The Dual Agenda: Improving Care for Seniors and People with Disabilities

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Voices for Better Health

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New Connections for Self-Advocacy and Innovation Conference
Bloomington, Minnesota
About Community Catalyst

• Non-profit health care advocacy organization
• Network of advocates in 40+ states
• Building advocacy infrastructure
• Leading broad-based issue campaigns
• Incubated nationally-recognized delivery system
• Advance **policies** that require coordinated, patient-centered care that allows Medicare-Medicaid beneficiaries to have a better quality of life

• Establish a **strong voice** for Medicare-Medicaid beneficiaries and caregivers in the health plans and provider groups that serve them
Target States

- Welcome to Michigan
- Welcome to New York
- Welcome to Ohio
- Welcome to Rhode Island
- Welcome to Massachusetts
Union of Policy and Practice

Consumers

Geriatric Providers
Center for Consumer and Community Engagement

• Teach, learn, and export knowledge about transforming the health system

• Collaborate with and support the work of organizations that represent and advocate for the most vulnerable

• Provide consumer health advocates with “next-generation” skills
Center Strategies

- Research and evaluation
- Investments in state advocacy
- Leadership development
- Strengthening state and federal advocacy infrastructure
- Providing support services to delivery systems
AGENDA

1. The Need
2. ACA-Inspired Innovation
3. Financial Alignment Initiative
4. Opportunities and Risks
5. The Transformative Power of Consumer Engagement
6. Takeaways: The Demos and Beyond
THE NEED
“Bill”

• 56 years old
• Spinal cord injury: quadriplegia
• Recurrent pressure sores
• Lives independently with his wife, who works full-time
• Inconsistent personal care support
• Lifelong asthma, progressive respiratory failure
• Frequent hospitalizations for bronchitis and pneumonia in recent years.
“Alice”

- 90 years old
- Lives alone
- Multiple chronic conditions
- Mobility issues
- Virtually no supportive services
- Isolation
Selected Demographic Characteristics of Medicare Beneficiaries, 2010

<table>
<thead>
<tr>
<th>Gender</th>
<th>Race/Ethnicity</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Other 5%</td>
<td>85+</td>
</tr>
<tr>
<td>Female</td>
<td>Hispanic 9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black 10%</td>
<td>75-84</td>
</tr>
<tr>
<td></td>
<td>White 77%</td>
<td>65-74</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt;65</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16%</td>
</tr>
</tbody>
</table>

Figure 13

Selected Measures of Health Status of the Medicare Population, 2010

Percent of all Medicare beneficiaries:

- 4+ CHRONIC CONDITIONS: 45%
- FUNCTIONAL IMPAIRMENT (1+ ADL LIMITATIONS): 34%
- COGNITIVE/MENTAL IMPAIRMENT: 31%
- FAIR/POOR HEALTH: 26%

NOTE: ADL is activity of daily living.
Figure 14

Distribution of Medicare Benefit Payments, 2014

- Medicare Advantage: 26%
- Hospital Inpatient Services: 23%
- Physician Payments: 12%
- Outpatient Prescription Drugs: 11%
- Skilled Nursing Facilities: 5%
- Hospital Outpatient Services: 7%
- Home Health: 3%
- Other Services*: 14%

Total Medicare Benefit Payments, 2014 = $597 billion

NOTE: *Other services includes ambulance services, ambulatory surgical centers, community mental health centers, durable medical equipment, federally qualified health centers, hospice, hospital outpatient services not paid for using the outpatient prospective payment system, outpatient dialysis, outpatient therapy services, lab services, rural health clinics, Part B drugs; also includes amounts paid to providers and recovered.

Circulatory conditions, such as heart attacks and high blood pressure, are the largest category of spending.

Total expenditures in $ billions by disease category, 2010

- Circulatory: $234
- Ill-defined conditions: $207
- Musculoskeletal: $170
- Respiratory: $144
- Endocrine: $126
- Nervous system: $120
- Cancers and tumors: $116
- Genitourinary: $111
- Injury and poisoning: $110
- Digestive: $102
- Mental illness: $79
- Infectious diseases: $58
- Dermatological: $38
- Pregnancy and childbirth: $38
- Other: $70

**Source:** Bureau of Economic Analysis Health Care Satellite Account (Blended Account)

**Note:** Expenditures on nursing home and dental care are not included in health services spending by disease.

**Peterson-Kaiser Health System Tracker**
Spending on the highest cost diseases has increased at varying rates

Total expenditures in $ billions by disease category, 2000 - 2010

Source: Bureau of Economic Analysis Health Care Satellite Account (Blended Account)
Note: Expenditures on nursing home and dental care are not included in health services spending by disease.

Peterson-Kaiser Health System Tracker
Figure 17

Number of Beneficiaries Enrolled in Medicare, Medicaid, and Both Programs, 2010

Total Medicare beneficiaries, 2010: 50 million
Total Medicaid beneficiaries, 2010: 66 million

SOURCE: Kaiser Family Foundation analysis of a 5 percent sample of Medicare claims from the Chronic Conditions Data Warehouse, 2010, and Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on FY2010 MSIS.
Figure 18

Dual Eligible Beneficiaries are a Diverse Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Type of Residence</th>
<th>Mental Impairments</th>
<th>Number of Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 85+</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 75-84</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 65-74</td>
<td>26%</td>
<td>Community 87%</td>
<td>3 Chronic Conditions 20%</td>
</tr>
<tr>
<td>Under Age 65</td>
<td>39%</td>
<td>Facility 13%</td>
<td>2 Chronic Conditions 20%</td>
</tr>
</tbody>
</table>

NOTE: Mental impairments were defined as Alzheimer's disease, dementia, depression, bipolar, schizophrenia, or mental retardation.
Figure 19

Dual- Eligible Beneficiaries as a Share of Medicare and Medicaid Enrollment and Spending, 2010

ACA-INSPIRED INNOVATION
ACA: The Other Side of the Law

• **Delivery reform**: testing new models and spreading successful ones

• **Payment reform**: encouraging the shift toward payment based on the value of care provided

• **Systemwide reform**: developing resources for systemwide improvement.
The $10 Billion Innovation Investment

- Identify new ways to pay for and deliver care
- Rapidly test and evaluate innovations
- Replicate innovations that work
- Lay groundwork for broader transformation

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The “Triple Aim”

- Better Care for Individuals
- Better Care for Population
- Lower Cost Through Improvement
Delivery Reforms

- Accountable Care Organizations (MN)
- Comprehensive Primary Care Initiative
- Multi-Payer Advanced Primary Care Program (MN)
- Federally Qualified Health Center Advanced Primary Care Practice Demonstration (MN)
- Independence at Home Demonstration
- Medicaid Health Homes (MN)
- Health Care Innovation Awards (MN)
- Community-Based Care Transitions Program
- Medicaid Incentives for the Prevention of Chronic Diseases (MN)
- Financial Alignment Initiative (MN)
Payment Reforms

- Medicare Hospital Readmissions Reduction Program
- Medicaid Hospital-Acquired Conditions Reduction Program
- Hospital Value-Based Purchasing Program
- Physician Value-Based Payment Program
- Bundled Payments for Care Improvement Initiative (MN)
- Reductions in Growth to Medicare Payment Rates for Certain Services
- Reductions in Payment to Medicare Advantage Plans
Systemwide Reforms

- State Innovation Models Initiative (MN)
- Medicaid Innovation Accelerator Program
- Patient-Centered Outcomes Research Institute
- Prevention and Public Health Fund
- Community Transformation Grants
FINANCIAL ALIGNMENT INITIATIVE
• Improve quality, reduce costs, improve beneficiary experience
• Ensure full access to services
• Improve coordination between federal/states
• Develop innovative care models
• Eliminate program misalignments
Demonstration Projects

• Design contracts to 15 states

• Two financing options:
  • **Capitated Model**: A state, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
  
  • **Managed Fee-for-Service Model**: A state and CMS enter into an agreement by which the state would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs.
State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiaries, July 2015

NOTES: *CO, CT, IA, MO, and NC proposed managed FFS models. NY, OK, and WA proposed both capitated and managed FFS models; WA received approval for both demonstrations, but subsequently withdrew its capitated model; NY withdrew its managed FFS proposal. All other states proposed capitated models.

Nearly 355,000 Dual Eligible Beneficiaries Are Enrolled in Capitated Financial Alignment Demonstrations in 9 States, as of June 2015

NOTE: States began their demonstrations at different times and therefore are at different stages in the enrollment process.
OPPORTUNITIES AND RISKS
The Opportunity

- Fewer hospital readmissions
- Integration of long-term services and supports
- Better overall function
- Greater autonomy, dignity and independence
- Smart cost containment
The Risk – Managing Money not Care
Consumer Policy Priorities

- Enrollment
- Marketing
- Provider Networks
- Long-Term Services and Supports
- Assessment
- Care Coordination
- Benefits Package

- Consumer Engagement
- Appeals and Grievances
- Payment Rates
- Savings Expectations
- Quality Measurement
- Cultural Competence
- Workforce
THE TRANSFORMATIVE POWER OF CONSUMER ENGAGEMENT
Guidance from CMS

“Medicare-Medicaid enrollees, their families and consumer organizations working with them… have a central role to play in helping to design a person-centered system of care…”

~ State Medicaid Director letter on Financial Alignment Initiative, July 11, 2011

“… 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
Levels of Engagement

- Individual
- System
- Policy
Policy

• Advocacy at the state and federal levels

• Levers for consumer engagement

• Stakeholder oversight bodies:
  • Massachusetts – One Care Implementation Council
  • Michigan – Stakeholder Advisory Committee
  • Ohio – MyCare Ohio Implementation Team

• Ombudsman offices
Delivery System

Meaningful consumer engagement is critical to success of any new model of care:

- Improves communication
- Expands promising practices
- Corrects potential, costly problems
A “Ladder of Engagement”

- Newsletters
- Surveys
- Comment cards

- Town hall meetings
- Focus groups
- Resource fairs

- Consumers on board of directors
- Consumer advisory board
- Committee membership
Person-Centered Model of Care

- Geriatrics-Competent Care webinars
- Training nurse case managers on geriatrics best practices
- Plans/Providers/Consumer workgroup
Individual – Patient Empowerment

Types of interventions and tools:
• Patient Activation Measure
• HowsYourHealth.org
• Evidence-based Self-Management Programs
• Patient Reported Outcome Measures
TAKEAWAYS: THE DEMOS AND BEYOND
Positive Signs

• Many positive design features
  • Comprehensive assessment
  • Interdisciplinary care team
  • Care coordination
  • Self-determination option
  • Continuity of care provisions
  • Consumer advisory committees

• Course corrections as needed
Challenges

- Enrollment
- Provider outreach/education
- Continuity of care
- Ombudsman outreach
- State capacity
- Cultural competence
Takeaways, Part 1

• Status quo is unsustainable
• Coordinated care can provide better care at lower costs over the long run; no quick fixes
• Health system transformation is a work in progress
• Outreach/education must be early and often
• Robust federal and state oversight is essential
• Ongoing consumer engagement is key
Takeaways, Part 2

- Ongoing partnerships are essential
- Measure (and reward) what matters most to patients/families
- Tell the story
- Data/transparency
- Build on what works; change what doesn’t
- Be intentional about reducing health disparities
- Keep people at the heart
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