

COMMONWEALTH CARE ALLIANCE

A REDESIGNED APPROACH TO FINANCE AND CARE DELIVERY FOR
DUAL AND MEDICAID ELIGIBLE BENEFICIARIES WITH THE
GREATEST NEED AND HIGHEST COST:

LESSONS LEARNED ABOUT WHAT IS NEEDED
TO BUILD EFFECTIVE CARE DELIVERY MODELS

ROBERT J. MASTER, MD

© 2015 Commonwealth Care Alliance, Inc.
Confidential & Proprietary Information

HEALTHY IS HARDER FOR SOME. That's why we're here.



CASE VIGNETTE

Anna C.

Anna C. is a 65-year-old woman, Medicaid, then Dually, eligible for 10+ years. She has long standing Multiple Sclerosis with complete paralysis in both legs, impaired bladder function, weakness and increasing spasticity in her arms.

Chronic depression, a prior major suicide attempt and a history of COPD and asthma exacerbated by heavy smoking, predated her MS. She has lived in the same apartment and slept on the same mattress for 20+ years, and in recent years has become increasingly isolated, despondent and depressed.

For many years, Anna was able to use a manual wheelchair and perform self catheterizations but with progression of upper extremity weakness, this became increasingly difficult. Anna has received 4 hours of Personal Care Assistant (PCA) care for the past five years without adjustment despite functional decline.

Care Failures

In the two years prior to enrollment, Anna has never had an effective primary care or behavioral health clinical relationship. There have been multiple hospitalizations for urinary tract infections, asthma exacerbations, pneumonias and two long sub acute post hospital stays for pressure sore management caused by extended hours in bed and a poorly fitted manual wheelchair. At enrollment she was emotionally withdrawn, functionally bedbound, incontinent, with rapidly worsening buttock and thigh pressure sores.

WHAT ARE THE PROBLEMS

- Primary care is grossly under resourced and poorly designed for those with the greatest need. For many, it is non existent
- The more medically and socially complex one is, the more likely one is to be a drift in a sea of disconnected, unaccountable care providers
- 90+% of hospitalizations occur as a result of missed opportunities to effectively manage predictable complications
- Costs to public payers as a consequence of shamefully poor care are extraordinary

WHAT IS THE OPPORTUNITY

- Integrated prepaid risk adjusted financing to a comprehensive clinical “Accountable Care Organization” responsible for delivering the totality of Medicare and Medicaid benefits
- Enhanced investment in, and redesign of primary care
- Enhanced investment in community based support services
- Dramatic reductions in hospitalizations, nursing home placements and associated costs

PRIMARY CARE REDESIGN ELEMENTS

- **PRIMARY CARE MULTIDISCIPLINARY TEAMS** with professional and non professional components with abilities to access, manage and coordinate in multiple settings, **REPLACES** the 20 minute ineffective medically focused physician office visit.
- **INDIVIDUALIZED CARE PLANS**, and resource allocations, for long term care, durable medical equipment, and behavioral health services, **REPLACES** the widespread “under resourcing” and “over resourcing” that characterizes “rule based” benefits management.
- Elastic nurse practitioner home response capability, to assess and manage new problems, **REPLACES** physician telephone management, the Ambulance and the Emergency Department.
- For those with physical disabilities – integrated durable medical equipment, clinical assessment and management, **REPLACES** distant prior approval processes and months of delay.
- Engagement by a culturally and linguistically familiar community health worker, **REPLACES** social isolation.
- For those in need of behavioral health (BH) services, **INTERGRATED BEHAVIORAL HEALTH CLINICIAN ASSESSMENT**, individualized care plan development, implementation and management **REPLACES** inaccessible BH carve out options or inaccessible services.
- 24/7 clinical availability and continuity management **REPLACES** “going it alone”.
- Web based EMR support **REPLACES** absence of clinical information transfer capabilities.

COMMONWEALTH CARE ALLIANCE

Description

- Massachusetts statewide not for profit, consumer governed prepaid care delivery system contracting with Medicaid and Medicare with responsibility for the totality of all Medicare and Medicaid covered services, financed by pooled risk adjusted premiums

WHY?

- Because total care system responsibility is the only way to be a “comprehensive population based ACO”

COMMONWEALTH CARE ALLIANCE

Senior Care Options Program: Medicaid and Dual Eligible Elders > age 65

- 6600+ Dual and Medicaid Only seniors as of December 2014
 - 76% nursing home certifiable—avg. Risk Score = 2.1
 - 62% primary language other than English
 - 67% with diabetes, 23% with CHF
- \$350M Blended Medicare/Medicaid Risk Adjusted Premiums in 2014
- 45 primary care sites in 8 hospital systems all over Massachusetts with integrated multidisciplinary care teams
 - \$29.6M increase in primary care expenditures, about over FFS Medicare
 - 140 RN/NPs, 44 SW/BH/PTs clinicians in practices, not there in 2004
 - 840 Full-time in home personal care assistants funded as per individualized care plans

One Care: Dual Eligible <65 with Disabilities

- 10,100 enrollees as of Dec 31, 2014, 33% with serious physical, developmental or mental illness related disabilities, most voluntarily enrolling
- Currently \$300M in blended Medicare/Medicaid risk adjusted premium annually
- Two primary care options:
 - Multiple existing primary care relationship “wrapped” by CCA interdisciplinary teams
 - CCA owned specialized interdisciplinary primary care practices for enrollees with physical, developmental, or mental illness related disability

COMMONWEALTH CARE ALLIANCE

Care and Cost Experience

- Significant reductions in hospitalization admissions and days*
 - Commonwealth Care Alliance risk adjusted hospital admissions and days, are 52% of the Medicare Dual eligible FFS experience (2009-2013)
- Significant reductions in hospital readmissions
 - CMS NCQA Measure: Commonwealth Care Alliance's 2010-risk adjusted 30 day hospital readmission rate = 4% vs. 13% the Medicare Advantage median, > 99th percentile
- Significant reductions in permanent nursing home placements
 - Nursing home certifiable elders permanently going to nursing home, 34% of the rate for comparable NHC frail elders**
- Nine year cost trend significantly below Medicare trend
 - Avg. annual medical expense increase 2004–2013 = 3.3% Nursing Home Certifiable (NHC) enrollees, 2.6% ambulatory enrollees
- CMS Quality Star Rating = 4.5 stars 2010–2013
 - 90th percentile of all Medicare Advantage Plans, 99+ percentile of all Medicare Advantage Special Needs Plans

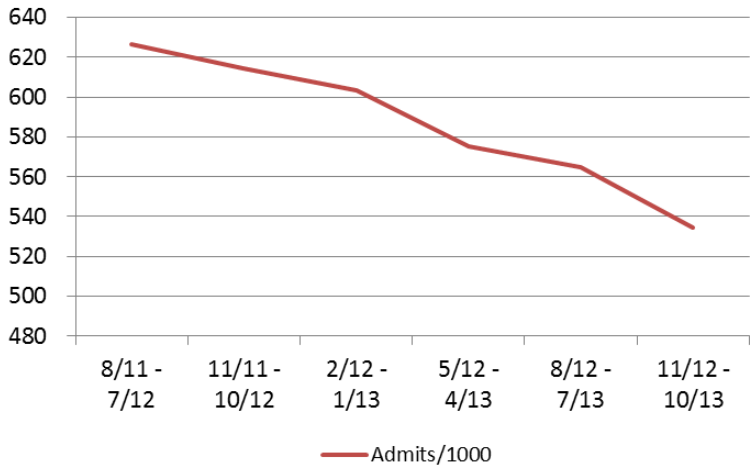
*Lewin Associates study commissioned by the SNP Alliance of member risk adjusted hospital utilization experience vs. Medicare benchmark

**JEN Associates Study Commissioned by Mass Health, 2009

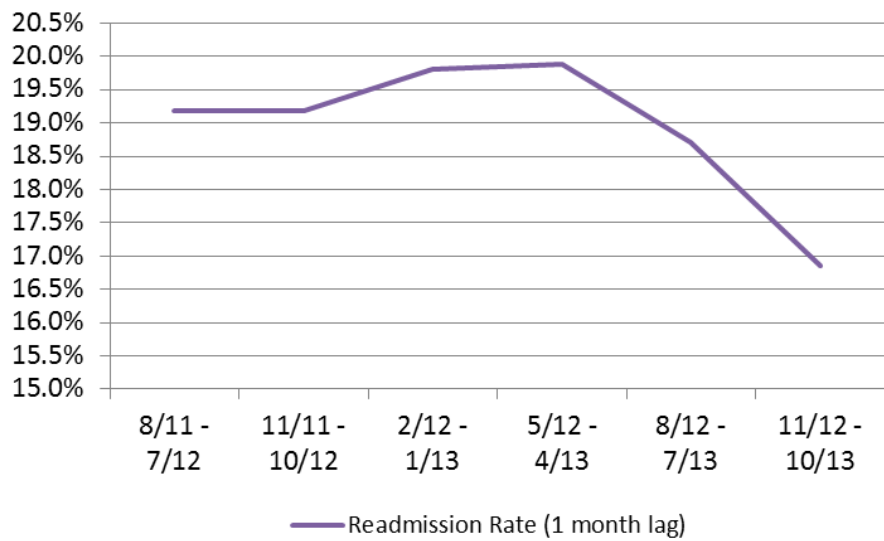
CCA's SCO Experience

INPATIENT ADMISSIONS AND READMISSION RATE

Admits/1000, NHC, Rolling 12 months



Readmission Rate, NHC, Rolling 12 months



2012 CMS Risk Adjusted All Cause Readmission Rate	9%	5 stars
--	-----------	----------------

Numbers are for rolling 12 month periods and include all CCA SCO members and claims data as of December 2013.



SUMMARY

PROBLEM	OPPORTUNITY
Inadequate, discontinuous, unengaged primary care	Team approach—RN/RNP/SW/BH/PCP Horizontal rather than vertical MD relationship
Inappropriate dependence upon Emergency Rooms for sick/non-emergent issues	24/7 telephonic access to care team, supported by member’s clinical record to inform clinical triage and decision making
Difficulty of getting to physician offices/clinics for care; Inability of physician to assess home environment	Capacity for home visits and transfer of clinical decisions to the home or other care settings as necessary; full “picture” of needs
Traditional “disempowered role” of member in the relationship with busy physicians	Meaningful consumer involvement in care management and care design
Fragmented relationships with specialists, hospital and institutional providers	Coherent and fully organized hospital, institutional and specialist network centered around the primary care physician and team
Insurance company “rules” regarding benefit requirements and service authorization	Fully empowered primary care team able to order/authorize all needed services (particularly in home LTSS services)
Lack of continuity and shared information among medical, behavioral health and long term care providers	Fully integrated network of all providers and the primary care team as the “hub” of the wheel to promote information sharing and care transitions
Incoherent “picture” of totality of member’s medical, behavioral health and support service needs	Fully integrated clinical record and state of the art data support