Reporting from Oz -
The Journey to Make a Better World in Aging

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The Changing Face of Aging in America

Expanding the world of possibilities for aging.
We’ve All Seen the Demographics

Number of people age 65 and over, by age group, selected years 1900-2000 and projected 2010-2050

Note: Data for 2010-2050 are projections of the population.
Reference population: These data refer to the resident population.
Source: U.S. Census Bureau, Decennial Census and Projections.

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Two-thirds of people in human history who have reached the age of 65 are alive right now!
Projected Growth in U.S. of Older Populations

- 2010 = **40.2 million** over 65 yrs of age
- By 2050 is it projected to more than double to **88.5 million**
- Those 65 and older identified as “white” are projected to decrease 10% by 2050
- The 85 yrs and older population is less racially diverse than the 65 yr and older group, but will see a similar increase in diversity
- The % of female elders over 85 will decrease from the current 67% to 61% (men are catching up)
Weathering the Economic Storm

**National Debt** – focus on spending cuts directly target Medicare, support programs such as meals, transportation and affordable housing. More debt ceiling battles looming later this summer...

*Medicaid*: 47 states implemented at least one new policy to control Medicaid costs in 2011, and all 50 plan did so in 2012,

- 24% reduced provider rates / 20% reduced optional benefits
Proposed Impact of Sequestration
2% Cuts to Medicare (Avalere Health LLC)

Share of Total FY13-FY21 Cuts, by Medicare Service Type

- Hospital Inpatient Care: 32%
- Skilled Nursing Facilities: 8%
- Physician Fee Schedule: 12%
- Hospital Outpatient Services: 14%
- Group Plans (includes MA): 8%
- Home Health Agencies: 7%
- Non-exempt Part D: 15%
- Other Services: 4%

LIS = Low-income subsidy
QI = Qualified individual

1. Medicaid, the Children’s Health Insurance Program (CHIP), Part D LIS, catastrophic coverage, and QI program, and exchange premium subsidies (administered as tax credits) exempted from the cuts
SCOTUS Ruling on the Affordable Care Act and it’s impact on delivery system changes

Some say it will cause confusion and “blow up” reform

Others say little will change because of fiscal pressures on states for Medicaid

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It’s true, the road ahead is filled with “Lions and Tigers and Bears...oh my!”

Lame Duck sequestration -prevention strategies

SGR – “Doc fix”

Further Debt-ceiling battles

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There is no better time than NOW to implement new ideas!
The Door is Open

• The Affordable Care Act presents multiple models
  – Community-based Care Transitions
  – Medication Therapy Management
  – Independence at Home
  – Multiple Chronic Conditions Care Coordination
  – Medical Home
  – Bundled Payments and variations on the Accountable Care Organization structure

• EACH has a potential impact on aging services
## CMS to Test Various Payment and Delivery Reforms

| ACOs | 32 Pioneer ACOs and 27 Shared Savings Program ACOs have been announced = **1.1 million** Medicare beneficiaries |
| Health Care Innovation Challenge | $1 billion available to test “shovel ready” approaches. CMS received an estimated **3000** proposals. First 26 awards have been released |
| Integrated Care for Dual Eligibles | **15 states** received planning grants to integrate Medicare and Medicaid for duals, in total **37 states** have letters of intent |
| Independence at Home Demonstration | CMS hoping to include 50 practices serving 10,000 Medicare beneficiaries to provide in-home primary care services. **First 16 sites** announced 4-12 |
Accountable Care Organizations

• **32 organizations** will participate in the **Pioneer ACO** initiative with the goal of saving $1.1 B per year – just announced Dec 19, 2011

• The first **27 Medicare Shared Savings Program ACOs** were announced in **April, 2012**. As of April 1, 2012 more than **1.1 million Medicare beneficiaries** are receiving care from providers in shared savings initiatives.

• Even if you are not part of such a network, LTSS really must be familiar with payment models – otherwise you risk being merely a “contracted vendor”
Bundled Payments for Care Improvement Initiative

• Link payments for multiple services patients receive during an episode of care

• 2 possibilities for continuum:
  • Inpatient stay plus post-discharge services
  • Post-discharge only
  • Inpatient prospective payment (maybe)

• Applications were due Nov. 4

Community-Based Transitions (sec 3026)

• Partner w/CBOs (e.g., Older Americans Act program grantees; providers serving medically underserved). As of 4-12 there are 30 sites in 20 states serving over 223,000 people

• Grants for models that:
  – Improve transitions from inpatient hospital setting to other care settings.
  – Improve quality of care
  – Reduce readmissions for high risk beneficiaries.
  – Document measurable Medicare savings
Independence at Home

• On Dec 20, 2011 CMS released the latest Affordable care Act Demonstration – Independence at Home
• IAH greatly expands the scope of in-home services Medicare beneficiaries can receive
• It will provide chronically ill patients with a complete range of primary care services with the goal of better support of chronic illness, reductions in avoidable hospitalizations and emergency room use
• Although specifically focused on physician and NP practices – the opportunity is there for home health and other LTSS to partner with these practices
IAH Demo Characteristics

**Eligibility:** Medicare beneficiary enrolled in Part A and B with 2+ Chronic illness with 1 or more hospital or NH non-elective admission and dependence in 2 ADLs. Patients cannot be enrolled in Medicare Advantage or in PACE

**Practice Definition:** Physician or NP, with access to addition IDT members as needed, available 24-7 to provide in-home care.

**Practice Size:** Must have **at least 200 eligible patients** in study year

**Technology:** Must have access to EHR and potential for remote monitoring and mobile diagnostics

**Payments:** Incentive payments will be based on calculated spending targets (based on PACE payment methodology – HCC + Frailty) when the practice actual Medicare A and B costs are 5% lower than the predicted target and threshold quality measures are met.

**Time frame:** Applications were due Feb 6, 2012 – 16 practice sites announced
About the Innovation Center
Established by the Affordable Care Act, the Center for Innovation is a new engine for revitalizing and sustaining Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) with the ability to rapidly test innovative care and payment models.

Our Mission: better care and better health at reduced costs through improvement.

Become Familiar with this Web-site:
http://innovations.cms.gov
“Dual” Integration

- CMS awards grants to 15 states to propose models to integrate Medicare and Medicaid Benefits
- 5.5 million of the total nine million “duals” are low income seniors
- They represent a diverse group – often with significant support needs, multiple serious chronic conditions and poor health: 46% of Medicaid spending goes to the “duals” / 58% of that for LTSS
- Most of the states’ models involve some form of managed care
Some Key Questions for the States’ Plans

• What services are needed and how are individual assessments made to link people to services?
• How to link home and community based service and supports, as well as housing into MCO plans?
• What are meaningful measures of access and quality for this population?
• Do integrated models actually decrease total costs?
• How to decrease the present fragmentation of services?
• How does the state plan ensure safe, flexible, accessible and high quality care for these heterogeneous and high risk groups
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services

Initial Announcement
The Money Follows the Person Rebalancing Demonstration Program

Date: February 2, 2012
New Hampshire will be the first State in the country to receive new Medicaid grant dollars—$26.5 million over three years—provided by the Affordable Care Act to keep people out of institutions and living productive lives in their communities, CMS announced March 2, 2012.
Service-enriched Housing

- 1.9 million elderly live in publicly assisted housing – more than the number in NHs
- Most are low-income single women in their 70’s – 80’s
- Several local programs have shown that integrated services can help seniors age in place, reduce re-hospitalization, and provided service-enriched environment substantially below NH costs for comparable population
- Some have co-located Program of All-inclusive Care for the Elderly (PACE) or Federally Qualified Health Clinics (FQHCs) within the house communities
Opportunities for Further Exploration with Housing and Service

- Evaluation of large, multi-state models
- Determination of which services impact outcomes
- Understanding of how to best target populations.
- How to fund existing properties – how to create *new* projects
- How can housing communities engage in innovative communities to improve transitions of care
- Explore the possible relationship of housing providers, services, and bundled payment models
- Creating of Learning Collaboratives where communities can design, test, share and replicate
Alzheimer’s and Related Dementia Care –

• May 15, 2012, the first ever national Alzheimer’s plan was released: http://aspe.hhs.gov/daltcp/napa/NatlPlan.pdf
• CMS has continued focus on reduction of antipsychotic medication use in the nursing home with a goal of 15% reduction by Jan, 2013
• Kohl has proposed language for informed consent requirements – some form likely in NHs
• Advancing Excellence has added a new goal of “Improving the Appropriate Use of Medications”, using antipsychotics as their first target
Evidence is Needed in Memory Care: What is Best Practice and How do we Replicate it?

- Work Force competencies
- Intergenerational Models
- End-of-life Care and Advance Decision-making
- Caregiver support and tools
- Quality of Life Measures

BEST CARE

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Looking to Technology

• Opportunities for improving the life and care of older people goes well beyond gadgets:
  – Monitoring (from post-discharge to seniors living alone)
  – Information-sharing (between caregivers, health professionals and seniors themselves)
  – Wellness and self-managed care support
  – Clinical care tracking (EMRs, personal health records, alerts)

• Questions that must be explored
  – What technologies make a difference? For which populations or settings?
  – What impact do they have on care costs? How do you calculate an ROI?
  – Where does the capitol come from? Can you link private and public payment?
Center for Aging Services Technologies (CAST) to release full report of 18 innovative communities who are successfully integrating technology into aging services.
The Opportunities for our Leadership are There When We Look...

- Service-enhanced Housing
- Tested Models of Memory Care
- Meaningful technology
- Person-centered quality measures linking sites and services
- Outcomes for persons enrolled in state Medicaid integration pilots
- Reducing hospitalizations through innovative communities
- Nursing home engagement in quality and Advancing Excellence
- Prepared work force

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All These Good Ideas....Why aren’t we Doing Them Already?

Failing to include Long Term Care and Supports in Health Care Reform (what’s HCBS??)

“Tyranny of the Urgent” (we are way too busy)

Risk models lack adequate incentives

We define care by where we provide it (system integration still has little operational meaning)

Uncertainty of What’s Behind the Next Corner (let’s just wait and see..)

Assumptions about quality (we know what they need)

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New Thinking is Needed

• Changes must occur quickly – strategic planning can only go 12 to 18 months
• Shift the focus from patients and single providers – to populations, integrated teams and communities
• Must move beyond traditional sites to look at how to link person-centered support and service across the continuum – focusing on where people are, and want to be
• Medicaid cannot be assumed to alone provide the needed safety-net for long term support and service
Cutting service is NOT the answer – only INNOVATION will create a sustainable world for aging services... and YOU all play a key role!

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Four Alternative Views of the Future

Jake Dunagan describes A quartet of Archetypes to define the future. *Generations vol 34 (3), fall, 2010*

- **Growth**: keeping things much like today – except anticipating more
- **Collapse**: when growth fails and the result leads to a spiral down
- **Discipline**: focus on constraint or reduction to attempt to maintain a steady state
- **Transformation**: Moving to a new form
4 Habits of a High-Value Aging Services Organization

1. Specification and Planning
   - Identifying specific populations
   - Planning for unique service needs targeted to subgroups

2. Deliberately designing micro-systems to meet subgroup needs
   - Policy and procedures
   - Space and staff
   - Budgets, incentives and goals

3. Measurement and oversight for internal control

4. Self-study

The Four Habits of High-Value Health Care Organizations; R. Bohmer; NEJM, Dec. 2011
Where we go next will depend on:

• Our vision of the future and our ability to “make” new solutions that transform
• Our ability to see through the current clouds of confusion – to identify the opportunities that are there
• Our ability to take on the unfamiliar – whether redesigned care models or changes in how we are paid
• Our ability to lead – in collaboration with others. Few wins will be sustained by working in isolation
In short....It will take Brains, Heart and Courage
LeadingAge Leadership
Imperatives as a Framework

• Strengthen the not-for-profit leadership
• Engage Consumers – understanding needs, defining quality, and providing transparency
• Create New Financing Paradigm
• Lead Innovation
• Cultivate talented people – Preparing the work force
• Pioneer Technology
"The greatest danger for most of us is not that our aim is too high and we miss it, but that it is too low and we reach it."

--- Michelangelo
“The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little”

--- Franklin D. Roosevelt
Time to React