Improving Care and Managing Costs for Dually Eligible, Elderly and Disabled Populations

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What is Commonwealth Care Alliance (CCA)?

- CCA is a Massachusetts, state-wide, not-for-profit prepaid care delivery system that:
  - Focuses exclusively on care needs of special needs populations
    - Medicare and Medicaid's most complex and expensive beneficiaries
  - Relies on Medicare and Medicaid risk adjusted premium to substantially redesign care
  - Incorporates proven clinical strategies of care coordination and care management
  - Expands access by bringing clinical strategies to scale
  - Ensures that the patient's voice is central
    - Consumer organizations as corporate members
      - Health Care for All
      - Boston Center for Independent Living

Medicaid (and Dually) Eligible Elderly and Disabled Population Characteristics

- Complex mix of chronic illness, disability, social and behavioral health issues.
- Very low thresholds to secondary medical complications, the driver of hospital expenditures.
- Important subsets (particularly those with significant BH issues) incur monthly medical costs of over $2400/month with >50% going to acute hospital care.
- Low income elders, who experience poor access to primary care and care coordination.

Massachusetts Dual Eligible Profile

- 130,000 elders with poor access to primary care, care coordination and very excessive rates of preventable hospitalizations and nursing home placements.
- 85,000 younger individuals with complex disabling conditions (clinically very similar to Medicaid, SSI eligible individuals).
  - AIDS
  - Spinal Cord Injury
  - Severe Mental Illness
  - Mental Retardation/Developmental Disabilities
  - Multiple Chronic Illness
- Collectively this population accounts for over 40% of Medicaid expenditures nationwide and nearly 50% of Medicaid expenditures in Massachusetts.

Special Needs Populations are Poorly Served by Traditional FFS or Managed Care Delivery Systems

- For these populations with the greatest needs…
  - Medical care is:
    - Uncoordinated
    - Inaccessible
    - Impersonal
    - Unresponsive
    - Ineffective
  - The human consequences are: loss of autonomy, function, independence and unnecessary hospitalizations
  - The cost consequences are: near double digit annual increases in Medicaid expenditures and tens of millions of dollars in expenditures for preventable hospitalizations.

Case Studies

- Ann C.
- Mattie H.
- Jimmy P.

CASE VIGNETTE

- A.C. is a 50 year old woman with long standing Multiple Sclerosis with secondary lower extremity paraparesis, requiring a walker and manual wheelchair. She has urinary retention requiring qid self catheterizations. She was in an abusive relationship with her ex-husband who is now barred from the home via a court ordered restraining order. There is a long standing history of depression, one prior major suicide attempt and a long-standing history of alcohol abuse as well. She is also a heavy smoker with recurrent episodes of asthmatic bronchitis. During the past few years there have been multiple hospitalizations for urinary tract infections, respiratory infections and asthma exacerbations. There has not been a consistent primary care or behavioral health relationship established.

Mattie H.

- 77 year-old woman
  - » Fiercely independent
  - » Lives alone
- Longstanding diabetes
- Hypertension
- 3 strokes
  - » Left-side weakness
  - » Requires significant personal assistance to maintain independence
- Depression

- Difficulty making appointments because of mobility limitations
- Medicare/Medicaid only pays for four hours/day of home health aide services
- Difficulty in accessing and managing aging network, or personal care attendant services
- Difficulty in accessing mental health services

- Three recent hospitalizations for poorly controlled diabetes
- Frequent falls
- Inadequate food intake
- Withdrawal
- Serious consideration of nursing home placement

Jimmy P.

- 48 year-old man
- Long-standing cervical spinal cord injury
- Quadriplegia
- Wheelchair dependence
- Frequent respiratory complications
  - » Asthma
  - » Chest muscle weakness

- Receives medical care from multiple specialists at a large teaching hospital
  - » Neurology
  - » Rehab medicine
  - » Pulmonary
  - » GI
- ✓ *Same day appointments for problems are rare*
- ✓ *"On call" physician always recommend "come to the emergency room" for asthma exacerbations*

- Multiple ED visits
- Six hospitalizations in the past 18 months
- Two hospitalizations (of the six) requiring intubations and prolonged intensive care

Elements of a Successful Care Model for Special Needs Patients

- Meaningful consumer involvement in care management and care design.
- Specialized primary care networks.
- Multidisciplinary team approach to care.
- Transfer of clinical decisions making to the home.
- 24/7 personalized continuity of care in all settings at all times.
- Fully organized, hospital and institutional alternative networks.
- Primary Care team empowerment to order/authorize all needed services.
- Full integration of Medical, Behavioral Health and Long Term Care Services.
- Electronic medical record, and state of the art data support.

SNP Service Stratification

- Level I – Those whose needs can be met by the "existing" physician practice model – 50%
  - Intervention – Administrative data surveillance
    - ED, hospital use
    - Patterns of primary care use
    - Pharmacy data regarding efficacy, cost, adherence
    - BH Use
- Level II – Those who need additional RN care coordination or BH Support-35%
  - Intervention
    - Supplemental RN/BH Clinician support to primary care sites
- Level III – Those who require a substantial system redesign-15%
  - Intervention
    - RNP/PC role
    - Separate call system
    - Separate benefit design and management
    - Home visiting

Commonwealth Care Alliance (CCA) / Boston's Community Medical Group (BCMG) Prepaid Care System *

The Care of Individuals with Severe Physical Disabilities: A Case in Point

- Nurse practitioners with a 1:40 caseload
- Home visiting
- System ability to respond immediately to new problems
- Continuity at all places at all times
- Authority to order whatever is needed

REPLACES

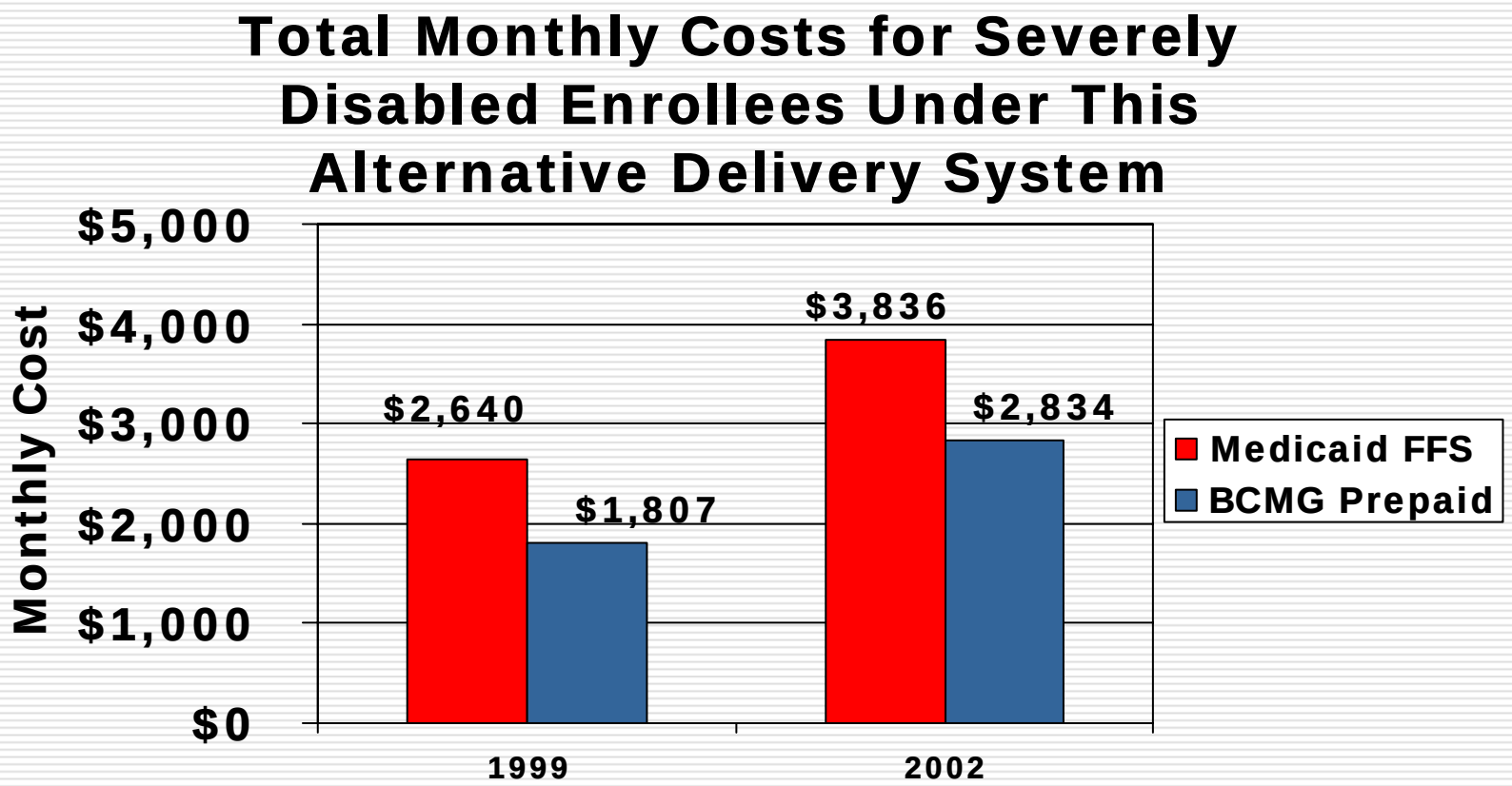
"Impersonal specialty clinics"

"The ED as sole resort"

"Cumbersome prior approval policies"

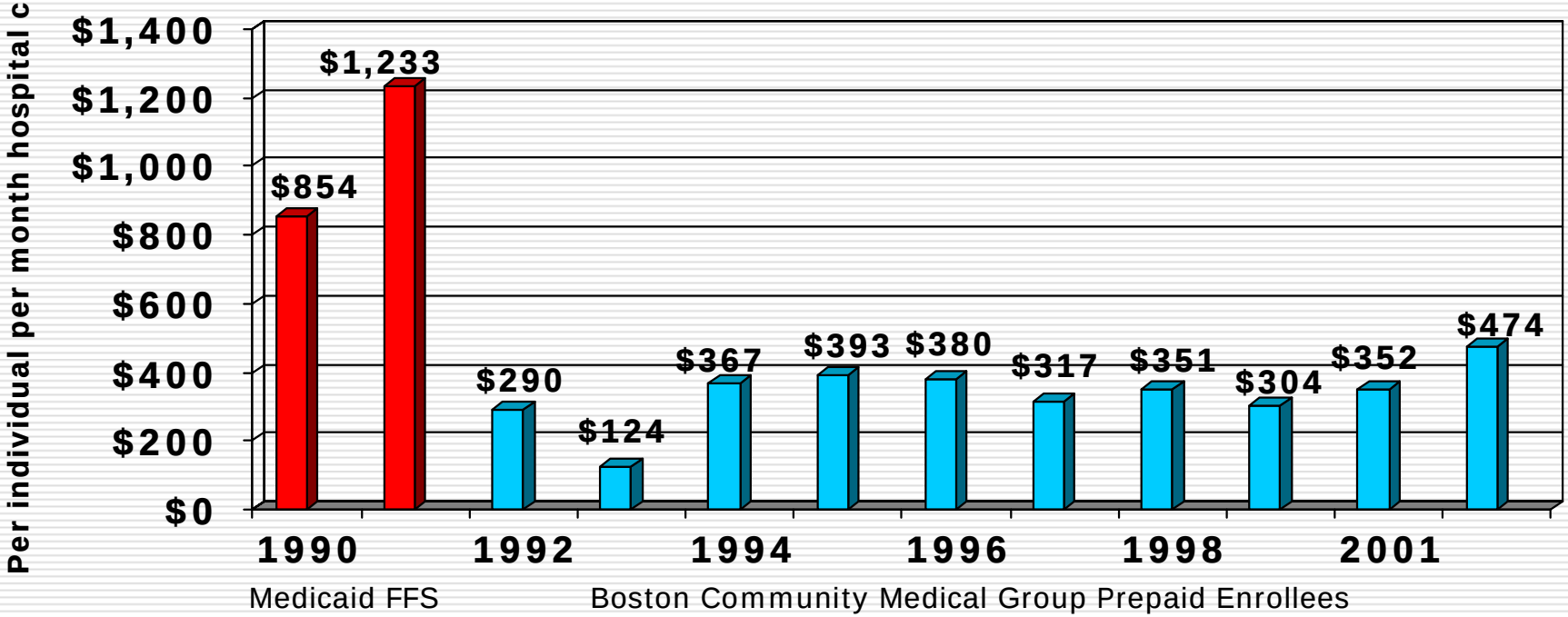
*BCMG is a non-profit wholly owned clinical affiliate of Commonwealth Care Alliance

Commonwealth Care Alliance (CCA)/Boston's Community Medical Group (BCMG) Experience – Medicaid SSI Eligibles with Severe Physical Disability

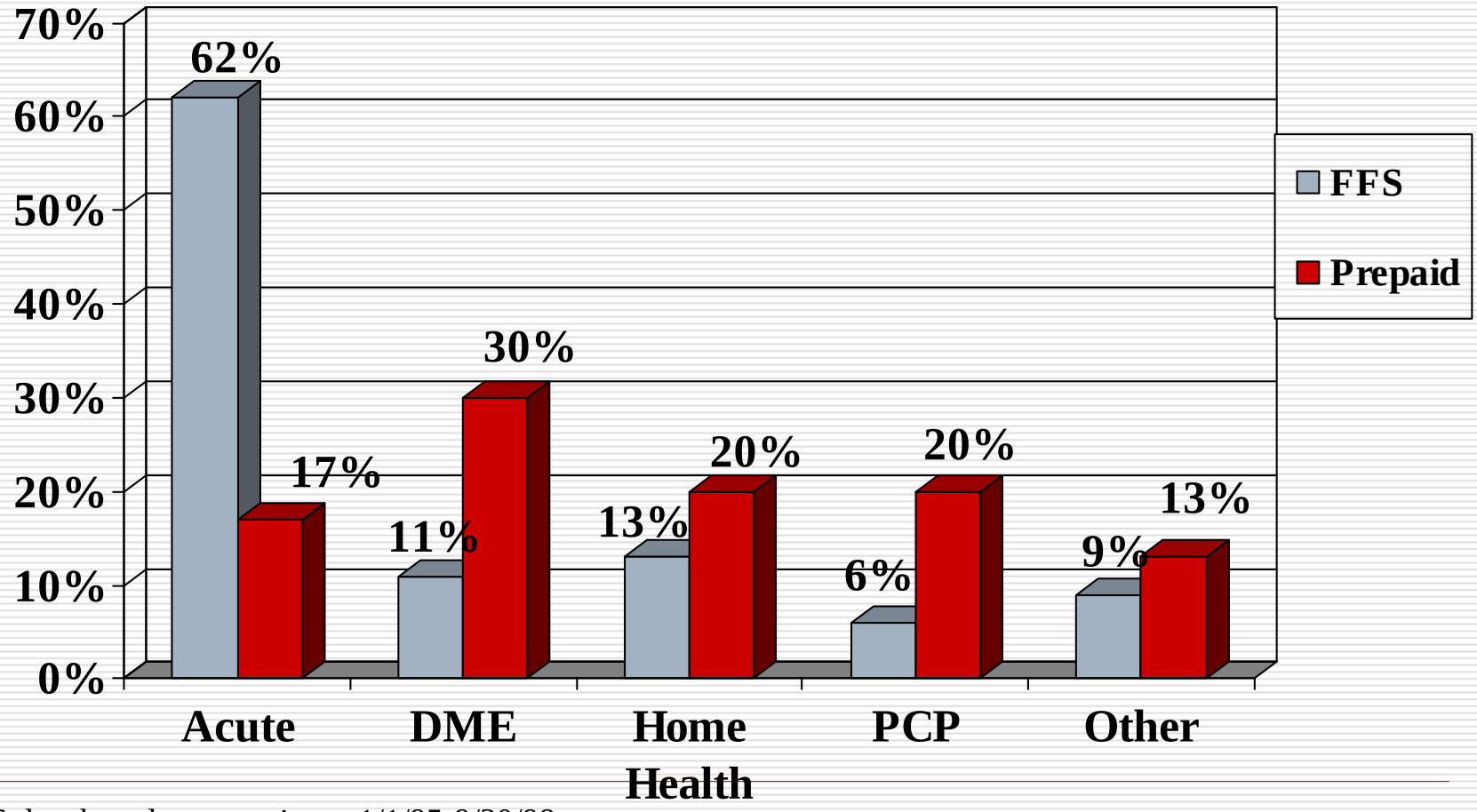


The Team Approach Shifted Care Out of Hospital

- Acute Hospital Costs for Medicaid and BCMG Individuals with Severe Physical Disabilities (Medicaid Only) 1990-91 (Medicaid FFS) and 1992-2002 (BCMG Capitated)



Distribution of Medical Service Costs for the Prepaid Care System Model for Patients with Severe Physical Disabilities and Ohio Medicaid Recipients with Paraplegia and Quadriplegia. (Kronick)



*BCMG data based on experience 1/1/95-9/30/98
Ohio data based on Medicaid claims experience.

Center for Health Care Strategies Funded evaluation of the Care Model, for Medicaid SSI* Individuals in Springfield, MA–2001-2003

- 960 potential (SSI eligible individual or disabled by state criteria) enrollees at Brightwood
- 345 enrolled into the prepaid program
  - Predicted service use of those enrolled, seventeen percent higher than the average.
- Stratified into Intensive Care Management and Intermediate Care Management Groups, for the care coordination model

*Clinically very similar to non-elderly dual eligible individuals with disability.

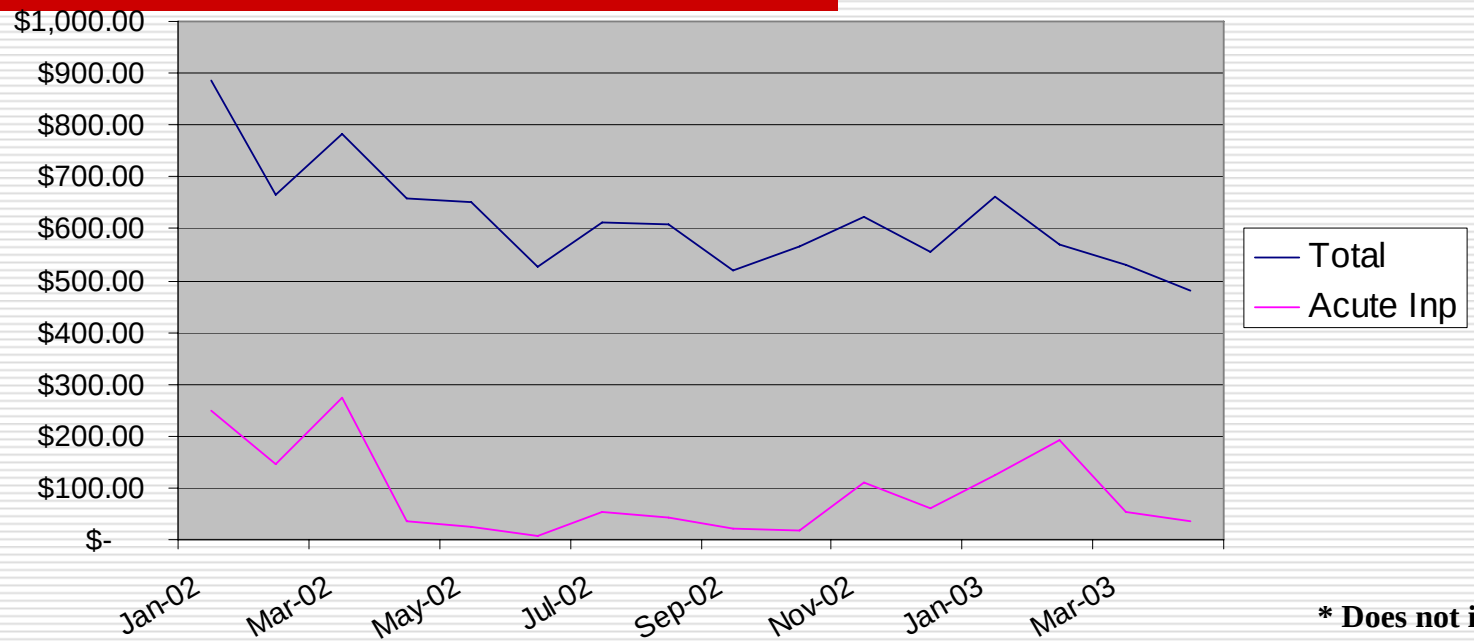
At the End of the Day….

- **Cost of the "intervention" = $86 PMPM**

- **Question -** does the cost of the intervention yield the improvements in care and reductions in cost to justify the investment?

*Evaluation by Carol Tobias Health and Disability Working Group, Boston University School of Public Health funded by CHCS

Center for Health Care Strategies Funded Prepaid Medicaid Disabled Evaluation
Total and Acute Inpatient Expenditures
$ PMPM*



$PMPM	CY2001	*1st Q/CY2003
Total Medical Expenditures	$834	$580
Acute Hospital Expenditures	$220	$88

*** Does not include cost of intervention ($86 PMPM)**

Commonwealth Care Alliance
Senior Care Options (SCO) >700 Dually Elderly Enrollees – 2004-2005

ENROLLEE CHARACTERISTICS

- 70% from minority communities experiencing considerable health care disparities
- English as primary language, <25% of enrollees
- 45% functionally "homebound" – "nursing home certifiable"
- Medicare Risk Scores
  - Ambulatory enrollee's predicted Medicare expenditures 30% greater that the age adjusted Medicare average.
- Nursing home certifiable enrollee's predicted Medicare expenditures 140% higher than the age adjusted Medicare average.

Commonwealth Care Alliance Senior Care Options (SCO) Experience 2004-2005

1. High degree of member satisfaction. Voluntary disnerollment <1%.
2. Greatly increased investment in primary care and care coordination.
3. Nursing home placement 20% of predicted.
4. Hospitalization expenses, represent 7% of premiums for ambulation enrollees and 12% of premium for nursing home certifiable enrollees.
5. Overall medical services expenditures <80% of premium.

Summary

- Redesigned prepaid care systems have enormous potential to improve care and manage costs for medically complex, vulnerable and expensive Medicaid and Dually Eligible beneficiaries.
- The results cited are not unique to CCA but also have been demonstrated in multiple clinically based, nonprofit, prepaid care demonstrations across the US.
- The question is no longer – “What Works”.
- The challenge is to bring to scale what we know “works”.

Medicaid Policy Proposals
Bringing "What Works" to Scale

1. Promote the use of health status (risk) adjusted premiums approach for duals, and Medicaid eligible disabled beneficiaries

2. Develop dual and disabled Medicaid specific "procurement" standards

3. Promote Medicaid and Medicare integration programmatically and financially

4. Remove "barriers to entry" to SNP participation for non profits entities and safety net providers;
   - By increasing access to capital for start up and reserves
   - By promoting aggregate risk sharing strategies