5-Year Medicaid Cost Savings for Duals in the ELDER PARTNERSHIP FOR ALL-INCLUSIVE CARE (Elder-PAC)

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Problem of Duals

- Sickest, frailest, least educated and most expensive Medicare and Medicaid beneficiaries
- The 8M duals represent 46% Medicaid and 25% of Medicare expenditures
- More than ¼ have 3 or more ADL dependencies, while 11% have 5 or more chronic conditions
- Complex social and medical needs
- Current siloed programs create inefficiencies, overlaps, and gaping holes through which beneficiaries end up institutionalized

Like VA's Home Based Primary Care and other Non-Institutional Care programs:

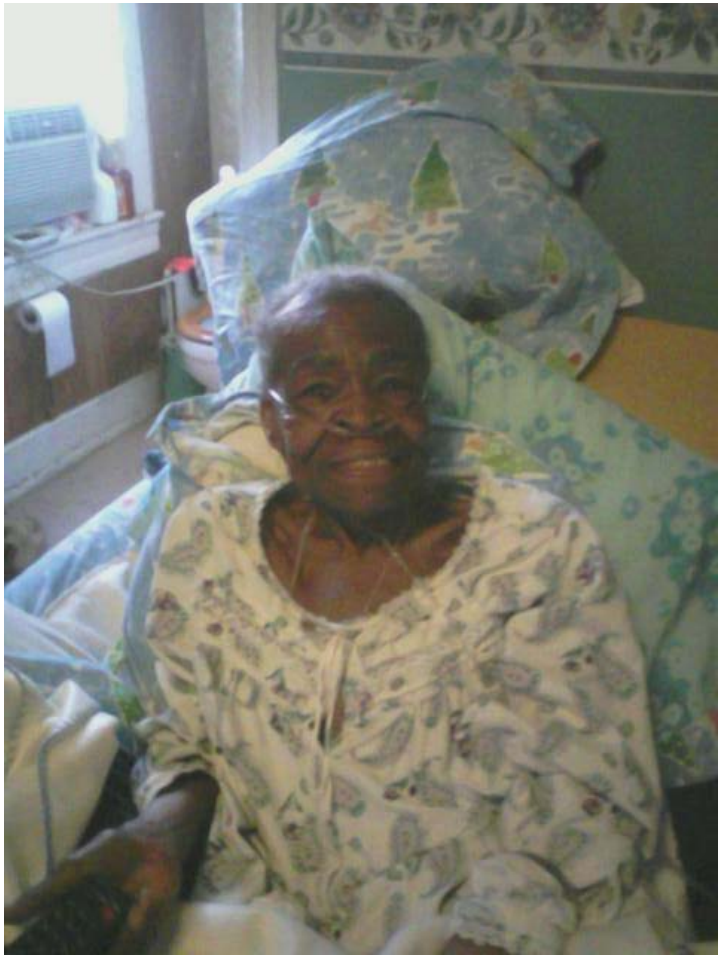
- Successful management has used integrated funding and service provision
  - Dual Special Needs Plans (D-SNPs)

    455 plans, 1.2M duals
  - Model SNPs (generally small, provider based)
  - Program of All-Inclusive Care for the Elderly (PACE) : Gold Standard for the frailest of the frail
  - Independence at Home-type practices contracted to SNPs, e.g., **INSPIRIS, Inc.**

Inspiris' IAH-type program and Outcomes

- Housecall team (MD, NP, RN, SW) contracted to manage a defined panel of high risk patients (2+ chronic conditions, 1+ admission) across 8 markets
- **63% reduction in hospital admissions** among 800 matched duals (1608/1000 to 593/1000 pts/yr)
- **33% reduction in 30-day readmissions** (21% to 14%)
- **42% reduction total cost** over 2009-2010 (15% absolute net reduction for 300 pts compared to all high risk duals in 15,000 member plan)
- **74% reduction in SNF days, 40% reduction in ED** use among 1000 pts in 50,000 member plan.

Source: **INSPIRIS, Inc.**

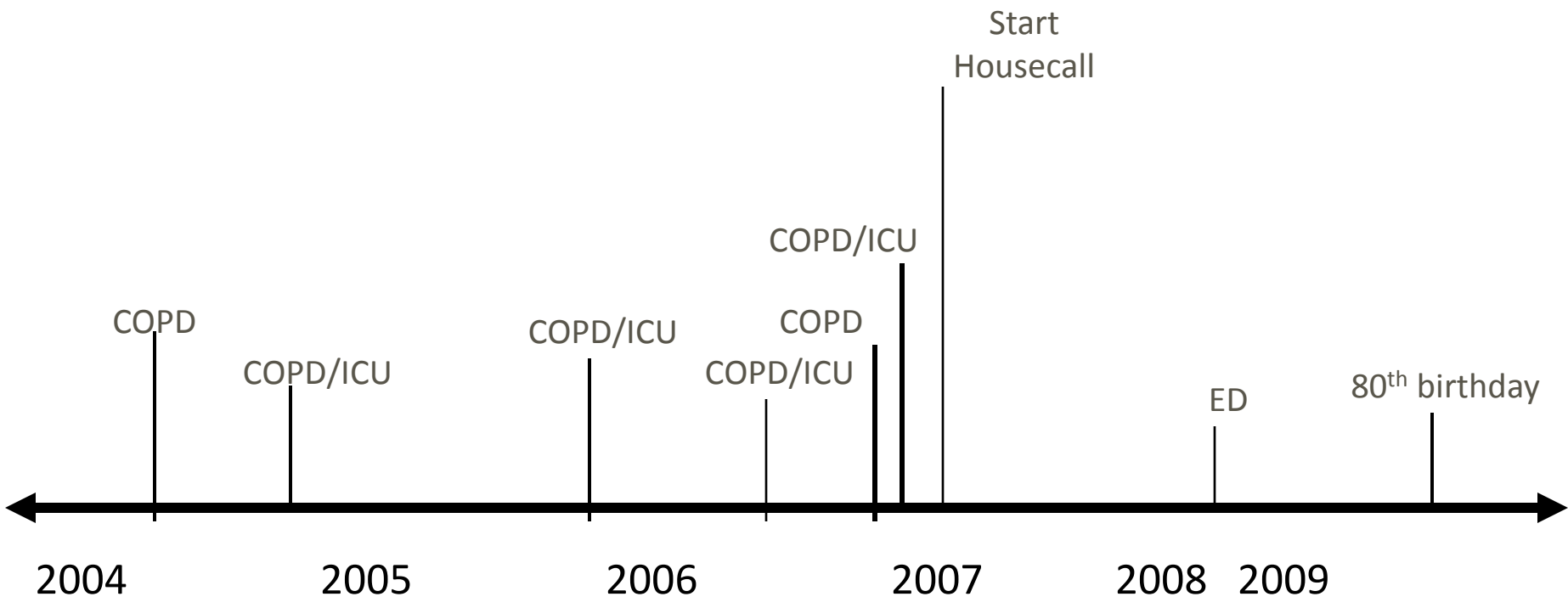


BJW

- 78 yo AA woman,
- Lives independently in neighborhood for past 50 years
- 2-story row home
- BiPolar daughter who lives in home with her along with her 2 children (one with autism)
- Recurrent utility crisis due to poor money management
- Oxygen dependent
- Held and personally catered annual block party
- Multiple cats with fleas
- Medicare risk score 4.6
- Personal goal to survive to 80th birthday

- 491.21 COPD
- 518.83 Resp Fail 02
- 327.3 Sleep Apnea
- 440.2 PVD
- 585.3 CKD
- 404.11 HTN c CKD and HF
- 416.8 Pulmonary Htn
- 428.3 Diastolic CHF
- 427.89 SVT
- 358.8 Neuropathy
- 274.0 gout
- 285.29 anemia
- 721.9 Cervical spondylosis
- 366.9 cataract
- 530.81 GERD
- 389.9 Hearing loss

BJW Hospitalizations Pre/Post Housecall Management



ElderPAC

- integrated, interdisciplinary team care for 12 years

- combines home and community based services through Philadelphia Corporation on Aging (the Area Agency on Aging for Philadelphia county) with medical care in an IAH-type program (In-Home Primary Care Program)

- ElderPAC team:
  - **NP/MD, SW from University Pennsylvania Health System**
  - **case manager from PCA**
  - **community nurse from Home Health Agency**

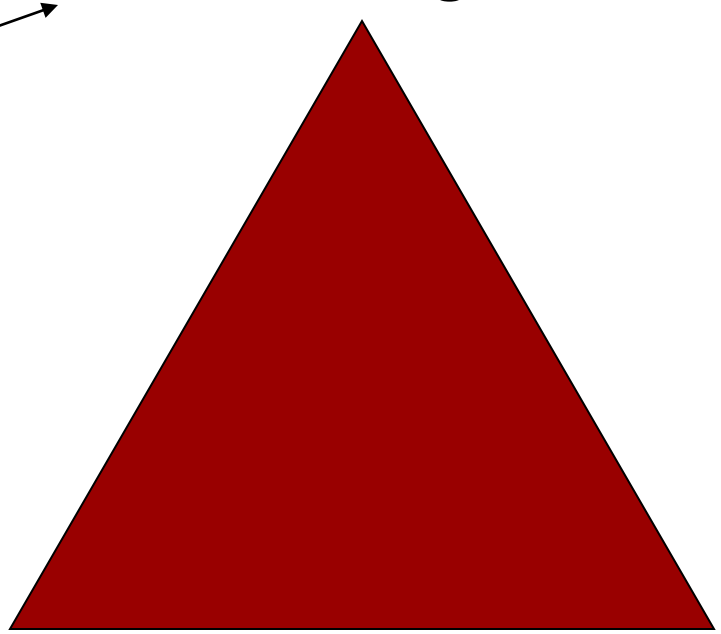
- serves both Waiver (dual) and Options (non-dual) nursing-facility clinically eligible consumers

Long Term Care:

Deconstructing a Nursing Home

Complex Health Management

Independence at Home



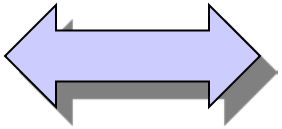
HCBC waivers

Supportive Living Services

Housing

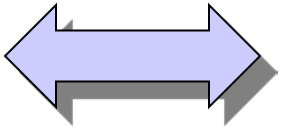
Pre-Elder PAC

3 Nurse Practitioners
180 patients



39 Case Managers
at PCA

Case Manager
60 PCA consumers

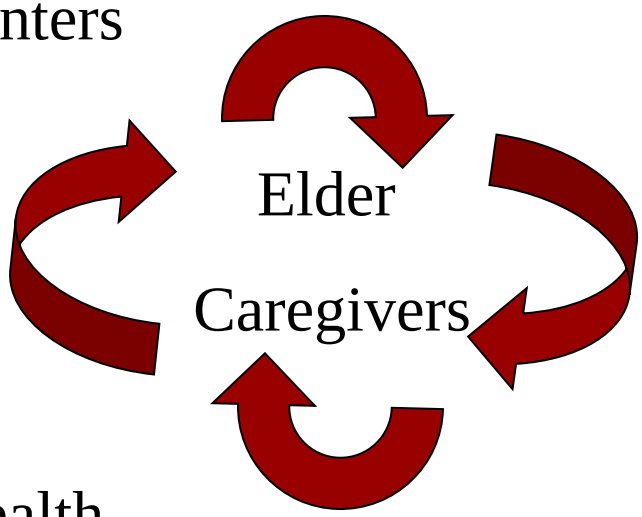


50 providers

Elder-PAC

Senior Centers

Philadelphia Corporation for Aging



Home Health Agencies

In-Home Primary Care Program

Cement

- Weekly team meeting for In-Home Primary Care Team (NP/SW/MD)

  -- Scheduled attendance with Physical Therapist, community Nurse
- Monthly team meeting with PCA
- Care Plans (PCA, Home Health Agency)
- Daily electronic communication:

  Text, email, phone, EMR

Does it work?

Objectives:

1. **Determine if an inter-agency IDT providing comprehensive, all-inclusive care could:**
   - ***Increase the share of total survival*** **spent in the community for frail elders**; and
   - ***Reduce Medicaid nursing home costs*** by providing **home and community based care to frail elders**.
2. **Estimate likely performance of an integrated care organization/Independence at Home practice**

Evaluation

- Original EPAC cohort study 1997-2002
- Reassembled E-PAC cohort for 2004 base year
- Accrued new consumers during subsequent 4 years
  - –Included all living at end of interval, rolling enrollment
- Controls: consumers matched for program (waiver/options), age, gender, zip code, LTC intake risk score (1-85, mean =69.2), year of enrollment

- Medicare costs estimated from HCC score for EPAC patients
- Medicaid costs for NH and HCBS taken from State SAMS system
- Death from state vital records
- Utilization (hospitalization) from program data
- HCBS costs (from AAA and from State Medicaid)
- Functional scores from AAA
  (all participants screened with common intake assessment)
- Measures: community survival (Kaplan-Meier), NH use, mortality, costs

3 Comparison Groups

- PACE (national) --Benchmark
- HCBS without ElderPac IDT

  (216 Waiver, 84 Options;6910 waiver months)
- HCBS with ElderPAC IDT

  (72 waiver, 20 Options; 4360 member- months)

Consumer Co-morbidities

- 92 consumers
- Age 82 (+/- 8)
- 86% female

- HCC score

  ElderPAC 3.55

  PACE 2.15

- ADL Impairments (mean)
  - ElderPAC 3.7

    48% 5-6

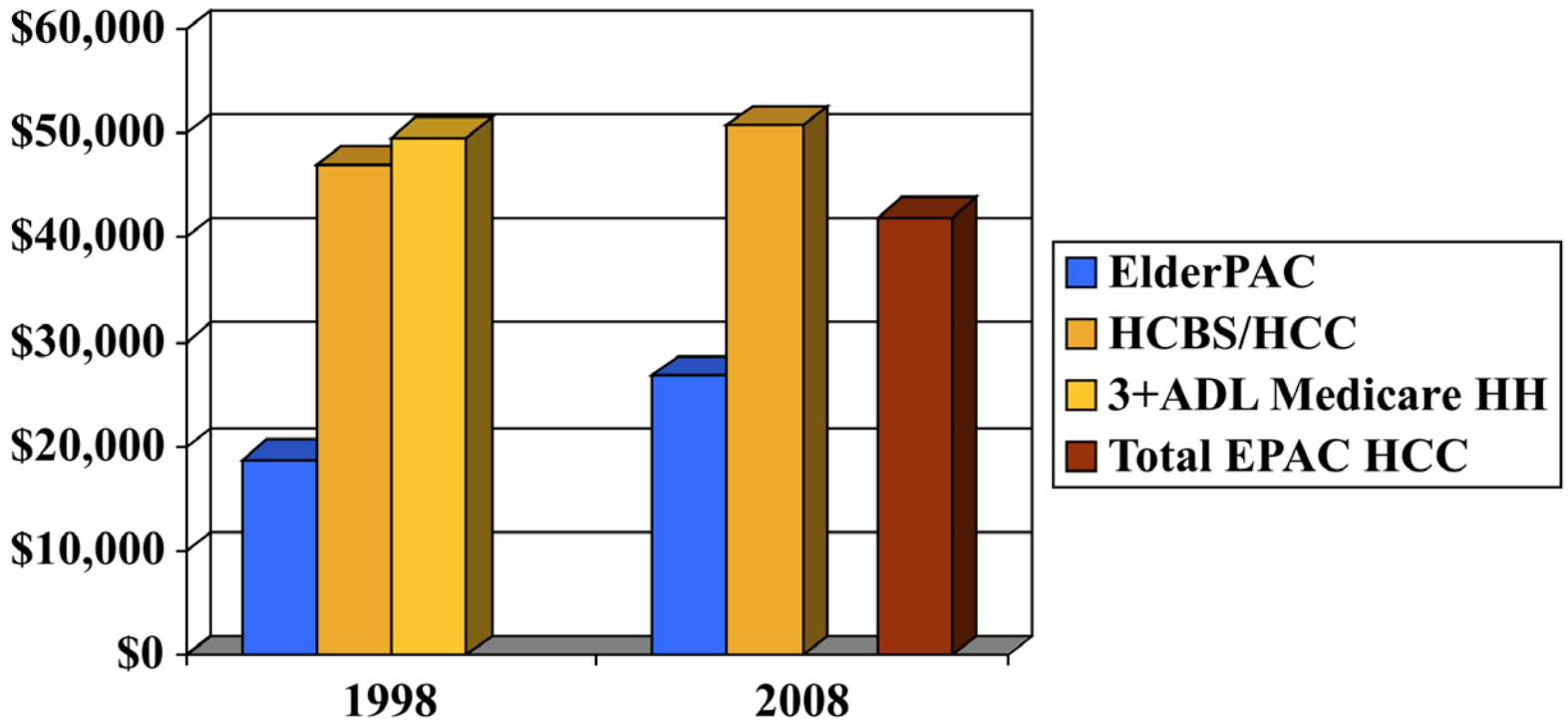
    -- PACE 3.8

    44% 5-6
  - HCBS 2.8

    24% 5-6

Medicare Costs: ElderPAC 1997-2000*

(*adjusted to 2010 dollars)



> HCBS: waiver option in PA

➢Medicare HH: ASPE 1999 - 2003 wave of LTCS data

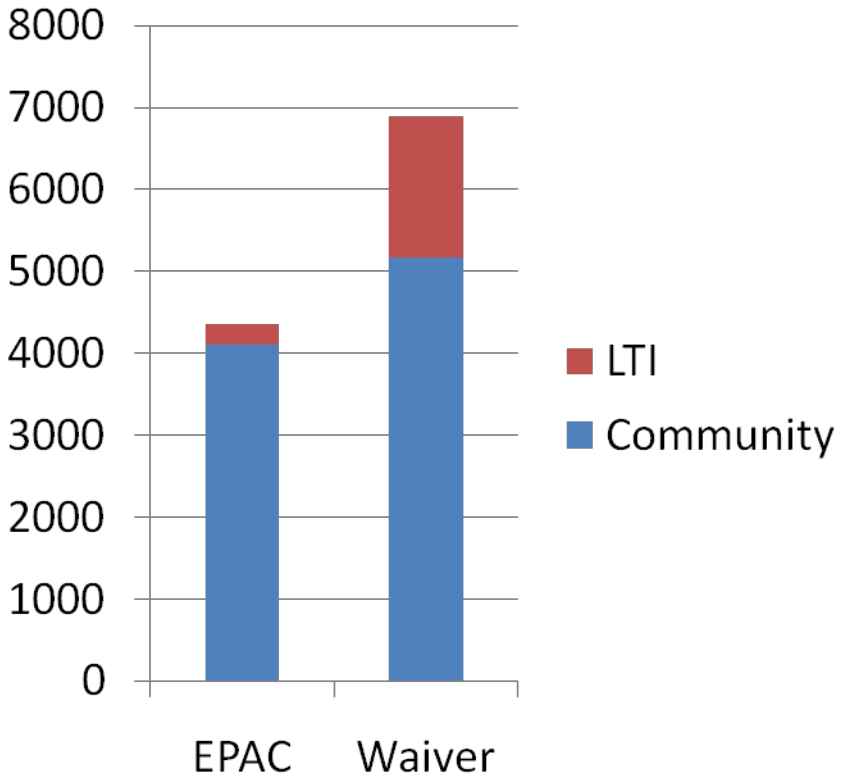
	E-PAC 2 (2004-2009) (N=92/4360 member months)	Waiver/Options Controls (N=216/ 6910 member-months)
Hospital	3.8 /100 mm	n/a
Long-term Nursing Home	5.9%	24.9%
Community Survival/ Survival 5-year	38% /43%	20%/28%
HCBS Care Plan mean cost/month Est. mean HCC Annual/ 5-yr Total	$1942 +/- 1117 3.55 $41,962/$15.3M	$1084+/- 477 n/a
Medicare Savings Annual/ 5-yr Total @ .48 @ .37	$20,054/$7.22M $15,458/ $5.5M	n/a

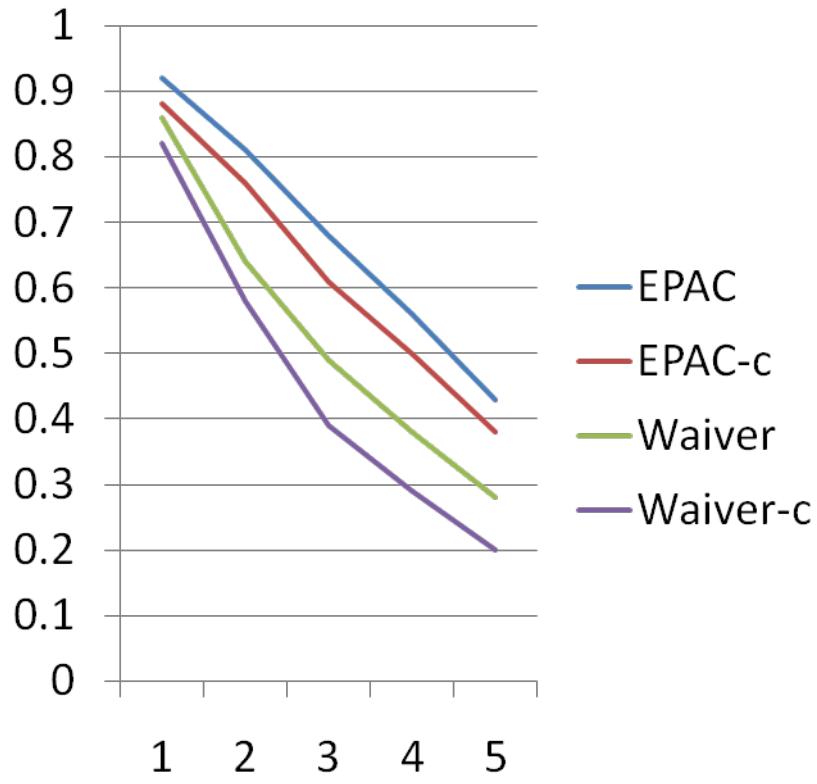
ElderPAC Increases both Survival and Community Survival compared to usual HCBS

Community months of survival/total months survival

EPAC 44.3/46.8 months

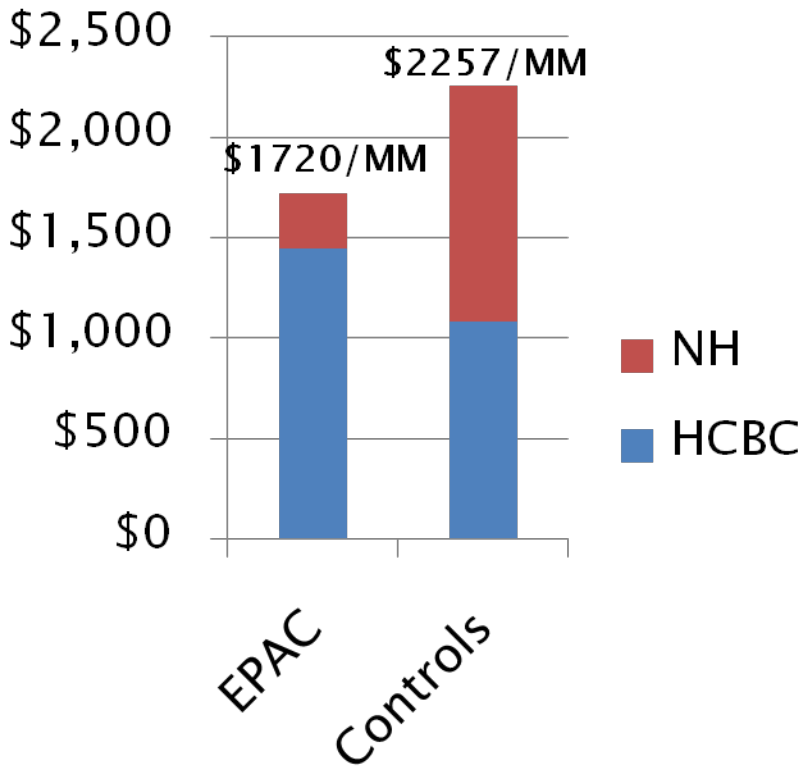
Waiver 24.2/31.9 months





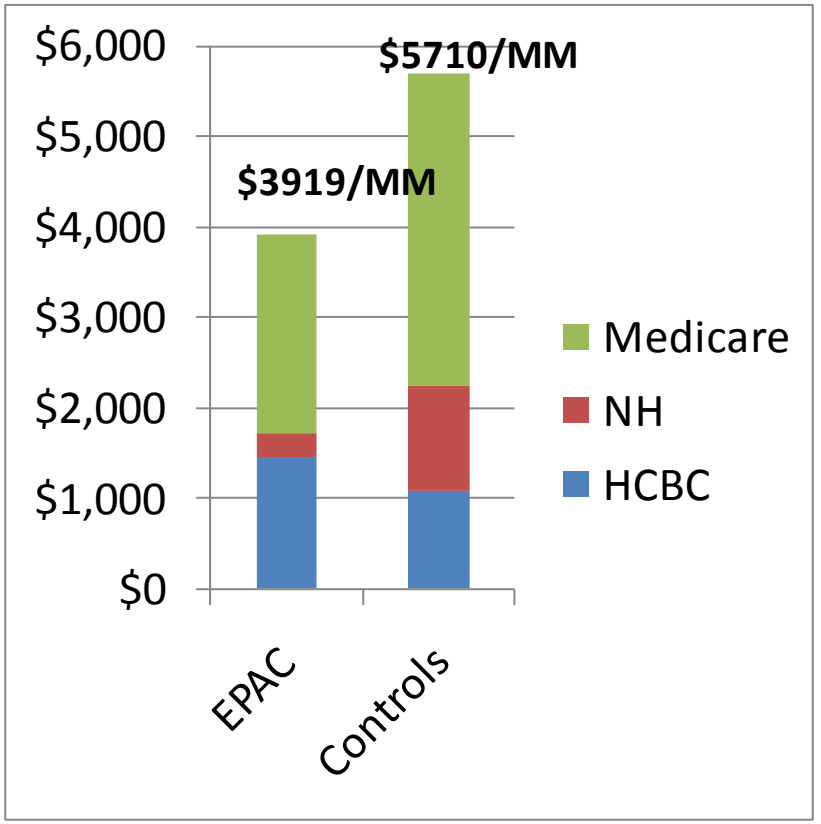
EPAC reduces Average Monthly Costs Compared to Waiver Controls

Medicaid : EPAC 24% less



EPAC : $20,640; **Waiver** $27,084

Medicaid+Medicare : 32% less



EPAC $47,028 **Waiver** $68,520

5-Year Total Cost of State Nursing Home and HCBS payments for E-PAC and Waiver/Options Consumers

Medicaid Only

$2.3M saving for 4360 member months **(23%)**

$6740/ Year of Life Saved

N=92

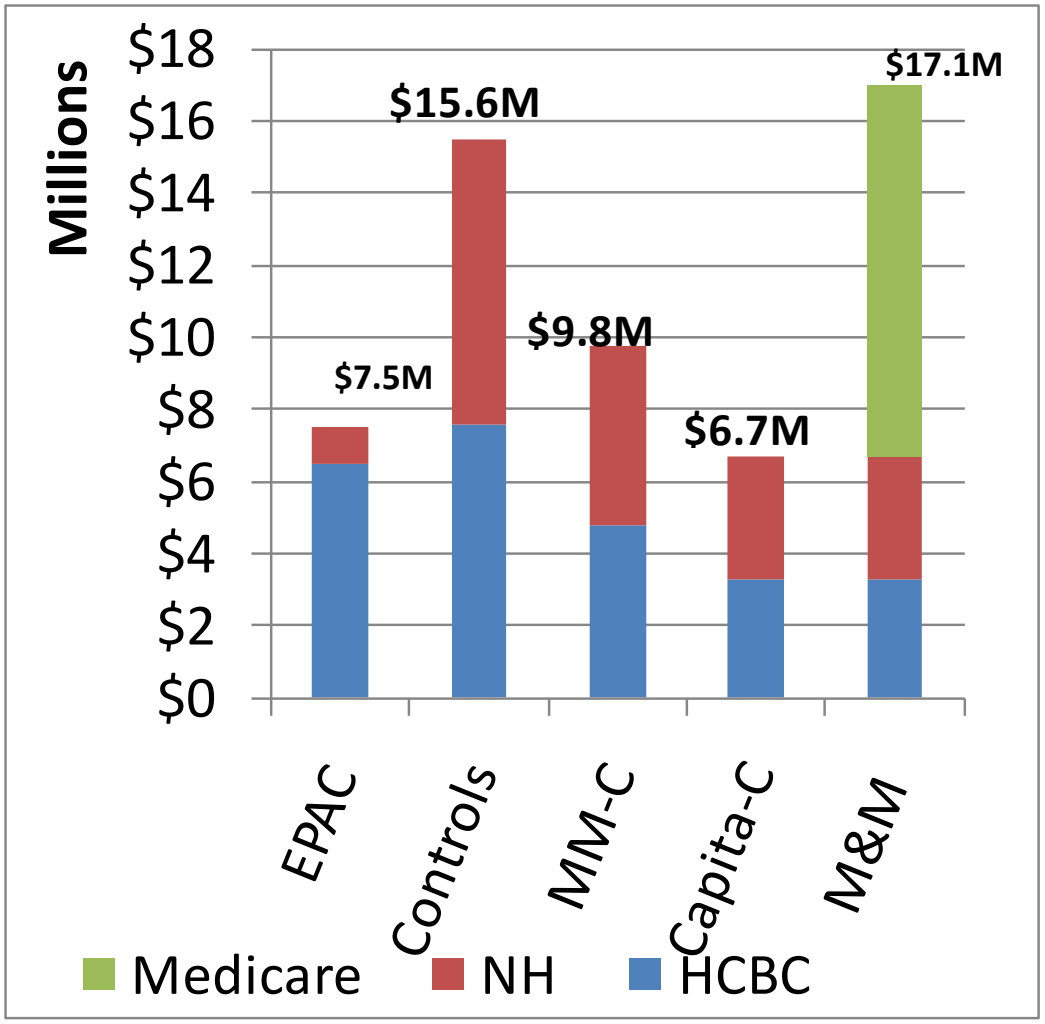
(4360 MM EPAC, 2994 MM HCBS)

Medicare & Medicaid

$7M - $8.7M saving for 4360 member months

$170 K - 1.7M saving for N=92

(4360 MM EPAC, 2994 MM HCBS)



Summary

- All-inclusive care delivered through a housecall practice can reduce Medicaid costs by 23% compared to usual HCBS.
- Despite a 46% increase in survival there was a net cost savings (up to $1.7M) to Medicare and Medicaid in an Integrated Care Organization/Independence at Home structure.

What's missing

- Financing structure to cover the cement that keeps the bricks together.
- Currently dependent upon individual commitment and effort to keep patients connected with all team members
- Need for new models of financing integrated care beyond single all-inclusive organizations–

    e.g., Independence at Home

- Substantial reduction in institutional care can be achieved by integrating services and adding flexibility rather than restricting services

- Success in reducing institutional care requires trust, built best by the patient provider relationship established within the home

- Greatest success in reducing institutional care requires an interdisciplinary team, and the economic incentives to sustain them.