

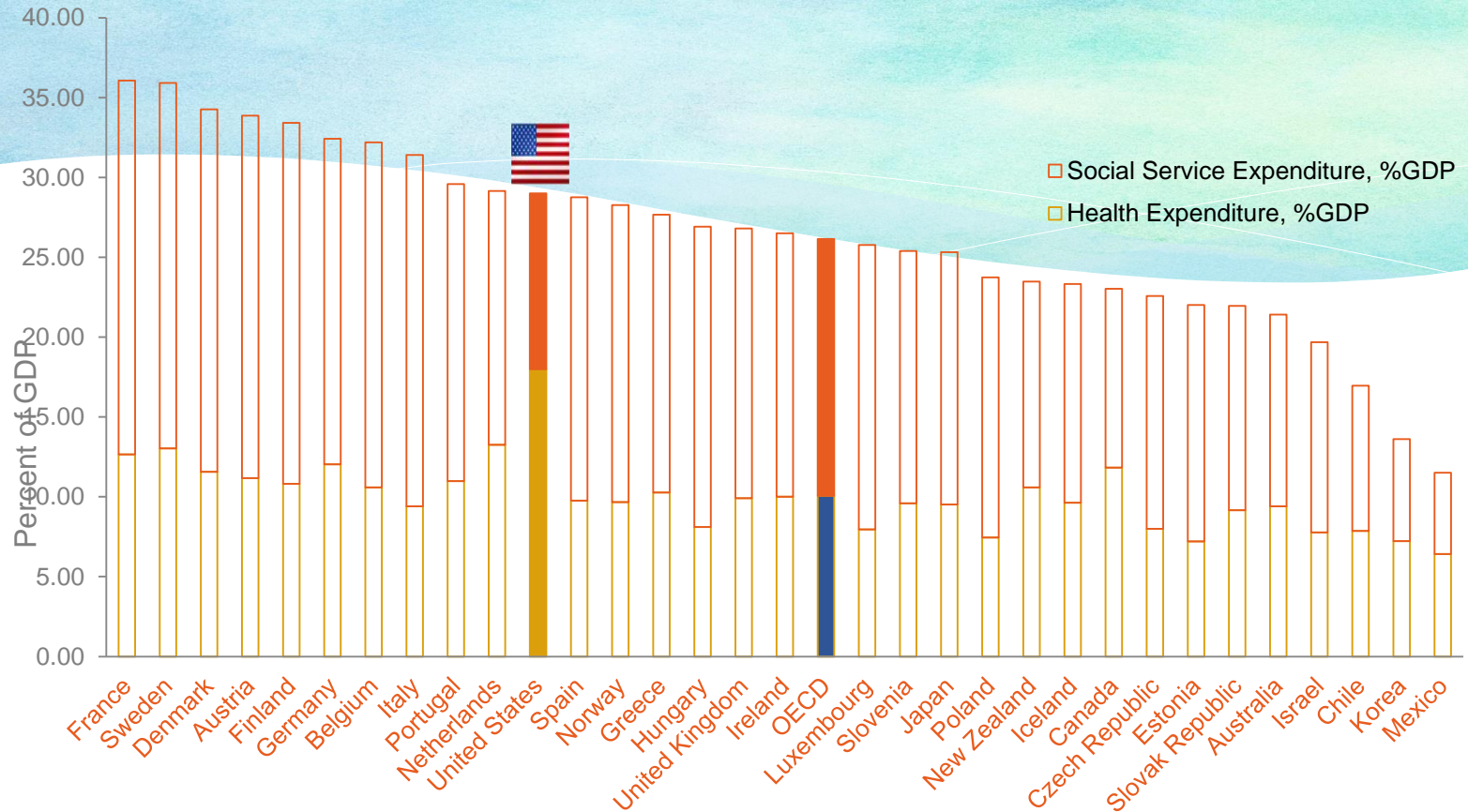
Transformation in Service Delivery for Older Adults: Policy Strategies and the Role of the Community

*Anne Montgomery, MS
Deputy Director, Center for Elder Care and Advanced Illness, Altarum
Institute*

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Total Expenditures as % of GDP, 2009*



*Switzerland and Turkey are missing data for 2009

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Prolonged dwindling

Mostly frailty and dementia
Now, most Americans have this course.
The numbers will triple in 30 years.

Function



Onset could be deficits in ADL, speech, ambulation

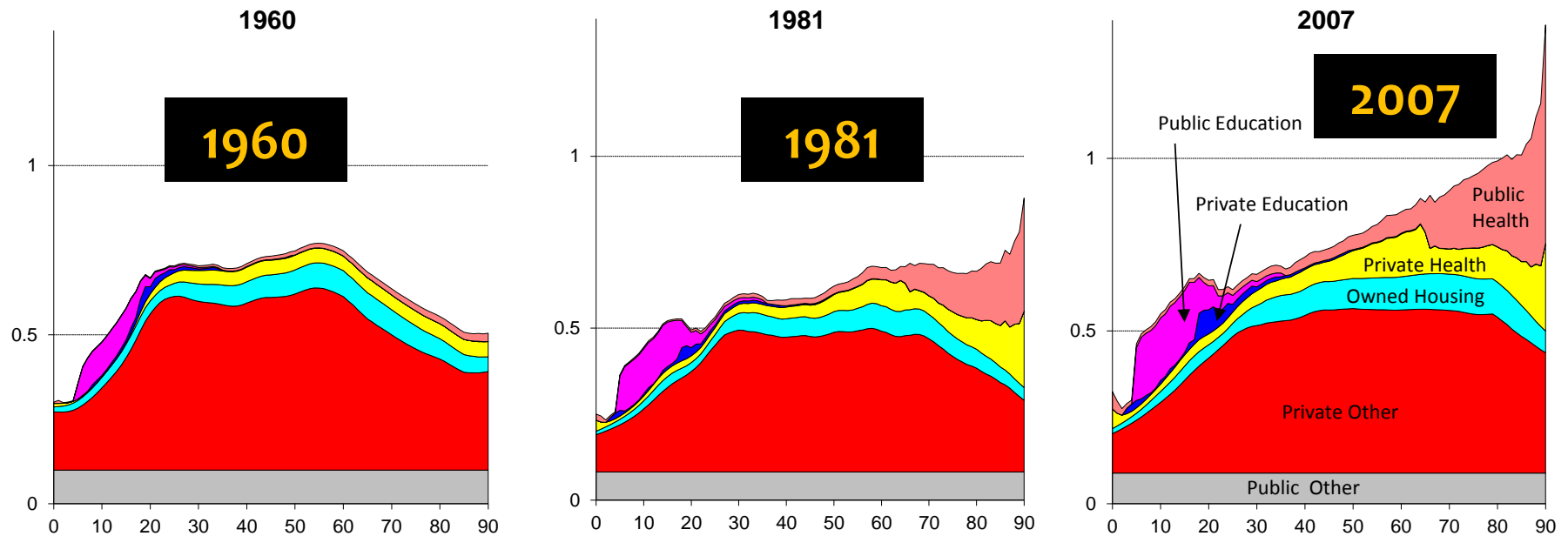
Time

Quite variable, often 6-8 years

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U.S. consumption (private + public)

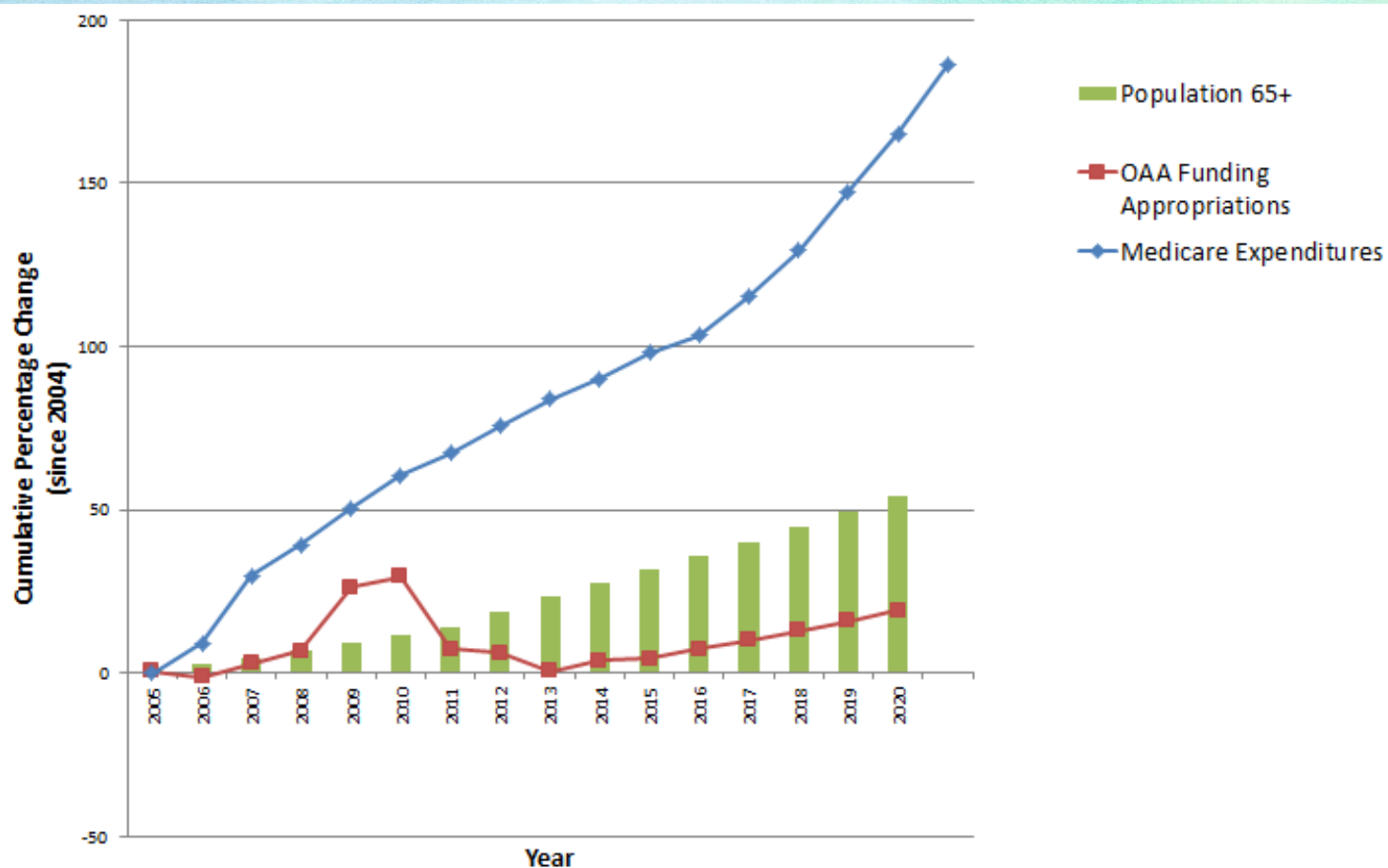
Y axis, 1 = Average Labor Income Ages 30-49



Source: U.S. National Transfer Accounts, Lee and Donehower, 2011.
Also in Aging and the Macroeconomy, National Academy of Sciences, 2013

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OAA Funding Appropriations vs. Medicare Expenditures and Steady Increase in 65+ Population



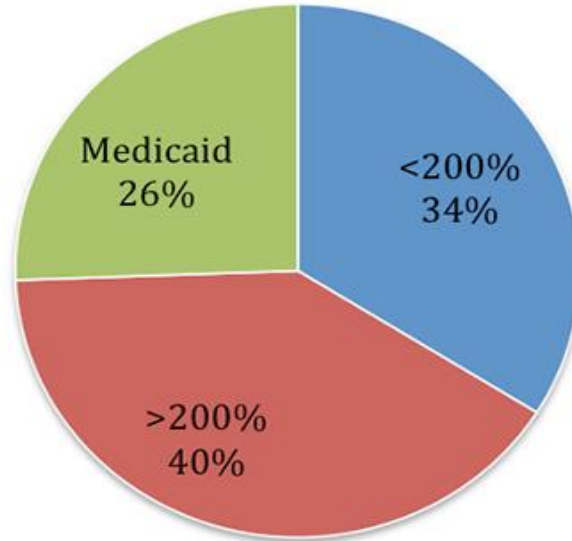
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Medicare “Help at Home” (Davis, Willink, Schoen)

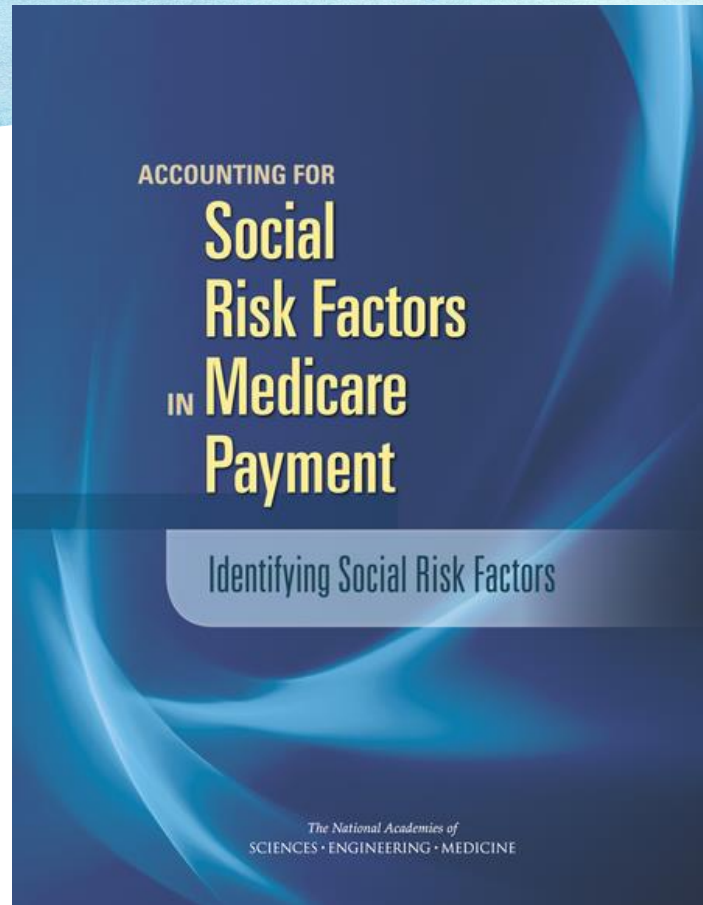
Poverty Distribution of those with Integrated Care Needs

19% of Medicare Beneficiaries Have Integrated Care Needs



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Social Determinants of Health (and Services to Address Them) Are Influencing Policy Thinking



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“You never change things by fighting the existing reality. To change something, **build a new model** that makes the existing model obsolete.”

--Buckminster Fuller

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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)**

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MediCaring Communities Financial Simulation

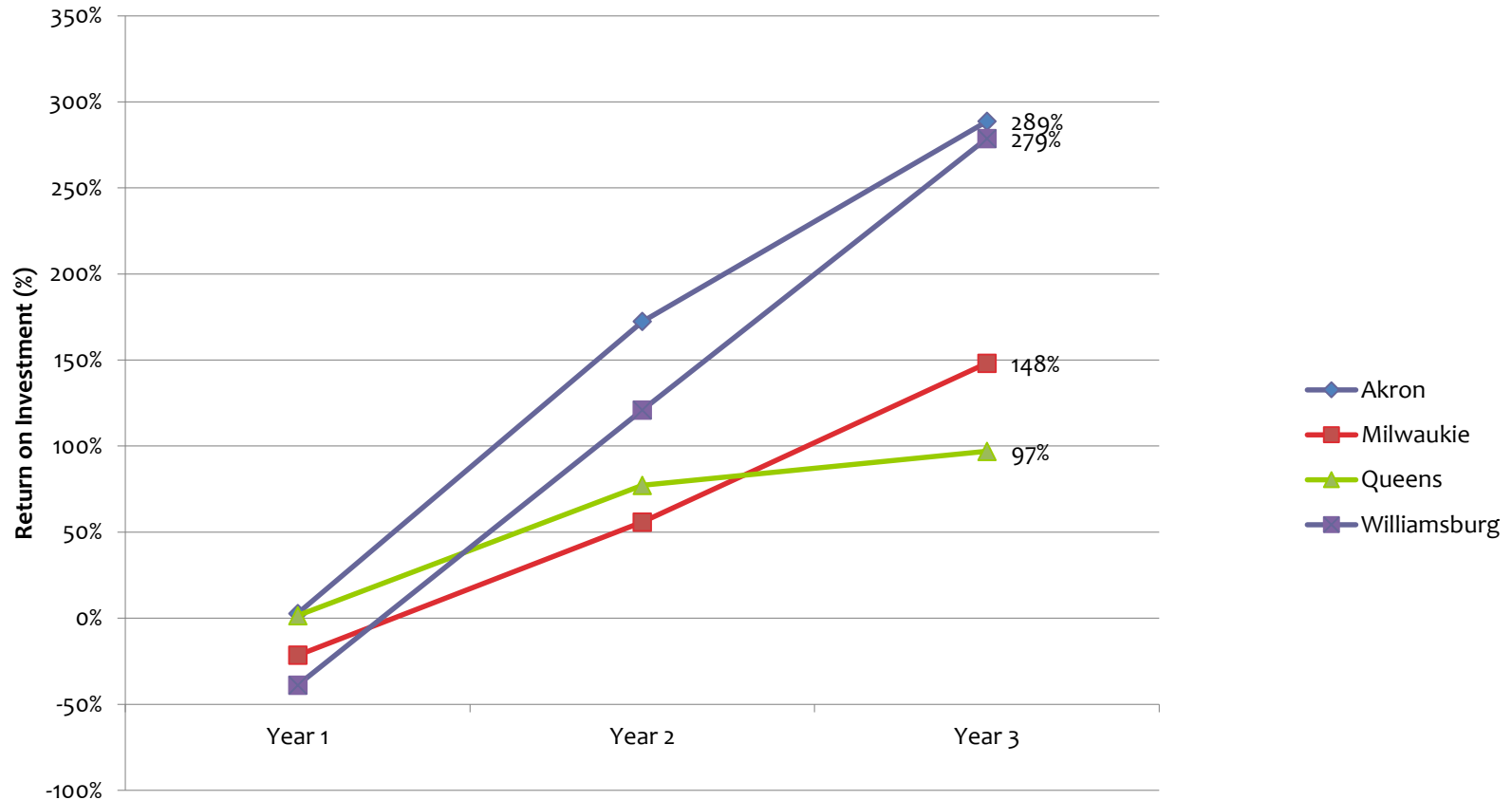
Per Beneficiary Per Month Savings (\$) by Site, Over Time



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MediCaring Communities Financial Simulation

Return on Investment, Years 1- 3



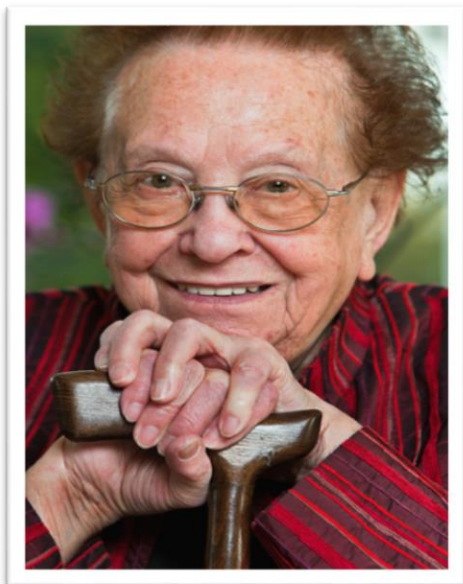
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PACE Innovation Act (enacted Nov. 2015)

- * 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

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What is the Need Among Frail Elders and How Could PACE Expansion Help?



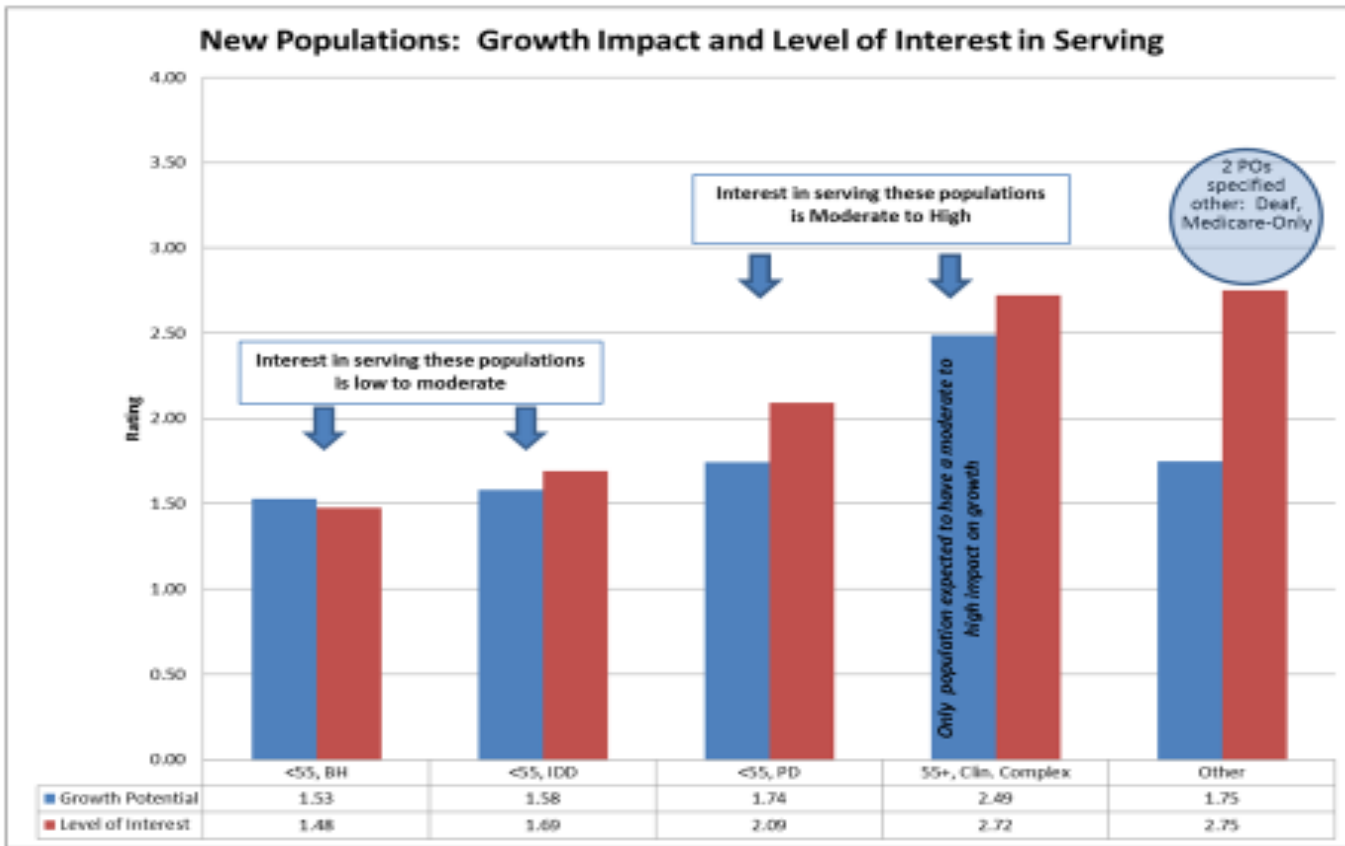
Increasingly frail, needing ready access to comprehensive care and coordination --
Many Medicare beneficiaries are not yet eligible for nursing home level of care (LOC) and many are not yet financially eligible for Medicaid.



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

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NPA Member Survey



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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

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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



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