



AgeTech California Center for Technology and Aging

Dual RFI Response Summary

*Improving Care through Integrated Medicare and
Medi-Cal Delivery Models*

Stakeholder Meeting
August 30, 2011



Organization Background

- AgeTech California enables aging-services and homecare providers in developing and implementing technology-based care models for better, more cost-effective care
- Center for Technology and Aging seeks to improve the independence of older adults with chronic care issues by promoting the diffusion of beneficial technologies through programs and initiatives that generate and disseminate best practice and provide tools for developing successful programs



Existing Problems that Should be Addressed by Demonstrations

- The overall opportunity is to leverage the maturation of remote monitoring and support (“telehealth”) technologies to better maintain dual-eligible beneficiaries in community-based settings
- Problem #1: Lack of means for continuous and cost-effective support in the community
 - Self-management support for chronic conditions
 - Environmental and ADL monitoring for frail elderly
 - Nearly continuous monitoring for potential exacerbations
- Problem #2: Difficulty in coordinating right care at right time between variety of organizations (healthcare and aging / supportive services)



Overview of Demonstrations

- AgeTech CA / Center for Technology and Aging believe home-telehealth-based interventions can meet challenge of defined problems, and will be central to efforts to integrate and better manage care for dual-eligible beneficiaries
- To further this goal, organizations recommend two pilots:
 - Program One with a COHS
 - Program Two with a consortium of homecare agencies
- Both based on care coordination and management model, using “telehealth” technology, developed by VA and now proven in other settings
 - VA has shown 20 percent admissions reduction with large population
 - Medicare Care Management for High-Cost Beneficiaries program showed 240 percent return for CMS



Consumer Protection Considerations

- In RFI, suggested opt-in model – contractors implementing will be required to document verbal or written consent
- Telehealth technology can be used to survey engaged beneficiaries frequently about satisfaction with program and services
- Program will have to be able to support beneficiaries who cannot use home telehealth technology (primarily telephonic monitoring)



Specific Care Integration Challenges

- Suggested pilot programs will implement a telehealth-based care coordination and management intervention with the goal of:
 - Maintaining dual-eligible beneficiaries in their homes through
 - Self-management support
 - Monitoring for early warning of complications
 - Coordination of key services – including in-home supportive services

Note: approach will create a more “activated” population of beneficiaries



Specific Care Integration Challenges

- Key dimensions:
 - Automated assessment and support of wide range of conditions, including mental health conditions, and individuals with multiple complex conditions
 - Example: Tech-enabled support of personal health and care management for those with specific chronic conditions
 - Exception-based workflow: Care coordinators attend to those beneficiaries with an identified need that day
 - Care coordinators establishes linkage with other providers and mobilizes them – as possible – to preventively remedy medical and non-medical risk factors



Measures for Success

- Key metric: Net cost savings relative to a propensity-matched sample based on one year of enrollment in program (N=TBD)
- Secondary metrics:
 - Utilization of healthcare services by category (primary, acute, post-acute, long-term care)
 - Engagement of assigned population
 - Beneficiary and provider satisfaction
 - Quality of life based on standard survey instruments
 - Population health measures relative to benchmarks as appropriate
 - Qualitative assessment of replicability as pilots succeed and programs are expanded statewide



Information Needed from CMS and California

- How will CMS and California provide data on timely basis given that this is a fee-for-service population?
 - What are the expected data lags?
- Will California and CMS specify a uniform evaluation methodology for all four pilot projects, or will each be able to propose its own?
- Will California and CMS provide any start-up funds for implementing new models (i.e. payment on full population assigned for x number of months)?
- Do California and CMS envision requiring assumption of downside risk at any point in the demonstration?



Supporting Slides



RFI Response Summary

- Suggest two pilots to transpose highly successful VA-developed telehealth-based care coordination model into fee-for-service program for dual eligibles
- Model #1: Implemented through county-organized health system
- Model #2: Implemented through confederation of homecare agencies



Definitions

- Remote patient monitoring represents range of technologies for moving care outside of traditional clinical and non-clinical settings
- For purposes of presentation, includes:
 - Telehealth
 - Wireless health
 - mHealth
 - Medication optimization
- Does not include telemedicine, which connects traditional points of care



Model Overview

- Developed by VA to focus on top 4 percent of non-institutionalized population that account for 40 percent of costs
- Intervention:
 - Place telehealth appliance in home to monitor vital signs, symptoms, behavior, knowledge of condition
 - First line of defense: Self-management support
 - Second line of defense: Monitoring to catch complication early, remedy with medication adjustment or



Value Proposition

- Focus: High-cost individuals
- Reduction in utilization of most expensive healthcare services and cost for high-cost individuals
- Improved patient outcomes and quality of life
- Improved efficiency of healthcare personnel
 - Exception-based workflow
 - Reduced homecare visits
 - Integrated provider solutions

Evidence

Study	Key Finding
VA Florida 2000	63% admission reduction
VA large study 17,000 – 2008	19.5% admission reduction; 25% reduction in bed days
Medicare Health Buddy 2006-2009	240% return on investment
Tufts-New England Medical Center 2005	72% reduction in CHF readmissions, 63% reduction in all-cardiac
Centura Health at Home	61.5% 30-day readmissions reduction
Sharp Health Care	66.5% 30-day readmissions reduction



Key Quote from VA 2008 Paper

“The cost of CCHT was \$1,600 per patient per annum. This compares very favorably to the direct cost of VHA’s home-based primary care services of \$13,121 per annum and market nursing home care rates that average \$77,745 per patient per annum.”

Adam Darkins et al., “Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions,” *Telemedicine and e-Health*, December 2008



Program Mechanics and Economics

- Target beneficiaries in (or at risk of being in) top 15 percent of spend / 140,000 beneficiaries (derived all-in PBPY cost = \$112,000)
- Enrollment target: 35 percent / 49,000 beneficiaries
- Gross savings target: 20 percent
- Annual technology-based care coordination cost: \$2,400 per beneficiary per year (estimate, will vary based on area of state)

Savings Analysis

Pre-intervention beneficiary cost	\$111,833
Gross savings – 20 percent	\$22,367
Intervention cost	\$2,400
Net per beneficiary savings	\$19,967



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