The Dual Imperative: What’s Next for Medicare-Medicaid Enrollees
What Does the Evidence Show?

Marc Cohen
Research Director, Center for Consumer Engagement in Health Innovation

Edith Walsh
Senior Director of the Aging, Disability and Long-Term Care Program
RTI International

Ashish Jha
Dean for Global Strategy
K.T. Li Professor of Global Health
Harvard T.H. Chan School of Public Health
What Do We Know from the Evaluation of the Demonstrations Under the Financial Alignment Initiative?

Edith G Walsh, PhD   Angela M Greene, MS, MBA
RTI International

The Dual Imperative: What’s Next for Medicare-Medicaid Enrollees?

Washington, DC
November 28, 2018
Presentation Overview

- Overview of evaluation activities
- Care coordination
- Service utilization
- Cost analyses
The demonstrations are being evaluated along the following dimensions:

**QUANTITATIVE METHODS**
- Extensive analysis of Medicare claims
- Analysis of Medicare-Medicaid plans’ encounter data
- Analysis of MDS (nursing home assessment) data
- Use of comparison groups
  - Key outcomes: service utilization trends and potential cost savings

**QUALITATIVE METHODS**
- Site visits
- State data review
- Stakeholder interviews
- Ongoing monitoring
- Focus groups
- Review of plans’ reported data, CAHPS, HEDIS, and other surveys and studies
- Data from consumer grievances and complaints
Care Coordination is the Centerpiece of the FAI Demonstrations

**Initial work:**
- Hiring and training CC staff
- Defining workflows and workloads
- Designing IT systems to support care coordination activities

**Currently:**
- By April 2018, 4,605 CCs hired across all capitated states; 3,870 assigned to care management and conducting assessments
Models vary greatly across states and MMPs
- Use of support staff for arranging and accompanying enrollees to appointments
- Varied clinical staff according to beneficiary needs
- LPNs and RNs for low and high risk beneficiaries
- Case loads vary between 70 and 192 in 2017

Flexible benefits and linkages to CBOs have focused on nursing facility diversions
- Some plans have transitioned enrollees from nursing facilities to the community; however, this requires housing supports

Coordination with behavioral health services has been especially challenging in some states due to siloed departments and privacy and data sharing rules

The Washington State managed fee for service model is intensive and has achieved substantial Medicare savings
- Targets very high cost beneficiaries, uses the Patient Activation Model, and monthly in-home visits
Successes noted by focus group participants

- Many were pleased with their care coordination experiences, stating that their care coordinator helped them obtain needed services (e.g., home-based services and supports, home modifications, and counseling) and that they were engaged in decisions about their care
- Many appreciated having one person to call to address a range of issues
- Care coordinators worked with them to improve self-care
- Black and Spanish-speaking focus group participants did not identify cultural or language barriers to their care

Challenges noted by focus group participants

- Not all were aware of care coordination
- Some experienced frequent turnover of care coordinators, difficulty reaching their care coordinators, or were unable to identify their care coordinators
Care Coordination: What Would We Like to Know?

- How is care coordination affecting home and community-based service plans? Are plans investing in additional LTSS?

- What models of care coordination, assessment and care planning represent best practices and produce the biggest impact?

- When are care coordinators approving flexible benefits?

- What are some models for improving data-sharing, especially to track transitions to and from the community and hospitals and nursing facilities and with behavioral health entities?

- What are some effective practices for enrollees in assisted living and nursing facilities and enrollees who are homeless?
Relative to the comparison groups for each state, for all eligible beneficiaries

- Inpatient and SNF admissions
  - Declined in Washington, increased slightly in Massachusetts

- Evaluation and management (E&M) visits
  - No impact in Washington, small increase in Massachusetts

- ER use
  - No impact in Washington or Massachusetts

- 30-day all cause readmissions
  - Higher in both Washington and Massachusetts

- Probability of any long-stay nursing facility use
  - Lower in both Washington and Massachusetts
What Would We Still Like to Know about Service Utilization?

- How do patterns evolve over time and in more of the demonstrations?
- What accounts for differences across demonstrations and plans?
- Is there evidence of any impact on long-term services and supports? On behavioral health utilization? What is happening that contributes to any observed effects?
- Are there any observable impacts of LTSS provision on medical service utilization and outcomes or vice versa?
Managed Fee-For-Service (MFFS) Model

– The results of the savings calculations for MFFS demonstrations are shared with CMS and determine whether a state is eligible for a performance payment under the MFFS Financial Alignment Model

Capitated Model

– The results of the savings calculations for capitated model demonstrations estimate the impact of the demonstration on cost from the perspective of the Medicare program
Analyses of Medicare savings have been conducted for the Washington MFFS demonstration for July 1 2013–December 31, 2016

Medicare savings were $107 million over the first three demonstration periods after applying outlier adjustments, representing 9.1 percent savings

- Year 1 (July 2013–December 2014) savings were $34.9 million (8.8 percent)
- Year 2 (CY 2015) savings were $30.2 million (9.1 percent)
- Year 3 (CY 2016) savings were $42.0 million (9.9 percent)

A separate Medicaid calculation will also be conducted as data are available
Medicare results only at this time due to data availability

- Medicaid data is delayed as States and CMS switch from MSIS to TMSIS
- Medicaid data is required for both demonstration States and comparison group States

Medicare results are preliminary due to extensive technical requirements that accumulate over time

- Allowing for adequate run out (number of months required to allow most claims to trickle in)
- Many adjustments needed that are not available immediately
  - AGA factors
  - Quality withhold information
  - Finalization of risk scores
  - Recoupments related to final risk corridor adjustments
Measuring quality from claims/encounter data alone is difficult, especially

- when these data are incomplete
- when enrolled populations are small relative to the eligible population

There aren’t a lot of good metrics for LTSS users, especially until we have Medicaid data

Analytic results need to be assessed for plausibility

- Are the findings concentrated among beneficiaries whose care was changed by the demonstration?
- Are the results consistent with qualitative findings such as which beneficiaries are targeted during the observed time period?
- Need to account for secular trends in the demonstration and comparison groups
- Are there consistent patterns over consecutive demonstration years within a state?
More Information

Edith G Walsh, PhD
Senior Director
Aging, Disability, and Long-Term Care Program
RTI International
+1.781.434.1754
ewalsh@rti.org

Angela M Greene, MS, MBA
Director
Aging, Disability, and Long-Term Care Program
RTI International
+1.919.541.6675
amg@rti.org
High-Cost Duals: What Does the Evidence Tell Us?

Ashish K. Jha, MD, MPH
November 28, 2018
@ashishkjha
Agenda

- Things you already know about dual-eligible people
- Why it's been hard to move the needle on their spending
- 3 things you may not have known about these individuals
- Future directions
What you already know

- Common
- Expensive
- Sick
What you already know

- Common
- Expensive
- Sick

There are about 12 million dual-eligible people
What you already know

- Common
- Expensive
- Sick

There are about 12 million duals-eligible people

Duals spend 4x more than non-dual patients.
What you already know

- Common
- Expensive
- Sick

There are about 12 million duals-eligible people

Higher rates of readmissions, mortality, preventable hospitalizations

Duals spend 4x more than non-dual patients.
Lots of interest in trying to reduce spending on this population
A major focus has been on preventable hospitalizations...

Resources

PACE Program Reduces Dual-Eligible Beneficiaries’ Risks of Hospitalizations, Re-hospitalizations, and Avoidable Hospitalizations

Latest Research

CMS Reports Reduction In Avoidable Hospitalizations Among Dual Eligibles

1/24/2017

Potentially Preventable Hospitalizations among Medicare-Medicaid Dual Eligibles, 2008
Statistical Brief #96
The impact on spending has been disappointing.
Why?
We need to better understand this population
What I didn’t know about the dual-eligible population
1. Persistence
Persistence of high-cost status among Medicare beneficiaries

Year 1
- High Cost: N=550,722
- Non-High Cost: 56%

Year 2
- High Cost: 44%
- Non-High Cost: 56%

Year 3
- Persistently High Cost: 28%
- Transiently High Cost: 16%
- High Cost: 10%
- Non-High Cost: 46%

Figueroa et al, Health Affairs
Persistently high-cost: Medicare only

- Persistently High-Cost: 28%
- Transiently High-Cost: 72%

1 in 4
Persistence of high-cost status among duals

Year 1

High Cost
N=192,835

Non-High Cost
31%

Year 2

High Cost
69%

Non-High Cost
31%

Year 3

High Cost
55%

Non-High Cost
14%

High Cost
7%

Non-High Cost
25%

Persistently High Cost

Transiently High Cost

Figueroa et al, Ann Int Med 2018
Persistently high-cost: duals

1 in 2

Persistently High-Cost 55%

Transiently High-Cost 45%

Figueroa et al, Ann Int Med 2018
2. Heterogeneity
Transiently HC and persistently HC groups look different

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Persistently HC (n=105,641)</th>
<th>Transiently HC (n=87,194)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean)</td>
<td>56.0</td>
<td>65.8</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>73.2%</td>
<td>62.3%</td>
</tr>
<tr>
<td>Black</td>
<td>17.9%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>6.4%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Other</td>
<td>2.6%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Medicare Status Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>71.1%</td>
<td>41.4%</td>
</tr>
</tbody>
</table>
Transiently HC patients are sicker

Figueroa et al, Ann Int Med 2018
3. Where the spending is
Major focus in past has been on preventable hospitalizations
But that’s not where the spending is.

All other spending 99%

Preventable hospitalizations 1%
Spending among persistently HC

- Long-term Care: 69%
- Inpatient: 7%
- Outpatient: 4%
- Post-acute: 4%
- Tests/Procedures: 9%
- Drugs: 6%
- Physician Services: 1%
Spending among transiently HC

- Long-term Care: 43%
- Inpatient: 14%
- Outpatient: 8%
- Post-acute: 12%
- Test/Procedures: 10%
- Drugs: 10%
- Physician Services: 3%
- Long-term Care: 43%
How does spending compare?

<table>
<thead>
<tr>
<th>Service</th>
<th>Persistently HC</th>
<th>Transiently HC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Care</td>
<td>6.5%</td>
<td>14.2%</td>
</tr>
<tr>
<td>Post-acute Care</td>
<td>3.6%</td>
<td>9.6%</td>
</tr>
</tbody>
</table>
So what should our strategy be?

- Begin by finding your persistently HC patients
  - Look at long-term care costs
  - Strategize how to better manage those
    - Institutional versus community-based
- Then focus on transiently HC patients
  - Focus on early identification strategies
  - Focus on those with complex medical needs
  - Targeting inpatient and post-acute care needs
Summary

- What we already knew:
  - Dual-eligible individuals are:
    - Common
    - Expensive
    - And often sick

- What we need to remember:
  - Duals are more persistently high-cost
  - Persistently and transiently high-cost look different
  - Segmentation of population is critical
  - Interventions customized to target areas of highest need
Thank you!
Defining Success: Achieving Care Integration

Kathleen M. Haddad
Senior Editor, Health Affairs

Lisa Lagana
Vice President of Integrated Care CareSource

Gwendolyn Graddy
Chief Medical Officer PACE Southeast Michigan
Our MISSION

To make a lasting difference in our members’ lives by improving their health and well-being.

CARESOURCE

• One of the fastest growing non-profit managed care plans in the country.

• 28-year history of serving low-income populations across multiple states and insurance products, coordinating their care as their eligibility changes.

• Using comprehensive, member-centric models of care to address our entire population’s health and social needs.

• Currently serving members in Ohio, Kentucky, Indiana, West Virginia, and Georgia.

Serving 2M members across a continuum of government programs, coordinating care as eligibility changes, and providing services to obtain total wellbeing.
Partnering with community-based organizations such as the Area Agencies on Aging is an evidence-based informed strategy to achieve the Triple Aim.

- Movement of Psychosocial Model to Medical Psychosocial Model
- One Primary Contact for Care Management and Service Plans
- Outcomes
  - CAHPS Performance
  - Quality Metrics Achievements
  - Improved Access
  - Lower Medical Cost
Community Mental Health Centers Partnership

- **Behavioral Health Model of Care**
  - Primary, Episodic & Consultative

- **Designated Care Manager Liaisons**
  - Single Point of Contact Community Mental Health Centers, CMHC and providers

- **Active Engagement Consortium**
  - ADAMHS, Alcohol Drug Addiction and Mental Health Services, Board
    - Integrated Care Plans- high utilizers, ED crisis
    - Telehealth
    - Provider Forums
    - Behavior Health Rapid Response Team
    - Internship -workforce development expertise

- **Outcomes**
  - Improved Access and Outcomes
    - Exceeding Follow-up after Hospitalization for Mental Illness within 30 days
    - Readmission Rates decreased by 8%
4 M Framework

• **What Matters:** Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to end-of-life care, and across settings of care.

• **Medication:** If medications are necessary, use Age-Friendly medications that do not interfere with What Matters, Mobility, or Mentation across settings of care.

• **Mentation:** Prevent, identify, treat, and manage dementia, depression, and delirium across care settings.

• **Mobility:** Ensure that older adults move safely every day in order to maintain function and do What Matters.
Integrated Service Delivery and Team Managed Care

PACE INTERDISCIPLINARY TEAM

- Registered nurse
- Recreation therapist
- Dietitian
- Occupational therapist
- PACE center manager
- Driver
- Personal care attendant
- Home care coordinator
- Master’s of Social Work
- Primary care provider
- Physical therapist
PACE Integrated Care Model

Participant

- Hospital and other services
- RN Case Manager
- Physician & Nurse Practitioner
- Behavioral Health Services
- Chaplain
- Transportation
- Day Health Center Staff
- Center Manager
- Home Health Care
- Dietician
- Recreational Therapy
- Physical & Occupational Therapy
- Clinic RN
- Social Work
- Pharmacist