COMMONWEALTH CARE ALLIANCE

DESIGN FEATURES TO PROMOTE IMPROVED CARE DELIVERY: IN THE CONTEXT OF RISK ADJUSTED GLOBAL PAYMENT FINANCING:

LESSONS LEARNED ABOUT WHAT IS NEEDED TO BUILD EFFECTIVE CARE DELIVERY MODELS FOR DUAL AND MEDICAID ELIGIBLE BENEFICIARIES WITH THE GREATEST NEED AND HIGHEST COST

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

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COMMONWEALTH CARE ALLIANCE:

A Fully Integrated Dual Eligible Special Needs Plan and a Prototype of a "Population Based ACO"

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

- 6,800+ Dual and Medicaid Only seniors as of April 2015
  - 76% nursing home certifiable—avg. Risk Score = 2.1
  - 62% primary language other than English
  - 57% with diabetes, 23% with CHF
- $360M 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
  - 907 Full-time in home personal care assistants funded as per individualized care plans

One Care: Dual Eligible <65 with Disabilities

- 10,300 enrollees as of April 2015, 43% with serious physical, developmental or mental illness related disabilities, most voluntarily enrolling
- Currently $340M in blended Medicare/Medicaid annualized risk adjusted premium
- 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

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PRIMARY CARE REDESIGN ELEMENTS

- **PRIMARY CARE INTERDISCIPLINARY TEAMS** with professional and non professional components with abilities to manage and coordinate care in multiple settings, **REPLACES** the 20 minute ineffective medically focused physician office visit.
- **ELASTIC CLINICAL URGENT 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.
- For those in need of behavioral health (BH) services, **INTERGRATED BEHAVIORAL HEALTH CLINICIAN ASSESSMENT** and management **REPLACES** inaccessible BH carve out options or siloed services.
- Web based EMR support **REPLACES** absence of clinical information transfer capabilities.

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PRIMARY CARE "WHITE SPACE" ENHANCEMENTS AND REDESIGN ELEMENTS

- **"A REDESIGNED CONTINUITY HOSPITALIST" MODEL** functioning as an extension of primary care into the hospital **replaces** traditional Hospitalist care in hospitals where volume is sufficient
- Less restrictive and lower cost **RESIDENTIAL CONTINUITY COMMUNITY BASED CRISIS STABILIZATION UNITS REPLACES** siloed unnecessarily restrictive psychiatric hospital care potentially for up to 70% of psychiatric hospital admissions
- **A COMMUNITY BASED "PALLIATIVE CARE" CONSULTATION AND EDUCATION SERVICE** promotes alternatives that **REPLACES** ED visits, hospitalizations and futile ICU days

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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 (2009-2014)
- 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

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SUMMARY

Problem	Opportunity
Inadequate, discontinuous, or overwhelmed primary care	Team approach - RN/RNP/SW/BH/PCP Horizontal rather than vertical MD relationship
Inappropriate dependence upon Emergency Rooms for non-emergent issues	24/7 telephonic access to care team, supported by member's clinical record to inform clinical triage and decision making
Difficulty 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
Hospitalist models of care, that are often at odds with the goals of a continuity care system	A redesign hospitalist models that functions as an extension of continuity primary care, within the hospital
Siloed, BH and psychiatry care from the provision of primary care and over reliance of psychiatric hospitals for care better provided in other settings	Integration of psychiatry, other addiction medicine and BH clinicians into the primary care setting and a creation of continuity community based crisis stabilization units with integrated primary care
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

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