Meeting the needs of Dual-Eligible Beneficiaries

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Shift Toward Value-Based Purchasing

- The current system is changing from Fee-For-Service to payment for outcomes
- Maryland is leading the way in pushing hospitals towards value-based payments – All Payer Waiver
  - In the past, there were real financial incentives to providers, when complications occur
  - Financial incentives have shifted towards outcome based payment models
Target Population

• The target population of many of the current changes in Healthcare are Medicare Eligible Beneficiaries
• The healthcare change mandates are dramatically impacting the actions of providers that serve Medicare beneficiaries
• Medicare Eligible Beneficiaries include the following:
  – People 65 or Older
  – People under 65 with certain disabilities
  – People of ANY age with End-Stage Renal Disease
  • Permanent kidney failure requiring dialysis or a kidney transplant
A system that pays for value will focus on where the highest cost drivers are.

- Institutional Care (Acute and Post-Acute Care)
- Nursing Home Placement
- Preventable Primary Admissions
- Readmissions
Emphasis on Duals

• The term “Dual” generally refers to beneficiaries that qualify for both Medicare AND Medicaid
• Duals make up the population that is most vulnerable to cost increases
• Eligibility generally requires
  – Aged (65+) or;
  – Disabled AND
  – Meets means testing for Poverty status
• Many Reforms impact both Public Payers
  – Medicare + Medicaid
• Medicaid eligibility pathways are defined by state-defined financial criteria related to poverty status

• About half of the dual-eligible beneficiaries who receive full Medicaid benefits qualify under a mandatory eligibility pathway based on their receipt of federal SSI benefits

• Supplemental Security Income (SSI) 2016
  – Available to disabled or elderly people whose incomes and assets are very low
    • $733 per month (Individual)
    • $1,100 per month for a couple
What are the characteristics of Duals?

- Nationally, there were 9.6 million dual-eligible beneficiaries
  - 3.9 million were under age 65
  - 5.7 million were aged 65 and older
- Per capita spending (Medicare)
  - Duals $17,668
  - Non-Duals $8,381
- Per capita spending when the ESRD population is removed
  - Duals $16,216
  - Non-Duals $8,042

*Data book: Beneficiaries dually eligible for Medicare and Medicaid — January 2015 MedPAC*
Which Population has the most chronic disease?

- Most chronic conditions were more prevalent for dual-eligible beneficiaries
  - 72% of dual-eligible beneficiaries had two or more conditions
  - Dual eligible beneficiaries were 1.7 times as likely to have 6 or more chronic conditions
    - 1.7 times more likely to have COPD
    - 1.6 times more likely to have heart failure
    - 1.4 times more likely to have diabetes
- 98% of readmissions, in 2010, were for Medicare beneficiaries with two or more chronic conditions
The Potential Impact in Maryland

- All Medicare Beneficiaries (CY2010) – 827,000
- Dual-Eligible Beneficiaries (CY2010) – 119,000

Data book: Beneficiaries dually eligible for Medicare and Medicaid — January 2015 MedPAC
Characteristics of the Dual-Eligible Population

9.6 MILLION DUAL-ELIGIBLES

- 59% Under Age 65
- 41% Ages 65 and older
Demographics of Duals

- White/non-hispanic: 58%
- African American: 20%
- Hispanic: 15%
- Other: 7%
• 24% of duals are institutionalized
• 76% live in community settings
• 55% report having at least 1 ADL limitation
• 33% report having 3 – 6 ADL limitations
Chronic Conditions

- 30% have a diagnosis of chronic depression
- 34% have a diagnosis of diabetes
- 23% have a diagnosis of heart failure
Spending per service per beneficiary

<table>
<thead>
<tr>
<th>FFS Services</th>
<th>Dual-Eligible Beneficiaries</th>
<th>Non-Dual Eligible Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>$18,489</td>
<td>$15,293</td>
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<tr>
<td>Skilled Nursing Facility</td>
<td>17,343</td>
<td>13,526</td>
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<tr>
<td>Home Health</td>
<td>6,305</td>
<td>4,970</td>
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<tr>
<td>Other outpatient</td>
<td>5,783</td>
<td>4,214</td>
</tr>
<tr>
<td>Part D Drugs</td>
<td>4,735</td>
<td>1,524</td>
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</table>
Medicare & Medicaid spending for LTSS users
What does the data tell us?

- Dual-Eligible Beneficiaries have substantially greater risks
- The burden of multiple chronic conditions and social determinants of health combine to drive increased expenditures
- Chronic depression and social isolation further compound the complexity of the care for this population
- Expanding the use of HCBS combined with evidence-based community interventions could potentially bring down Medicare AND Medicaid costs
How Can We Impact Spending on this Group

- Keep people healthy, active, and engaged in their community as long as possible
  - Reducing institutional care
  - Increase the use of HCBS to support consumers in the community as long as possible
  - Increasing patient activation
  - Improving consumer disease self-management skills
  - Community-based interventions
- Bring disease management to the consumer
Alignment of Payment Incentives

• Incentives to reduce Medicare and Medicaid directly impacts providers that serve duals
• Reductions in Medicare costs and Medicaid costs can have a dramatic impact on the overall cost of care
• Medicare
• Medicaid (Medicare Supplemental Coverage)
• Managed Long-Term Services and Supports – Medicaid Waiver
Recommendations in the Literature

• CMS - Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries (2015)
  - Direct collaboration between hospitals, community physicians, and CBOs to address the medical, social, and behavioral factors impacting health outcomes

• CMS Interpretive Guidance for Hospitals
  - Discharge Planners should directly engage Area Agencies on Aging, ADRCs, and CILs to determine eligibility and delivery of expanded HCBS for hospitalized patients
Examples from the Field – Southern Maine

• ACO / Hospital / CBO collaboration
• Food insecurity and malnutrition found to be a contributing factor to readmissions for segments of the Medicare population
• Malnutrition diagnosis and recommendation for home delivered meals incorporated into the discharge plan
• ACO, hospital, and CBO collaborate to address this identified need, impacting the population
Hospital pays for home delivered meals as part of the discharge plan, unless it can be covered by Medicaid or another source (2 week blocks).

Intervention has been wildly successful.

“More Than a Meal Service”
- Home safety check
- Daily interaction with the meal delivery person
- Social interaction which triggers notification of mental status changes
- ADA compliant, disease-specific meals
Example #2 - Alabama

- Community Care Solutions (CCS) is an Alabama non-Profit Corporation, formed by SARCOA.
  - SARCOA – Southern Alabama Regional Council on Aging
  - Purpose is to improve health outcomes for persons who are moderate-to-high risk community-dwelling residents of Alabama.

- SARCOA and TARCOG will be the lead entities providing services in the initial target markets.
  - TARCOG – Top of Alabama Regional Council of Governments
Past Performance

- 2013 – Present: SARCOA and TARCOG are both contracted by the Centers for Medicare & Medicaid Services’ Innovation Center to provide evidence-based care transitions interventions for moderate-to-high risk Medicare beneficiaries.

- CMS Independent Evaluator validated that our intervention has provided a 41.4% decrease in readmissions for those served by the program.
  - N = 11,757
  - Intervention outcomes documented against 2010 baseline performance data
  - Weighted Average for all partner hospitals
  - Evaluation period – 10 consecutive quarters
Intervention Overview

• 30-Day intervention targeted to beneficiaries with one or more acute hospital admissions
• A person-centered intervention plan is developed based on assessment findings.
  – Discharge Planning Assessment
  – In-Home Assessment
  – Medication Review / Reconciliation post-discharge
  – Referral to an evidence-based community-intervention
In-Home Assessment

- Post-Discharge, each participant receives an In-Home Assessment
- In-Home Assessment includes the following topics:
  - Level I Nutrition Risk Screen
  - Medication Review
  - Home Environment Safety Scan
Medication Review / Reconciliation

• Medication Review occurs in the home, post-discharge.
• Review begins with an analysis of discharge medication orders.
• Confirmation of medications that have been filled, as compared to discharge orders.
• Identification of other medications or OTCs taken in addition to the discharge medications ordered.
• Discrepancies are reviewed and reconciled with the support of partnering Hospitalist / Primary Care Providers, appropriate nursing staff, and pharmacy.
  – Meets current HEDIS Measure requirement
Home Environment Safety Scan

- Identification and reduction of the number of home hazards
- Fall and Safety Risk Reduction to include a review of safe railing, flooring, clutter/hoarding at key access points
- Social Determinants Risk Screening
  - Access to food
  - Transportation
Initial Service Area
Collaborating Hospitals

• Collaborating Hospitals commit to the following items
  – Access to ADT (Admission, Discharge, Transfer) data on a daily basis.
  – Direct access and collaboration with facility hospitalists, discharge planners, and nursing staff.
  – Participation in the multi-disciplinary discharge planning process.
• Hospital Return on Investment
  – Reduced Readmissions
  – Bundled Payment support documenting a reduction of Ambulatory Sensitive Admissions / Emergency Dept. Visits
  – Increased Outpatient service utilization
    • Increased number of patient encounters per year
    • Improved efficiency of the practice
• Medication Review / Reconciliation
  – Increased Medication Adherence
• Sustainability Plan
  – Expanded TCM & CCM service delivery
  – CBO provides care transitions services in direct collaboration with the hospitalist and hospital-owned physician practice
  – Hospital-based physician practice is the benefactor of increased compliance with outpatient visits, information about social determinants, and community partnership
  – Physician practice billing of TCM and CCM services that flow back to the CBO -- supporting the achievement of shared goals
  – Expanded use of HCBS for hospitalized patients
Questions

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