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Center for Health Care Strategies

Integrated Care Planning for Medicaid Members with Complex Needs: Lessons from MassHealth

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TAKEAWAYS

- Integrated and cross-organizational care teams — including care coordinators, care managers, community health workers, nurses, nurse practitioners, physicians, physician assistants, and social workers — offer a valuable solution to provide high-quality care for people with complex health and social needs.
- Successful integrated care planning places the individual at the center of the care, ensuring that their experience is coordinated among multiple providers and health systems. To achieve this goal, it is important to build relationships, establish clear communication channels, and clarify shared care planning processes.
- This brief outlines lessons from the *MassHealth Care Planning Learning Collaborative* where Massachusetts Accountable Care Organizations and Community Partners integrated care planning across their organizations to improve care for Medicaid members with complex needs.
- While focused on the MassHealth context, the solutions outlined in this brief can inform providers, payers, and community partners in any setting seeking to enhance services for patients.

Interdisciplinary, cross-organizational team-based care can help address the uncoordinated and fragmented services that many people experience with health and social service systems that exist in siloes.

This brief outlines lessons from the *MassHealth Care Planning Learning Collaborative*, led by the Center for Health Care Strategies (CHCS), where Massachusetts Accountable Care Organizations (ACOs) and Community Partners (CPs) worked together to improve shared care planning for members across their organizations.

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Accountable Care Organizations and the Need for Shared Care Planning

Uncoordinated care is inefficient, costly, and associated with poorer health outcomes, especially for people with complex health and social needs.[1] People enrolled in Medicaid who receive care from multiple providers, within and across health systems, experience uncoordinated care, and report lower quality of health and increased levels of stress.[2] Massachusetts, along with other states, has been working to improve the coordination of care and services for its Medicaid population, as well as health care access and quality while reducing ever-growing health care costs.

In 2017, MassHealth (Massachusetts' Medicaid and Children's Health Insurance Program) renegotiated its 1115 waiver to authorize $1.8 billion in funding over five years through the Delivery System Reform Incentive Payment (DSRIP) Program. MassHealth invested DSRIP funding to support the creation of Medicaid Accountable Care Organizations (ACOs) — networks of physicians, hospitals, and other community-based health care providers — that are financially accountable for total cost of care, quality, and member experience.[3] One of MassHealth's primary DSRIP objectives was to integrate historically siloed health sectors. The state used DSRIP resources to provide incentives for ACOs to participate in delivery system restructuring efforts designed to better serve MassHealth members with complex health and social needs.

To support Medicaid ACOs and CPs, MassHealth leveraged DSRIP funding in four areas:

1. Startup funding for ACOs;
2. Startup funding for CPs, as well as payment for care coordination supports;
3. Funding to support the ACOs and CPs in their restructuring efforts by investing in statewide infrastructure, workforce capacity, and technical assistance (i.e., Statewide Investments funding[4]); and
4. State operations and implementation, including oversight of the DSRIP program.

In this new care delivery model, MassHealth contracts with ACOs to deliver physical health care, mental health care, substance use disorder treatment, long-term services and supports (LTSS), and certain health-related social services to eligible MassHealth members.[5] To facilitate access to community-based services for members with behavioral health and/or LTSS needs, ACOs partner with CPs, community-based organizations that provide care planning and care coordination support.

There are three ACO models in Massachusetts (Exhibit 1). The majority of ACOs fall into Model A. All three types of ACOs must contract with Behavioral Health and LTSS CPs.

Exhibit 1. Distinguishing Characteristics of Massachusetts ACO Models[6]

ACO MODEL	ACO CHARACTERISTICS
Accountable Care Partnership Plan (Model A)	• Partners with a single managed care organization (MCO); each Partnership Plan has an exclusive group of primary care providers. • Paid a capitated rate and at risk for upside savings and downside losses. • Defines their own service areas, with MassHealth's approval. • Must meet MCO requirements (e.g., capital reserves).
Primary Care ACO (Model B)	• Has an exclusive group of participating primary care providers. • Paid through MassHealth's fee-for-service claims system, including shared savings and losses based on total cost of care and quality performance. • Covers behavioral health services via MassHealth's managed behavioral health contractor.
MCO-Administered ACO (Model C)	• Part of the PCP network for one or more MassHealth-contracted MCOs. • May contract with multiple MCOs; an MCO may also contract with multiple MCO-administered ACOs.

At the onset of the Medicaid ACO program, all ACOs were required to contract with all Behavioral Health CPs that had shared service areas, and with at least two LTSS CPs that had shared service areas. Over the last two years, MassHealth has allowed ACOs and CPs to sunset partnerships that were supporting very few members and focus on "preferred relationships." To coordinate services across systems, MassHealth requires ACOs to create a member-centered care plan. This care plan must include input from the member's entire care team, including staff from the ACO or MCO, the primary care practice, and the CP, and focus on the member's care needs and goals. ACOs are also required to assess the member's health-related social needs, identify additional community supports, and provide information and navigation to services that can address those needs. Creating a shared care plan across the health care system requires a focus on planning between staff in multiple locations and organizations, and processes to support it.

> **"The [Medicaid ACO and CP program] looks at the journey of the patient. Traditionally, health care [systems] have thought about health being administered and managed solely in a medical setting, but most people don't spend their life in the doctor's office, so pulling the community organizations [CPs] into this and helping to bridge those silos that exist has been pivotal.**
>
> - Christine Rooney, MD, Chief Medical Officer, Merrimack Valley ACO, AVP Clinical Initiatives & School Based Health Centers, Greater Lawrence Family Health Center

Shared Care Plan Definition

According to the Agency for Healthcare Research and Quality (AHRQ), "*a shared care plan is a patient-centered health record designed to facilitate communication among members of the care team, including the patient and providers. Rather than relying on separate medical and behavioral health care (treatment) plans, a shared plan of care combines both aspects to encourage a team approach to care*."

While shared care planning is a key part of high-quality integrated care, coordinating a shared care plan across unconnected organizations and different parts of the health care system can present challenges. As MassHealth was rolling out its vision for a shared care plan created by an interdisciplinary team with the member at the center, it was important for participating provider organizations, primary care provider (PCP) practices, health plans, and community-based organizations to agree on existing cross-organization processes that were working well. They also needed to commit to establishing new working relationships to improve team-based care delivery where processes were lacking.

The MassHealth Care Planning Learning Collaborative

Supported through Massachusetts DSRIP Statewide Investments funding, MassHealth and Abt Associates partnered with CHCS to implement the *MassHealth Care Planning Learning Collaborative*, a 12-month project to help Massachusetts' Medicaid ACOs and CPs[7] work together to improve their shared care planning processes for people with complex health and social needs.[8] Different types and levels of staff from the ACOs and CPs participated in the collaborative including care coordinators, care managers, nurses, outreach specialists, PCPs, program managers, and social workers.

Prior to the learning collaborative, CHCS conducted stakeholder interviews to explore existing processes and identify strengths and opportunities for improvement. Interviews with ACOs, primary care practices, and CPs revealed no single set of best practices for high-quality shared care planning and a lack of agreed-upon processes and communication pathways between organizations. Addressing these challenges as well as building trust and improving communication between ACO and CP staff members, became key objectives of the learning collaborative.

How to Achieve Successful Integrated, Interdisciplinary Care Planning

Achieving effective, shared care planning requires that staff have protected time to develop and test new workflows, especially those that support clear and direct communication between teams. During the learning collaborative, ACOs and CPs analyzed their shared workflows and identified points in the care planning process where communication between teams would improve care to help inform a more effective planning process.

MassHealth requires all ACOs and CPs to document how their organizations will work together to deliver care. However, interviews between CHCS and the ACO/CP teams revealed that while workflows and processes existed on paper, they were not consistently carried out on the ground. ACOs and CPs interviewed acknowledged a need to identify gaps, duplicative efforts, and ineffective workflows across organizations.

Many ACOs and CPs began the learning collaborative to improve the engagement process of members enrolled in the CP program, recognizing that improvements would yield immediate benefits for both members and care team staff. A faster, more efficient and coordinated member engagement process would allow CPs to build relationships with members earlier and continue providing services to members after initial outreach (see sidebar).

Community Partners Engagement Process

MassHealth, ACOs, and MCOs work together to identify eligible Medicaid members that have complex behavioral health and LTSS needs, based on previous service use, or identified through assessments and screenings as needing additional support and services. Care managers, PCPs, social workers, and other staff at ACOs or CPs can also refer Medicaid members into the CP program, as can members themselves.

After being enrolled and obtaining consent from the member to participate in the CP program, ACO and/or CP staff conduct a comprehensive assessment of the member's health and social needs. They use this information to create a member-centered care plan, with input from the member. The care plan is sent to the PCP (or their designee) for sign off, at which point the member is considered "engaged" and could begin accessing additional services and the CPs could receive payment. After a period of time, members could receive additional CP supports even if they had not been "technically" engaged, but CPs would not be paid for providing those services.

In joining the learning collaborative, ACOs and CPs identified a set of high priority challenges to work on together. Drawing on lessons from the collaborative participant activities, the following sections detail central components of successful collaboration between ACOs and CPs to:

1. Elevate member-centered care;
2. Establish effective shared care planning processes;
3. Use technology to better share data and information; and
4. Ensure leadership support of improving shared care planning processes.

1. Elevate Member-Centered Care

A crucial principle of high-quality care planning is to center the plan on the goals of the member or patient (and not the clinical staff).[9] Person-centeredness or member-centeredness is an approach to care that is directed by the participant to identify their strengths, assets, capacities, preferences, needs, and desired outcomes.[10] Exhibit 2 from the *NEJM Catalyst*, illustrates seven core values of patient-centered care.[11]

Exhibit 2. Patient-Center Care

Source: New England Journal of Medicine Catalyst. What Is Patient-Centered Care? Available at https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559. © Massachusetts Medical Society.

In the learning collaborative, ACOs, primary care practices, and CPs worked together on strategies to make shared care planning between their various organizations more member-centered. ACO and CP staff noted challenges to making the care plan more member-centered when there was lack of alignment between the goals the member

wanted to prioritize and the goals that member's care team wanted to focus on. For example, a member might feel that obtaining housing or transportation was their main concern and something that needed to be addressed before they could focus on managing their chronic disease. The care teams in the learning collaborative sought to ensure that the entire team agreed on understanding and prioritizing member goals. They tested strategies to help the member simultaneously focus on critical medical needs and goals in addition to their health-related social needs.

As part of their commitment to member-centeredness, some ACO and CPs explored how to bring members into integrated case conferences to test out best practices in centering the member's goals and care.

2. Establish Effective Shared Care Planning Processes

Ideally, shared care planning process improvements must come from those doing the work every day. Five key principles regarding how to best establish effective shared care planning processes emerged from the learning collaborative: (a) understand and delineate roles and responsibilities; (b) create clear communication pathways to reach members; (c) improve the care plan sign-off process; (d) involve PCPs and practice staff; and (e) implement integrated case conferences.

A. UNDERSTAND AND DELINEATE ROLES AND RESPONSIBILITIES

Learning collaborative participants recognized gaps in the understanding of what each organization on the care team did or what services they provided. ACOs and CPs used the following strategies to help understand and delineate care team roles:

- **Meet everyone on the care team through Zoom or, eventually, in person through regularly established meeting times.** Learning collaborative participants appreciated finally "putting a face to the name" of other care team members. This simple strategy established trust, familiarity, and fostered a team environment.
- **Use process mapping to identify care team roles and responsibilities and remove duplication.**[12] Once participants clarified roles, they outlined the staff who are responsible for which tasks and the associated processes required to complete those tasks. Several participating ACO and CP staff found that process mapping helped them remove duplicative roles and re-assign staff to new tasks.

These strategies provided the foundational elements of an effective care team that functioned more efficiently and improved members' experience and satisfaction with their care.

B. CREATE CLEAR COMMUNICATION PATHWAYS

Initially, participants from different organizations reported multiple outreaches to the same member from care managers, care coordinators, outreach specialists, and social workers. The organizations needed to streamline processes between ACOs and CPs to create clear communication pathways and avoid multiple outreaches to the same member.

- **Designate a single point of contact for each member.** A single point of contact, or one designated care coordinator for each member on an interdisciplinary cross-organizational care team, can make it easier for members to engage in care and for the care team to coordinate with one another. By establishing main points of contact, organizations avoided multiple outreaches to the same member and could more effectively coordinate with each other on other aspects of shared care planning.

> **The patient is at the center and the single point of contact is the central force of communication between partners at the PCP practice. We invite care coordinators to come and meet the patient at the practice and we do warm handoffs to create a close relationship and make the patient understand we are all part of the care team.**
>
> - Gerald Iralien, Community Resource Specialist, Beth Israel Deaconess Medical Center

C. IMPROVE THE CARE PLAN SIGN-OFF PROCESS

Another significant issue participants in the learning collaborative wanted to address was challenges with the member engagement process, especially care plan sign-off. CPs need a PCP, or a PCP designee, to review, approve, and sign care plans for members to be deemed "engaged" in the program. Participants, working in ACO and CP teams, needed to identify if the process was stalling or stopping and, more importantly, to determine why this might be happening.

There is a standard process for members to become engaged in the CP program (as described on page 5).[13] Many participants in the learning collaborative worked on refining their processes to achieve care plan sign-off in a timely manner. For example, after analyzing their care plan sign-off workflow, a program manager at Mass General Brigham discovered that care plans were going to a "zombie email inbox" and were not getting timely sign off by PCPs or designees — causing bottlenecks for CPs and others. She worked with colleagues to design a new care plan sign-off workflow so that

> **Our motivation [to create a new workflow for PCP care plan sign-off] was to not only make this process more efficient, but more meaningful and sustainable from the PCP perspective by bringing issues to their attention and allowing them to actively participate and provide feedback in the care plan process.**
>
> - Erin Maher, Program Manager, Population Health, Mass General Brigham

these documents go to the "orders" section of the electronic health record, prompting a timelier response from PCPs and designees.

D. INVOLVE PRIMARY CARE PROVIDERS AND PRACTICE STAFF

Learning collaborative participants were eager to improve collaboration with, and increase the involvement of, PCPs and primary care practices in the care planning process. CPs and other stakeholders wanted to engage PCPs not only as a source of referrals to the program, but to have PCPs actively involved in integrated care planning when appropriate. PCPs and primary care practices also expressed the desire to participate more in member care planning, but voiced concerns regarding their limited bandwidth and desired clarity on their specific role. Learning collaborative-developed strategies to increase PCP and primary care practice staff involvement in the care planning process included:

- **Identify when to involve PCPs and when practice staff are better positioned to address issues.** Staff at primary care practices such as care managers, nurses, or social workers were well suited to respond to a range of inquiries from CPs and not everything on the care plan must be directly handled by the PCP. Better relationships between CP staff and primary care practice staff resulted in more efficient use of PCP time and resources. For example, some CP learning collaborative participants identified a key contact at the practice, other than the PCP, to reach out to with member issues.
- **Create an elevator speech to describe CP services.** Some CPs created an "elevator speech" intended to assist PCPs, primary care practice staff, and members to quickly grasp what the CP program offered. CPs noted that PCPs and primary care practices in general had less knowledge about what LTSS services were and how they could help specific members with complex needs. In response they created talking points describing what LTSS services were available for PCPs and practice staff.
- **Understand the differences in PCP and Behavioral Health/LTSS CP communication styles and bridge the gap accordingly.** Behavioral Health and LTSS CP staff frequently write narrative progress notes whereas health care providers, trained in the medical model, typically use a standard format of bulleted SOAP (subjective, objective, assessment, and plan) notes to convey diagnoses and treatment plans usually with little narrative.[14] Many CPs in the learning collaborative found that summarizing their progress notes or extended narrative care plan made it easier for PCPs to participate in the integrated care planning

process. These improvements included providing PCPs with a bulleted list of information and highlighting important requests that were just for PCPs. Streamlining this process allowed CPs to get responses on care plans from primary care practices in a timelier manner and to access critical data they needed about the member to move forward with service delivery. This adaptation also led to more PCP involvement in the care planning process as PCPs could quickly grasp the overall care plan, as well as their responsibilities in that plan.

- **Underscore that CPs can help relieve some of the burdens on PCPs.** A PCP participating in the learning collaborative shared that CP services — such as helping address a member's food insecurity, providing referrals for their legal counsel, and coordinating various care from specialists — were invaluable to PCPs because they knew their patients' health-related social needs affected their medical issues, but PCPs and their staff did not always have time to address them.

E. IMPLEMENT INTEGRATED CASE CONFERENCES

While some ACOs and CPs met on their own to discuss high-risk cases, at the beginning of the learning collaborative participants noted that few interdisciplinary care teams met regularly to discuss members who were high-risk or experiencing a crisis. Hence, many participants designed and tested integrated case conferences as a method to improve care for members and better coordinate care across organizations.

> **When we set on this journey to improve and to evolve our integrated case conference, we really wanted to root it in shared goals between organizations.**
>
> - Chris Mauro, ACO Clinical Program Manager, Wellforce ACO

A key objective of an integrated case conference is to build authentic collaboration between organizations across disciplines to provide better care for members. ACO, primary care practice, and CP participants in the learning collaborative identified key best practices for successful integrated case conferencing including:

- Build trust between partners to support open and honest dialogue;
- Ensure responsiveness to communication and inquiries to facilitate care delivery;
- Share resources to drive further collaboration; and
- Understand the unique mission and cultural differences in approaches to care delivery between different service providers (e.g., between medical, behavioral health, and LTSS).

Learning collaborative participants found that integrated case conferences were most successful when there was a standing meeting time that did not get moved or scheduled over. In addition, learning collaborative participants needed: (1) to determine who should attend the case conference; (2) identify which high-risk members to discuss; (3) develop an agenda; and (4) communicate effectively when presenting pressing issues with high-risk members. One team instituted an SBAR (Situation, Background, Assessment, Recommendation) format for their integrated case conferences.[15] This communication method enabled them to review and assess cases more quickly, leading to more efficient case conferences and the ability to discuss more members.

A "root cause analysis"[16] tool developed by the Camden Coalition of Health Care Providers enhanced the effectiveness of the integrated case conferences. This tool includes four domains to identify and address mutually agreed upon needs of the member: medical, behavioral, social, and systems. "Systems" refer to the various organizations involved in a member's care — oftentimes organizations need to reassess how well they are working together to meet members' needs. If there are breakdowns in collaboration and communication, members may not be able to access services seamlessly.

3. Use Technology to Better Share Data and Information

Learning collaborative participants leveraged information technology tools to support shared care planning; however, many described challenges they faced with systems that were not interoperable. They also cited proprietary, regulatory, and privacy issues that added to the challenges they faced when trying to seamlessly exchange data to support team-based care. Despite these hurdles, participants were able to use technology more effectively to make progress in sharing data that helped facilitate shared care planning. Improvements included:

> **[Eliot Behavioral Health CP] had a shared interest in member level utilization information. We're bringing member-specific information into our meetings; bi-directional exchange of clinical information is needed. In our meetings, we have our EMR open and we prepare to talk about members to provide additional clinical information that may or may not be top of mind.**
>
> - Noreen Melanson, Director of Behavioral Health Innovation, Eliot Human Services Behavioral Health CP, Lexington, Massachusetts

- **An increase in DocuSign use** by primary care practices making it easier to obtain necessary signatures and care plan sign-off;
- **Read-only access to electronic medical records** (EMRs) for CPs. The ability for a collaborating CP to gain read-only access to EMRs meant they could follow the

clinical history, obtain an updated medication list, and confirm the CP had the most up-to-date member contact information;

- **Expansion of the use of telehealth**, which helped to increase access for some members, and meant that members did not have to worry about transportation or taking time off work to see a clinician; and
- **Zoom video functionality** that made it easy to meet across organizations. Staff were able to readily participate in either process meetings or clinical case conferences virtually.

4. Ensure Leadership Support of Improving Shared Care Planning Processes

A productive shared care planning process requires support from state Medicaid agencies and organizational leadership across health systems, payers, and community providers to be successful. In Massachusetts, improvements to care planning did not happen without investment, resources, and prioritization among care team staff, all of which required representation and support from leadership. Leadership from ACOs and CPs made important decisions that supported successful team-based care. Key decisions included, for example, allowing read-only access to EMRs — a game-changing practice that enabled CPs to have additional health and social services information about shared members, without having to ask ACO or PCP colleagues to spend valuable time sending it to them.

Engaged leadership is critical to advancing and achieving successful partnerships between ACOs and CPs. We know that our staff needs our support and the time to learn from past experiences and to test new processes within their practices and with our CPs. Building high-quality working relationships between primary care practices and our CPs is a priority for our organization and one that we know will make major differences for our staff, partners, and, most importantly, for the members that we serve.

- Christina Severin, President and CEO, Community Care Cooperative (C3), an ACO with over 160,000 Massachusetts Medicaid members

Looking Ahead to MassHealth's 1115 Waiver Renewal

Through 1115 waiver negotiations with the Centers for Medicare & Medicaid Services (CMS), Massachusetts is prioritizing plans for ongoing investments in the ACO and CP model, and shared care planning for members with complex health and social needs. Massachusetts is continuing its commitment to state innovation and interdisciplinary care planning as a core focus of MassHealth's current 1115 waiver period and will continue to be a priority during its next 1115 waiver period. MassHealth recently submitted its waiver renewal proposal to CMS and intends to continue the CP program.[17]

There are other parts of Massachusetts's waiver renewal proposal that support integrated, team-based care, such as implementing primary care sub-capitation payments for ACOs. This shift from fee-for-service to alternative payment models for primary care practice sites in Massachusetts will give practices upfront financing to hire community health workers and other front-line staff.

Additionally, Massachusetts will continue another innovative component of the current waiver, which is the Flexible Services Program.[18] This program provides funding to ACOs to pay for certain housing and nutrition supports for eligible members in the hope that closer integration of the delivery of health-related social services and medical care can lead to improved health outcomes and better member experience, while reducing the total cost of care.

Finally, a major focus area in the state's next 1115 waiver is investment in health equity. MassHealth recognizes the importance of identifying and reducing health care disparities to advance health equity. To achieve these goals, MassHealth will be offering substantial financial incentives to ACOs, and ACO-participating hospitals focused on health equity. Much of the work that ACOs and the hospitals will need to do to close disparities will require integrated care to help identify why the disparities exist, and what specific, targeted interventions can help close those disparities.

Closing

The opportunities discussed in this brief outline actionable strategies that health systems, community-based organizations, and other care providers can take to transition to interdisciplinary care planning. Participants in the MassHealth learning collaborative and other stakeholders in Massachusetts made clear that shared care planning processes requires upfront investment, dedicated time, and a commitment from each organization. While this brief is focused on MassHealth, the lessons herein

can inform work in other states. These strategies represent the foundational work on relationships, process improvement, and collaboration that are necessary for interdisciplinary care to work effectively and improve care for people with complex health and social needs.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

ENDNOTES

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