

# SNP Alliance

# Best Practices



**October 2013**

## **Commonwealth Care Alliance: Best Practices in Care for Frail and Disabled Medicare Medicaid Enrollees**

Commonwealth Care Alliance is a Massachusetts-based non-profit, fully integrated, prepaid health care delivery system. It began as one of the legacy dual demonstration entities in Massachusetts, Minnesota and Wisconsin that have informed so much of the Affordable Care Act. Commonwealth Care Alliance cares for over 5,400 low-income seniors through its Senior Care Options (SCO) Program which was started in 2004. In addition, Commonwealth Care Alliance provides care for over 650 adults with severe physical and/or developmental disabilities through legacy prepaid contracts with Massachusetts Medicaid. The care of these beneficiaries is financed by over \$300 million of risk-adjusted integrated Medicare and Medicaid premiums on an annualized basis, in return for the delivery of the totality of Medicare and Medicaid benefits. Its service area includes all cities and towns in Essex and Suffolk counties, and areas in Franklin, Hampden, Hampshire, Middlesex, Norfolk, and Plymouth counties.

### **SENIOR CARE OPTIONS PROGRAM**

#### **Target Population**

The SCO program is open to Massachusetts residents aged 65 and older who are eligible for both Medicare and Medicaid, or Medicaid alone, and live in our approved service area. As of September 2013, total enrollment in our SCO program is over 5,400. Of this population, 68% of members are female and 32% are male. 62% of members speak a primary language other than English. 77% of members are functionally homebound and clinically eligible for nursing home placement but are maintained in the community through the care and services provided through the SCO program.

Our members are among the most frail and medically complex subset of Medicaid beneficiaries and they live mostly in communities that experience significant disparities in healthcare services. The average Medicare risk score for Commonwealth Care Alliance SCO membership overall is exceedingly high at 1.67. For Commonwealth Care Alliance functionally homebound members, it is 1.81, scores that are among the highest in the country for Special Needs Plans [Massachusetts Benchmark: 850,000 Medicare eligible seniors (Risk Score 1.0)].

For seniors with complex needs and homebound elders, the current organization of primary care is simply ineffective. Our SCO model of care makes the difference in achieving the objectives of improved health, independence, and quality of life for our members.

## Model of Care

Our unique care model is person-centered and team-based, as well as comprehensive and flexible, and is designed to help people achieve their goals for improved quality of life. Each member is assigned a dedicated team of health care practitioners chosen to meet his or her individual needs. Core team members include the primary care provider, a primary care NP/RN and a Geriatric Support Services Coordinator (GSSC), with others, such as behavioral health practitioners, social workers, physical therapists, etc., as needed, and all working collaboratively to provide ongoing health management, early intervention, and response to episodic and urgent care.

Our clinical teams provide medical care and support services 24/7, wherever members need them, whether at home or in a doctor’s office, a hospital or other location in the community. Each individualized care plan is based on an assessment and is highly individualized with care decisions made collaboratively by the clinical team and the member and the member’s family or guardian. The primary care team can make and approve decisions about medical tests, medications, durable medical equipment, dental care, eyeglasses and transportation based on each member’s needs — all provided at no cost to the member. For those with physical disabilities, our integrated durable medical equipment clinical assessment, management and individualized allocation bypasses the rule-based prior approval processes and months of delay associated with Fee-for-Service (FFS) programs. For those with mental illness and behavioral health needs, behavioral health clinicians are integrated into the primary care teams providing individualized care plan development and management which is a dramatic improvement over the inaccessible mental health clinics, structurally siloed from primary care, that are the norm for FFS programs.

Our members are further supported by innovative programs that educate and promote self-management of their health conditions. Our Life Choices program supports our primary care teams in ensuring that member and family wishes are central and respected when end-of-life choices must be made. Our Life Choices palliative care services allow our members to remain in the care of their SCO primary care team and receive end-of-life care that is aligned with their wishes. The results of this program are shown in the chart below:

Indicator	Pre Project Implementation on Baseline Time Period	Baseline	Benchmark Performance Goal	2009	2010	2011	2012
<u>Dying at home</u> % members dying at home	CY 2009	19%	>45%	19%	29.6%	37%	50%
<u>ICU days at end of life</u> Average # ICU days per decedent in last 6 months of life	CY 2009	2.72 days	< 2 days	2.72 days	1.49 days	1.53 days	1.76 days
<u>Advance care planning</u> % members with evidence of advance care planning in medical record	CY 2008	CY 2008	56%	>90%	67%	59%	74%

Our Cardiovascular Disease program improves care and self-management skills of diabetics at highest-risk of developing new cardiovascular disease or complications of established cardiovascular disease. Other programs include depression care management and personal care attendant support when members need assistance. These innovative programs are available to SCO members and are designed to ensure that members receive care that contributes to better health, independence and quality of life. A good indicator of member satisfaction with our program is the low disenrollment rate, with voluntary disenrollment of 2.75% for 2012.

Other good indicators of member satisfaction are stories from our members and their families. These stories best illustrate the life-changing impact that our SCO program has on the individuals we care for. Here is a story from the daughter of one of our members:

*Loretta's 80-year-old mother had been in a nursing home for three months and she wanted to come home. Loretta made the decision to care for her mother herself and began to figure out how she could make that happen.*

*When Loretta went to pick up her mother from the nursing home, the nurses stood by with their arms crossed. They didn't offer any advice or words of encouragement. They said to each other, "Don't worry, she'll be back."*

*Loretta's mother never returned.*

*Loretta's mother became a Commonwealth Care Alliance member and with the support of an interdisciplinary care team, Loretta was able to keep her mother in the familiar, comfortable surroundings of her own home and successfully meet her healthcare needs. The care team included a nurse practitioner (and team manager) with home visiting capabilities, a social worker, a geriatric social services coordinator from Somerville-Cambridge Elder Services (the local area agency on aging), a primary care physician, a personal care attendant/home-maker, and a visiting nurse (only for the first three months post-discharge from the nursing home). A few months later, hospice support was introduced.*

*Commonwealth Care Alliance empowers its primary care teams to authorize all needed services, an autonomy that enables immediate medical intervention, seamless delivery of care, and avoids unnecessary emergency department visits and hospital admissions. This ability to act quickly meant that any acute episode that Loretta's mother experienced, such as a urinary tract infection, was treated and resolved before it became a more complicated, and more expensive to treat, condition.*

*Twelve months after leaving the nursing home, Loretta's mother passed away peacefully in her own home, after being cared for by Loretta and Commonwealth Care Alliance for almost a year. Every day at home was a victory for Loretta and, more importantly, for her mother.*

## Quality and Cost Performance

Over the years, our unique model of care has been proven to improve our members' health outcomes and reduce the overall cost of care. We invest heavily in home and community-based, long-term care supports as part of individualized plans for care for our members, particularly for those who are functionally homebound. In 2011, we financed 629 personal care attendants (full-time equivalents) as a key component of individualized care plans. The enhanced financial investment into primary care infrastructure, care coordination, and home and community long-term care services is financed from savings achieved by reducing hospitalization and nursing home placements. These

strategic resource allocations are deliberate cost effective service substitutions and we know, through nine years of caring for SCO members, that they work effectively to improve health, independence and quality of life for the individuals we serve.

In 2012, Commonwealth Care Alliance invested \$29.2 million above what Medicare FFS would have reimbursed our contracted primary care practice partners to fund the interdisciplinary teams and Commonwealth Care Alliance's supporting infrastructure, with the following results:

- According to a Lewin Associates study commissioned by the SNP Alliance, hospital admission and days were 56% of the risk-adjusted Medicare dual-eligible FFS experience (2009 to 2011).
- The CMS reported all-cause 30-day hospital readmission rate in 2012 was 9%, achieving a 5-star rating.
- The permanent nursing home placement rate for nursing home certifiable SCO members between 2009 and 2011 was 34% of that seen in a Nursing Home Certifiable frail elder population in FFS care.
- The seven-year annual average total medical expense increase is 3.3% and 2.8% for nursing home certifiable and ambulatory enrollees, respectively, well below the Medicare trend.
- CMS Quality Star Ratings of 4.5 Stars for performance in 2011 and 2012 placed CCA in the 87th percentile of all Medicare Advantage Plans. No SCO program in Massachusetts has a higher rating than Commonwealth Care Alliance's SCO.
- In a recent survey, 97% of physicians agreed that Commonwealth Care Alliance "helps me achieve better outcomes for my SCO patients."

From a clinical perspective, data shows:

- 67% of Commonwealth Care Alliance members have been diagnosed with diabetes and 95% of these members received a glycosylated hemoglobin test in 2012.
- 82% of Commonwealth Care Alliance members received a flu vaccine for the 2012 flu season earning a 5-star rating.
- Commonwealth Care Alliance earned a 5-star rating for performance in 2012 on all of the following measures — BMI assessment; breast cancer screening; colorectal cancer screening; glaucoma screening; diabetic eye exams; diabetic kidney disease monitoring; annual medication review; annual functional status assessment; annual pain screening; all-cause readmissions; monitoring of physical activity; reducing the risk of falling; medication adherence for diabetes; medication adherence for hypertension; and medication adherence for cholesterol. From a cost perspective, data shows the following annual rate of total medical expenditure increase:
  - Homebound (Nursing Home Certifiable) Elders (2004–2010) = 3.3%
  - Ambulatory Elders: (2005–2010\*) = 2.6%\*

\* Insufficient ambulatory enrollment prior to 2005

## INTEGRATED CARE PROGRAM

Massachusetts One Care: Medicaid Plus Medicare plan is part of the national duals demonstration program under the Affordable Care Act. Its purpose is to integrate financing and delivery of care for people who are eligible for both Medicare and Medicaid in Massachusetts and are eligible for Medicare due to a disability. Today, dual eligibles nationally comprise 15% of the Medicaid population, yet account for 39% of its spending. Given the complexity of this population's needs, there is great opportunity to improve the quality and cost-effectiveness of care through care coordination and integration across the continuum of Medicare and Medicaid community services. Efforts to reduce costs and provide better care for the population have generally been ineffective under the fee-for-service environment which promotes cost-shifting between programs, at the federal and state levels. One goal of the demonstration is to improve quality of care and reduce costs by aligning these two discrete systems which are often in conflict with each other.

Massachusetts will be the first state in the country to launch this program under the national initiative. There are three health plans including Commonwealth Care Alliance participating in the demonstration in Massachusetts. Commonwealth Care Alliance will launch with the broadest geographic coverage in this initial offering, covering nine counties in total. CCA's plan is available in all areas in the state in which the program will be available, and is the sole plan offered in five of the nine counties that make up the service area.

Enrollment in the program will begin through a self-selection process and be followed by a process of passive (or auto) enrollment. Enrollees will always have the option of returning to the fee-for service option if they choose. The model of care for this program is structured to integrate primary care and behavioral health care as well as long-term support services. The One Care plans receive payment from MassHealth and Medicare and are accountable for delivery and management of the care and are at risk for the cost of the services, with certain financial risk protections.

Commonwealth Care Alliance is leveraging its current experience with both the senior population under the SCO program and its experience through its clinical group, Commonwealth Community Care, caring for individuals with severe physical disabilities, in planning for the new One Care program. We recognize that there are some important differences between the populations in the SCO and One Care programs. While both programs serve individuals who are economically challenged and receiving Medicaid, there are noteworthy differences relating to the age eligibility and other characteristics of persons eligible for Medicare due to a disability. Interestingly, the vast majority of our seniors are categorized as "nursing home certifiable," and benefit from our intensive care model. The One Care membership will be much younger, and will have a smaller percentage of individuals who need the most intensive level of services. We expect approximately 25% to be in this category. In addition, a very significant percentage of the population has serious mental health issues — either as a primary condition or as a secondary diagnosis. Therefore, our model of care for the One Care program is being modified to take into account these different population characteristics.

### Target Population

Approximately 90,000 people with Medicare and MassHealth Standard/CommonHealth coverage (Medicaid), who are between the ages of 21 through 64 years, are eligible for the program. Excluded from the program are people receiving services through the home and community-based service waivers. The characteristics of this population are as follows:

- 34% have serious mental illness/70% have a mental health diagnosis
- 13% have an intellectual or developmental disability
- 54% have a chronic medical diagnosis
- 14% are high users of long term services and supports
- 28% have substance use disorders

## Model of Care

The program is similar to SCO in that its focus is on enhanced primary care, care coordination/management, interdisciplinary care teams, and individualized care plans. The SCO model has been adapted for this younger population with more diverse conditions, and there are basically three variations in our care model to serve this group. We have an intensive care management model for the more complex cases, and a less intensive model called supportive care management that includes a very strong behavioral health component for those who need it. The third approach is through contracted “health homes” that may be either based on a “behavioral health home” model or a “primary care health home” model. We are partnering closely with these health homes and providing clinical support as needed. In addition to intensive behavioral health services, this program has a strong focus on long term supports and services, and members will have a long-term support and services coordinator to connect them to the services they need. Our model of care integrates primary care, behavioral health care, and long-term supports and services. Clients will have an interdisciplinary care team which can include nurse practitioners, physician assistants, physicians, social workers, physical/occupational therapists, behavioral health specialists, DME coordinators, and the member. The team will deliver or arrange every type of care needed by the individual. A personal care plan will be developed with and for the individual to determine types and levels of services. Each member will have a care manager — nurse, social worker, or other individual — depending upon the needs of the individual.

The program philosophy is based on a commitment to the independent living model, as compared to the traditional medical model.

Medical Model	Independent Living Model
<ul style="list-style-type: none"> <li>• “Disability” refers to problems of individual people</li> <li>• Solution is care, medical treatment</li> <li>• Health Care Provider is competent expert</li> <li>• Patient’s role is to cooperate</li> <li>• Health care provider is principle decision-maker and maintains accountability</li> <li>• Emphasis on acute and restorative care</li> <li>• Goal: safety over independence</li> </ul>	<ul style="list-style-type: none"> <li>• “Disability” refers to problems of societies that fail to accommodate differences</li> <li>• Solution is to change social thinking, make communities accessible</li> <li>• Individual is knowledgeable about own care needs</li> <li>• Patient is a consumer and self-advocate; empowered and accountable</li> <li>• Emphasis on environmental change and quality of life</li> <li>• Goal: self-determined life</li> </ul>

We have unique expertise in disability competent care with our clinical affiliate, Commonwealth Community Care (formerly known as Boston Community Medical Group), and we collectively bring over 30 years of experience caring for people with disabilities and complex medical needs.