

Program for needy patients struggles

Costs high in state, enrollment low for unique One Care initiative

By Kay Lazar

| GLOBE STAFF NOVEMBER 10, 2014

An experiment to improve care for thousands of Massachusetts' sickest residents is proving more complex and expensive than health insurers and regulators envisioned, forcing the state and federal governments to shoulder more costs for the first-in-the-nation program.

Called One Care, the initiative was designed to better coordinate health care services for about 95,000 disabled and low-income adults under age 65 when it launched last October. But the state's latest count shows fewer than 18,000 enrolled, and officials have repeatedly declined to release detailed information about the program's finances or the quality of patient care because they say they want to be able to analyze a year's worth of data first.

One of the three insurers managing patients' care for the program said in an internal memo that the company was losing \$1 million a month at one point. And executives at all three companies with contracts to manage patients' care said even locating patients can prove daunting, often because of errant information from state regulators.

The experience with the trial so far opens a window onto the remarkably complicated needs of patients whose conditions include paralysis, severe mental health problems, and addiction. Executives from the three companies said they have been surprised by the extent of patients' needs.

Robert Master, chief executive of Commonwealth Care Alliance, a nonprofit that oversees health care for about half of the patients in the One Care program, listed the challenges his company has confronted in connecting with patients: "The transience is extraordinary, behavioral health issues, homelessness . . . we kind of anticipated that, but we didn't realize how bad it is."

For years, two massive and often conflicting government programs, federally run Medicare and state-run Medicaid, paid the health bills for this group of patients.

But soaring health care costs nationwide, particularly for patients with complex medical needs, prompted federal regulators to announce a new initiative that aims to better coordinate patients' mental health, medical, dental, and substance-abuse services, hoping to avoid more expensive hospitalizations.

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States were invited to design their own programs that combine the money from Medicare and Medicaid into one streamlined service that would offer better care for less money.

Massachusetts was the first state to sign on, and four other states have launched similar initiatives, with similar complications.

The program in Massachusetts scraps the traditional model of paying physicians for every blood test, medical scan, or other health service they provide. Instead, companies in One Care receive a lump sum each year to manage all of a patient’s care, often coordinating and paying for services not typically handled by an insurer, such as transportation, housing, and even food deliveries.

Robin Callahan, deputy director of Massachusetts’ Medicaid program, said the state didn’t have anyone to copy from when it launched One Care a year ago and said regulators are doing their best while learning as they go.

Callahan acknowledged that the state recently increased the amount it will pay to manage patients’ care to the three companies in One Care — Commonwealth Care Alliance, Fallon Total Care, and Tufts Health Unify. She said the state also agreed to share more of the companies’ losses for the next two years because of the large number of unexpected difficulties they faced.

But Callahan declined to release details. While only scant information about One Care has been released by the state, officials have disclosed monthly enrollment figures and preliminary results from a recent survey of 375 patients.

That survey indicated 94 percent said they were “completely or somewhat satisfied” with One Care, but fewer than half said they had been connected with a coordinator to manage their services long-term — a feature considered critical to successfully managing their care.

“This is a basic benefit that people are not getting,” said Al Norman, executive director of Mass Home Care, a network of nonprofit agencies focused on home-based care. “Millions of dollars in public money have been invested in this experiment. We need full disclosure.”

The lack of information has frustrated patient advocates, who say it is impossible without details about finances and the quality of patient care to gauge whether the program is effective and should be continued.

“Our concern is that people will say, ‘Where are the savings?’ and we will not have the information to say we anticipated losses in the first year, but here is why the costs are high,” said Dennis Heaphy, cochairman of both a disability rights coalition and an independent council appointed by state regulators to promote “accountability and transparency” in One Care.

Heaphy, a 53-year-old Boston quadriplegic, is one of One Care’s biggest champions. Since enrolling a year ago, Heaphy said he has access to bandages that help prevent pressure sores from his wheelchair and bed. Medicare often balked at paying for the bandages because, under its complex guidelines, bandages used for preventive care were not covered, Heaphy said. One Care has also helped Heaphy get a hospital bed in his apartment and a machine that helps him cough.

“My health plan makes the guidelines now and goes with what the person needs, rather than some bureaucratic guidelines,” he said.

Leaders of the health plans say one reason they are facing such high costs is a lack of appropriate housing for patients with serious mental illnesses. Master, chief executive of Commonwealth Care Alliance, said his plan often has as many as 60 people in psychiatric hospitals at a cost of \$1,100 a day, when many of them would be better served in community-based crisis stabilization units at half the cost. But there are few such units in Massachusetts.

An August memo from Master to staff members said their company was losing about \$1 million a month because of this problem. So the company is creating its

own units and opened its first in October in a renovated floor it leases at Carney Hospital in Dorchester. A second is slated to open in January in a renovated Boston Victorian.

Master said the company's significant losses have eased since August, but he declined to share details.

"I think we are going to come out of the year with manageable losses," Master said. But "we do not think we will get to break even until 2016."

Creative approaches have sprung from the obstacles confronted by the health plans, particularly in tracking down homeless patients. The plans are required to complete a comprehensive assessment of each patient within 90 days of enrollment.

"Part of the challenge here is, how do you come up with highly customized care for members that meets their needs, but do it in a way that you can produce data and that gives us reproducible outcomes?" said Dr. Christopher "Kit" Gorton, president of public plans for Tufts Health Unify.

Tufts officials noticed that while the homeless are not inclined to visit a clinic, they are diligent about filling prescriptions. So the insurer started leaving notes that pharmacists hand to patients telling them a nurse wants to meet to talk about their health. That has helped Tufts complete face-to-face assessments with at least 80 percent of its enrollees, Gorton said.

Fallon has had better luck catching up to homeless patients in the hospital.

"If someone is hospitalized, staff get up and drive over to see them," said Dr. Dan Rome, a medical director at Fallon Total Care, which manages care for about 6,100 patients.

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