COMMONWEALTH CARE ALLIANCE

PROGRAMS AND STRATEGIES TO IMPROVE AND INTEGRATE MEDICAL SERVICES AND LONG TERM SERVICES AND SUPPORTS

LOIS SIMON, PRESIDENT
COMMONWEALTH CARE ALLIANCE

National Coalition for Health Care
Long Term Quality Alliance
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HEALTHY IS HARDER FOR SOME. That's why we're here.

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WHAT IS COMMONWEALTH CARE ALLIANCE?

- A Massachusetts, consumer governed, not-for-profit, comprehensive, prepaid care delivery system created in 2003
  - A hybrid of care delivery and payer roles
  - Accountable Care Organization Prototype for Complex Populations
  - Redesigns care by investing in and transforming primary care; enhances primary care and care coordination capabilities through deployment of Interdisciplinary Primary Care Teams
- Mission driven concentration – focuses exclusively on the care of Medicare and Medicaid's most complex and expensive beneficiaries
- Proven track record for providing high quality care while bending the health care cost curve
- One of the few organizations nationally with depth, longevity of experience and demonstrated success in integrating primary, acute, and long term services and supports financed by a risk adjusted global capitation

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MARKET LEADER IN INTEGRATED CARE FOR DUAL ELIGIBLES

Senior Care Options Program

- Fully Integrated Dual Eligible Medicare Advantage Special Needs Plan (FIDESNP)
- Approximately 6000 elder members in Greater Boston, W. Mass and North Shore
- $350M+ in annualized blended premium
- 77% of members meet nursing home criteria yet live in the community
- 30+ primary care sites affiliated with 8 hospital systems with integrated, multi-disciplinary primary care teams

One Care Program

- Implemented Oct 1, 2013 – first in the nation Financial Alignment Demonstration
- Of three OneCare Plans, CCA has the broadest service area, enrolling beneficiaries in nine counties
- Over 7000 enrollees with CCA, projected to grow to 20,000 and $400M + in premium by 2015
- Serves dual eligibles under 65 with chronic illness and disabilities, 70% of whom have a behavioral health diagnosis
- Served through a platform of primary care and human service partners, as well as an expanded medical and behavioral health provider network

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CARE DELIVERY APPROACH AND COMMUNITY PARTNERSHIPS

Model of Care:

- Integration of care delivery and financing across medical, behavioral health, and long term services and supports
- Individualized person-centered care planning: flexible, responsive, creative solutions
- Interdisciplinary Care Teams
- Continuity of care across care settings: fully supported transitions of care to ensure smooth handoffs
- Enhanced primary care (home visiting capacity, episodic care), care management/ coordination – virtual staff model

Our Partners in Care:

- Area Agencies on Aging (ASAP network in MA) and Independent Living Centers (ILCs)
- Human service providers (backbone of residential and community based support for individuals with intellectual disabilities and mental health needs, etc.)
- Housing providers (assisted living, rest homes, skilled nursing facilities, specialized adult foster care/caregiving providers)
- Patient centered medical homes – primary care providers (FQHCs, medical group practices, etc.)
- Transportation, durable medical equipment providers
- Substance abuse providers

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MAKING A DIFFERENCE…

The Challenges:

- Primary care is grossly under resourced and poorly designed for those with greatest need.
- 90+% of hospitalizations occur as a result of missed opportunities to effectively manage predictable complications.
- There is no systematic connection between and accountability across medical, behavioral and social support providers leading to fragmented and poorly coordinated care.
- Trusting relationships need to be established to best support and facilitate acceptance of services that may be needed to optimize healthy independent living
- There are MAJOR gaps in the care delivery system for some sub-populations, for those with behavioral health issues in particular.
- Getting the regulatory and financing framework right is a work in progress.

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MAKING A DIFFERENCE….

What success can look like – the opportunities:

- **Juanita**:
  - 89 years old; medical fragility, need for close coordination across primary care, specialists, home visiting team and family: *critical partnership with supportive housing*
- **Kevin**:
  - 42 years old; behavioral/substance issues, frequent ER visits/ admissions, need for coordination of home care services to support effectiveness of BH/SA interventions: *critical role of Health Outreach Worker*
- **Dawn**:
  - 54 years old; significant medical and mental health issues including agoraphobia, need for primary care, medication management and health education: *critical role of home based primary care*

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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 (2009-2012)
- 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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DUAL ELIGIBLE COST & UTILIZATION

A Comparison

	FFS Care Avg RS = 1.24	Commonwealth Care Alliance Avg RS = 1.86
% of total "medical spend" for primary care*	4%	12%
% of total "spend" for hospital care FFS Disability population***	43%	16%
Severity adjusted hospital/days/k/yr****	3,383 days/k/yr.	1,622 days/k/yr.
LT nursing home placement by community living NHC enrollees per 100/yr.*****	12.0	4.1
30 day hospital readmission rate******	20.1%	16.4%

* MedPAC Analysis, Medicare Beneficiary Survey Cost and Use File 2006
** MassHealth, SCO Procurement, Databook 1999-2002
*** Medicaid claims analysis comparable, FFS physical disability population
**** Lewin Associates, FFS hospital admission analysis-Medicare Beneficiary cost and use fill 2007
***** JEN Associates study for MassHealth 2004-2005; includes RNP visits
****** Jencks et al *NEJM*, Vol. 360: pp.1418-1428, 2009

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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

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