Robert Master, MD is founder and chief executive officer of the Commonwealth Care Alliance, a non-profit care delivery system with 25 primary care sites providing integrated health care and social support services to Medicare and dual eligible populations throughout Massachusetts. He has served as medical director for both the Massachusetts Medicaid program and one of the state’s first community health centers. Dr. Master also founded the Urban Medical Group, a practice that did pioneering work with nurse practitioners, providing home care for complex patients.

ABOUT THE INNOVATOR

Having experienced what he calls ‘medical care apartheid’ during his childhood in Boston, Dr. Robert Master has focused on providing high-quality care to low-income patients with complex needs for over 40 years. His tireless efforts to improve health care delivery for complex patients have made him one of the country’s foremost leaders in the field of publicly financed health care.

As a teenager, Dr. Master would frequently accompany his grandfather, who had been diagnosed with cancer, to doctor’s appointments, and recalls that, as a family “rich in many things, but not money,” they were frequently relegated to the hospital basement for care. This segregated health care system provided his family with lower quality care in almost every sense. “I said to myself, ’If I ever get to become a physician, I have to do something about this.’” And so he did.

Dr. Master began his professional career at a clinic just two miles from the hospital that had cared for his grandfather. Frustrated by the traditional medical structure that allowed for only short visits with patients suffering from a multitude of chronic conditions, he began a career-long mission in pursuit of new models and payment structures to comprehensively and sustainably address patients’ medical and social needs.

This quest has led Dr. Master to become an expert in understanding what program models and payment structures can best support patients with complex needs. Over his career he has honed his vision of better care by spearheading several health care delivery innovations. In the ’70s, Dr. Master formed the Urban Medical Group, a primary care practice that used nurse practitioners to conduct home visits for Medicaid patients with complex needs, resulting in lower average health care costs. Several decades later, he founded a Medicaid managed care plan for individuals with disabilities and/or HIV, pioneering use of a risk-adjusted, capitated payment arrangement with Massachusetts to support the model.

In 2003, Dr. Master created Commonwealth Care Alliance (CCA), a non-profit health plan and delivery system focused on providing patient-centered, team-oriented care to individuals with an array of socially and medically complex needs. Today the program is recognized nationally as a model for providing low-cost, high quality care to Medicaid and Medicare patients. Dr. Master has ambitious visions of scaling up and expanding CCA’s care delivery programs as he continues to blaze new trails in better addressing the needs of complex populations.

“The reimbursement structure valued short, rapid visits that were narrowly medically focused, and had a doctor alone in his office. That’s a very one-dimensional model that doesn’t fit what people with multiple, complex conditions really need.”

---

The Center for Health Care Strategies’ Complex Care Innovation Lab, made possible by Kaiser Permanente Community Benefit, is bringing together leading innovators working to improve care for vulnerable populations with complex medical and social needs. Participants will explore new ways to advance complex care delivery at the local, state and national level. These profiles highlight Innovation Lab participants. For more information, visit www.chcs.org.
## ABOUT THE INNOVATION

### Commonwealth Care Alliance

**Program Description:** Commonwealth Care Alliance (CCA) is a health plan that provides care to some of Massachusetts’ most vulnerable populations. CCA has numerous partnerships with clinics, medical groups, and social service agencies that help deliver care to its patients. It provides services well beyond those typically covered by a health plan, including in-home care, 24-hour provider access, patient education, and enhanced behavioral health services. These features have helped CCA achieve impressive cost-savings and reductions in nursing home placements.

**Population:** The organization serves Medicare and dual eligible seniors through its Senior Care Options plan, and individuals with disabilities through its Disability Care Program. There are more than 5,500 members enrolled in CCA, the majority of whom have such high needs that they have been deemed eligible for nursing-home placement.

**Delivery Model:** CCA’s multi-disciplinary care team is led by nurse practitioners and includes geriatric social workers, behavioral health providers, community health workers, and other specialists. Teams provide direct treatment and care coordination services, frequently in the patient’s home. Teams create a care plan with the patient that outlines the patient’s goals and the interventions necessary to meet them. The care team works closely with the patient to ensure that the goals are being met and adjusted as needed.

**Financing:** CCA has risk-adjusted capitated contracts with Massachusetts Medicaid and Medicare. It also has a contract with Neighborhood Health Plan to provide services through its Disability Care Program. It has partnerships with community clinics, health plans, and providers, and pays these entities a portion of the capitated rate for services. Savings are aggressively reinvested in the organization to finance its multi-disciplinary staff of clinicians and health care professionals, and to support the provision of enhanced services.

### KEYS TO SUCCESS

1. **Global payment financing** that is risk adjusted, thereby allowing delivery systems to be accountable and responsive;

2. **Enhanced primary care** that brings together a team of individuals to care for the patient, rather than a single primary care physician (CCA’s experience is that almost three times more money needs to go to support this model of primary care and patient management than the current standard investment);

3. **Emphasis on home- and community-based care,** recognizing that many enrollees are frail, homebound, and/or need palliative care, and thus have difficulty traveling to a clinic;

4. **Individualized care plans** that empower the care team to proactively provide necessary services to the patient;

5. **Flexible staff schedules and organizational processes** that allow nurse practitioners to quickly respond to the urgent patient needs that regularly arise; and

6. **Information technology that “ties it all together,”** providing care teams with 24-hour access to electronic medical records and case management/care plan development capabilities.

---

### Spotlight: Lessons from the Complex Care Needs Program

Having tested new approaches in this field for over 40 years, Dr. Master knows that “innovation means, if you’re not getting some failures, you’re not pushing the envelope enough.” In 2010, CCA partnered with the Cambridge Health Alliance (an integrated health care system) and Network Health (a nonprofit health plan) to launch a pilot Complex Care Needs Program to reach Medicaid-covered adults and children with multiple chronic conditions. CCA served as a subcontractor, connecting some of Network Health’s most complex patients, many with substance abuse and mental health disorders, to enhanced primary care.

In spite of recruiting a significant number of participants, the project was stymied by the issue of patients continuously cycling on and off Medicaid rolls. This churn was due to various factors, including patients not renewing their eligibility on time or temporarily exceeding the income requirement. At any given time, Dr. Master estimates that 40-45 percent of the population was churning, making it virtually impossible to provide continuous services. “We would get referrals, do comprehensive assessments, engage the patients, do the work, and then get notice that the person was no longer eligible,” says Dr. Master. “It was a continuous care system operating under a discontinuous financing system.” Though this systemic issue ultimately proved too large a challenge to overcome, and the program was eventually phased out, valuable insights were gained. In particular, the necessity of going ‘upstream’ to identify and address the issues that can impact a well-intentioned intervention.