MONTGOMERY COUNTY DUAL ELIGIBLE WORKGROUP

Overview of the Action Plan for Montgomery County's Dual Eligible Elderly

by

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Madlyn and Leonard
Abramson Center
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CARE ADVISORS · SHORT STAY REHAB · HOME CARE · RESIDENTIAL CARE
MEDICAL ADULT DAY SERVICES · DIALYSIS · HOSPICE · RESEARCH

Today our services include:

- **Abramson Residence** - Skilled 270 bed nursing and Alzheimer's care in a warm, family atmosphere.
- **Mildred Shor Inn** – 48 Residential living apartments with personal care services, as well as independent living, in beautifully appointed apartments provide the peace of mind of having help on hand when needed.
- **Abramson Hospice** - Care, comfort, dignity and support for seniors and their families facing serious, life-limiting illness, in the privacy of their own homes or senior communities.
- **Birnhak Transitional Care** - Comprehensive 54 bed short stay rehab focused on safely returning patients to their homes after a hospital stay.
- **Abramson Home Care** - Healthcare and homemaker services in the comfort of home.
- **Abramson Medical Adult Day Services** - Daytime care with nursing and social services, and stimulating activity-filled days in a safe cheerful environment.
- **Renal Dialysis** - An eight-chair dialysis center in conjunction with Fresenius Medical Care, providing service to patients at the Center and in the community.
- **Abramson Care Advisors** - Around-the-clock information and referral source for Abramson Center and community resources for seniors and their families.
- **Counseling for Caregivers** - Counseling, information, referral, and education for families caring for older relatives.
- **Polisher Research Institute** - Helping to improve the quality of life of seniors by testing groundbreaking concepts in the care of older people, with a special emphasis on those living with Alzheimer's disease and dementia.

Overview of Workgroup

- North Penn Community Health Foundation funded our Workgroup to develop an "Action Plan for Montgomery County's Dual Eligible Elderly".
- Began in July 2013
- Focused on potential strategies to improve access to better coordinated care for the county's dual eligible elderly.
- Issued draft report in December 2013
- The draft will be finalized after we complete a series of community conversations with local providers, health plans, consumers, county government, and state leaders.

Overview of Workgroup

- Participants include:
  - Carol Irvine, Abramson Center for Jewish Life
  - Linda Abram, North Penn United Way
  - Jennifer C. Barnhart, United Way of Greater Phila & Southern NJ
  - Tricia Bradly, Your Way Home, Montgomery County DHCD
  - Joanne Kline, Executive Director, Montco Aging and Adult Services
  - Mark Lieberman, Family Services of Montgomery County
  - Sarah Maus, Muller Institute for Senior Health (Abington Hospital)
  - Diane Menio, Executive Director, CARIE (Center for Advocacy for the Rights and Interests of the Elderly)
  - Barbara O'Malley, Montgomery County Health Department
  - Ouida Williams Simpson, Benefits Advisor and Caregiver
  - Mary Beth Snyder, Executive Director, Montco County Assistance Office
  - Ann Torregrossa, author, "Future of Medicaid LTCS in PA: A Wake Up Call"
  - We are staffed by consultants Alissa Halperin, JD and Jennifer Campbell, PhD.
- Broad representation but not inclusive of all stakeholders
  - which is why we've invited you for this discussion session and hope to gather your input

Dual Eligibles

- Dual Eligible Elderly are persons who are 65+ and qualify for both Medicare and Medicaid.
- They are low income and have limited resources. Pennsylvania has over 333,096 full dual eligibles enrolled in its Medicaid program.
- Approximately 7,500 full dual eligibles age 65+ live in Montgomery County.

Dual Eligibles

- Dual eligibles are poorer and sicker than the rest of the Medicare population.
  - 58% have incomes under the poverty level v. 10% of non-dual Medicare participants;
  - 18% report being in poor health v. 7% of non-dual Medicare participants;
  - 20% of duals are institutionalized v. 2% of non-dual Medicare participants; and
  - Dual eligibles have a greater incidence of cognitive impairments, mental disorders, diabetes, pulmonary disease, stroke and Alzheimer's disease than do non-dual Medicare participants.
  - Dual eligibles account for 17% of the Medicare population but 29% of Medicare spending; they account for 18% of PA's total Medicaid population but 43% of PA's total Medicaid spending.

Dual Eligibles

- Accessing care is made more complicated for the dual eligible elderly by virtue of the multiple sources for services. Here are some of the different sources of coverage a typical dual eligible could have:
  - **Medicaid**
    - **Physical Health Services** - Medicaid FFS program.
    - **Behavioral Health Services** –county-based BH Managed Care Organization
    - **Transportation** - Medical Assistance Transportation Program with services provided through county-based transportation contractors.
    - **Home and Community Based Services and Supports** - 1915(c) HCBS Aging Waiver Programs.
  - **Medicare**
    - **Physical Health and Behavioral Health Services -** Traditional Medicare or through Medicare Advantage (MA).
    - **Prescription Coverage -** Medicare Prescription Drug Plan or through a Medicare Advantage plan.
  - **Other -** Some dual eligibles are also eligible for healthcare or long-term care through the Veterans Health Administration or additional sources

Recommendation #1: Managed Long-Term Supports and Services Pilot Program

- ***Background:***
  - Many states have moved or are moving part or all of their long-term supports and services (LTSS) delivery system to a managed care system. As LTSS are extremely costly to state Medicaid budgets, MLTSS has become an appealing way to control LTSS costs. States can adopt programs in which they implement managed care for only their home and community based LTSS, for both their home and community LTSS and facility-based LTSS, for all LTSS plus all other state Medicaid services, or for all state Medicaid services plus all Medicare services. With the likelihood of MLTSS for Pennsylvania increasing, it is important that the providers and community be prepared for the implementation of MLTSS.

Recommendation #1: Managed Long-Term Supports and Services Pilot Program

- ***Recommendation:***
  - Consider a state pilot test of voluntary Managed LTSS in Montgomery County through which the state incorporates all Medicaid physical health care, behavioral health care, and LTSS. With dual eligible elderly as the target population, the state could test program design elements that could ease a subsequent expansion to full integration. This approach could potentially test additional systems changes, such as Medicaid funding of assisted living through the inclusion of assisted living in the MLTSS benefit package.

Recommendation #2: PACE Implementation

- ***Background:***
  - The federal Program for All-Inclusive Care for the Elderly (PACE) (known as the Living Independently for Elders or LIFE in Pennsylvania) gives Providers a per capita payment from Medicare and Medicaid to deliver all covered healthcare and LTSS through a highly integrated, intensive model of care management and service delivery. Most services are delivered in an enhanced adult day setting where doctors and specialists are on staff or under contract. Additional services including hospitalization, homecare, meals, home modifications and other measures that support life in the community are provided up to and including services in a long term care facility. The PACE model has long been considered one of the most fully integrated Medicare and Medicaid programs available.

Recommendation #2: PACE Implementation

- ***Recommendation:***
  - Establish a collaboration effort of providers to revisit and reinitiate efforts to implement a PACE program for Montgomery County, reinvigorating the County-wide effort that had been collaboratively developed in 2009. In the alternative, the County and Providers could build up additional models of enhanced medical day care, using bundled care and bundled payment strategies outside of PACE, positioning for future opportunities to implement PACE.

Recommendation #3: Dual Eligible ACO Providers

- ***Background:***
  - Accountable Care Organizations (ACOs) are partnerships of groups of doctors, hospitals, and other health care providers operating with the goal of meeting the health and LTSS needs of a defined group of patients for a pre-determined budgeted amount.

Recommendation #3: Dual Eligible ACO Providers

- ***Recommendation:***
  - Conduct a feasibility study on Accountable Care Organizations and dual eligible elderly, incorporating a full array of LTSS. The goal of this feasibility study would determine if a Medicare ACO, focusing on long-term supports and services and meeting the needs of dual eligible elderly is possible. One potential funding source of the feasibility study would be a CMS Innovation Grant and the unique approach of a dual eligible ACO might be ideal for a Innovation Grant. *Note: Writing the Innovation Grant proposal is extremely complicated and time consuming and funding support from an outside source would be essential.*

Recommendation #4: Primary Care Medical Home Development and Facilitation

- ***Background:***
  - In recent years, Primary Care Medical Homes (PCMHs) have evolved as a new approach to better coordinate care for all patients. Medical homes emphasize prevention, health information technology, care coordination and shared decision making among patients and their providers.

Recommendation #4: Primary Care Medical Home Development and Facilitation

- **Recommendation:**
  - Convene county providers, payers, philanthropy, and other stakeholders in an effort to incentivize all providers and practices in the County to obtain their PCMH certifications from the National Committee for Quality Assurance (NCQA). Target those practices that serve dual eligible elderly and facilitate their advancement toward PCMH certification. This will help position them for increased reimbursement from payers who pay more to NCQA certified providers and practices and for delivering better care to dual eligible elderly.

Recommendation #5: Primary Care Medical Home – Severe Mental Illness Integration

- ***Background***:
  - The Primary Care Medical Home (PCMH) is an enhanced primary care delivery model that endeavors to provide better access, coordination of care, prevention, quality, and safety within the primary care practice. In 2009, the County participated in a PCMH demonstration focused on integrated physical health and behavioral health care for persons with severe mental illness (SMI). The County had applied for but did not, in the end, receive a federal Innovation Grant to expand the demonstration to a broader population, include dual eligible older adults.

Recommendation #5: Primary Care Medical Home – Severe Mental Illness Integration

- ***Recommendation:***
  - 1) Continue the county's blended PCMH-Systems Navigation work that was conducted through the Severe Mental Illness integration demonstration.
  - 2) Resubmit the county's Innovation Grant request with specific focus on the dual eligible elderly population or, alternatively, pursue other funding to permit it to expand and enhance the concepts tested in this very successful demonstration.

Recommendation #6: NORC Plus or NORC as Anchor

- ***Background:***
  - Naturally Occurring Retirement Communities (NORCs) are neighborhoods or buildings in which a large segment of the residents are older adults. NORCs are not usually purpose-built senior housing or retirement communities. NORCs are not intended to meet the particular health and social services needs and wants of the elderly. NORCs provide an invaluable opportunity to deliver targeted health and supportive services cost-effectively; increase service availability; organize cooperative health promotion, crises prevention, and community improvement initiatives; and develop new resources for the benefit of older residents. NORCs provide an excellent opportunity to improve quality of care where older dual eligibles live.

Recommendation #6: NORC Plus or NORC as Anchor

- ***Recommendation:***
  - Utilize existing NORCs to develop a multi-faceted approach to providing services including: 1) a paid System-Navigator whose role it is to connect dual eligible elderly to services and 2) an array of primary care providers that have been incentivized to become PCMHs for all residents. In addition, the PACE program and the Independence at Home initiative for the higher acuity residents would support older adult dual eligible remaining in the community and avoiding institutionalization.

Recommendation #7: Independence At Home Services and Home and Community-Based Services Waiver

- ***Background:***
  - The Independence at Home (IAH) Demonstration Program tests the use of designated medical practices comprised of primary care teams of physicians, nurse practitioners, and others to deliver care to high needs populations in their own homes and to coordinate care across all treatment settings. Home-based primary care provided to the highest cost, most chronically ill Medicare beneficiaries will significantly reduce costs, allowing the participants to remain independent in their homes and avoid high cost unnecessary hospitalizations, emergency room visits, nursing home stays, medications and laboratory tests.

Recommendation #7: Independence At Home Services and Home and Community-Based Services Waiver

- ***Recommendation***:
  - Integrate HCBS Waivers with IAH which will enable primary care and other medical services to be provided in the home. This will serve those dual eligible older adults who are too frail to seek medical services in the community. It will also provide a PCMH for those who are less frail able to see health care providers in their offices.

Recommendation #8: Dual Eligible Targeted Case Management

- ***Background:***
  - Targeted case management (TCM) is a service which provides selected Medicaid participants with access to comprehensive medical and social services to encourage the cost effective use of medical care and community resources, while ensuring the client's freedom of choice and promoting the well-being of the individual. TCM is currently provided to individuals who fall into the AIDS target group.

Recommendation #8:
Dual Eligible Targeted Case Management

- ***Recommendation:***
  - Establish a demonstration project to test an intensive care navigation similar to the TCM available through Medicaid and Ryan White Block Grant funding for the HIV/AIDS population. A "System Navigator" would coordinate insurance coverage for duals eligible older adults. This single-individual system navigator would be an expert in both Medicare and Medicaid, and have access to key contact people in both systems. This approach would ensure adequate coverage of required and preventative services.

Recommendation #9: Dual Eligible Care Transitions

- ***Background:***
  - Episode-based approaches are care coordination models built around a single episode of care, such as a hospitalization. Payments may be linked for multiple services during an episode of care or payment penalties might be linked to a hospital readmission prompting an incentive to ensure the smooth transition back to the community, as in the care transitions initiative.

Recommendation #9: Dual Eligible Care Transitions

- ***Recommendation:***
  - Establish a pilot program, funded by local or foundation dollars, to test the impact of care transition efforts with longer-term needs of dual eligible older adults. Through this effort, the County or a local philanthropy would fund a navigator that would be assigned solely to dual eligible elderly during care transitions from the hospital back to the community. The care transition role would serve as a starting point for providing additional services and referrals. The effort could be one initially focused on the immediate transition and then on providing needs assessment, care navigation, and study of outcomes for a year following the initial discharge. This could be a mechanism to test Montco's rapid response capability (ie. the ability to meet sudden LTSS needs, improve LTSS and ensure that hospital discharge planners are aware of these services.)

Discussion and Feedback