Commonwealth Care Alliance Presentation for Vermont Blueprint for Health

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Improving care for people with disabilities and chronic health needs

Commonwealth Care Alliance (CCA)

Total cost of care experience with complex members as a **payer and a provider**, with >30,000 members and $1.4 billion of premium

Roots in a decades-long collaboration between clinicians, advocacy groups, community organizers, philanthropists, government agencies, and policy makers, **always with a social determinants of health focus**

NATIONALLY RECOGNIZED CARE MODEL

"…the lessons Commonwealth Care has learned could provide the template for the Medicare program of the future"

Top Medicare Medicaid Plan patient satisfaction score in the nation for the past 3 years

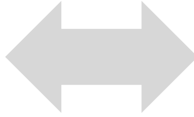
CCA's core population reflects the upper end of patient complexity

<65 yrs Medicare-Medicaid Duals Plan

14x	**cost of caring** for <65 population averages to $2,858 per member per month, 14 times the average for general population
64%	**have a serious mental illness** such as schizophrenia, bipolar disorder, severe depression (excluding SUD)
32%	**have substance abuse disorder**
7.5%	**are homeless**

>65 yrs HMO D-SNP

76	**average age**
65%	**are nursing home certifiable,** yet are able to live at home
59%	primarily speak **a language other than English**
63%	have four or more **chronic conditions**
56%	**have diabetes**



Care models have been developed to serve patients with varying needs and under different payers

Mobile Integrated Health (MIH)

CCA **triages and responds to patient urgent care needs in members' own homes**, avoiding unnecessary ED visits. Specially trained paramedics communicate with on call staff and evaluate and treat members in their own residence.

Wrap Care Model

The model stratifies members into structures most appropriate for individual's needs. Each patient has **one Care Partner** in our clinical group based on **individual** medical, behavioral and social need.

Ready Resource Team

A team of on-demand multidisciplinary clinicians who **augment care partners through direct care delivery**, coordination and consultation as needed. Provide **episodic** support and **"on call" services** after hours.

Life Choices Palliative Care

An **alternative to traditional hospice** with a broader ranger of in-home services available throughout the course of serious illness, **not just end of life**. CCA RN palliative care clinicians work closely with care partners.

Crisis Stabilization Units (CSU)

Unlocked **crisis units** that help people in acute BH crisis to **stabilize and avoid hospitalization**. Offer rehabilitative and recovery focused services. Staffed by full time CCA LICSW and Psych NP.

Full Spectrum Primary Care

Commonwealth Community Care offers support beyond a traditional practice for high-risk members. Sites provide **enhanced primary care support** to members **who do not thrive in a traditional PCP model** due to physical and psychosocial disability.

Continuity Hospitalist Program

This program provides **medical expertise** and **care coordination** across care settings while enhancing patient experience. Located at the inpatient setting, this program provides medical consultation with insight on individual members and expertise on caring for members with complex medical and psychosocial needs, particularly those with disabilities.

Care model results in high-need population

>85%

patient engagement rate

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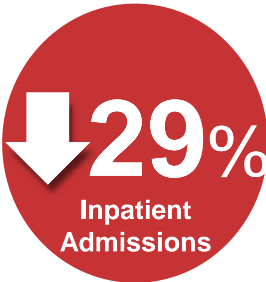
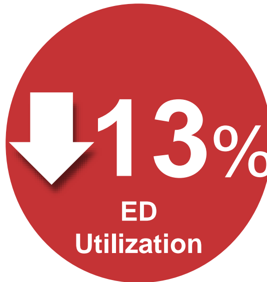
leads to…





* Analysis of a subset of members, retrospective analysis

External research on specific care model innovations

- **Medically Tailored Meals**
  - Harvard Medical School et al
  - *Health Affairs*, 10.1377/hlthaff.2017.0999
    HEALTH AFFAIRS 37,NO. 4 (2018): 535–542
- **Crisis Stabilization Units**
  - Mathematica Policy Research
  - ICRC Technical Assistance Brief
- **Community Paramedicine**
  - Mathematica Policy Research
  - Center for Health Care Strategies, Inc. Brief
- **Complex Care Hospitalist Service**
  - Harvard Business Review

Medically tailored meals (MTM) delivery programs reduce the use of costly healthcare in the duals population

A **two year study** of two groups totaling over 750 participants demonstrated that the average monthly medical costs for MTM participants was $843 vs. $1,413 for the comparison group, **reflecting a gross difference of $570 per month,** and a net difference of $220 (factoring in the cost of the meals).
MTM participation was associated with **fewer emergency room visits, inpatient admissions, and emergency transportation services** compared to controls.

EXHIBIT 3

Estimated average monthly medical spending per person, by intervention and in control groups

	Intervention group	Matched control group	Gross difference	Net difference
Medically tailored meals program	$ 843	$1,413	−$570***	−$220
Nontailored food program	$1,007	$1,163	−$156**	−$10

SOURCE Authors' analysis of data from Commonwealth Care Alliance. **NOTES** Spending is in inflation-adjusted 2016 dollars. Estimates from gamma regression models adjusted for the factors listed in the notes to exhibit 2. Gross difference represents the estimated difference in health care spending by intervention status. Net difference represents the estimated difference in health care expenditures, accounting for the cost of the intervention. p values test the null hypothesis that the difference in gross spending between intervention and matched controls is equal to zero. **$p < 0.05$ ***$p < 0.01$

Alternatives to inpatient psychiatric facilities (IPFs), such as CCA's Crisis Stabilization Units (CSUs), can lower utilization and PMPM costs

Early lessons from the successes of the CSUs demonstrated that key components include a comprehensive model of care, clinical leadership team with strong risk management practices, experienced community-based partners, and fewer than 20 beds.

PMPM costs decreased from 10.7% per month between October 2013 and creation of the Carney CSU, to **1.5% per month** from October 2014-June 2015.
IP psych admissions largely stabilized, with utilization decreasing from 9.6 admissions per 1,000 members per month in the period October 2013-September 2014, to 8.5 for the period October 2014-July 2015.
Inpatient psychiatric days per 1,000 members per month decreased in the same period from 125 to 100.

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CCA's community paramedicine program reduces unnecessary ED use and shifts service back to community-based and home settings

Analysis of 15,592 episodes in Eastern, Central, and Western Massachusetts demonstrated that **patients diverted from the ED had lower average costs** than those not diverted on a patient-episode basis (per patient savings were $791 for a seven-day period, $3,677 for a 15-day period, and $538 for a 30-day period).

Cost Drivers:

- **Patient Volume:** 10% increase in patient volume would increase savings by 18%.
- **ED Diversion Rate:** A 2.5% increase in the average ED diversion rate would increase savings by 5%.
- **Operating Costs:** A 10% increase in ACC operating costs would decrease estimated savings by 8%.
- **Per-Episode Utilization and Health Care Spending:** A 10% increase in the difference between per-episode utilization or costs for diverted and non-diverted patients leads to a 3% decrease in estimated savings.

CCA's complex care service delivers specialized inpatient care for high-need patients

As outlined in **Harvard Business Review**, CCA's Complex Care Service provides a **consultative inpatient service for complex members** to provide a specialized view of medical, behavioral and social management.

Expertise in Complex Care

Relationships & Trust

Engagement & Education

Access

Transitions of Care

Thank you

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