Brief Context: Dual Eligible Individuals

Individuals Dually-Eligible for Medicare and Medicaid

• “Dual Eligible” beneficiaries: individuals who receive both Medicare and Medicaid
  – Low-income seniors
  – Adults aged 21-64 with low-income, and disabilities:
    • Physical disabilities
    • Intellectual/developmental disabilities
    • Severe persistent mental illness
    • Multiple chronic illnesses or functional and cognitive limitations

• Racial and ethnic minority groups are over-represented in this population, given higher poverty rates and rates of disability
Multiple co-morbid conditions, high costs of care

- High prevalence of chronic conditions, particularly diabetes, cardiovascular disease and depression
- Significant socio-economic challenges: more than half have annual household income of $10,000 or less (vs 8% of non-dual Medicare beneficiaries)
- Higher rates of emergency room use and inpatient hospitalization than other Medicare beneficiaries
- Significant long term services and support needs
Multiple co-morbidities, fragmented care

55 y.o. man with:
- Traumatic brain injury
- Schizoaffective disorder
- Seizure disorder
- Morbid obesity
- Hypertension
- Hyperlipidemia
- Chronic hepatitis C
- Active smoker

- Takes 15 daily medications, including three antipsychotics; intermittently compliant
- Lives in a group home, independent for ADLs but needs frequent prompting
- Daily skilled nursing visits x several years
- Sees PCP monthly for med refills and orders. PCP often not notified of acute visits
- Behavioral health clinician at a different location. PCP cannot view behavioral health records
- Community case worker through mental health provider; significant staff and caregiver fatigue
- Three insurance cards; sees on average eight different outpatient providers / year
Meet “Jack” (2)

Multiple co-morbidities, fragmented care

Pattern of high utilization:

• In a single year, "Jack" visited the emergency department 22 times for a variety of complaints

• 10 admissions in 12 months – approx. 50/50 psychiatric and acute medical

• Each admission typically lasts between 5 and 10 days

• Care dominated by acute complaints; weight continues to climb, behavior remains challenging

• PCP and behavioral health provider have never spoken

- Is Jack getting what he needs from his healthcare system?
- How many providers and how many payers are involved in Jack's care?
- What would an ideal care structure look like for him?
Focus exclusively on integrated care for individuals dually eligible for Medicare and Medicaid

- **Senior Care Options (SCO):** Fully Integrated Dual Eligible Medicare Advantage Special Needs Plan
  - Over 7,000 elder members across the state
  - $350M+ in annualized blended premium
  - 75% meet nursing home criteria; 99% are community-dwelling
  - 55+ primary care sites with integrated, multi-disciplinary primary care teams

- **One Care:** First in the nation Financial Alignment Demonstration begun in October 2013
  - Serves dual eligible individuals under 65 with chronic illness and disabilities, 70% of whom have a behavioral health diagnosis
  - Almost 10,000 enrollees with CCA: 80% of total enrolled population in MA
Population characteristics

Individuals with complex medical and social needs

Senior Care Options (over 65s):
• 62% speak a primary language other than English. Over 25 primary languages are represented
• Two thirds did not complete high school
• More than 65% report their general health status to be “poor” or “fair”
• 70% have four or more chronic conditions
• 45% have three or more activities of daily living (ADL) impairments
• Race: 49% “Black” or “Other”; 51% “White”

One Care (21-64 year olds):
• 70% have a behavioral health diagnosis; 45% screened positive for depression
• 15% have schizophrenia
• 7% are homeless; many more are marginally housed
• Almost 15% have a current or prior substance or alcohol dependency
• Average per member per month costs of care >$2,000
• High rates of “unmet need”, particularly in primary care and long term supports and services
• Race: 32% “Black” or “Other”; 68% “White”

Source: Centers for Medicare and Medicaid Health Outcomes Survey 2015
Primary Care Redesign Elements

• **Single payer source** with the full perspective and ability to align incentives, build a provider network and coordinate care around the beneficiary.

• **Primary care delivered in multidisciplinary teams** with professional and nonprofessional components and the ability to deliver and coordinate care in partnership with the PCP.

• **Full integration of physical, behavioral health, and long-term supports and services** enables investments in primary care, community supports and preventive behavioral health services to yield decreases in preventable acute care utilization.

• **Person-centered care** rooted in principles of independent living and disability rights fosters therapeutic alliances, cultural competency, trust-building and shared decision-making.

• **Active management of care transitions** through on-the-ground staff at key hospitals and post-acute settings ensures continuity of care and return to community living.

• **Flexible, accessible, pro-active end-of-life care** encourages early engagement in palliative care and supports death in the community whenever possible.
Clinical Innovations

Creative programs and partnerships to improve care

• Unprecedented collaboration between the Commonwealth of Massachusetts, the federal government and the One Care entities to meet shared challenges

• Creation of CCA’s specialized primary care practices
  • Filling void for people with involved disabilities
  • >2,000 members served in 4 practices across the state
  • Only sustainable under a capitated /merged financing model

• Creation of CCA’s own sub-acute psychiatric capacity
  • Over half of our members hospitalized to inpatient psychiatry could be equally or better served in a less acute setting at a fraction of the cost
  • CCA opened two crisis stabilization to provide alternatives to inpatient psychiatric hospitalization

• Community Paramedicine Program
  • Preventing ED visits and hospitalizations with extended hour paramedics attending to needs in the community, instead of transporting to ED
Clinical Innovations (2)

Creative programs and partnerships to improve care

• Hospital inpatient service at 3 major hospitals
  • Clinicians embedded within hospitalist services to help with care transitions
  • Access to personal care attendants for individuals with disabilities
• CCA Health Homes: collaborations with human service provider organizations
  • Building on existing community-based capacity and expertise
  • Conducting learning collaboratives to disseminate best practices
• Community health workers deployed
  • Provide supports with social determinants, close personal relationships and advocacy
• “A la carte” end-of-life program
  • Flexible, easily accessible palliative care embedded within primary care
  • Decreases acute care utilization at the end of life and improves concordance with patients’ wishes
What does this mean for “Jack”?

A single, integrated care delivery system

"Jack" is assigned a care manager, a nurse practitioner with the ability to make home visits and coordinate with his PCP and specialists

- Continues relationship with his behavioral health provider, and during psychiatric emergencies, is admitted to CCA's Crisis Stabilization Unit
- Medication list is simplified and meds are delivered in blister packs to his home
- Receives a personal care attendant weekly for help with ADLs
- Assigned a health outreach worker who checks in regularly and accompanies him to important medical appointments
- Home nursing care, when needed, is provided by his dedicated CCA care team, instead of visiting nurses
- Enrolled in a day program where he socializes with peers and engages in activities
- Begins to build trust with his care team, enabling early engagement and identification of medical issues before an emergency ensues
- PCP able to provide screening and preventive care for medical comorbidities
- Health information contained within a single integrated record
Impacts on the system as a whole

Promising early results from the CCA One Care program

• Positive trend in total costs of care for CCA One Care enrollees is gradually decreasing over time (i.e. “bending the cost curve”), most notably in the population with severe persistent mental illness

• Significant investments in long term supports and services (personal care, home health attendants, etc.) address unmet need prior to enrollment

• Increased spending for outpatient behavioral health services, with concomitant decrease in acute psychiatric utilization

• Extremely positive consumer experience; very low voluntary disenrollment

• Key learnings about strategies to engage, support and care for this population with the most complex needs and socio-economic vulnerabilities
Recommendations and Next Steps

Strategies to enhance outcomes for individuals with disabilities

• Expansion of alternative payment models and demonstration programs to enable integration of medical, behavioral health and long term supports and services for individuals with disabilities

• Increased funding opportunities to support and evaluate innovative approaches to care delivery, and to further scale existing solutions

• Incorporation of social determinants into risk stratification models, to ensure that the appropriate resources are invested in caring for individuals with complex social needs, particularly those with disabilities

• Improved access to training for clinical and non-clinical staff in interdisciplinary team approaches to care, with disability competency and person-centered approaches as core components of the curriculum

• Policy solutions to decrease barriers to interdisciplinary communication and collaboration, while continuing to safeguard patient privacy