Transformation in Service Delivery for Older Adults: Policy Strategies and the Role of the Community

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Total Expenditures as % of GDP, 2009*

*Switzerland and Turkey are missing data for 2009
Onset could be deficits in ADL, speech, ambulation

Quite variable, often 6-8 years

Prolonged dwindling

Mostly frailty and dementia
Now, most Americans have this course.
The numbers will triple in 30 years.
U.S. consumption (private + public)

Y axis, 1 = Average Labor Income Ages 30-49

OAA Funding Appropriations vs. Medicare Expenditures and Steady Increase in 65+ Population
Medicare “Help at Home” (Davis, Willink, Schoen)

Poverty Distribution of those with Integrated Care Needs
19% of Medicare Beneficiaries Have Integrated Care Needs

- Medicaid 26%
- <200% 34%
- >200% 40%
Social Determinants of Health (and Services to Address Them) Are Influencing Policy Thinking
“You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete.”

--Buckminster Fuller
The MediCaring Community Model: Core Elements

1. Frail elders enrolled in a geographic community
2. Longitudinal, person-driven care plans
3. Medical care tailored to frail elders (including at home)
4. Incorporating health, social, and supportive services
5. Monitoring and improvement guided by a Community Board
6. Core funding derived from shared savings from current medical overuse (e.g., a modified ACO)
Per Beneficiary Per Month Savings ($) by Site, Over Time

Year 1
- Akron: $153
- Milwaukie: $136
- Queens: $125
- Williamsburg: $100

Year 2
- Akron: $285
- Milwaukie: $253
- Queens: $250
- Williamsburg: $234

Year 3
- Akron: $328
- Milwaukie: $291
- Queens: $467
- Williamsburg: $269
Return on Investment, Years 1-3

Year 1
Year 2
Year 3

Return on Investment (%)
PACE Innovation Act (enacted Nov. 2015)

* Provides CMS Innovation Center (CMMI) with broad statutory authority to adapt PACE:
  * Eligibility
  * Delivery system
  * Payment
  * And most other requirements

* CMMI cannot waive:
  1) Comprehensiveness of services, no co-pays and deductibles
  2) Voluntary enrollment and disenrollment
What is the Need Among Frail Elders and How Could PACE Expansion Help?

Increasingly frail, needing ready access to comprehensive care and coordination --
Many Medicare beneficiaries are not yet eligible for nursing home level of care (LOC) and many are not yet financially eligible for Medicaid.

These patients can pay privately for risk-stratified LTSS services.
NPA Member Survey

Third Annual Palliative Care Institute Conference
Private Pay for LTSS: Medicare-Only Enrollees

- Medicare-only beneficiaries have more financial resources available than dual eligibles and are likely to want to make more choices, have more flexibility, and to take more risks.
- Enrolling beneficiaries would all receive a base PACE package: assessment, care planning and navigation, coordination, access to appropriate specialists and services, access to PACE center, stand-by services.
- Generally, enrollees will have various and changing needs and preferences, so progressive tiers (groups of services) and some menu-driven services would be priced and available in the negotiated care plan.
PACE Expansion Enables Shift to Population Health Quality Monitoring, Management of Community–dwelling Frail Elders

Generally

* Community Board

* Helps to determine priority service needs in local community for frail elders
* Monitors, guides and manages system capacity and quality

* Community Dashboard

* Reports on measures of quality and supply important to frail elders, making performance metrics publicly available

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George HW Bush