Improving Care and Managing Costs for Dually Eligible, Elderly and Disabled Populations

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Medicaid (or Dually) Eligible Elderly and Disabled Population Characteristics:

- Mix of chronic illness, disabilities, social and behavioral health issues.

- Low thresholds to secondary medical complications - the main driver of ED and hospital use.

- Vast majority (80-90%) of hospitalizations admissions occur via the ED. The majority of ED encounters (>50%) lead to a hospitalization.

- Subset with significant BH issues with chronic medical conditions average $2400 per individual/mo. expenditures. 58% for acute inpatient care.
Case Studies

- Andrea C.
- Mattie H.
A.C. is a 50 year old woman with long standing Multiple Sclerosis with secondary lower extremity paraparesis, requiring a walker and manual wheelchair. She has urinary retention requiring qid self catheterizations. She was in an abusive relationship with her ex-husband who is now barred from the home via a court ordered restraining order. There is a long standing history of depression, one prior major suicide attempt and a long-standing history of alcohol abuse as well. She is also a heavy smoker with recurrent episodes of asthmatic bronchitis. During the past few years there have been multiple hospitalizations for urinary tract infections, respiratory infections and asthma exacerbations. There has not been a consistent primary care or behavioral health relationship established.
Mattie H.

77 year-old woman
  » Fiercely independent
  » Lives alone

Longstanding diabetes

Hypertension

3 strokes
  » Left-side weakness
  » Requires significant personal assistance to maintain independence

Depression

Difficulty making appointments because of mobility limitations

Medicare/Medicaid only pays for four hours/day of home health aide services

Difficulty in accessing and managing aging network, or personal care attendant services

Difficulty in accessing mental health services

Three recent hospitalizations for poorly controlled diabetes

Frequent falls

Inadequate food intake

Withdrawal

Serious consideration of nursing home placement

Recent hospitalizations

Frequent falls

Inadequate food intake

Withdrawal

Serious consideration of nursing home placement
WHAT HAS PROVEN SUCCESSFUL?

Multiple small (clinically based) prepaid pilot programs with a redesigned primary care model, selective primary care networks and integrated care coordination approaches. e.g. NHP/CMA programs: Axis, Wisconsin Partnership programs, PACE Programs, CCA, Senior Care Option Program.

WHAT IS THE CHALLENGE?

Bringing these pilot clinical models to a meaningful scale.
Elements of a Successful Care Model for Special Needs Patients

- Meaningful consumer involvement in care management and care design.
- Specialized primary care networks.
- Multidisciplinary team approach to care.
- Transfer of clinical decisions making to the home.
- 24/7 personalized continuity of care in all settings at all times.
- Fully organized, hospital and institutional alternative networks.
- Primary Care team empowerment to order/authorize all needed services.
- Full integration of Medical, Behavioral Health and Long Term Care Services.
- Electronic medical record, and state of the art data support.
Medicaid, Disabled and SNP
Dually Eligible Service Stratification

- Level I – Those whose needs can be met by the “existing” physician practice model – 50% (costs substantially below “average”)
  - Intervention – Administrative data surveillance
    - ED, hospital use
    - Patterns of primary care use
    - Pharmacy data regarding efficacy, cost, adherence
    - BH Use

- Level II – Those who need additional RN care coordination or BH Support-35% (costs = 1.2 x)
  - Intervention
    - Supplemental RN/BH Clinician support to primary care sites

- Level III – Those who require a substantial system redesign-15%- (costs = 3.5 x)
  - Intervention
    - RNP/PC role
    - Separate call system
    - Separate benefit design and management
    - Home visiting
The Care of Individuals with Severe Physical Disabilities: A Case in Point

- Nurse practitioners with a 1:40 caseload
- Home visiting
- System ability to respond immediately to new problems
- Continuity at all places at all times
- Authority to order whatever is needed

**REPLACES**

“Impersonal specialty clinics”
“The ED as sole resort”
“Standard prior approval and benefit management policies”

*BCMG is a non-profit wholly owned clinical affiliate of Commonwealth Care Alliance*
Commonwealth Care Alliance (CCA)/Boston’s Community Medical Group (BCMG) Experience – Medicaid SSI Eligibles with Severe Physical Disability

### Total Monthly Costs for Severely Disabled Enrollees Under This Alternative Delivery System

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<tr>
<th>Year</th>
<th>Medicaid FFS</th>
<th>BCMG Prepaid</th>
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The Team Approach Shifted Care Out of Hospital

- Acute Hospital Costs for Medicaid and BCMG Individuals with Severe Physical Disabilities (Medicaid Only) 1990-91 (Medicaid FFS) and 1992-2002 (BCMG Capitated)

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<tr>
<th>Year</th>
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<th>Boston Community Medical Group Prepaid Enrollees</th>
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<td>2001</td>
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Commonwealth Care Alliance
Senior Care Options (SCO) >700 Dually Eligible Elderly Enrollees – 2004-2005

ENROLLEE CHARACTERISTICS

- 70% from minority communities experiencing considerable health care disparities
- English as primary language, <25% of enrollees
- 45% functionally “homebound” – “nursing home certifiable”
- Medicare Risk Scores
  - Ambulatory enrollee’s predicted Medicare expenditures 30% greater that the age adjusted Medicare average.
  - Nursing home certifiable enrollee’s predicted Medicare expenditures 140% higher than the age adjusted Medicare average.
Commonwealth Care Alliance
Senior Care Options (SCO)
Experience 2004-2005

1. High degree of member satisfaction. Voluntary disenrollment <1%.

2. Greatly increased investment in primary care and care coordination.

3. Nursing home placement 20% of predicted.

4. Hospitalization expenses, represent 10% of premiums for ambulation enrollees and 12% of premium for nursing home certifiable enrollees.

5. ED/PMPM facility expenditures are 0.6% and 0.5% of premiums for ambulatory, and nursing home certifiable enrollees, respectively.