COMMONWEALTH CARE ALLIANCE

Creating sustainable Medical homes within the context of a fully prepaid care system caring for Medicaid and Dual eligible beneficiaries with the most complex needs and highest cost

ROBERT J. MASTER, MD
PROBLEMS AND OPPORTUNITIES

Case Vignette: Mary J.

Mary J. is a 29 year old woman born with cerebral palsy, causing spastic quadriplegia, severe dysarthria, mild intellectual impairments, Type I Diabetes and a seizure disorder. She has significant risks for aspiration pneumonias with requirement for G-tube feedings for supplemental nutritional support and frequent insulin adjustments for blood sugar control. Since leaving a state school at age 22, she has lived independently with Medicaid funded PCA support and close family involvement.

Care Failures

Mary has never had an effective primary care relationship. Care is provided via neurology, pulmonary, orthopedic, GI, endocrine and rehab medicine clinics in three hospital systems. Seven years of independent living have been characterized by multiple recurrent hospitalizations for pneumonia (including one requiring intubation, tracheotomy and months in a respiratory rehab hospital), poorly controlled diabetes, seizure management and functional GI problems.
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 predicable complications

• Costs to public payers as a consequence of shamefully poor care are extraordinary

WHAT IS THE OPPORTUNITY

• 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
VISION

• Sustainable primary care investment and redesign occurs through prepaid, risk adjusted (integrated) financing

TO

• A comprehensive Accountable Care Organization that is responsible for delivering the totality of services
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”
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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
PRIMARY CARE REDESIGN ELEMENTS

- PRIMARY CARE INTERDISCIPLINARY 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 COMMUNITY CARE

A specialized primary care model for individuals with involved disabilities whose needs overwhelm typical primary care practices

- Fully-integrated interdisciplinary care teams that provide, allocate and coordinate comprehensive medical, behavioral and long term care services and supports
- Established in collaboration with Boston Center for Independent Living in 1988
  - Care is not delivered “to” but “in collaboration with” those with disabilities
  - Nurse Practitioners, nurses, physicians and coordinators provide integrated primary care and care coordination with 85% of assessments occurring in the home and community setting
  - Commitment to the principle that the network of specialists and long term services and support providers is determined by the member/family and not the “plan”; thus rendering the term “out of network” irrelevant
**COMPOSITION OF THE COMMONWEALTH COMMUNITY CARE (CCC) PRIMARY CARE TEAM**

(*Adjustments made at each site based on member mix, provider capacity, and availability of staff)

<table>
<thead>
<tr>
<th>Clinician</th>
<th>FTE Case Ratio</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNP</td>
<td>1:40</td>
<td>Comprehensive assessments, care plan development and management, 1st responder for new clinical problem, 24/7 first call availability integrated care coordination into primary care.</td>
</tr>
<tr>
<td>MD</td>
<td>1:300</td>
<td>Shared decision-making with RNPs, integrating and/or providing specialty and hospital care, complex care management, “curbside” consultations, 24/7 care availability</td>
</tr>
<tr>
<td>BH Clinician (e.g. LICSW, or CNS)</td>
<td>1:140</td>
<td>BH assessment, BH care plan development, monitoring and network management.</td>
</tr>
<tr>
<td>SW</td>
<td>1:150</td>
<td>Response to housing, eligibility, financial issues, crisis management.</td>
</tr>
<tr>
<td>PT/OT</td>
<td>1:75</td>
<td>Functional care plan development, monitoring and management.</td>
</tr>
<tr>
<td>DME Coordinator</td>
<td>1:110</td>
<td>Management and allocation of medical equipment supplies.</td>
</tr>
</tbody>
</table>
Total Monthly Costs* for Enrollees in the Prepaid Model Program

*Actuarially determined Medicaid premium for all Medicaid benefits except PCA services.
**Includes all medical, hospital, pharmacy, BH, community and institutional LTC services, excludes PCA services.
### COMPARABLE 2008 MEDICAID FFS EXPENSES VS. CCC 2008 PMPM PREPAID EXPENDITURE EXPERIENCE

<table>
<thead>
<tr>
<th></th>
<th>Medicaid FFS Costs-2008 PP PM clinically similar population with similar PCA use</th>
<th>2008 CCC Model Program Costs PMPM- 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Primary Care” (mostly specialists)</td>
<td>$41</td>
<td>$840</td>
</tr>
<tr>
<td>DME</td>
<td>$243</td>
<td>$728</td>
</tr>
<tr>
<td>Acute Hospital Care</td>
<td>$2230</td>
<td>$591</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>$313</td>
<td>$151</td>
</tr>
<tr>
<td>All Other*</td>
<td>$1383</td>
<td>$1291</td>
</tr>
<tr>
<td><strong>TOTAL EXPENDITURES</strong></td>
<td><strong>$4210</strong></td>
<td><strong>$3601</strong></td>
</tr>
</tbody>
</table>

*Excluding PCA Costs
## SUMMARY

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

- “Managing Care the Right Way”, Boston Globe Editorial, March 26, 2008


BIBLIOGRAPHY

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