

Can Health Plans that Address Non-Medical Needs Lower Health Care Costs?

Authorsⁱ

Jennifer Windh, MPP, G. Lawrence Atkins, PhD, Anne Tumlinson, MHSM, Jennifer Wolff, PhD, Amber Willink, PhD, John Mulcahy, MSPH

Functional Limitations Help Drive Health Care Costs

The high and growing cost of American health care is an area of longstanding concern. Since just 5 percent of Americans incur nearly half of all health care spending,ⁱⁱ improving care and reducing costs in this population is a high priority. Within this subgroup, functional limitations are a major driver of spending. Medicare spends nearly three times as much per person on individuals with functional limitations who need long-term services and supports (LTSS) as on those without.ⁱⁱⁱ Concerns about constrained resources are likely to increase in the coming decades as more Americans reach very old ages at which risk for having LTSS needs is particularly high.

Medicare does not, however, cover LTSS, which is typically reimbursed by Medicaid or out of pocket by individuals and families.

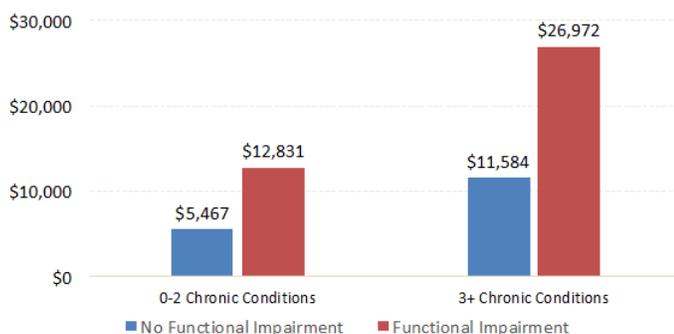
Can Plans that Cover and Integrate LTSS Help Reduce Medical Utilization?

Policymakers have shown an interest in the potential for non-medical services, including LTSS, to reduce avoidable medical utilization. Plans that integrate Medicare health benefits and Medicaid managed LTSS for beneficiaries enrolled in both programs (so called “dual eligible beneficiaries”) offer the best opportunity to test the effect of providing non-medical services on medical utilization by people with complex care needs.

States have moved in recent years to adopt managed LTSS (MLTSS) for aged and disabled Medicaid beneficiaries to manage costs and improve outcomes. Nearly half of the states now have MLTSS,^{iv} and policymakers are working to better integrate Medicare with MLTSS for dual beneficiaries. Early integrated options, like the Program for All-inclusive Care for the Elderly (PACE) and the Senior Care Options (SCO) program in Massachusetts, have enrolled only a minority of dual beneficiaries. The more recent model – the Medicare-Medicaid Plan (MMP) – is still being tested in a handful of states. So, while 80 percent of dual eligible beneficiaries reside in states with MLTSS,^v still only 9 percent today are enrolled in integrated plans.^{vi}

Functional Impairment Associated with High Medical Costs

Per Capita Medicare Spending, 2015



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Note: Data is limited to fee-for-service Medicare beneficiaries living in the community
Source: 2015 MCBS linked to claims

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Congress took a step last year, through the enactment of the bi-partisan CHRONIC Care Act,^{vii} to encourage adoption by states and enrollment of dual eligible beneficiaries in integrated plans. The Act also created a new opportunity for Medicare Advantage plans to offer non-medical benefits to Medicare beneficiaries with chronic conditions. In both cases, the Congress placed a bet that addressing the non-medical needs of Medicare beneficiaries with complex care needs will pay for itself by reducing medical utilization.

While addressing non-medical needs of those with functional limitations may reduce avoidable emergency room visits, and hospital or skilled nursing facility admissions, available evidence is largely anecdotal. Empirical evidence^{viii} is just now emerging to support this belief,^{ix} but the results are early and mixed. A recently completed a study^x from the Long-Term Quality Alliance (LTQA), with support from the Laura and John Arnold Foundation, adds to this evidence base by examining differences in medical utilization of beneficiaries with LTSS needs that occur in different types of integrated plans^{xi} as compared with a population having a similar level of functional impairment but enrolled in traditional Medicare.

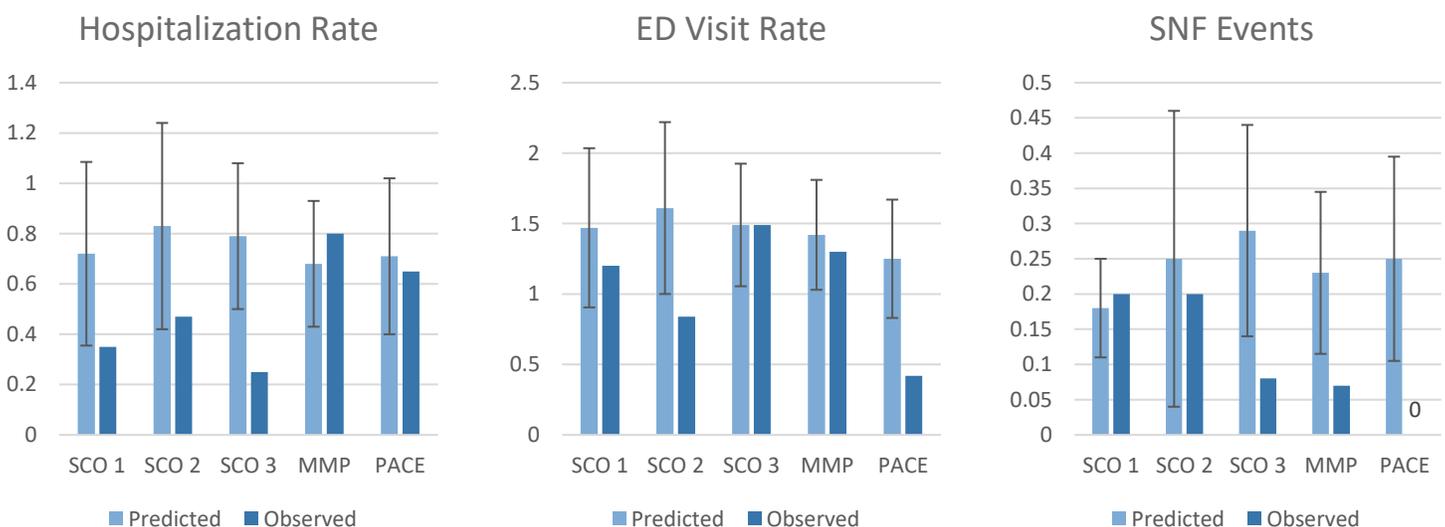
The study compares results for five integrated plans -- three Senior Care Options (SCO) plans, a Medicare-Medicaid Plan (MMP), and a PACE program – both in terms of the difference across the plans in medical utilization from traditional Medicare and the differences among the plans.

Plans that Integrate LTSS Do Have Lower Rates of Medical Utilization

LTQA found generally lower medical utilization rates for enrollees with functional limitations in integrated plans than predicted for a similar population in traditional Medicare. Each of the plans had some rates that were lower, but no plan had lower rates across the board and the rates that were lower varied by type of plan.

Overall:

- Hospitalization rates were lower than the rates predicted for traditional Medicare in all but one of the plans, but the difference was significant for only one. The difference was most pronounced for the plans that had been operating the longest.
- Emergency department (ED) visit rates were lower than the predicted rates for



Error bars represent the 95% confidence interval for Predicted results. Significant Observed results lie outside this range.

SCO – Senior Care Option Plans MMP – Medicare-Medicaid Plan PACE – Program of All-inclusive Care for the Elderly

four plans but were significant for only two.

- Skilled Nursing Facility (SNF) utilization was one-third or less the predicted rate for three of the plans and these results are significant for those three.

Medical Utilization Rates Vary for Different Types of Plans

The variation in differences between observed and predicted medical utilization across plans suggests that differences in how the plans structure and implement LTSS integration influence whether the plan has lower rates for ED visits, hospitalizations, or SNF admissions. Several factors potentially contribute to these differences:

How long you have been doing it matters

One plan (an MMP) whose data was from its first full year of operation had a high hospitalization rate -- higher than the rate predicted for a similar population in traditional Medicare. By contrast, the three SCO plans, all in operation for over a decade, had lower hospitalization rates. Initial medical utilization may be high in a plan newly enrolling a high-need population with unmet health needs. Over time, though, as care management and home-based supports take hold, the potential for lowering utilization may improve.

How you do it matters

The care models vary across the plans, resulting in different approaches in how care planning and care management operates and how plan members access institutional care. A very tight and targeted model – like PACE – with its site-specific care delivery through an interdisciplinary care team including a primary care provider has strong tools to prevent avoidable institutional care, contributing to

comparatively low ED visits and SNF admission rates.

Who you do it for matters

The study population was a subset of members within the plans who met the definition of need for LTSS. This sub population typically has higher levels of medical utilization that can be most substantially affected through well-managed LTSS. Two plans had a potentially higher-acuity population than the other three. State-specific differences in the description of this level of need precluded a complete adjustment for this in the study.

Integrated Plans Can Contribute to Limiting Health Care Spending

A movement is underway to refocus our health care system from an over-reliance on highly-specialized, institution-based medical intervention to a greater emphasis on prevention, non-medical services and supports, and addressing social determinants of health. Plans that integrate Medicare benefits and Medicaid MLTSS can play a role in redirecting medical spending to provide better supports for individuals with complex care needs in the home and community. Findings from our recent report suggest that, with time, lower medical utilization may result from more effective care management and in-home supports and services for the small, but very costly, subset of the population with functional limitations. Federal and state policymakers will need more and better evidence that investing in services can yield a return in health care savings to justify the shift toward reliance on integrated plans in the broader strategy to refocus health care.

New data resources^{xii} are coming that will enable matching of individual plan enrollee and fee-for-service enrollee records in

Medicare and Medicaid to support further research on the ways non-medical supports and services, including through integrated plans, reduce health care utilization. It remains for future studies to translate findings on utilization into measures of cost savings and the return on investment from the inclusion of non-medical supports including LTSS.

The hope is that this strategy of incorporating non-medical services within the scope of Medicare may someday rise to meet the challenge of financing LTSS for a growing and aging population.

ⁱ Author affiliations: Jennifer Windh and G. Lawrence Atkins of the Long-Term Quality Alliance, Washington, DC; Anne Tumlinson of Anne Tumlinson Innovations, Washington, DC; and John Mulcahy, Jennifer Wolff, and Amber Willink of the Department of Health Policy and Management at Johns Hopkins Bloomberg School of Public Health, Baltimore, MD.

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^{vi} Medicare-Medicaid Coordination Office (2019) *Fact Sheet: People Dually Eligible for Medicare and Medicaid*. Center for Medicare and Medicaid Services. <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DualEligiblesFactSheet.pdf>

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<https://www.finance.senate.gov/imo/media/doc/CHRONIC%20Care%20Act%20of%202017%20Introduced.pdf>

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