The First Social ACO: Lessons from Commonwealth Care Alliance

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JSI Research & Training Institute, Inc.

Jim Maxwell, PhD
Christine Barron, BA
Angel Bourgoin, PhD
Rachel Tobey, MPA

Robert Wood Johnson Foundation

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This White Paper was authored by:

Jim Maxwell, PhD
Christine Barron, BA
Angel Bourgoin, PhD
Rachel Tobey, MPA

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Introduction

To address the underlying problems in how health care is organized, delivered, and paid for in the United States, the Affordable Care Act (ACA) of 2010 has promoted the spread of innovative payment and delivery models throughout the health care system.[1] The provisions in the ACA were designed to achieve the Institute of Health Improvement's Triple Aim of improving patient experience of care and the health of populations while reducing the overall cost of health care.[2] One of the most prominent innovations promoted by the ACA is the accountable care organization (ACO), which has been broadly defined as "a group of health care providers who accept shared accountability for the cost and quality of care delivered to a population of patients."[3] ACOs have proliferated across the United States in the wake of the Affordable Care Act, with over 600 ACOs established as of June 2014, covering an estimated 20.5 million lives in risk-based contracts.[4,5]

Although most ACOs are being formed to provide care for Medicare beneficiaries, some ACOs are emerging to serve Medicaid populations. In applying the ACO concept to care for these populations, terms such as "social ACO" and totally accountable care organization ("TACO") have emerged.[6,7] These approaches are based on the idea that improving health and cost outcomes of vulnerable populations will necessitate incorporating health, behavioral health, and social services into the ACO model. Social ACOs serve populations with complex and often unmet social and economic needs that impact health outcomes and health system utilization, including needs related to housing, food security and nutrition, legal assistance, employment support, and/or enrollment assistance.

Although most Medicaid ACOs are of relatively recent origins, Commonwealth Care Alliance (CCA) of Massachusetts is an early innovator in developing a social ACO approach. Over a decade ago, CCA developed a model rooted in providing person-centered, community-based care to support economically disadvantaged persons with a heavy burden of disease and disability. CCA's care model is grounded in providing comprehensive care coordination embedded in enhanced primary care, and CCA has distinguished itself from other providers by addressing the medical, behavioral, and social needs of complex patients. As a pioneer of the social ACO approach, its story offers insights into the factors and processes that promote successful realization of the Triple Aim for other emerging ACOs focused on complex patient populations.

Three key themes have emerged from CCA's experience. First, CCA has developed a social ACO model that relies on an integrated care team that addresses unmet social needs alongside medical and behavioral needs. This model, which involves embedding nurse care managers in primary care, is bolstered by comprehensive assessments for patients, and multidisciplinary care teams to address patients' multifaceted needs. The model is also characterized by linkages to community-based providers and long-term care supports;

such linkages are carefully cultivated through the development of enhanced referral networks. These components of CCA's care model have become essential elements of high-cost, high-risk management programs and safety-net ACOs emerging today. CCA has served as one of the most prominent models for the development of such programs, and has demonstrated positive results in reducing hospital utilization and total medical expenses.[8]

Second, CCA's care model is supported by preferred provider and referral networks and global capitated payments. This model of payment allows CCA the financial flexibility to provide a broad mix of services and the aligned financial incentives necessary for reducing total medical expenses. This payment mechanism also provides CCA with the upfront capital needed to make investments, and enhances CCA's ability to align financial incentives with its key contracting partners.

Third, CCA's culture of innovation and adaptability was an important factor in the success of its programs. In response to the unique needs of its high-risk patients, CCA uses an iterative process to develop new and enhanced services, employ professionals and paraprofessionals in creative ways, and innovate approaches to fill critical gaps in service delivery. This culture of adaptability and innovation, fostered under strong leadership from one of its co-founders, Dr. Robert Master, allowed CCA to directly address the needs of a unique, high-risk population.

Given the strong interest in managing care for such high-risk patients, CCA can serve as a successful social ACO model from which others can learn. This white paper will assess the development of CCA's care, payment, and delivery reforms, as well as the visionary leadership of CCA's founders, primarily focusing on its key innovations, challenges, and lessons for the field.

Methods

With support from the Robert Wood Johnson Foundation, in January 2015, the JSI Research and Training Institute, Inc. (JSI) research team conducted site visits at CCA with executive, financial, and clinical leaders. The team also conducted background research using publicly available documents and interviewed CCA's contracted community health centers. The research team selected CCA because of the organization's unique hybrid payer-provider structure and experience as an early innovator in providing community-based care to support economically disadvantaged persons with a heavy burden of disease and disability. JSI's qualitative research with CCA leadership followed a semi-structured interview guide that focused on:

- History and development of the ACO;
- Governance, leadership, and organizational structure;
- Market, policy, and regulatory context;
- Payment arrangements;
- Integrated delivery system and population health management, including high-cost care management, clinical care strategies, and care transitions;
- Partnerships with community and social services;
- Patient engagement; and
- Monitoring and measurement of key processes and Triple Aim outcomes.

History and Formation

The history of CCA lends insight to the origins of its innovative care model. In 2003, Dr. Robert Master and Lois Simon co-founded CCA with the goal of offering a care delivery model to a broad range of vulnerable patients, particularly those who are dually eligible for Medicare and Medicaid services. Dr. Master is widely considered a visionary leader who was responsible for the organization's culture of innovation and adaptability; Ms. Simon's role has often been described as the person who was able to deliver on or operationalize Dr. Master's profound and innovative vision. In establishing CCA, their goal was to "bring high-quality and personalized care to people with complex medical and behavioral health needs, resulting in improved health and better self-management of chronic illness, thereby reducing hospitalizations and institutionalizations."[9]

Dr. Master had dedicated his earlier professional career to developing and implementing care models for vulnerable populations, particularly low-income elderly and persons with disabilities.[10] In 1973, Dr. Master and his colleague Dr. Roger Mark, residents at Boston City Hospital, received a grant to study Medicaid-eligible nursing home residents' access to care in the inner city. Their findings highlighted importance of primary care for high-risk Medicaid patients, ultimately prompting the two to start their own practice. In 1977, they started the Urban Medical Group (UMG), which sought to shift care delivery for vulnerable homebound elderly and non-elderly disabled from a clinic-based to a home-visit-based primary care model. UMG saw promising early results in reducing the annual hospitalization rate and average lengths of stay. This success encouraged Dr. Master to consider methods of scaling up this care delivery model and expanding its scope to care for more complex patients, while working within the limitations posed by Medicare and Medicaid's complex and separate funding streams. His vision was realized in 1989, in large part due to his vocal advocacy, when the Massachusetts State Medicaid Commissioner approved a demonstration of a prepaid, capitated Medicaid managed care plan targeting severely disabled and HIV-positive patients.

Drawing upon the lessons learned from UMG, Dr. Master founded Community Medical Alliance (CMA) in 1990. Dr. Master has described CMA as a "laboratory" that facilitated better understanding of chronically ill patients and allowed for the testing of new models of care. CMA relied on a capitated payment structure that provided CMA flexibility in spending for non-traditional services that addressed both medical and social needs. Funds were used to coordinate care and to develop services and early interventions that would address care needs of disabled and HIV-positive patients, including home care, durable medical equipment, case management, and adult day care.[11] This program, with its flexibility in services provided and fixed payment structure, was a precursor to the care delivery models of today's safety-net ACOs. CMA's role as a "laboratory" for testing and adapting new models of care for high-risk patients also served as the foundation of CCA's current culture of innovation and adaptability, and was the result of several decades of iterations and improvements in response to the unique needs of high-risk populations.

Lois Simon brought an equally essential yet complementary set of skills to CCA, building on decades of experience working in collaboration with Dr. Master. Ms. Simon's background includes

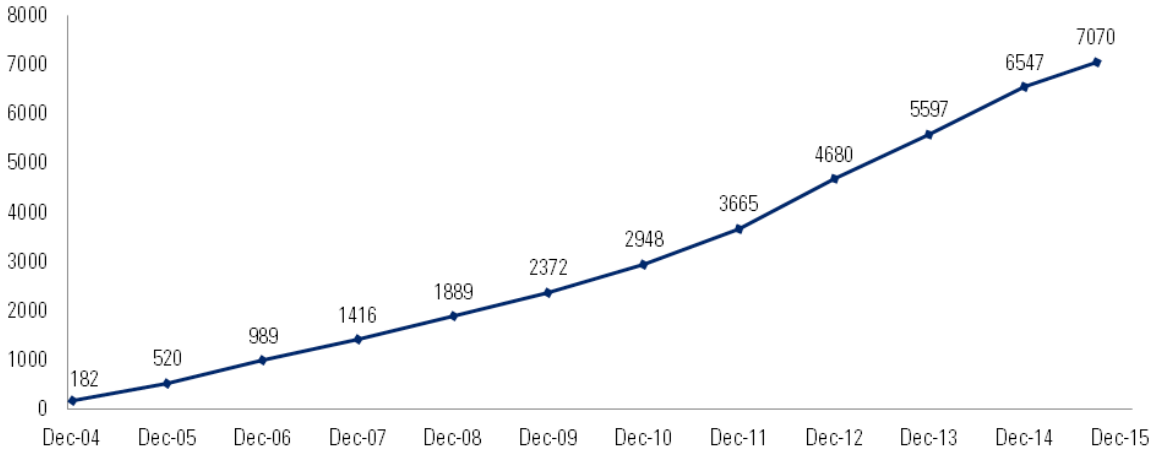
working in government policy, healthcare provider operations, and managed care operations. Through these experiences and working with Dr. Master at Neighborhood Health Plan, a Massachusetts safety-net managed care plan, she obtained particular expertise in developing programs and services for elders and individuals with disabilities of all ages with an emphasis on integrated models incorporating physical, behavioral, and long-term services and supports in varied clinical settings.

The final key feature of the founding of CCA was the involvement of advocacy organizations. Dr. Master and Ms. Simon deliberately established a governance structure with advocacy organizations as corporate members of its board of directors to ensure that the voice of consumers was reflected in all of their activities. Community Catalyst, Health Care for All, and the Boston Center for Independent Living were all influential in the organization's founding. The latter two organizations continued to play a central role in CCA's governance for more than a decade. Ms. Simon described this governance structure as "pretty compelling and unusual, and perhaps a piece of CCA's secret sauce. It was a very intentional sort of movement on our part to ensure that we held our own feet to the fire."[12]

CCA Today

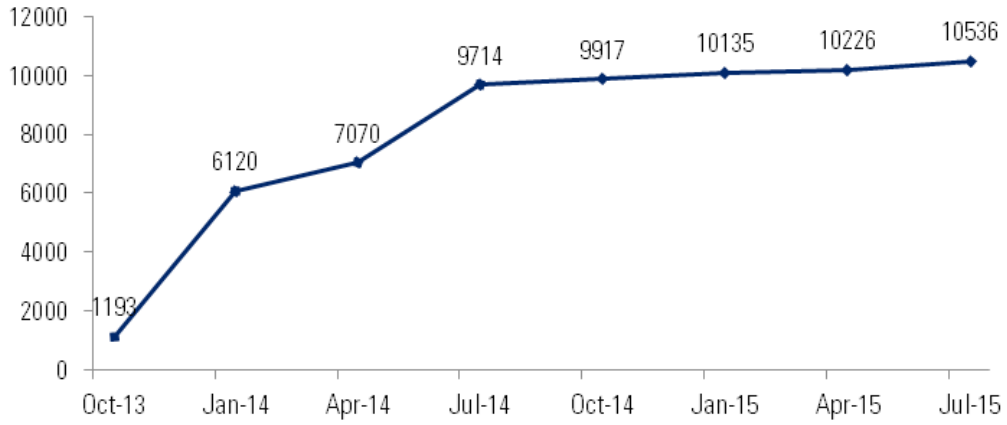
The establishment of CCA was made possible by the launch of the Senior Care Options (SCO) demonstration for individuals dually eligible for both Medicare and Medicaid, developed by the Centers for Medicare & Medicaid Services (CMS) and the Massachusetts' Medicaid agency, then known as the Division of Medical Assistance.[13] Massachusetts's SCO program was established to serve the community-dwelling frail and institutionalized elderly ages 65 and older in Massachusetts, and plans covered a wide range of benefits either directly or through subcontracts.[14] As a whole, dual-eligible Medicare and Medicaid beneficiaries are among the most complex and costly patients in the health system. This population faces high prevalence of chronic illness, disabilities, and behavioral health issues. In addition, they also experience striking disparities in socioeconomic status and access to health services in Massachusetts as elsewhere, particularly with regard to housing, transportation, adequate nutrition, language barriers, and social network support. Across the country, these beneficiaries account for a disproportionate share of spending in both programs, due to their poorer health status and resultant higher use of services as compared to other beneficiaries.[15] Enrollment in the Massachusetts SCO program began in 2004, and as of December 2015, CCA has 7,070 SCO enrollees (see Figure 1).

Figure 1. CCA SCO Enrollees
December 2004 - December 2015



In 2013, CCA began serving patients enrolled under a second Massachusetts demonstration for non-elderly dual eligible patients, called One Care. Through the One Care program, Massachusetts was the first state to start a demonstration program on dual-eligible individuals between the ages of 21 and 64. Given their younger eligibility for Medicare, One Care members have a different mix of disabilities when compared to the SCO population, including serious and persistent mental illness, developmental disabilities, and physical challenges. As of 2014, 70% of One Care members have a diagnosis of a known mental health condition, and 20-25% have a serious mental illness. The goal of CCA's One Care program is to better coordinate care for the population of younger low-income disabled adults, and similar to SCO, to continue to fulfill the mission of CCA by addressing both medical and social needs of vulnerable patients.[16] As of July 2015, CCA has 10,536 One Care members (see Figure 2).

Figure 2. CCA One Care Enrollees
October 2013 - July 2015



Source: Executive Office of Health and Human Services (EOHHS). One Care Monthly Enrollment Reports, MassHealth. Accessed 9/30/2015 from http://www.mass.gov/eohhs/consumer/insurance/one-care/one-care-enrollment-reports.html

CCA Care Model

CCA's model is based on enhanced primary care and intensive care management, coordinated through a single point person that is responsible for the patient's care (see Figure 3). To support this model, CCA employs interdisciplinary, integrated teams of nurse practitioners, behavioral health professionals, social services providers, personal care attendants, and other professionals to support the primary care clinician.[17] Preferred networks and referral systems are key to managing costs and coordinating services to meet the multifaceted needs of patients. With the understanding of the impact that social determinants have on health, CCA leadership sought to institutionalize the provision of services to support non-medical needs and referrals to social services. The CCA Care Model is also consumer-driven, meaning members and families have an active voice in developing highly individualized care plans. CCA's basic care model is increasingly being emulated by multiple payer and provider organizations; it is worth nothing that these elements were innovations at the time of their introduction over a decade ago.

The following key characteristics of CCA's care model will be explored below:

- Emphasis on primary care
- Emphasis on consumer engagement
- Comprehensive needs assessment
- Interdisciplinary care team
- Provision of non-medical services
- Long-term services and supports
- Linkages to social services

Figure 3. CCA Care Model

Emphasis on Primary Care

CCA's consumer-driven care model relies heavily on enhanced primary care and care coordination. From the time of enrollment, members are encouraged to be active participants in their own care, and members select their primary care provider (PCP) upon enrolling in a SCO or One Care plan. Allowing members to select a primary care provider allows them to maintain existing relationships with providers, or to select providers that are capable of best meeting their specific needs. The PCP selection informs where members will receive their comprehensive assessment, and CCA structures the Care Team around the selected primary care sites.

CCA's model features two types of primary care relationships. The majority of members see a PCP that CCA has contracted through a preferred primary care network, many of whom were the members' PCP prior to enrollment in SCO or One Care. The remainder sees primary care physicians

employed directly by CCA. More complex members who do not enroll with an established primary care provider are referred to primary care physicians employed by CCA, who are more familiar with the complex population and able to provide a variety of services to help stabilize the member, such as home visits. In either case, the primary care provider can be a nurse practitioner, physician assistant, or a physician, which allows for the care delivery model to be more financially viable and efficient.

Preferred primary care relationships are key to CCA's continued development. CCA continues to expand its networks, and is developing relationships with a selected network of primary care practices. CCA selects primary care practices, including health centers and private practices, by reviewing care patterns to identify primary care sites already caring for their members, identifying practices that are best able to provide the variety of services required by more complex patients, and ensuring a practice's receptivity to working in a collaborative practice model with CCA's interdisciplinary teams.

Emphasis on Consumer Engagement

A major part of CCA's model involves engaging consumers actively in the development of their care plans. CCA encourages patients to establish their own goals in collaboration with their providers, which can either be medically focused or involve quality of life issues. In CCA's view, this process is essential in building a trusting and reciprocal relationship between a patient and a provider. In addition, CCA's focus on consumer engagement is reinforced by its dedication to consumer involvement on the CCA Board of Directors. In addition to ensuring that its Board is comprised of individuals committed to the importance of consumer voice in governance matters, CCA actively collaborates with service groups in the community, such as independent living centers, that have major roles in patient and consumer advocacy.

"For many of our members, medical care is the least of the issues. Helping people to address the more fundamental challenges they experience in their daily living is far more the priority to help improve quality of life."

- Lois Simon, MPH,
Chief External Affairs Officer

Comprehensive Needs Assessment

Following enrollment in a SCO or One Care plan, CCA members must have a face-to-face comprehensive needs assessment in order to ensure that CCA has an in-depth understanding of the member's clinical, functional, nutritional, social, and long-term care needs. For the SCO program, there is also a supplemental portion to the assessment, which incorporates MassHealth requirements and functional items from CMS's Minimum Data Set - Home Care (MDS-HC). In the case of One Care, this assessment must be performed within the first 90 days of enrollment in the program. During the One Care comprehensive assessment, members are asked whether they would like to meet with a Long-Term Services and Supports (LTSS) Coordinator. The evaluation ultimately informs CCA in assembling the patient's Care Team, as well as the clinical and social services required for the individualized care plan. The Care Team then revisits the comprehensive assessments at least every six months to review and modify the individual care plan.

Interdisciplinary Care Team

At the center of CCA's interdisciplinary care team model is its dedication to assigning a single point person that is responsible for coordinating the patient's care. Care Teams are configured to include primary care practitioners, nurse practitioners, geriatric social service coordinators, registered nurses, physical and occupational therapists, and behavioral health specialists.[18] While many CCA members are high-risk and, consequently, require more intensive in-person care, lower risk members may receive telephonic care management, particularly in the One Care Program.

Provision of Non-Medical Services

The provision of non-medical services to address social needs is a cornerstone of CCA's care model. Unmet social needs associated with poverty—such as unstable housing, unemployment, food insecurity, social isolation, and lack of transportation—serve as stressors and structural barriers that diminish an individual's ability to access services and comply with self-management plans. To mitigate these adverse impacts, CCA has institutionalized the provision of services to meet unmet social needs. The financial flexibility provided by CCA's global capitation payments is a key factor in CCA's ability to provide these non-medical services. While CCA is not unique in recognizing the importance of unmet social needs, CCA is one of the first to develop strategies to address them.

CCA has institutionalized responsibility for providing non-medical services by delegating responsibility to care managers to determine patient needs and approve routine requests. Care managers approve non-medical expenses to address a particular patient's needs, which allows the decision-making to be performed by someone in a close relationship with the patient, rather than an approval body with less knowledge of the patient's needs. Some examples of services that

> *"For individuals with a serious disability or chronic illness, inadequate attention to their social and mental health needs quickly translates into increased medical service and hospital costs."*
>
> *– Dr. Robert Master, former Chief Executive Officer*

CCA has been able to cover for members include air conditioning, wheelchair ramps, meals, and pet care when hospitalized. CCA has also paid for transportation to church or other community activities in order to combat social isolation among the elderly, a common trigger for depression.[19] This provision is similar to the approach that some Coordinated Care Organizations are taking in Oregon, which are giving local community health workers, called "health resiliency specialists," a small flexible spending account that they can utilize to fund patients' non-medical needs, such as a refrigerator for medication, in a discretionary fashion.[20]

Long-Term Services and Supports (LTSS)

Both SCO and One Care members may require LTSS, for which there is a coordinator. Though responsibilities and level of involvement in care coordination varies, members will have one point of contact to advocate for the member's priorities. In order to coordinate care, SCO members rely on geriatric service and support coordinators that work for Aging Services Access Points (ASAPs), who are local gatekeepers of support benefits and services offered to seniors. One Care patients are connected to care coordinators employed by an array of community-based agencies including independent living centers, ASAPs, and recovery learning centers. For those needing personal care

assistant (PCA) services, CCA facilitates through a fiscal intermediary the members' ability to employ their own workforce just as they are able to do under the state's fee-for-service PCA program, allowing members to have more direct control of service provision.

Linkages to Social Services

In recent years, there has been a growing interest in better coordinating social services, behavioral health, and public health in the safety net, recognizing that vulnerable individuals often have unmet needs spanning multiple systems. While this idea is just beginning to spread across ACOs nationally, CCA has almost a decade of experience in linking its members with social services.

Needs related to social supports are documented during CCA's patient assessment process. The patient's care manager then incorporates social service needs into the member's care plan and facilitates and coordinates their referrals. In cases where multiple social services supports may be necessary, the Care Team may assign a health outreach worker to the patient's care team. The health outreach worker then works with the care manager and serves as a liaison between a member and many social services. The health outreach workers are then responsible for assessing needs and connecting members with resources to address key social determinants of health.

Housing insecurity and homelessness in particular remain pressing issues for many CCA members, and CCA Care Teams assist in connecting members with housing services and applications. CCA has also offered higher levels of assistance, such as housing coordination, to SCO members discharged to the home and transitioning back to more independent living. Given the high needs for housing, especially amongst One Care members, the organization is in the process of searching for a more sustainable solution to address these issues among its members.

Development of Preferred Networks and Referral Systems

A key strategy for implementing CCA's care model is the development of a preferred network and referral systems with various community entities. This important strategy mirrors the strategies of many ACOs emerging in both safety-net and commercial markets. The goal of these networks is twofold. First, they seek to facilitate coordination among CCA's patients using services outside of CCA's immediate provider network. These preferred networks facilitate handoffs, care transitions, and communication regarding CCA patients. Second, the creation of preferred networks is a key element of CCA's strategy to reduce costs. In building these networks, CCA sought out both clinical and non-clinical partnerships that shared a common vision, reinforced by the provision of capitated payments that, in some instances, allow partners to share in financial benefits. Given the regional dispersion of CCA members across the state, the identification, development, and growth of these preferred networks are particularly important to better controlling quality of care and member costs.

While it works with many hospital systems, CCA shares highly aligned clinical relationships with a small number of hospitals that treat a significant volume of its members, and these facilities are most equipped to provide programmatic interventions needed by both SCO and One Care members. In one case, CCA maintains a staff of hospitalists on-site 365 days of the year from 7:00 a.m. to 7:00 p.m., and a nocturnist after 7:00 p.m. In two other hospital systems, CCA employs embedded nurse care managers. CCA's hospitalists are particularly important because they are familiar with the multitude of complex social factors that impact the health of CCA's complex patients, and can more effectively facilitate care transitions and referrals within CCA's networks. CCA will encourage patients to use these sites in order to receive care so that CCA members in these hospitals have an individual advocating for and guiding their care. These preferred relationships have led to improvements in the total cost of care, admissions, and readmissions, and have been crucial for managing care for members.

CCA also developed preferred networks for nursing homes and skilled nursing facilities, with the goals of improving length of stay and readmissions to skilled nursing facilities. CCA refers SCO members to long-term care facilities when required. The SCO program prioritizes member independence, and strives to keep members out of nursing homes, meaning that only the frailest within the SCO program will require long-term care facilities.[21] Many of those who use long-term care facilities do so only for short duration stays (4 months, or often, less) for rehabilitation.[22] As a result, CCA has witnessed downward trends in utilization of nursing home services for SCO members. Furthermore, within the Commonwealth Care Alliance program, the percentage of nursing home-certifiable patients permanently placed in the nursing home per year is 8.5 percent, compared with the Massachusetts rate of 12 percent.

While developing preferred networks of long-term care facilities is a priority for CCA, there have been challenges in identifying facilities that are equipped with the resources required to care for CCA's complex SCO members. For SCO members, achieving the necessary provider capacity has been challenging because of the geographic dispersion of elderly members and because of the importance of family preference in nursing home placements.

Innovations in Enhanced Services for Vulnerable Patients

CCA's culture of innovation and adaptability were important factors in its development of a unique set of integrated services for vulnerable patients, and this emphasis on innovation is consistent with Dr. Master's vision of CCA being a laboratory for innovation. Indeed, despite the success of SCO, the care model developed for the SCO program had to be extensively redesigned to meet the needs of the under-65 population of dual eligible patients. Low-income, vulnerable individuals such as those in the One Care program are more likely to experience a multitude of health, behavioral health, and social needs, requiring care navigation across multiple and fragmented systems. These fragmented systems often result in uncoordinated, insufficient care and unmet needs at the patient level. Furthermore, many of the services that do exist are not integrated with traditional healthcare and are not available at a reasonable cost. In order to address these issues, CCA is identifying gaps in the existing system and pursuing a number of innovative solutions that fill the unmet needs of its patients. The goal of the following innovations is to provide access to services that directly fill many of the common service gaps in a fashion that is cost-effective and integrated with traditional healthcare services.

Medication Management

Medication management was a key area where CCA adapted its practices to improve quality and cost outcomes. Previously, a practitioner from a certified home health agency would dispense medications for a significant number of CCA's members two to three times a day. This service was very costly, and CCA desired to provide more cost-effective services without compromising quality of care. To address this issue, CCA has partnered with a local pharmacy and uses pharmacy staff, who provide the services at lower cost, to assist in medication management, which includes dispensing of medications, education, and medication reconciliation services. This care delivery change was found to be safer, more coordinated, cost-efficient, and engages members as a respected part of the care team. This practice was initially developed for the SCO program, and resulted in large savings. It is now it is being introduced in One Care.

> *"All of these innovations are to fill a clinical need that we see as providers."*
>
> *—Dr. John Loughnane, Medical Director*

Mobile Integrated Health Services

CCA was also an early innovator in preventing inappropriate emergency department visits and subsequent inpatient acute care utilization. CCA developed a community paramedicine pilot consisting of paramedics employed by an ambulance company (a strategic partner) who provided urgent care to members at home under the medical direction of CCA primary care teams. The pilot, which began in October 2014, consists of community care paramedics who are dispatched to see patients in their homes between 6:00 p.m. and 2:00 a.m. by CCA providers. They are capable of providing a majority of the care that an emergency department can, including stat laboratory studies, EKGs, IV fluid, and medications including antibiotics, diuretics, and pain/anxiety agents. To ensure high quality of care, paramedics in the pilot were required to have an extra 300 hours of training structured by CCA and to have previous extensive paramedic work experience. The paramedic scope of practice includes routine medical care, behavioral health, and end of life care.

Discharge Pilot Program

CCA's discharge pilot program represents another innovation in preventing hospital readmission by providing extra support to patients during transition home from the hospital. It starts with an emergency medical technician (EMT) meeting the member in his or her hospital room. The EMT is actively involved the discharge process and follows the member back to their home. If, upon arrival at the member's home, the member requires medications or food, the EMT team assists the patient with these needs prior to leaving the patient at home alone. This process has since spread from one highly aligned hospital to others with whom CCA contracts. The processes have now been embedded into the hospital teams at the preferred hospitals that CCA works with.

Palliative Care Program

CCA is an early innovator in the realm of palliative care. The inefficiencies of traditional Medicare hospice models and the lack of flexibility they offered, coupled with its lack of integration with primary care teams, prompted CCA to redefine the payment and structure of the delivery of end-of-life care. Under the traditional model, CCA members referred to hospice would often be separated from the integrated care they had experienced with their CCA providers before entering into hospice. Furthermore, the majority of revenues would accrue to the hospice provider, rather than to CCA. To address this issue, CCA began negotiating with hospice agencies to develop a cost-effective, integrated care model that combines ongoing medical care with hospice services on a fee for service schedule instead of a per diem payment. Under this program, CCA's providers engage hospices to provide open-ended end-of-life care, removing many of the artificial barriers that often keep patient's from entering into a palliative care approach at the end of life. The teams are structured such that hospice providers are considered partners in the Care Team, but do not lead end-of-life care in a traditional primary care setting. Under this innovative program, CCA members not only benefit from increased continuity of care, but also receive hospice-related benefits, such as RN palliative care visits and night coverage for acute health care needs that otherwise would be unavailable under traditional hospice programs. Members appear to have responded positively to this care structure. On an average day, CCA has the vast majority of its members whose disease trajectory is consistent with end of life care in the Palliative Care Program. Also, CCA members generally enter into focused end of life care much sooner than their Medicare Hospice counterparts. While all CCA members have the right to choose their Medicare Hospice benefit, only a small number choose to do so.

Crisis Stabilization Unit

Psychiatric inpatient admissions represented another area where CCA applied its culture of innovation for better patient care and improved costs. In reviewing psychiatric inpatient admissions, CCA found significant cost inefficiencies and gaps in appropriate mental healthcare services. For example, during the month of June 2014, CCA had approximately 65-70 of its 2,000 One Care members with significant mental health needs in a psychiatric inpatient hospital setting at a per diem cost of about $1,100/day. CCA determined that at least half of these hospitalized patients could and should be served in less acute Crisis Stabilization Unit (CSU) settings at a per diem cost of about $550/day. However, at the time, CSU capacity and essential step-down supported housing capacity was very limited in Massachusetts.

In response to this lack of an intermediate level of care between inpatient and outpatient settings, CCA made its own investments to build the essential community capacity. CCA opened its own CSU located in a closed wing of a local community hospital in Dorchester, Massachusetts, and opened a second in Brighton (a neighborhood of Boston) later in 2015. In doing so, CCA is able to direct its patients away from higher cost inpatient stays to more appropriate crisis stabilization settings

at approximately half the cost. This innovation is particularly important for the One Care population, given the number of patients with behavioral health needs who present with episodes requiring immediate stabilization.

Behavioral Health Homes

The introduction of the One Care program required CCA to adapt services for a large number of new patients with behavioral health needs. For patients with serious mental illnesses requiring extensive care management and psychiatric services traditionally unavailable in primary care settings, CCA increasingly recognized the need for coordinating patient care from a mental health setting. This led CCA to establish behavioral health homes integrating mental health providers with medical providers who were capable of supporting high-risk members with behavioral health issues. CCA uses specific human service providers to address the needs of members with substance abuse and serious mental health issues. For instance, CCA has built a relationship with one such provider, which assists in treating individuals with all levels of addiction, and treats patients with complex medical and psychiatric needs. CCA was also intentional in partnering with some behavioral health homes that had Community Based Flexible Supports, Department of Mental Health financed services, so as to maximally leverage rehabilitative interventions and supports for adults with mental illness. Many of CCA's current behavioral health homes have established mentoring programs, which include monthly case reviews to discuss high service utilizers with complex medical issues.

> *"Innovation is not just the original idea—it's how do you alter what you do to get the best system that you can."*
>
> *—Dr. John Loughnane, Medical Director*

Organizational Support for Innovation

These recent innovations are embedded in a larger culture of innovation at CCA, which has become a central feature of its operations. This culture of being a laboratory for innovation was started by Dr. Master, but has become institutionalized at CCA over time. The medical and business leadership work together on a weekly basis to identify service gaps and opportunities for improved service and cost reductions. The medical and business leadership also meet weekly to discuss the opportunities for enhanced services, often relying on recommendations from providers in the field. Furthermore, data is considered key to decision-making, and CCA prides itself on being a data-driven organization. Opportunities for innovation are identified through analysis of utilization and cost data, which can reveal serious problems in patient care. When innovations are implemented, they are carefully monitored in order to judge their success. Furthermore, CCA uses its data to inform continuous quality improvement efforts, and shares data back with its partners using quarterly reports to keep them informed of its progress towards goals.

Payment Models

CCA's care model is supported by two unique aspects of the organization's structure. First, CCA as an organization receives upfront global capitation payments for its members, which allows CCA to spend funds more flexibly than traditional fee-for-service (FFS) payments in order to offer a broader mix of enhanced services that can meet its patients' complex needs. Second, CCA is a unique hybrid organization, serving both as a health care provider and health insurer to their patients. The payer-provider nature of the organization allows CCA to be both patient- and provider-oriented, and entertain balanced perspectives of both health plans and provider organizations.

CCA as Payee

CCA receives upfront capitated payments through two separate blended funding streams from Medicare and Medicaid. The ratio of Medicare to Medicaid payments is close to 50/50 for the SCO program. The per-member-per-month (PMPM) capitated rate is updated year over year in both programs.

CMS pays the Medicare portions of CCA rates, which are risk-adjusted by Medicare using the Medicare Hierarchical Condition Categories (HCC) model, which uses diagnostic codes to create a different rate for each member. CCA thus receives higher Medicare payments for more medically complex patients. For Medicaid, MassHealth assigns each SCO or One Care member to a discrete rating category, based on each member's clinical profile, care setting, and the geographic region in which the member resides. Members enrolled in One Care are automatically given a proxy-rating band by MassHealth using an algorithm based on its claims data. Certain diagnoses map to rating bands. However, members enrolled in CCA are often misclassified by MassHealth or under-classified in medical complexity, resulting in lower premiums than are required to provide care for many complex patients. Therefore, CCA runs a separate algorithm to assign members to a rating band, which includes long-term services and supports as well as diagnoses. To do so, CCA uses a version of the Minimum Data Set for the basis of the comprehensive assessment, with supplementary questions about social issues like mental health, employment, recovery and housing. Following CCA's internal assessment, members may be re-categorized or upgraded in complexity in the MassHealth payment categories. This process is crucial for CCA to receive sufficient reimbursement to provide the critical array of services to its most complex members.

CCA as a Payer

CCA seeks to align the payments it receives from CMS and MassHealth with its payments to contracting provider groups, as it believes that provider groups will perform more efficiently if they share a financial stake in the outcomes. While many ACOs are only beginning to address this, CCA has had over a decade of experience in aligning its own payments with that of contracted providers.

Currently, all risk-based contracting is done through the SCO program. There are a wide variety of risk-based contracting arrangements among CCA's contracted providers. A small fraction of CCA's providers are 100% at risk and are paid under a global capitation for all services provided, minus a small administrative fee collected by CCA. A subset of CCA's providers are partially at risk and may share in a percentage of savings, and a number of CCA's providers remain in purely fee-for-service arrangements. Finally, CCA also provides supplemental PMPM-based payments for certain services such as behavioral health homes. For some providers, these incentive-based payments can be significant, contributing to providers' bottom lines. Overall, CCA has full or partial risk arrangements with several hospital and primary care provider organizations with whom they contract. In these instances, CCA is delegating the responsibilities for

care coordination to the provider groups providing primary care through its risk-based contracts.

CCA decided against instituting risk-based contracts in the first year of One Care, recognizing that it would be difficult to create reasonable targets for performance payments given the lack of appropriate data. Another hurdle in expanding to One Care was contracting with providers for the new types of services offered through this program. CCA has had internal task forces looking at community long-term services and supports and behavioral health providers, as well as nursing homes. CCA wants to extend risk-based contracting to these entities, but does not have sufficient volumes to have exclusive arrangements given the geographic variation in its membership base. While CCA wants to develop preferred relationships with mental health agencies delivering behavioral health services and community long-term supports as well as nursing home care, this is difficult because of geographic dispersion of its contracted provider network. Despite its commitment to capitation, this leaves many of CCA's services to be continued to be paid on a fee-for-service basis. Notwithstanding some challenges, CCA's unique hybrid structure of being both a payer and a payee have allowed the organization key flexibilities to provide care and align incentives with contracted providers.

"Our care teams meet our members 'where they are,' working diligently to build a trustful relationship. This may be in their homes, at an agency's office, or under a bridge. We do what it takes."

– Lois Simon, MPH,
Chief External Affairs Officer

Challenges to Implementing the Social ACO model

Despite the continuing success of SCO, CCA's main challenges today involve adapting its care model to meet the needs of the under-65 population of dual eligible patients. CCA continues to address four key challenges in this area: patient engagement, appropriate access to behavioral health services, coordination with long-term services and supports, and receiving adequate level of payment for infrastructure and services to meet the needs of complex patients.

First, one of the most pressing challenges that CCA currently faces is introducing and engaging One Care members into its new care model. Patient engagement requires identification of members; establishing initial contact; meeting for comprehensive needs assessment; individualizing a care plan with input from the member; and maintaining engagement in care processes over time. Unlike SCO members who enroll voluntarily, some One Care members have enrolled voluntarily whereas large numbers of others were initially auto-assigned to CCA. Within a few months following the startup of One Care, CCA found itself with nearly 3,600 new patients, which were required by Medicaid to have a comprehensive assessment completed within 90 days of enrollment. This would have presented major logistical problems for any small organization, and the complex nature of the population presented even greater challenges. Failure to complete the comprehensive assessment in a timely manner risks financial losses due to noncompliance with regulatory requirements or having the member categorized into an inappropriately low rating band.

CCA's challenges in identifying One Care patients begin with the limitations in the data that CCA receives from its government payers pertaining to its assigned members, which is often incomplete or inaccurate. Compounding this issue was the significant proportion of members in this population

with inconsistent access to phones. In order to address these challenges, CCA attempts to contact members multiple times and at different times in the day. CCA has also strategically used pharmacy data to obtain current phone numbers for members. Nevertheless, an estimated 30% of membership was unreachable for a number of months. This inability to reach members was partially attributable to an auto-enrollment process that despite CCA's efforts, is often misunderstood by members until they have a health care encounter, and partly due to some members avoiding the comprehensive assessment.

It has proven difficult to identify and assess patients who may not want to engage in the health care system, particularly members with serious mental illnesses and substance abuse disorders. These patients may not realize or accept problems requiring treatment or be willing to meet with CCA outreach staff about the services and benefits available to them. While there is pressure to complete the assessments within a window of time, CCA's first priority is creating a rapport with members from the time of enrollment. This involves building trust, which can be difficult for many members because of previous untoward experiences with the health care delivery system. Building trust often includes meeting members where they feel comfortable, in their homes, an office, or public places. CCA also sends "Call Me" letters to enrolled members, requesting them to call CCA so they can present the services available. CCA is beginning to perform an internal assessment on whether and which activities have been effective.

Second, access to appropriate behavioral health services poses another significant challenge for CCA. As described above, care coordination is the linchpin of CCA's care model. CCA has a relatively mature care coordination model, which has many of the essential elements of other emerging social ACOs and other high cost care management programs being implemented by safety net providers. Although considered largely successful by CCA leadership, it has faced two challenges in extending the model to One Care members. First, CCA confronted an unexpectedly high need for behavioral health care among its One Care members. CCA had already established integrated behavioral health care programs as part of its interdisciplinary care teams, but they had to be extensively redesigned given the severity of the problems among One Care members with serious mental illnesses. Many members, including those with serious mental illness, do not already have community supports, because they were seen as too complicated to be managed due to their clinical difficulties and poor compliance. Some were Department of Mental Health (DMH) clients that were not well connected, or there were patients with behavioral health issues who did not meet DMH client requirements. CCA had to build infrastructure for behavioral health supports in inpatient and outpatient settings, which meant contracting with providers who specialized in providing care for persons with serious mental illnesses. This process involved developing behavioral health homes with the contracting mental health agencies described in the sections above.

Third, CCA has to develop a new infrastructure for providing community supports for One Care members through contracts with the independent living centers, ASAPs, and recovery learning centers throughout the state. These contracts involved establishing the new role of LTSS Coordinators. Defining this new role and coordinating it with other team members remains a challenge.

Fourth, sufficient reimbursement and appropriate risk adjustment has also arisen as a key challenge for CCA. The financial flexibility provided by CCA's global capitation payments is a key factor in CCA's ability to provide non-medical services. In the One Care program, while it has been critical in supporting a comprehensive care model for patients, several related financing challenges have emerged.[23] One of these limitations is the method by which Medicare and Medicaid risk-adjusts for social and medical factors. During the start-up period, CCA felt that a substantial number of patients were placed in inappropriate risk categories, and therefore the rate did not provide adequate payment for the patients' level of medical complexity. At the same time, the start-up costs for the One Care program were higher than expected, due in part to the state's rapid auto-assignment of large numbers of members to CCA. Furthermore, many of these members were underserved prior to being enrolled and arrived with complex untreated medical and service support issues. As a result of the influx of members with high needs, CCA's startup infrastructure cost was substantially higher than expected, requiring the addition of a large number of new staff and upgrades to various systems. However, the state did not pay directly for these upfront startup or infrastructure costs for the One Care program. CCA was not alone in experiencing financial difficulties in implementing the One Care program, as evidenced by Fallon Health's recent withdrawal from the state program for similar financial reasons.[24]

These challenges are similar to those being experienced by many emerging safety net ACOs across the country. The issues of engaging patients, adapting care models to meet the unique needs of high-risk populations, uncovering significant unmet needs, revising global capitation payments to adequately reflect social and medical risk, and obtaining funding to cover up-front investment costs are issues that will impact social ACO's ability to reap financial rewards and achieve Triple Aim goals.

Conclusions and Lessons for Other Emerging ACOs

Commonwealth Care Alliance is an early innovator in developing a social ACO that provides person-centered, community-based care. CCA has developed an effective model for members of the SCO program, effectively replacing expensive hospitalizations and nursing home placements with enhanced primary care and care management in the community. To date, the results for the SCO program have been promising: the number of hospital days per year for a CCA dual-eligible member is 2.0 days, 77 percent lower than the rate of hospital days per dually eligible patient enrolled in the Medicare fee-for-service program.[25] Average annual medical expense increases have also been lower for nursing home and outpatient care in CCA.[26] It remains to be seen whether CCA can achieve comparable results for its One Care program.

CCA's experience offers a number of lessons for other providers and health plans looking to develop care models for vulnerable populations:

1) An integrated care team that addresses unmet social needs alongside medical and behavioral health is a necessary to achieve the social ACO goals of improving health outcomes and costs for vulnerable populations. CCA's success in addressing unmet social needs of its patients highlights the potential for provider organizations to address a broader range of social determinants that can affect health. In contrast with some social ACO models emerging currently, which are more fully integrated and led collaboratively with social service and/or mental health agencies, CCA remains predominantly a medically-focused service provider. However, despite the fact that CCA is not a fully integrated multi-service provider, CCA has successfully institutionalized the direct provision of linkages to non-medical services that address unmet social needs, coordinated from a medical setting.

2) Global capitation provides the financial flexibility to provide a broad mix of services and the financial incentive to innovate to reduce hospitalization and total medical expenses. These capitated payments from Medicare and Medicaid provide CCA with the flexibility to provide a broader mix of services that address the social determinants of health, including social services than would otherwise be possible under a volume based fee-for-service system. With this flexibility, CCA can pay for services such as durable medical equipment and minor home modifications that may be restricted by federal or state regulations governing benefits in the Medicare or Medicaid programs. The financial flexibility is bolstered by the fact that with a blended funding stream, CCA can reap financial rewards for reducing avoidable hospitalizations, which is not possible under standard Medicaid payment policies. This also allows CCA to better align its financial incentives with its preferred network of primary contracting partners.

3) CCA's culture of innovation and adaptability is a model of organizational culture that will likely be necessary for future ACOs serving vulnerable populations. Nearly a decade prior to the proliferation of ACOs, CCA began developing its own integrated care model, incorporating enhanced, team-based primary care services and the creative provision of community-based services. These elements have become standard practice for many emerging ACOs and high cost case management programs today; however, their creation and evolution over the past decade required CCA to develop a culture of innovation and adaptability throughout the organization. Initially, the visionary leadership of Dr. Master was critical in developing this culture; however, in the decades since, this culture of innovation has been institutionalized throughout the organization, led by both its medical and business leadership, which relies on its use of its data analytic capabilities in decision-making about new clinical programs.

The results for the SCO program have been promising: the number of hospital days per year for a CCA dual-eligible member is 2.0 days, 77 percent lower than the rate of hospital days per dually eligible patient enrolled in the Medicare fee-for-service program.[25]

Perhaps more than any of CCA's other key strategies, its culture of innovation and adaptability allowed CCA to realize success as an organization.

Payment and delivery reform promises to transform care for the nation's most vulnerable citizens. This is needed more than ever given rising healthcare costs and continued fragmentation of the care system. CCA's social ACO model represents one approach to caring for some of the highest risk populations, though even this approach has had to be adapted extensively for the dual-eligible population under 65. Given its longevity of refining a care model, a global capitation payment model and a culture of innovation to care for high-risk, vulnerable populations, CCA's experience is relevant to any provider organization seeking to transform care for high-risk populations.

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