care can improve outcomes and lower costs for patients like Diane and Michelle who have complex needs.

Commonwealth Care Alliance (CCA), the Boston-based Medicare Advantage plan and care delivery network to which Diane and Melissa were assigned, is a participant in the One Care demonstration. CCA has had more than a decade of experience providing integrated care to “dual eligibles” age 65 and older as part of the Massachusetts’ Senior Care Options (SCO) program. (The older members are part of CCA’s Special Needs Plan, while dual eligibles under age 65 are enrolled in a Medicare–Medicaid Plan.)

At the core of CCA’s One Care model are interprofessional care teams comprising nurse practitioners, physician assistants, social workers, community health workers, and other professionals. These teams work with complex patients to identify their unmet medical, behavioral health, and social service needs and then deploy resources as needed, using the flexible benefits that team members have authority to approve. When this approach was tried with elderly patients, it led to significant declines in nursing home admissions and a drop in hospital admissions.<sup>1</sup>

The nonelderly patients CCA seeks to help through One Care are more challenging to connect with and care for, making similar reductions in utilization harder to achieve. This is one of the reasons CCA’s efforts are being closely watched by policymakers and other health care organizations. “I think everybody is hoping that CCA, using the model that has been developed, [can] actually do the work of bringing it to scale,” says Jeff Scavron, M.D., a CCA board member and a physician at a nonprofit community health center that participates in the program.

### One Care: MassHealth plus Medicare

The One Care program, a partnership of Massachusetts’ Medicaid agency and the Centers for Medicare and Medicaid Services, is the first demonstration to focus exclusively on “dual eligibles” under age 65—a vulnerable group with a variety of often overlooked care needs. Participating health plans receive capitated Medicare and Medicaid payments, which are used to provide enrollees with the medical, behavioral health, dental care, and long-term services and supports they require. Plans must also work with community-based organizations and external coordinators for long-term services and supports.



Toyin Ajayi, M.D., CCA’s chief medical officer, looks for cost-effective ways to meet member needs including tapping paramedics to deliver urgent care, which has helped avert emergency department visits.

## COMMONWEALTH CARE ALLIANCE'S TARGET POPULATION

Under the One Care demonstration, CCA provides coverage to 11,134 dual eligibles under age 65 in Massachusetts—81 percent of the state's residents who have opted to participate or been automatically enrolled in the program.<sup>2,3</sup> Roughly 80 percent of CCA's One Care members have multiple chronic health conditions, behavioral health problems, or functional limitations because of physical and developmental disabilities. Some have been rendered virtually homebound from muscular dystrophy or cerebral palsy. Some are homeless or cycling in and out of correctional facilities as a result of severe mental illness or substance abuse. Still others struggle in poverty to cope with multiple chronic conditions.

Approximately 30 percent of CCA's One Care enrollees account for 70 percent of expenses. Among these high-risk enrollees are patients with serious mental illnesses or substance abuse problems; people with four or more chronic illnesses, including life-threatening ones such as HIV, heart failure, or chronic obstructive pulmonary disease; and homebound individuals with catastrophic conditions like Lou Gehrig's disease or quadriplegia that require long-term services and supports.

### Commonwealth Care Alliance's One Care Enrollees

- ▶ **81% have two or more chronic conditions**
- ▶ **80% have serious mental illnesses, such as schizophrenia, bipolar disorder, or severe depression, and/or substance abuse problems**

Source: Commonwealth Care Alliance.

## KEY PROGRAM FEATURES

### Interdisciplinary Care Delivered Where Patients Need It

Many of CCA's One Care members have difficulty establishing and maintaining relationships with primary care providers. Those with physical and cognitive disabilities, for instance, often struggle to make and keep appointments with the multiple specialists they require, while those with serious mental illnesses and substance abuse problems may not seek care at all (according to CCA staff, no-show rates for primary care and psychiatry appointments in this population are as high as 60 percent to 70 percent). Rather than asking these patients to adapt to the existing health care system, CCA assembles care teams around them. The teams go where they are needed—to patients' homes, primary care practices, and community settings—to identify gaps in care and increase access to services.

In the case of Diane and Melissa, a CCA nurse practitioner visited their home and quickly arranged for palliative care and skilled nursing services when she realized Diane was nearing the end of her life. Not long after, Diane suffered a stroke. Following a short hospitalization, however, she was able to return home, where she preferred to spend her remaining days.

In the months after, Melissa relapsed. The team was able to arrange for substance abuse treatment for her under Care One's expanded benefit. When Melissa reported chest pains, they also arranged for her to see a specialist, who discovered occlusion in a coronary artery. “There aren't a whole lot of patients like this who are that acute, but the few who are require very, very intensive intervention,” says Laura Black, N.P., a clinical director at CCA.

Some of the teams provide direct care within four CCA-run primary care practices, which offer home- and clinic-based care to members with the most significant physical, behavioral health,

and social needs. For patients who have well-established relationships with community-based primary care practices, the teams play a more limited role, helping to build bridges between primary care providers, specialists, and the hospitals, nursing homes, and skilled nursing facilities that serve One Care patients. Other teams may partner with mental health agencies, which are the primary source of care for patients with behavioral health problems, as well as other human service agencies. These agencies are delegated by CCA to provide case management services, including coordination of physical and behavioral health care, with training from CCA's care team members.

“Our goal is to identify where strong relationships exist between members and providers and to reinforce rather than supplant them,” says Toyin Ajayi, M.D., CCA's chief medical officer.

### Shoring Up Behavioral Health Services

Soon after enrolling patients, CCA found a high prevalence of behavioral health problems in new members and significant gaps in the availability of outpatient services to meet their needs. This led to high rates of hospitalization and emergency department use.

In some locations, outpatient providers have been unwilling to see One Care enrollees or have set visit limits, says Peggy Johnson, M.D., CCA's chief of psychiatry. CCA also has had difficulty finding facilities that can provide detox or step-down services to support sobriety. To address these gaps, CCA has created two crisis stabilization units (CSUs) that provide short-term acute psychiatric care, including detox services. They also have partnered with Bay Cove Health Services, a nonprofit social service agency, to provide treatment and care transition services. The average length of stay in the units is 10 days, during which staff assess patients' medical, behavioral health, and social support needs and establish or reestablish patients' connections to primary care providers.<sup>4</sup>





## HOW CCA CARE TEAMS WORK

Interprofessional teams include a wide variety of providers, selected according to each patient's needs:



Nurse Practitioners



Physician Assistants



Registered Nurses



Licensed Practical Nurses



Physical Therapists



Occupational Therapists



Social Workers



Behavioral Health Counselors



Coordinators of Long-Term Services and Supports



Medical Assistants



Community Health Workers



Peer Counselors

Team leaders have authority to approve benefits, including unconventional items that have an impact on health, such as clean bedding and air conditioners.

The following examples illustrate the interactions between patients and care teams.

### Caring for Severely Disabled Patients in CCA-Staffed Clinics or via Mobile Teams



Joe, 32

**PATIENT:** Joe, 32, suffered a spinal injury three years ago. Living in a cramped apartment, he is underweight and weak, suffers from pressure sores, and has a thyroid condition. A family member cares for him. Joe feels isolated and depressed.

**RESPONSE OF CARE TEAM:** After visiting Joe's home to assess his medical needs and home environment, a physician assistant refers him to a physical therapist. Joe receives a new wheelchair to address the source of his pressure sores. A social worker is called in to help Joe move into a handicapped-accessible apartment, arrange for the caregiver to receive payment for personal care duties, and find social activities to engage Joe. The physician assistant continues to work on Joe's medical issues, arranging for appointments with a pulmonologist and an ear, nose, and throat specialist, among others.

**RESULT:** Joe's pressure sores abate, he gains weight and muscle mass, and he becomes more independent—cooking for himself and going to the gym. He even begins dating. Instead of relying on home-based visits, Joe goes to a CCA clinic. His visits with specialists decrease to once or twice a year.

### Supporting Primary Care Practices That Have Relationships with One Care Enrollees



Harry, 54

**PATIENT:** Harry, 54, is an alcoholic who drinks up to 30 beers per day. He also has a clotting disorder that requires ongoing monitoring and suffers from coronary disease and other heart problems. He lives in subsidized housing and has several crack users squatting in his apartment.

**RESPONSE OF CARE TEAM:** The nurse practitioner who visits Harry's home finds that his personal care attendant is using drugs, that Harry's drinking is spiraling out of control, and that his mental health is deteriorating. Because of his fragile condition, he is placed in a crisis stabilization unit run by CCA while a CCA social worker and community health worker focus on finding alternative housing that he can move into once his condition is stabilized. They make referrals to a substance abuse program and update his primary care physician on their work.

**RESULT:** The team is able to remove Harry from a risky situation, possibly avoiding a costly admission to a psychiatric hospital. Despite their intervention, Harry returns to drinking. Team members stay in close contact with him, making home visits to monitor his medical conditions.

### Supporting Patients in Behavioral Health Homes



Robert, 42

**PATIENT:** Robert, 42, lives in a group home and suffers from severe, disabling anxiety. With poorly managed diabetes and asthma, he is frequently brought to the emergency department. He relies on skilled nursing providers to ensure he is taking his diabetes medication appropriately.

**RESPONSE OF CARE TEAM:** A nurse practitioner sets up a conference call with the mental health agency's care coordinators, encouraging them to arrange for more frequent, lower-cost home health care rather than skilled nursing staff to help Robert with asthma and diabetes management.

**RESULT:** Robert's visits to the emergency department are curtailed as both his medical conditions are brought under control.

One of the CSUs, Marie's Place, a home in Brighton, Massachusetts, accommodates up to 14 patients who are experiencing crises but do not need to be hospitalized in locked wards. Marie's Place shares many features of inpatient units, such as an on-duty psychiatric nurse practitioner; licensed clinicians, such as a social worker to run support groups; and mental health counselors, who assess patients' needs on site. Psychiatrists are also available for consultation and support. CCA has established a second 12-bed CSU, The Carney, by leasing space at a community hospital. Care in the CSUs averages \$630 per day compared with \$1,100 per day for inpatient stays.<sup>5</sup>

### Coordination of Long-Term Services and Supports

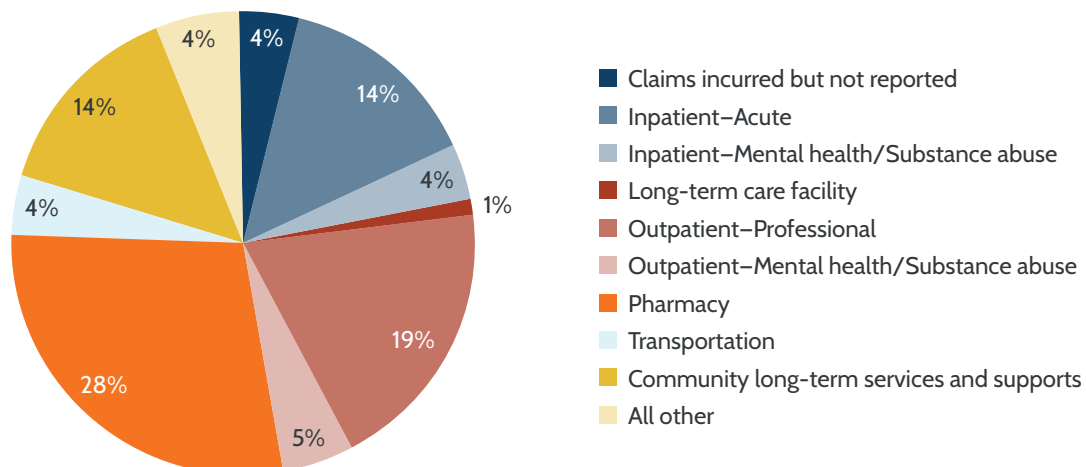
As part of the demonstration, One Care enrollees have the option of getting help from a long-term services and supports coordinator from a community organization, such as the Boston Center for Independent Living. The coordinators serve as advocates for enrollees, help identify needed services and resources, and help develop and monitor the care plan. "They are real assets to our team," Ajayi says.

## FINANCING

To provide comprehensive care for roughly 10,000 One Care enrollees, CCA received \$385.7 million from Medicaid and Medicare in 2015 and \$256.9 million for the 15 months ending December 2014.<sup>6</sup> The state's Medicaid contribution ranges from roughly \$120 per member per month for relatively healthy patients to \$9,000 or more for patients with extended stays at long-term care facilities (see [Appendix A](#)).<sup>7</sup> The base rate for Medicare Part A/B capitation payments ranges from \$770 to \$960 per member per month.<sup>8</sup> On average, per member per month spending amounted to \$2,641 in 2015 and \$2,205 in the 15 months prior.<sup>9</sup>

### CCA's spending on One Care enrollees in 2015

Demonstration year 2 average per member per month = \$2,641



Source: "One Care: MassHealth plus Medicare Demonstration to Integrate Care for Dual Eligibles," Open Meeting, May 24, 2016, <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/2016/160524-masshealth-presentation.pdf>.

## RESULTS

A study of 4,500 of CCA’s One Care enrollees found that, after 12 months of enrollment, they had 7.5 percent fewer hospital admissions and 6.4 percent fewer emergency department visits than in the 12 months prior to enrollment. They also made greater use of long-term services and supports. The majority (82%) of enrollees said they were satisfied with the program.<sup>10</sup> A preliminary analysis also found that the crisis stabilization units, in particular, contributed to lower admissions.<sup>11</sup> The early findings may change as enrollees gain more experience with the program.

Despite these improvements, CCA lost \$34.9 million on revenue of \$256.9 million in the first 15 months of the program, a loss that was reduced to \$18.4 million by a risk corridor program intended to mitigate insurers’ extreme gains or losses. The health plan came close to breaking even for 2015, with a projected loss of \$416,000 on revenue of \$385.7 million, and expects to achieve savings in 2017.<sup>12,13</sup>

CCA leaders say the risk-adjustment techniques initially used by both Medicaid and Medicare to set capitated payment levels were a factor in the early loss because they vastly underestimated the number of enrollees with behavioral health needs and the scope of their problems. For example, some patients with schizophrenia were deemed average risks by Medicare. Moreover, many enrollees had been underserved in the fee-for-service system, creating pent-up demand for medical care, behavioral health services, and social supports, says Christopher Palmieri, CCA’s CEO and president.

This was a problem for all the plans participating in the One Care program, says Daniel Tsai, assistant secretary for MassHealth and the state’s Medicaid director. “We saw folks who we thought were one level of need but once they got on to a One Care plan, including Commonwealth Care Alliance, and had an actual assessment, they turned out to be much more complex,” he says.

Member assessments, combined with better documentation and more accurate coding, enabled CCA to reclassify roughly 25 percent of its One Care enrollees into higher-risk categories. The Centers for Medicare and Medicaid Services (CMS) and MassHealth also increased reimbursement rates and made modifications to risk-sharing agreements that resulted in CMS and MassHealth assuming greater responsibility for losses.<sup>14</sup>

## INSIGHTS AND LESSONS LEARNED

***With underserved populations, better care coordination may lead to higher spending in the short run.*** It is often assumed the fee-for-service payment leads to greater use of services while capitation models encourage providers to do less. But for dual eligibles who have been poorly served by traditional delivery models, better coordination and oversight often lead to the discovery of unmet needs and potentially greater use of services following enrollment in comprehensive care programs such as One Care, as Melissa’s case revealed. CCA found spending on newly enrolled members was higher than expected initially; it took about 18 to 20 months to return to historical levels as the plan optimized their care. These higher initial costs may be offset in the long run by the savings from more judicious use of long-term services and supports, the avoidance of high-cost institutional care (including inpatient psychiatric facilities), and better management of chronic disease and care transitions. However, these take time and money to achieve.

“This requires intensive upfront capital investment, which states need to be aware of and support,” Ajayi says. “Expecting savings in the very beginning and baking in rate reductions clearly is problematic.”



*Meeting the needs of patients with substance abuse disorder, building out and enhancing provider networks, managing care transitions—all of this requires intensive upfront capital investment, which states need to be aware of and support.*

**Toyin Ajayi, M.D.**  
CCA Chief Medical Officer

***Patient assessments help ensure that plans have the resources they need but can be difficult to execute.*** Incomplete data about enrollees' clinical problems and social challenges makes risk adjustment and rating difficult. While assessments can help, CCA found they are a challenge to complete because of members' transitory lives. "Telephone contacts are virtually futile," reaching only 20 percent, Black says, and going directly to enrollees' homes isn't as fruitful as one would expect. "The addresses are wrong more often than not. And when you do find someone, there's a lot of historic distrust."

In addition to in-person outreach, CCA staff look at pharmacy claims to locate current home addresses should they need them later. These claims also yield the names of their providers, which can be useful for improving care coordination or communication with patients' providers and for outreach.

CCA staff also locate individuals by sending teams to meet patients in the hospital when their admissions are flagged in the electronic health record system. In other cases, they ask the health plan's member services department to refer enrollees to care management services when they are looking for help with transportation or other supports.

***Active enrollment facilitates patient engagement but may be slower to scale.*** In the early months of the program, roughly half of CCA's One Care members were automatically enrolled in the program but allowed to opt out (passive enrollment), while the other half opted in (active enrollment). Both approaches have trade-offs: automatic enrollment allows the state to recruit a sizeable number of patients, but many can be difficult to locate, assess, and treat—putting the plans at financial risk for enrollees they could not find.<sup>15</sup> In contrast, enrollees who actively choose to enroll in the program



are easier to locate and more accepting of the model and its care coordination component. But this method requires significant outreach, which can slow program implementation.<sup>16</sup>

***Partnering with advocacy groups helps to engage patients.*** CCA works closely with organizations that enrollees already trust, not only to refine its care model but also to help publicize the program and its benefits. Tsai says such partnerships have been useful in countering resistance to the program from some providers of long-term services and supports who feared a more integrated approach would reduce demand for their services.

## NEXT STEPS

Going forward, Commonwealth Care Alliance continues to look for cost-effective ways to improve outcomes for enrollees and reduce service gaps. It has engaged local pharmacists to provide medication management services for One Care enrollees and has created a pilot program to leverage the skills of community-based paramedics to reduce emergency department use. The pilot was sparked by a review that found more than half of emergency department visits of CCA members could have been managed at home or another care setting.

As part of the pilot, paramedics employed by a local ambulance company are dispatched to patients' homes between 6 p.m. and 2 a.m. to provide urgent care, including intravenous therapy, antibiotic administration, and lab tests.<sup>17</sup> The paramedics have access to patients' electronic medical records and confer with CCA's doctors and nurses by phone. "Patients, particularly those who have a behavioral health diagnosis, love it. They feel they are seen more quickly and they don't feel anxious and disempowered as they do in the emergency department, where people don't know their medical history," Ajayi says. According to member reports, in 85 percent of cases the visit from a paramedic averted an emergency department visit.

Meanwhile, Massachusetts is looking to expand the One Care program. As of June 2016, state officials had enrolled roughly 13 percent of eligible residents, and they expect to enroll more now that risk-adjustment problems have been resolved. The state also has extended the demonstration through 2018. "It's good policy, it's good care, [and] it's good coordination," Tsai says. "We know it's the direction we want to head in, and we're trying to work with the community to figure out what's the fastest but most responsible way of doing that."

## Features of the Commonwealth Care Alliance (CCA) “One Care” Program

	<b>Targeting the population most likely to benefit</b>	Low-income adults under age 65 who are enrolled in both Medicare and Medicaid, including those with comorbid mental illness and substance abuse problems, catastrophic health problems such as HIV/AIDS, and members who make use of long-term services and supports.
	<b>Assessing patients' health-related risks and needs</b>	Nurses conduct intake assessments for all new enrollees, consulting as needed with behavioral health specialists and long-term services and supports coordinators.
	<b>Developing patient-centered care plans</b>	Interdisciplinary care teams tailor care plans with input from patients or, for patients needing long-term services and supports, in collaboration with patient-selected coordinators in community-based organizations.
	<b>Engaging patients and family in managing care</b>	Mobile care teams engage hard-to-reach members in their homes or on the streets. Teams meet patients in the hospital when their admissions are flagged in the electronic health record system. Member services staff refer enrollees to care management services when they are looking for help with transportation or other supports.
	<b>Transitioning patients following hospital discharge</b>	CCA has tapped emergency medical technicians to meet patients at hospitals and accompany them home. They assist patients with their medications, confirm they understand postdischarge instructions, and ensure they have the supplies and home supports necessary to remain safe in the community.
	<b>Coordinating care and facilitating communication among providers</b>	As needed, interprofessional teams help build bridges between primary care providers, specialists, and the hospitals, nursing homes, and skilled nursing facilities that serve One Care patients.
	<b>Integrating physical/behavioral health care</b>	Interprofessional teams partner with mental health agencies, the primary source of care for patients with mental health and substance abuse problems. The agencies are delegated by CCA to provide case management services and coordinate physical and behavioral health care.
	<b>Integrating health and social services</b>	A flexible benefit structure allows CCA to provide some social supports, including transportation, and to purchase air conditioning units and clean bedding when needed for health reasons.
	<b>Making care or services more accessible</b>	CCA deploys teams to patients' homes, primary care practices, and community settings to identify gaps in care and increase access to services. The teams provide direct care in four CCA-run clinics, created for and designed to be accessible to those with physical disabilities.
	<b>Monitoring patients' progress</b>	CCA's model is predicated on building trusting relationships between beneficiaries and their CCA care teams, enabling follow-up and early identification of acute needs. Cases are reviewed regularly using standard reports, weekly team meetings, and, as needed, consultation among relevant team members.

Notes: This exhibit describes common features of effective care models for high-need, high-cost patients; see: D. McCarthy, J. Ryan, and S. Klein, *Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis* (The Commonwealth Fund, Oct. 2015).

## APPENDIX A. HOW MASSACHUSETTS DETERMINES HEALTH PLAN REIMBURSEMENT FOR ENROLLEES IN THE "ONE CARE" PROGRAM

The state's payment rates were tied to patterns of use in its fee-for-service population with adjustments for patients with significant need for behavioral health treatment and long-term services and supports. Medicare's reimbursement rates were set according to its experience with fee-for-service and Medicare Advantage enrollees.

**F1:** Individuals with a long-term facility stay of more than 90 days

**C3:** Individuals who have a daily skilled need; limitations on two or more activities of daily living and three days of skilled nursing need; and individuals with four or more limitations with activities of daily living

*Subdivided into:*

- **C3B:** Those with diagnoses such as quadriplegia, ALS, muscular dystrophy, and respirator dependence
- **C3A:** The remainder of C3 individuals

**C2:** Individuals who have a chronic and ongoing behavioral health diagnosis

*Subdivided into:*

- **C2B:** Individuals with co-occurring diagnosis of substance abuse and serious mental illness
- **C2A:** The remainder of C2 individuals

**C1:** Individuals in the community who do not meet the other criteria

Note: F=facility; C=community.  
Source: Commonwealth Care Alliance.

## NOTES

- <sup>1</sup> R. J. Master, “Commonwealth Care Alliance—A Redesigned Approach to Finance and Care Delivery for Dual and Medicaid Eligible Beneficiaries with the Greatest Need and Highest Cost: Lessons Learned About What Is Needed to Build Effective Care Delivery Models,” Presentation at the Alliance for Health Reform, March 2015.
- <sup>2</sup> In 2015, the remainder of the One Care participants were covered by two competing plans, one of which has since left the program.
- <sup>3</sup> Enrollment figures as of October 2016. See <http://www.mass.gov/eohhs/docs/masshealth/onecare/enrollment-reports/enrollment-report-october2016.pdf>.
- <sup>4</sup> R. S. Lester and J. Verdier, *Alternatives to Inpatient Psychiatric Services for Medicare-Medicaid Enrollees: A Case Study of Commonwealth Care Alliance* (Center for Medicare and Medicaid Services’ Integrated Care Resource Center, May 2016).
- <sup>5</sup> Ibid. Note: Comparative costs for inpatient care are based on 2012 Medicare, while CCA estimates are from 2014 and beyond.
- <sup>6</sup> The 2014 figure includes a risk corridor payment (\$16.5 million), while the 2015 figure excludes potential risk corridor payments or recoupments. See <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/2016/160524-masshealth-presentation.pdf>.
- <sup>7</sup> “Demonstration to Integrate Care for Dual Eligible Individuals,” Final Rate Report, Feb. 26, 2016.
- <sup>8</sup> See slide 49 at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/2016/160524-masshealth-presentation.pdf>.
- <sup>9</sup> “Demonstration to Integrate Care for Dual Eligible Individuals,” Final Rate Report, Feb. 26, 2016.
- <sup>10</sup> CCA met three of six quality benchmarks, earning 50 percent of its quality withhold, or \$431,883, in 2014. These pass–fail measures track the use of consumer advisory boards, completion of member assessments, discussion of care goals, and access to long-term services and supports coordinators, among other things. CMS and MassHealth also monitor scores on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey and the Healthcare Effectiveness Data and Information Set (HEDIS). According to its 2015 CAHPS scores, CCA performed slightly better than the national average for Medicare Advantage and Medicare–Medicaid plans. On HEDIS measures for 2014, CCA performed better than the 90th percentile for Medicaid plans on access to preventative/ambulatory health services, the identification of alcohol and other drug services, and behavioral health service utilization. It scored below the 75th percentile on follow-up after hospitalization for mental illness and average length of stay for acute-care hospitalizations, but may have improved on these measures since.
- <sup>11</sup> CCA is still evaluating the impact of its CSUs on utilization and costs. A preliminary analysis found that admissions per 1,000 members per month decreased from 9.6 in the year before The Carney opened to 8.5 in the 10 months after. Inpatient psychiatric days per 1,000 members per month decreased during the same period from 125 to 100. See R. S. Lester and J. Verdier, *Alternatives to Inpatient Psychiatric Services for Medicare-Medicaid Enrollees: A Case Study of Commonwealth Care Alliance* (Center for Medicare and Medicaid Services’ Integrated Care Resource Center, May 2016).

- <sup>12</sup> The 2015 figure excludes potential risk corridor payments or recoupments. The 2015 figures include claims submitted through Jan. 31, 2016, for calendar year 2015. See slide 47 at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/2016/160524-masshealth-presentation.pdf>.
- <sup>13</sup> Fallon Total Care, which provided coverage to roughly 5,000 members and exited the program, lost \$11.0 million on revenues of \$97.1 million in the first 15 months. Tufts Health Unify, a health plan that provides coverage to fewer members (roughly 3,000 members as of June 2016), lost \$461,963 on revenues of \$30.4 million in the first 15 months of the program. In 2015, it earned \$3.0 million on revenues of \$54.3 million. The losses for Tufts and Fallon may be offset by risk corridor payments that have yet to be determined.
- <sup>14</sup> The original payment formulas had called for reductions in capitation rates based on assumed savings of 0.5 percent in the last eight months of 2014, 1 percent savings in 2015, and 2 percent savings in 2016. These were suspended, which had the effect of raising reimbursement rates.
- <sup>15</sup> Massachusetts attempted to mitigate the financial risk this situation posed to plans by limiting automatic enrollment to lower acuity patients.
- <sup>16</sup> As of April 2016, two-thirds of CCA's members have been assigned through active enrollment.
- <sup>17</sup> Commonwealth Care Alliance and EasCare Ambulance LLC, "[Acute Community Care: Reshaping Healthcare Delivery Through Community Paramedicine](#)" (May 2016); and J. Maxwell, C. Barron, A. Bourgoin et al., "[The First Social ACO: Lessons from the Commonwealth Care Alliance](#)" (JSI Research and Training Institute, Feb. 2016).



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The aim of Commonwealth Fund-sponsored case studies of this type is to identify institutions that have achieved results indicating high performance in a particular area of interest, have undertaken innovations designed to reach higher performance, or exemplify attributes that can foster high performance. The studies are intended to enable other institutions to draw lessons from the studied institutions' experience that will be helpful in their own efforts to become high performers. It is important to note, however, that even the best-performing organizations may fall short in some areas; doing well in one dimension of performance does not necessarily mean that the same level of performance will be achieved in other dimensions. Similarly, performance may vary from one year to the next. Thus, it is critical to adopt systematic approaches for improving performance and preventing harm to patients and staff.



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