Better Care: Maximizing Opportunity in the ACA and Beyond

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Better Care: Health Care That Works for All of Us
Salt Lake City, Utah

About Community Catalyst

- Nonprofit health care advocacy organization
- Network of advocates in 40+ states
- Building advocacy infrastructure
- Leading broad-based issue campaigns
1. The Status Quo
2. The Opportunity
3. What’s Needed to Make it Happen?
Anna C.

- 65-year-old dually-eligible woman
- Longstanding Multiple Sclerosis (MS), complete paralysis in both legs, impaired bladder function, weakness and increasing spasticity in her arms
- Chronic depression
- Severe asthma exacerbated by heavy smoking
- Over two year period: hospitalized multiple times for urinary tract infections, asthma flare-ups and pneumonias; two long hospital stays for pressure sores
- No primary care or behavioral health relationships
- Emotionally withdrawn, functionally bedbound, incontinent, worsening pressure ulcers

Our Fragmented System

Absence of Patient-Centered Care

- Inappropriate Rx
- No One to Find & Arrange Non-Medical Services
- Little or No Info upon Discharge
- Too Frequently Hospitalized
- Inaccessible facilities, equipment, scheduling
- Duplicate Tests & Procedures
- Providers Unable to Coordinate
- Preventable Hospitals Readmissions and NF stays
Disparate Impact

- Older adults with multiple chronic conditions
- People living with disabilities
- Racial and ethnic minorities
- Dually eligible beneficiaries

Multiple Chronic Conditions

More Than Three-Fifths of Health Care Spending Is on Behalf of People With Multiple Chronic Conditions

- 5+ Chronic conditions 21%
- 4 Chronic conditions 12%
- 3 Chronic conditions 16%
- 2 Chronic conditions 17%
- 1 Chronic condition 18%
- 0 Chronic conditions 16%
Dual Eligibles

Medicaid Enrollment, 2009
- Adults 26%
- Children 49%
- Other Aged & Disabled 10%
- Duals 15%

Total = 63 Million

Medicaid Spending, 2009
- Other Aged & Disabled Spending 28%
- Children & Adult Spending 34%
- Long-Term Care 25%
- Acute 38%
- Prescribed Drugs 0.4%
- Premiums 3%
- Medicare Acute 7%
- Other 2%

Total = $359 Billion

Source: Center for Budget and Policy Priorities (CBPP)

31 States Have Addressed or Have Projected Shortfalls for Next Year

Source: Center for Budget and Policy Priorities (CBPP)
• Insert graphic re: Medicaid expansion (just a question mark?)
The Opportunity

Affordable Care Act
"The Triple Aim" 

Better Health 
Better Care 
Lower Cost 

Health Equity 

- Reduce hospital readmissions 
- Collect race/ethnicity/language data 
- Culturally competent care
Center for Medicare & Medicaid Innovation (CMMI)

- State Innovation Models Initiative
- Financial Alignment Initiative

Financial Alignment Initiative (Dual Eligibles)

- Arizona
- California*
- Colorado*
- Connecticut*
- Hawaii
- Idaho
- Illinois
- Iowa
- Massachusetts*
- Michigan*
- Minnesota*
- Missouri
- New Mexico
- New York*
- North Carolina*
- Ohio
- Oklahoma*
- Oregon*
- Rhode Island
- South Carolina*
- Tennessee*
- Texas
- Vermont*
- Virginia
- Washington*
- Wisconsin*
Health Homes Option

- Two years of 90 percent federal matching funds
- Approved:
  - Alabama
  - Iowa
  - Missouri
  - New York
  - North Carolina
  - Ohio
  - Oregon
  - Rhode Island

Home and Community-Based Services

- Community First Choice Option
- Balancing Incentives Payment Program
Medicaid Can Lead the Way

Enrolled in the Commonwealth Care Alliance
Assign a multidisciplinary care team: primary care physician, in-home nurse practitioner, behavioral health clinician, physical therapist
Assessed needs and developed intensive care plan:
  - Primary care visits
  - In-home wound care
  - Specialized air mattress and a motorized wheelchair with needed seating adaptations
  - In-home behavioral health assessment, individualized care plan for medication and counseling
  - Transportation to specialty appointments, dental care and other activities
  - Smoking cessation
  - Nurse practitioner as “first responder” for new problems and manage clinical issues via home visits.
Anna C.

- More engaged with her life, family and community
- Improved ability to self-manage her conditions
- Pressure ulcers healed
- Decreased number of asthma flare-ups
- Good/continuous relationship with primary care physician, registered nurse practitioner, neurologist
- Decreased use of the emergency room and hospital
- In the first year, she had only 2 emergency room visits for asthma and one three-day hospital stay for a urinary tract infection

What’s Needed to Make it Happen?
Implementation of these models will rely on effective partnerships with States and success will largely be contingent upon engagement with and the capacity of health care and service providers that support and care for Medicare-Medicaid enrollees in their communities. Medicare-Medicaid enrollees, their families and consumer organizations working with them also have a central role to play in helping to design a person-centered system of care. Therefore, **CMS encourages and expects active and meaningful State engagement with stakeholders in both models.**

~ State Medicaid Director letter on Financial Alignment Initiative

July 11, 2011
State Infrastructure

- Cross-agency
- Dedicated staff
- Oversight mechanisms
- Stakeholder engagement
State-Level Oversight

Independent Ombudsman
- Receive and respond to individuals complaints
- Identify systemic problems

External Oversight Body
- Review key data
- Monitor overall demonstration activity

Ongoing Consumer Engagement

“Collaboration with consumer and consumer advocacy groups is critical. In order to achieve the important goals of better health and better care with lowered costs, we must continue to put our beneficiaries first. This is a time of significant change in the Medicaid program, and we should ensure beneficiaries’ voices are heard in the design, implementation, and oversight of new initiatives.”

~ State Medicaid Director letter on Integrated Care Models
July 10, 2012
Delivery System Collaboration

- Newsletters
- Surveys
- Comment cards
- Town hall meetings
- Focus groups
- Resource fairs
- Consumers on board of directors
- Consumer advisory board
- Committee membership

Enrollment

- Good marketing materials
- Outreach via respected community-based organizations
  - Aging and Disability Resource Centers
  - State Health Insurance Programs
  - Independent Living Centers
  - Recovery Learning Centers
Care Coordination

- Comprehensive assessment of medical and non-medical needs
- Interdisciplinary team: beneficiary, caregiver, physician, advanced practice registered nurse, social worker, pharmacist, nutritionist, specialist
- Care manager
- LTSS coordinator

Getting Payment Right

- Avoid windfall profits or devastating losses
- No incentive for denying or minimizing services
- Incentive to provide care in community-based settings
Learning Networks

- Integrated Care Resource Center (Center for Health Care Strategies)
- Advancing Accountable Care Organizations: A Learning Collaborative (Center for Health Care Strategies)
- Promoting Integrated Care for Dual Eligibles (PRIDE)
- Duals Demo Advocacy (National Senior Citizen Law Center)
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