



Medicare Special Needs Plans: Year Three

Lois Simon, Chief Operating Officer

What is Commonwealth Care Alliance (CCA)?



- CCA is a Massachusetts, state-wide, not-for-profit prepaid care delivery system that:
 - Focuses exclusively on care needs of special needs populations
 - Medicare and Medicaid's most complex and expensive beneficiaries
 - Relies on Medicare and Medicaid risk adjusted premium to substantially redesign care
 - Incorporates proven clinical strategies of care coordination and care management
 - Expands access by bringing clinical strategies to scale
 - Ensures that the patient's voice is central

Medicaid and Dually Eligible Disabled Population Characteristics



- Complex mix of chronic illness, disability, social and behavioral health issues.
- Very low thresholds to secondary medical complications, the driver of hospital expenditures.
- Important subsets (particularly those with significant BH issues) incur monthly medical costs of over \$2400/month with >50% going to acute hospital care.
- Poor access to primary care and care coordination.

Current CCA Clinical Programs

CCA Leadership Has Successful Experience Designing and Operating Care Programs For Special Needs Populations

Program	Geography	Population	Approx. Enrollment
Dual Demonstration Program (Transitioning to SNP)* Senior Care Options	Greater Boston, Lynn and Springfield	Medicare/Medicaid Eligible Elders Fully Integrated Medicare and Medicaid	1300+
Special Needs Program: Commonwealth Care Connection	Greater Boston, Lynn and Springfield	Medicare/Medicaid Eligibles Medicare Only	200
Severe Physical Disability Program: Boston's Community Medical Group*	Greater Boston	Medicare/Medicaid eligible individuals with severe physical disability including those with mental retardation; Medicaid Only	400
PCCP Pilot Program*	Springfield	Medicaid eligible individuals with general disability, and those with Advanced HIV/AIDS Medicaid Only	400

****All have demonstrated enhanced quality, satisfaction, reduced hospitalizations and effective cost management***

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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 or other care settings when necessary.
- 24/7 personalized continuity of care in all settings at all times.

Elements of a Successful Care Model for Special Needs Patients (cont.)

- 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 member record, and state of the art data support.

The Gold Standard for Medicare/Medicaid Integration: Senior Care Options Program

- Fully integrated care delivery system for members.
- Medicare A/B, Part D, full Medicaid benefit package including behavioral health and long term care services.
NO CARVE OUTS!
- Fully empowered primary care “team” making benefit authorization decisions.
- One enrollment process for beneficiaries.
- Single membership card and integrated member materials describing the program and benefits.
- Simplicity for the beneficiary and providers.

Goals and Challenges: SNP without Medicaid Integration



- **Enhanced Primary Care Access and Care Coordination:**
 - Home Visiting and Timely Response to Urgent Needs/Sick Visit Access
 - Development of Individualized Plan of Care
 - Monitoring of Clinical Interventions and Services

- **Consumer Engagement and Understanding:**
 - Enrollment Process
 - Member Materials: including clarity of benefit package
 - One Stop Shopping

Goals and Challenges: Medicare Only Product



- **Flexibility and Creativity in Designing Care Interventions:**
 - Use of specialized vendors and services
 - Timely response to need for interventions – e.g.. Transportation, DME, pharmacy, home and community based supports
- **Data Driven Decision Making:**
 - Quality and outcome tracking
 - Monitoring patterns of care

Summary



- SNPs have enormous potential to improve care and manage costs for medically complex, vulnerable and expensive Dually Eligible beneficiaries.
- The results cited are not unique to CCA but also have been demonstrated in multiple clinically based, nonprofit, prepaid care demonstrations across the US.
- The question is no longer – “What Works”.
- The challenge is to bring to scale what we know “works”.

Follow-Up/Contact Information

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