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

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What is the Problem?
Care is fragmented, duplicative and poorly coordinated
Care is Expensive, mainly due to Excessive Hospitalization

ANNA C.

- A.C. is a 50 year old woman with long standing Multiple Sclerosis with secondary lower extremity paraparesis, requiring a walker and manual wheelchair; and urinary retention requiring id 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, respiration infections and upper GI bleeding episodes. There has not been a consistent primary care or behavioral health relationship established.

Medication List:

- Lactose 15 ml qd
- Neurontin 1250 tid
- Clonazepam 0.5 mg hs
- Ditropan XL mg q am
- Vioxx 25 mg
- Colace 100 mg bid
- Dulcolax Supp 1 pr q hs
- Desipramine 100 mg bid
- Oxycodone 5 mg q 4 prn
- Prednisone 30-40 mg qd for asthma, or MS exacerbation
- Baclofen 10 mg tid
- Duragesic 25 mcg/h q 72 hr
- Diflucan 150 mg prn

Improving Care and Managing Costs for the Medicaid and Dually Eligible Disabled

- ## What is the opportunity?

  Prepaid comprehensive clinical care systems focusing exclusively on Medicaid and dually eligible elderly and disabled populations.

- ## What is the Challenge?

  Bringing to a meaningful statewide scale strategies that have demonstrated success in improving care and managing costs in many small prepaid clinical programs.

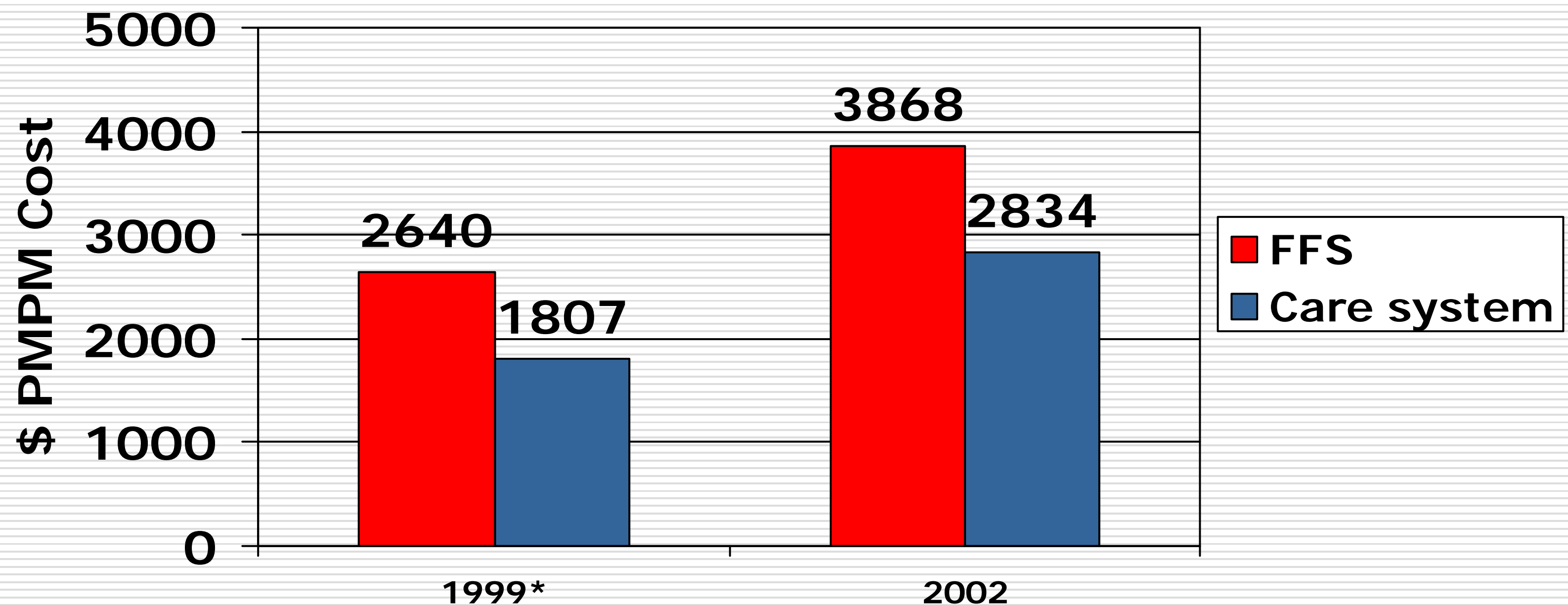
Prepaid Clinical Programs with Demonstrated Success in Improving Care and Managing Costs

Program	Geography	Population	# Served
CMA AIDS Care Program	Greater Boston, Worcester , New Bedford	Those with Advanced AIDS	200
CMA Special Kids Special Care	Mostly Greater Boston	Medically involved children in DSS custody	80
Boston's Community Medical Group	Greater Boston	Those with severe physical disability including those with mental retardation	250
Brightwood Health Center	Springfield	Those with Advanced AIDS	100 (in CY 2003)
Brightwood Health Center	Springfield	Medicaid eligible individuals with general disability	350

Elements of a Successful Care Model for Special Needs Patients

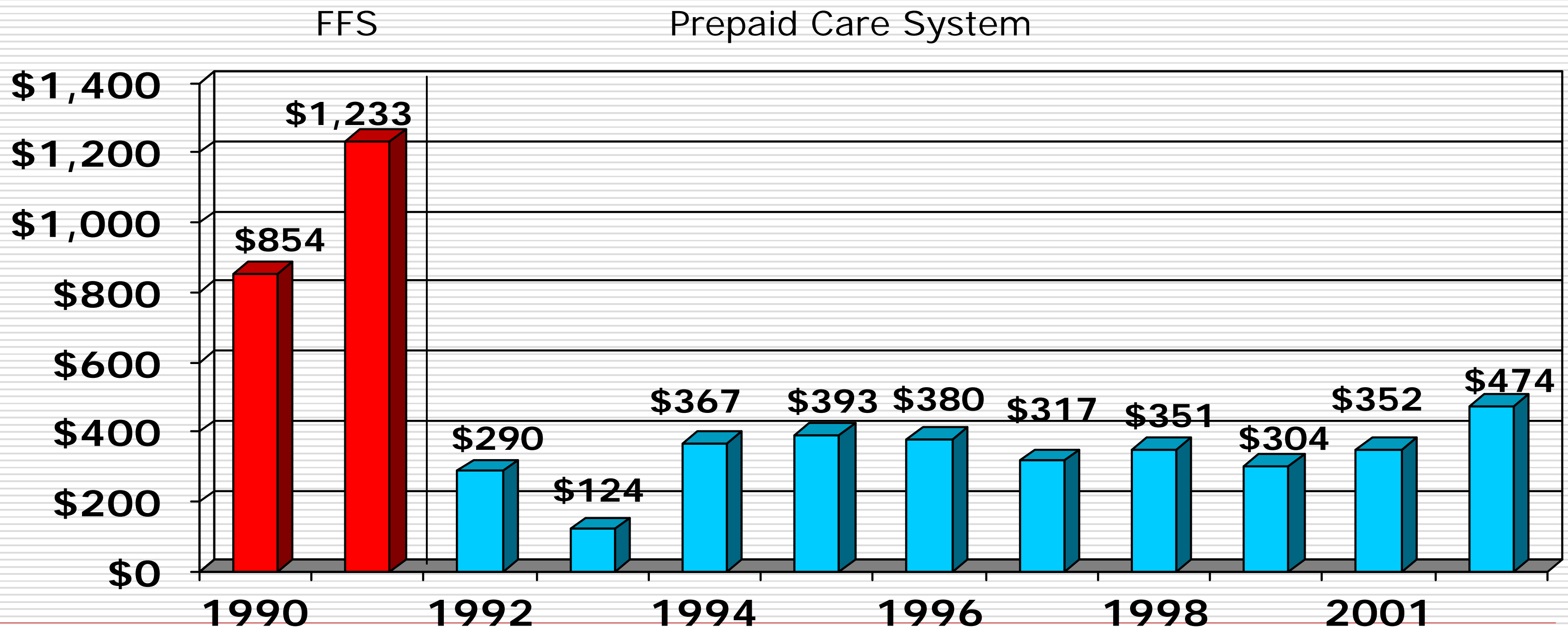
- Specialized primary care networks.
- Team approach to care via RN/RNP's.
- Transfer of clinical decisions making to the home.
- 24/7 personalized continuity of care in all settings at all times.
- Fully organized, hospital and institutional alternative networks.
- Primary Care team empowerment to order/authorize all needed services.
- Meaningful patient involvement in care management.

Boston's Community Medical Group Prepaid Care System experience for 250 Individuals with Severe Physical Disabilities

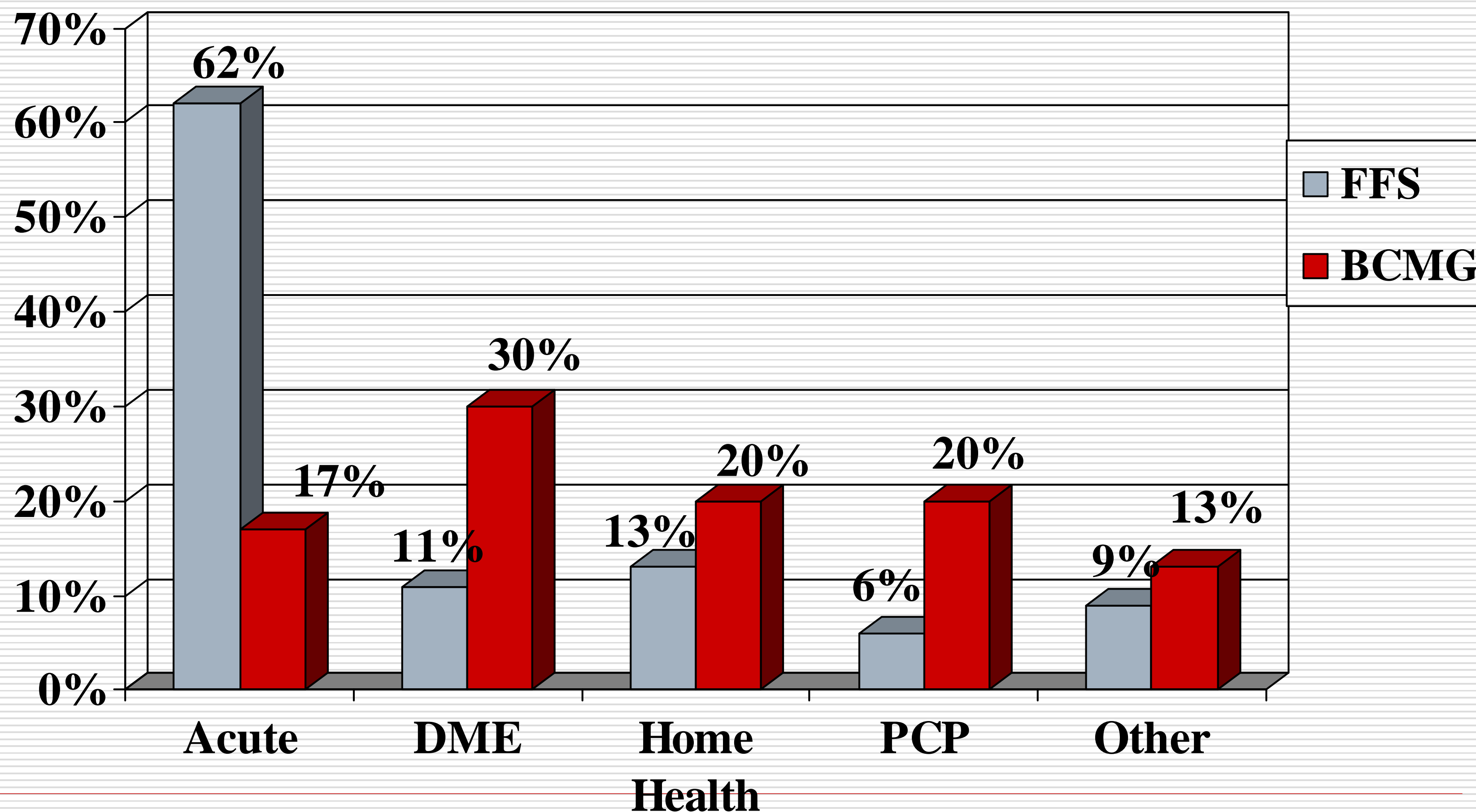


Prepaid Care System Approach Shifted Care Out of the Hospital

Acute Hospital PMPM Costs for Boston's Community Medical Group Patients with Severe Physical Disabilities (Medicaid Only) 1990-91 (FFS) and 1992-1999 (Capitated)



Distribution of Medical Service Costs for Boston's Community Medical Group (BCMG) Patients with Severe Physical Disabilities and Ohio Medicaid Recipients with Paraplegia and Quadriplegia



*BCMG data base don experience 1/1/95-9/30/98
Ohio data based on experience in 1991.

Brightwood Program Participants

- 960 potential RC2 (SSI eligible or disabled by state criteria) enrollees at Brightwood
- 345 RC2 members enrolled in program
  - Physician identification of those who could benefit
  - Predicted to use services that cost 17% more than NHP RC2 membership
- Further stratified into Intensive Care Management and Intermediate Care Management Group

Brightwood Program Model

- Enhanced primary care, behavioral health and care coordination
- Multidisciplinary clinical team model
- All care authorization done by team
- Behavioral health/physical health integration
- Non-clinician team members (substance abuse peer councilors)

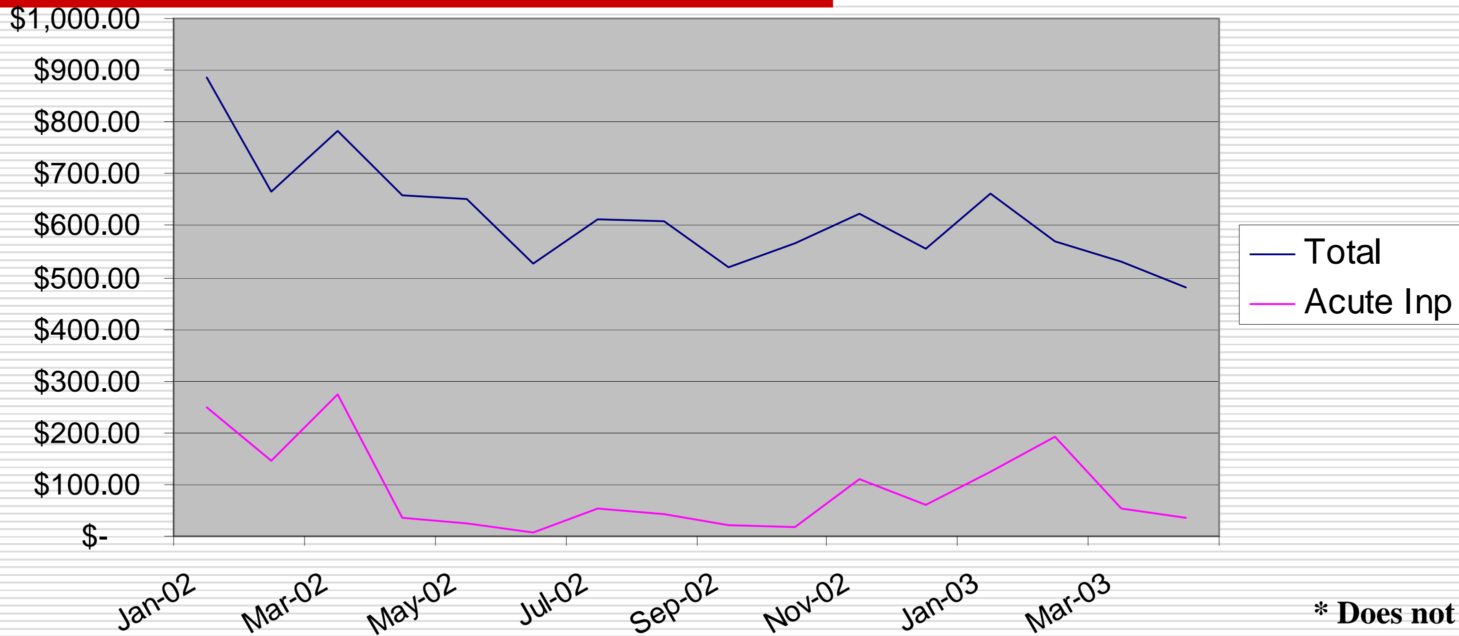
At the End of the Day….

- **Cost of the "intervention" = $86 PMPM**

- **Question -** does the cost of the intervention yield the improvements in care and reductions in cost to justify the investment?

*Evaluation by Carol Tobias Health and Disability Working Group, Boston University School of Public Health funded by CHCS

Total and Acute Inpatient Expenditures $ PMPM*



* Does not include cost of intervention ($86 PMPM)

$PMPM	CY2001	*1st Q/CY2003
Total Medical Expenditures	$834	$580
Acute Hospital Expenditures	$220	$88

Lessons Learned

- **Outpatient care increased overall while inpatient care declined**

"Before I only went to the doctor when I was feeling bad. I was in bed 9 months, very depressed and bad. Now they come here every week."

"I see Dr. S once a month and talk with T every other day. Before I saw Dr. S only twice a year."

Lessons Learned

- **For a small subset of people, costs declined dramatically**

"Before I started the program my health was out of control. Four years back I used to go to the hospital every month or 2-3 times every month. I had to leave my kids alone in the house. Now I go every 6 months or one year. I haven't been in the hospital for 2 years."

What Does It Take To Bring These Programs to Scale?

1. Foster the establishment of multiple clinical prepaid care systems through:

    - Procurement policies to promote the ability of new entities to enter

    - a comprehensive risk adjustment system for Medicaid eligible disabled (e.g. DPS)

    - Aggregate risk sharing

    - Change MassHealth policy to conform to DOI's policy RE: "surplus notes" to foster the entrance of non profit community based care systems

2. Continue to prioritize the SCO initiative

3. Promote "SCO" models for the under age 65 Medicaid and dually eligible disabled populations

4. Enhance MassHealth's MCO infrastructure to promote new models of prepaid contracting