The MediCaring Communities Reform
Building from PACE

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Single Classic “Terminal” Disease

Function

Onset incurable disease

Time

Often a few years, with decline usually < 3 months

Mostly cancer

Hospice

Death
Onset could be deficits in ADL, speech, ambulation.

Function

Time

Death

Quite variable, Mean ~ 2 years, can be >8 years

Mostly frailty, multiple chronic conditions, and dementia

Now, most Americans have this course.

The numbers will triple in 30 years.
Sad Tale – NY Times Sept 28, 2014

Fighting to Honor a Father’s Last Wish: To Die at Home

By NINA BERNSTEIN  SEPT. 25, 2014
The MediCaring Community Components

- Recognize Frailty
- Elder-Directed Care Plans
- Geriatricize Medical Care
- Enhance Supportive Services
- Determine Community Priorities
- Use Medical Care Savings for Community Priorities

J Lynn, MediCaring Communities: Getting what We Want and Need in Frail Old Age at an Affordable Cost. Altarum Institute, 2016. Available on Amazon.com
Frail Elderly People Need Some New Spending…

- Housing
- Nutrition
- Personal Care
- Caregiver training, respite, income
- New drugs and other treatments

Where will it come from?
My Mother’s Broken Back
“The Cost of a Collapsed Vertebra in Medicare”

- Actual: ~5,000
- Usual: ~25,000
- Optimal: ~15,000
[Better Care & Lower Cost] for Advanced Illness

- PACE – 75% lower hospitalizations; 14% lower nursing home
- Aetna Compassionate Care – 22% lower net costs
- GRACE – net savings 23%
- Independence at Home – saving $3070 per person per year
- Sutter’s AIM – Medicare saved $760 per person per month
- Veteran’s HBPC – VA + Medicare costs reduced 11.7%

Summary in J Lynn, MediCaring Communities: Getting What We Want and Need in Frail Old Age at an Affordable Cost. Altarum Institute, 2016, pp 57-66.
MediCaring Communities Financial Simulation

Per Beneficiary Per Month Savings ($) by Site, Over Time

http://www.milbank.org/the-milbank-quarterly/early-view-articles
Piloting the MediCaring Community

• Use a flexible “Accountable Care Community”
  – Serve all eligible and willing frail elders
  – Define geographically
  – Account for co-existing shared savings models and demos

• Many communities with leadership organizations interested
  – Raising start-up funds appears feasible
  – Best practices emerge from testing in diverse settings
  – Can build revenue model from MCO, ACO, SNP, or PACE, with waivers

• Successful piloting requires
  – Rapid cycle improvement with technical assistance
  – Sustaining the endeavor through shared savings
Components of the Frail Elder Expanded PACE Program

- Expanded Clinical Eligibility
- More Flexible Care Model
- More Flexible Payment Model for Private Pay (Medicare only)
- Expanded Geographic Focus; Accountability for Community Elder Well-Being
<table>
<thead>
<tr>
<th>ELDER NEEDS NURSING HOME LEVEL OF CARE</th>
<th>MEDICARE ONLY</th>
<th>DUAL ELIGIBLE</th>
<th>MEDICAID ONLY</th>
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</thead>
<tbody>
<tr>
<td>Expansion #1: Poor, but not in Medicaid</td>
<td></td>
<td></td>
<td>Current PACE</td>
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<tr>
<td>Not usually possible in current PACE</td>
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<tr>
<td>Expansion #2: Adequate Assets</td>
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<td>Current PACE</td>
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<tr>
<td>Possible but rare in current PACE</td>
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<td></td>
<td>Small numbers</td>
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<tr>
<td>ELDER HAS WORSENING DISABILITIES BUT DOES NOT NEED NURSING HOME LEVEL OF CARE</td>
<td>Expansion #3</td>
<td>Expansion #3</td>
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<td></td>
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<td>Small numbers</td>
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</tbody>
</table>
The Opportunity to Care for the Pre-Dual Medicare Only Population

Increasingly frail, needing ready access to comprehensive care and coordination -- Many are not eligible yet for nursing home level of care; virtually all have Medicare, but many not yet financially eligible for Medicaid.

These patients can pay privately for risk-stratified LTSS services.
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%
Components of At Risk PACE Expansion

- Expanded Clinical Eligibility
- More Flexible Care Model
- More Flexible Payment Models
- Expanded Geographic Focus; Accountability for Well-Being of Elders in Community
A Proposed Set of LTSS Tiers

Tier 0
- Introductory package with comprehensive assessment, care planning and navigation
- Available to Medicare beneficiaries for a modest fee (before PACE enrollment)

Tier 1
- Ongoing comprehensive assessment, care planning, navigation, caregiver training and support, medication management
- Short-term day care, short-term respite, adapted transportation, 24/7 on call assistance

Tier 2
- All of the above plus personal care services of up to 45 hrs per week, including regular day care
- More bundles or a menu for some services may be better

Tier 3
- All of the above plus personal care of more than 45 hours per week or long term nursing home placement
PACE Medicaid Revenue, Prototypical Participant

Green area = PACE retaining revenues
Red area = PACE spending more than current income
Aim – do a little better than balancing
PACE Private Payment Revenue
Prototypical Participant, 4 Tiers

Green area = PACE retaining revenues
Red area = PACE spending more than current income
Aim – do a little better than balancing
Next Steps to Operationalizing PACE Expansion

• Working with National PACE Association, interested states, PACE organizations, Aging Network, other experts and stakeholders to garner support
• Either get waivers or
• Work with MCOs or ACOs
• Get the first few sites operational
• Learn and evaluate!
PACE Expansion: Broader Effects

• Savings from careful use of high-cost Medicare services would be used to address:
  – Service supply gaps and quality problems
  – Workforce development
  – Community planning and management, dashboard implementation
• State savings would accrue from slowing Medicaid spend-down rates
• Frail elders (Medicare-only and duals) would have longitudinal, integrated care plans, more flexible service availability, and slower spend-down, enhancing the last years of life
PACE to Anchor MediCaring Communities

- Enabling all frail elders and their families to get long-term care services, mostly at home
- Delivering and/or managing services that reflect each elder’s situation and goals
- Supporting an independent community board that reflects community priorities on behalf of community-dwelling frail elders, and monitors progress
- Re-investing savings from better medical care and the effects of adequate social supports in community priorities.
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Interested in Research in this Area, Or in Broad ElderCare Reform in Your Community?

Contact us!

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