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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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
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.
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
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 (2009-2014)
- 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
### SUMMARY

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<th>Problem</th>
<th>Opportunity</th>
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<td>Inadequate, discontinuous, or overwhelmed primary care</td>
<td>Team approach - RN/RNP/SW/BH/PCP</td>
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<td>Inappropriate dependence upon Emergency Rooms for non-emergent issues</td>
<td>Horizontal rather than vertical MD relationship</td>
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<td>Difficulty getting to physician offices/clinics for care;</td>
<td>24/7 telephonic access to care team, supported by member’s clinical record to inform clinical triage and decision making</td>
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<td>Inability of physician to assess home environment</td>
<td>Capacity for home visits and transfer of clinical decisions to the home or other care settings as necessary</td>
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<td>Hospitalist models of care, that are often at odds with the goals of a continuity care system</td>
<td>A redesign hospitalist models that functions as an extension of continuity primary care, within the hospital</td>
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<td>Siloed, BH and psychiatry care from the provision of primary care and over reliance of psychiatric hospitals for care better provided in other settings</td>
<td>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</td>
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<td>Lack of continuity and shared information among medical, behavioral health and long term care providers</td>
<td>Fully integrated network of all providers and the primary care team as the “hub” of the wheel to promote information sharing and care transitions</td>
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<td>Incoherent “picture” of totality of member’s medical, behavioral health and support service needs</td>
<td>Fully integrated clinical record and state of the art data support</td>
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