Socioeconomic Determinants of Health and Well-being

Presentation to Green Mountain Care Board

November 13th, 2014

Today’s speakers

- Ed Paquin, VCDR, DRVT
- Sam Liss, VCIL
- Nancy Eldridge, SASH
- Sarah Launderville, VCIL
- Barbara Donovan, VTrans

Major Themes

- Holistic, Non-traditional Medical Approach/Community Health Care Workers
- Other than Fee-for-Service/Claims-Driven
- Elimination of Silos
- Person-Driven (In addition to being Person-centered)
- Need to Maintain “Standard Health Care”
- Co-exist w/Other Facets of Wellbeing : Holistic Principles
- Eliminate/Minimize Barriers: Employment; Stable Housing; Adequate Transportation

VHCIP Project – DLTSS Workgroup
Model of Care (MOC) Plan

Attempt to

Coordinate and Align Goals and Objectives

Model of Care
for People with Disabilities and
Long-term Services and Supports (DLTSS) Needs

June 16, 2014

Why are DLTSS Fundamental to Health Care Reform?

- For at least a decade, there has been consensus that older people and those with disabilities or multiple chronic conditions are the most complex and expensive populations that Medicaid supports. *(Sources: Kaiser, Robert Wood Johnson, Center for Health Care Strategies, CMS)*

- Evidence suggests that integration of care (primary care, acute care, chronic care, mental health, substance abuse services, and disability and long-term services and supports) is an effective approach to pursuing the triple aim: improved health quality, better experience of care, and lower costs. (*Sources: Commonwealth Care Alliance, SNPs)*

- DLTSS helps prevent the need for care in more expensive, acute care settings - thus improving a person's well-being, improving quality of care, and controlling health care costs.

- *Research has shown that environmental and socioeconomic factors are crucial to people's overall health. DLTSS provide assistance related to these factors on an individualized basis.*
  - *For example, people that are employed tend to be healthier and therefore have lower utilization of health care services. Other social determinants of health include financial resources, housing, education, safety, nutrition, and access to transportation. (Source: IBM Cúram Research Institute, 2013)*

DLTSS-Related Services Covered by Medicaid

- DLTSS-related specialized services funded by Medicaid include, but are not limited to:
  - Assistance with activities of daily living (e.g. personal care, eating, grocery shopping, food preparation, money management)
  - Mental health counseling
  - Crisis services
  - Medication management
  - Substance abuse treatment
  - Assistive Technologies
  - Employment and Housing Supports
  - Residential Services
  - Nursing Home Care
  - Support during medical services (primarily DS)
  - Assistance to make connections in the community
  - Case Management & Coordination
- Some individuals who meet stringent clinical/level of care and/or funding priority criteria receive DLTSS through Medicaid-funded specialized programs (CfC, DS, CRT, TBI, and SED)
- Any Medicaid enrollee can receive some of these DLTSS on an as-needed basis through Medicaid fee-for-service benefits

DLTSS Providers

- Specialized mental health, developmental disability, and substance abuse treatment services and supports are provided by:
  - 11 Designated Agencies and 6 Specialized Service Agencies

- Other long term services and supports are provided by diverse groups:
  - 112 Residential Care Homes
  - 36 Therapeutic Community Residences
  - 40 Nursing Homes
  - 12 non-profit Home Health Agencies
  - 1 for-profit State-wide Home Health Agency
  - 5 Area Agencies on Aging
  - 14 Adult Day Providers
  - Substance Abuse Providers
  - Traumatic Brain Injury Providers
  - Durable Medical Equipment Providers
  - Vocational Rehabilitation
  - 6 Designated Regional Housing Organizations and 16 Housing Authorities and Land Trusts
  - Vermont Center for Independent Living and other peer support and advocacy providers and organizations
  - Guardians – both public and private
  - Thousands of direct care/personal care workers who work directly for elderly and disabled individuals or their family
  - Other independent practitioners and providers (e.g., mental health, rehabilitation, physical and occupation therapy)

Gaps, Barriers and Disincentives in Receiving Services

- For most people, DLTSS for individuals with more than one condition are managed by different state agencies and community providers
- Many individuals (and their families) must navigate through different provider systems (e.g., Medical, Mental Health, Developmental Disability, Home Health, DME, Area Agencies on Aging, Centers for Independent Living, Vocational Rehabilitation, Housing Providers) to try to get all their needs met
- The network of DLTSS providers is complex, multifaceted, specialized, isolated from other service providers, and confusing to the average consumer. Few providers in the DLTSS network evaluate a person's overall situation in order to arrange for the right combination of services based on one's actual needs. Instead, access to services is often organized in relationship to their funding streams. (*Commission on Long-Term Care, September 2013 Report to Congress*)
- Many people with DLTSS needs do not have case management or other DLTSS:
  - *They do not meet clinical and/or financial criteria for Medicaid Specialized Program eligibility (i.e., people who are not able to get developmental services due to the increasing restrictions on Funding Priorities in the State System of Care Plan, or are not eligible for CfC, CRT, TBI or SED services due to strict clinical criteria)*
  - There may be limitations on the availability of Medicaid resources for case management or other services related to health and well-being (e.g., employment supports, adult dental care)
  - Medicare and Commercial insurance do not typically cover case management or DLTSS
- Those enrolled in Medicaid Specialized Programs (i.e., CfC, CRT, DS, TBI, SED):
  - May have multiple case managers and treatment plans that do not inform each other (e.g., medical care vs DLTSS needs)

Basis for Design of Proposed DLTSS Model of Care

- Person-Centeredness the person is at the center of his/her care planning and Person-Direction the person is actively involved in how his/her care is delivered - both as the Foundation
  - Builds on Vermont's DLTSS current emphasis on self-determination and that people have a right to live meaningful lives in their communities
- Builds on Strengths of Existing Vermont System of Care and Health Care Reform Elements (e.g., Blueprint, Community Health Teams, SASH, Medicaid Health Home "Hub and Spoke" model; DLTSS system of care)
  - Utilizes existing Vermont Waiver population care models and guidelines promulgated by the State departments (i.e., DAIL, DMH, DOH) responsible for these specific populations (i.e., CFC, DS, TBI, CRT and Substance Abuse)
  - Augments and develops additional mechanisms to address identified barriers, using national evidence-based strategies
- Vermont Dual Eligible Demonstration Work Group Discussions and Products:
  - Person-Centered Care Work Group, Person-Directed Work Group and Essential Components of Person-Directed Approach Report
  - Service Delivery Model Workgroup
  - Individual Assessment & Comprehensive Care Plan Workgroup
- DVHA Medicare-Medicaid Plan Model of Care Submission to CMS (as part of DE Demonstration)
  - DVHA Model of Care approved by CMS and NCQA (March, 2013) for three years (highest approval range) with a score of 96%

Access to Independent Options Counseling & Peer Support

- Provide independent, easy-to-access information and assistance to assist individuals and families/caregivers to:
  - Understand insurance options, eligibility rules and benefits
  - Understand specialized program eligibility rules
  - Choose services
  - Choose providers
  - Navigate the delivery system
  - Obtain information and on-going peer support regarding self-management of services and supports
  - Make decisions about appropriate long-term care choices
- Examples:
  - Aging and Disability Resource Connections (ADRCs) Member Organizations, such as:
    - Area Agencies on Aging
    - Vermont Center for Independent Living
    - Green Mountain Self Advocacy
    - Vermont Family Network
    - Brain Injury Association of Vermont
  - Peer-run Mental Health Programs
  - Health Care Advocate Office, Long-term Care and Mental Health Ombudsmen

What should improve under this MOC?

- Beneficiary experience:
  - Increased involvement in decision-making
  - Decreased frustration regarding care coordination and access to services and supports due to integrated service delivery
  - Routine and timely primary care visits
  - Support during care transitions
  - Increased overall satisfaction with services and supports
  - Decreased out-of-pocket costs (e.g., fewer co-pays for ER, other services)

- Staff experience:
  - Increased efficiency regarding assisting consumers
  - Improved collaboration and communication between the medical and DLTSS systems of care

- Improved Consumer Outcomes:
  - Decreased emergency room utilization
  - Decreased avoidable hospital admissions / re-admissions
  - Decreased nursing home utilization
  - Increased appropriate use of medication

- Decreased Provider Cost-shifting across Payers
  - Due to more service oversight and coordination across all of the individual's medical and DLTSS needs via a single point of contact, comprehensive care plan, and integrated care team

- Decreased Overall Costs for Health Care System

Employment as Determinant

- Healthier, More Content, Individuals
- Less Costly, More Productive Individuals
- BTW: Societal Economic Stimulus – Increase in Consumer Spending, etc.

Eliminate Employment Barriers in Federal/State Programs

- Examples: SSI, SSDI, Medicaid Buy-in/Medicaid for Working Persons w/ Disabilities (MWPD)
- Encourage Employment to Extent Possible
- Maintain Adequate Health Care Availability

Medicaid for Working Persons with Disabilities (MWPD)

Aka Medicaid “Buy-in” for PWD

Medicaid for WPWD

MWPD Program

Purpose:

- Work Incentive for PWD
- Community inclusion and independent living through employment and heightened socioeconomic productivity
- Allow PWD who can/desire to work to maintain health care benefits (insurance) at affordable cost
- http://www.acl.gov/NewsRoom/blog/2014/2014_10_27.aspx
- The Administration for Community Living (ACL) Blog, in honor of Disability Awareness Month, reviewed the benefits of the Medicaid Buy-In Option. he Blog states, "The Medicaid Buy-In program continues to provide workers with disabilities an opportunity to improve their economic well-being and achieve a better life. Inspired through the independent living movement, the Medicaid Buy-In program is an optional State Medicaid benefit group for workers with disabilities who have earnings in excess of traditional Medicaid rules. So people with disabilities who would be ineligible for Medicaid because of earnings can work and access the services and supports they need. Ideally, it means workers with disabilities do not need to choose between healthcare and work.

MWPD ("Buy-in") Eligibility Requirements

- BBA (Section 4733) 1. Family income (based upon size) less than 250% of FPL (generally subject to premiums at 150% of FPL)
  2. Meets definition of disabled under SS Act and eligible for SSI (except for earned income)
  3. If not receiving/eligible for SSI (not necessary), states decide upon "disabled" determination
- TTW/WIIA: for individuals 16-64 years of age; states can set income/resource limits

Vermont's MWPD

- SFY 2015: GMCB: some review authority over Medicaid benefit "packages"
- MWPD established under Federal Balanced Budget Act of 1997

Vermont's MWPD Program

- Created Jan. 1, 2000 under authority of BBA of 1997, Section 4733 and VT Act 62 of 1999
- As of 9/30/2008: 684 (estimated 68% of potential, given employment patterns among PWD) beneficiaries/enrollees – most (90%-95%), but not all, "dually eligible" for Medicare/Medicaid

VT MWPD vs. Other States

- Based upon comparisons with 35 other state Medicaid “Buy-in” programs for PWD, VT’s MWPD program has *more restrictive eligibility criteria than most:*

  1. 25 states: greater entry-level asset limits

  2. 15 states disregard spousal income

  3. 17 states disregard spousal assets

  4. 23 states have a grace period/ work-stoppage protections (e.g. periods of unemployment/hospitalization)

- VT does, though, have relatively great population coverage among potential beneficiaries

VT MWPD Barriers (Disincentives) to Employment

- Restrictive income/asset limits
- Lack of spousal asset/income disregards (both for sake of MWPD beneficiary *and* non-MWPD Medicaid eligible spouse)
- Lack of reasonable "grace period" or work stoppage protection
- Lack of clearly delineated rules regarding DD services among MWPD beneficiaries
- Dropping of State payment of Part "B" Medicare premiums for many MWPD beneficiaries.

  Note: significant potential savings to State estimated (pending cost analysis) to be derived from State assuming payment of Medicare Part "B" premiums for *all* MWPD beneficiaries; however, if "dual eligibles" program design is implemented, distinction becomes blurred between Federal and State costs for this population - point may become mostly moot!
- Limited outreach to potential beneficiaries with regard to availability of VT MWPD program

Considerations for Elimination of Work Disincentives

- Although a dearth of State data to reinforce rationale exist, national analyses have shown that higher employment rates are associated with:
- 1. higher earned income limits
- 2. shorter grace periods
- 3. more stringent work verification requirements
- After 2005/6 enhancements to VT MWPD program, no observable rate of growth in enrollees
- Preliminary data (i.e. cost/benefit analysis) show that for every $1 on new Medicaid claims/benefits, earning increase by $1.23 (Tim Tremblay – 8/2/2006)

Advocacy/Legislative Action

- Based upon 2008 legislative bill (S.279), Department of Disabilities, Aging and Independent Living (DAIL) - in conjunction with DVHA and DCF - voluntarily agreed to submit report to legislature on possible changes to the State MWPD program to enhance work incentives/eliminate disincentives.
- Report submitted to legislature in January, 2009.
- Research and analysis led to 7 discrete recommendations to enhance work incentives/eliminate work disincentives – 3-4 considered possibly not to require additional ongoing State expenditures; one possibly cost-saving to the State.

Advocacy/Legislative Action (Cont.)

- DAIL verbally agreed to implement a few “cost-neutral” changes on an Administrative basis (e.g. those requiring simply a change in Medicaid rule).
- Due chiefly to staffing shortages, caused by recessionary pressures (RIF’s, etc.), DAIL postponed implementation of any changes to the MWPD program.
- H. 422 and S.89 introduced in 2011 legislative session calling for DAIL/DVHA/DCF to conduct cost-analyses and other measures implicit in the 2009 report to the legislature prior to implementation of any work incentive enhancements. Legislation pending during 2nd year of biennium.
- MIG Supplemental grant of $250,000, applied for and obtained from CMS by State Voc Rehab allows independent contractor to perform data analyses as stipulated in H. 422/S. 89. May also pay costs associated with implementation (e.g. necessary IT adjustments to DVHA/DCF infrastructure).

Impediments

- Internal DAIL/DVHA/DCF analyses:

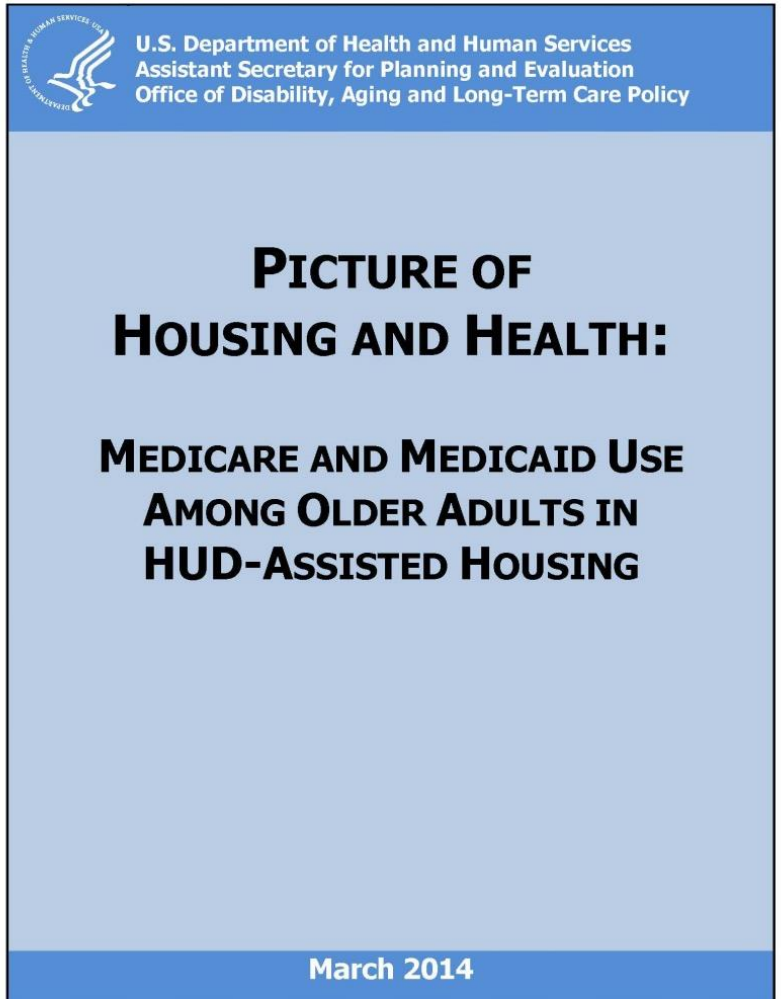
  1. Continued Payment of Part “B” Medicare Premiums – slight COST to state

  2. Other data could NOT be culled due to insufficiencies of inflexible state IT system; hence, enhancement of work incentives/changes to MWPD program postponed
- New initiative to incorporate necessary data into newly implemented flexible IT system, along w/ all non-MAGI aged, blind and disabled data
- Delays due to IT issues; ultimate goal: demonstrate cost-effectiveness and proceed with enhanced work incentives w/i MWPD program

Summary/Conclusion

- Increase in socioeconomic productivity over long run by heightening employment among PWD – through eliminating disincentives inherent in Federal/state programs (as Medicaid) – should benefit society as a whole and reduce entitlement costs:
- Greater consumer spending; increase in public revenue without raising tax rates; less need for costly institutionalization as more PWD become self-sufficient and able to live independently; a decrease in associated costs of emergency room visits by uncovered individuals, emergency housing costs and, possibly, Corrections System expenditures.
- Enhancing work incentives in VT State MWPD program, as is currently being explored, could further this trend.

Social Circumstances and Health



- PMPM costs for Medicaid FFS were 32% higher for HUD-assisted (HA)
- Of the HA Medicare beneficiaries, 68% were dually eligible
- 55% of HA had 5+ chronic conditions
- Medicare costs 16% for HA due to higher usage

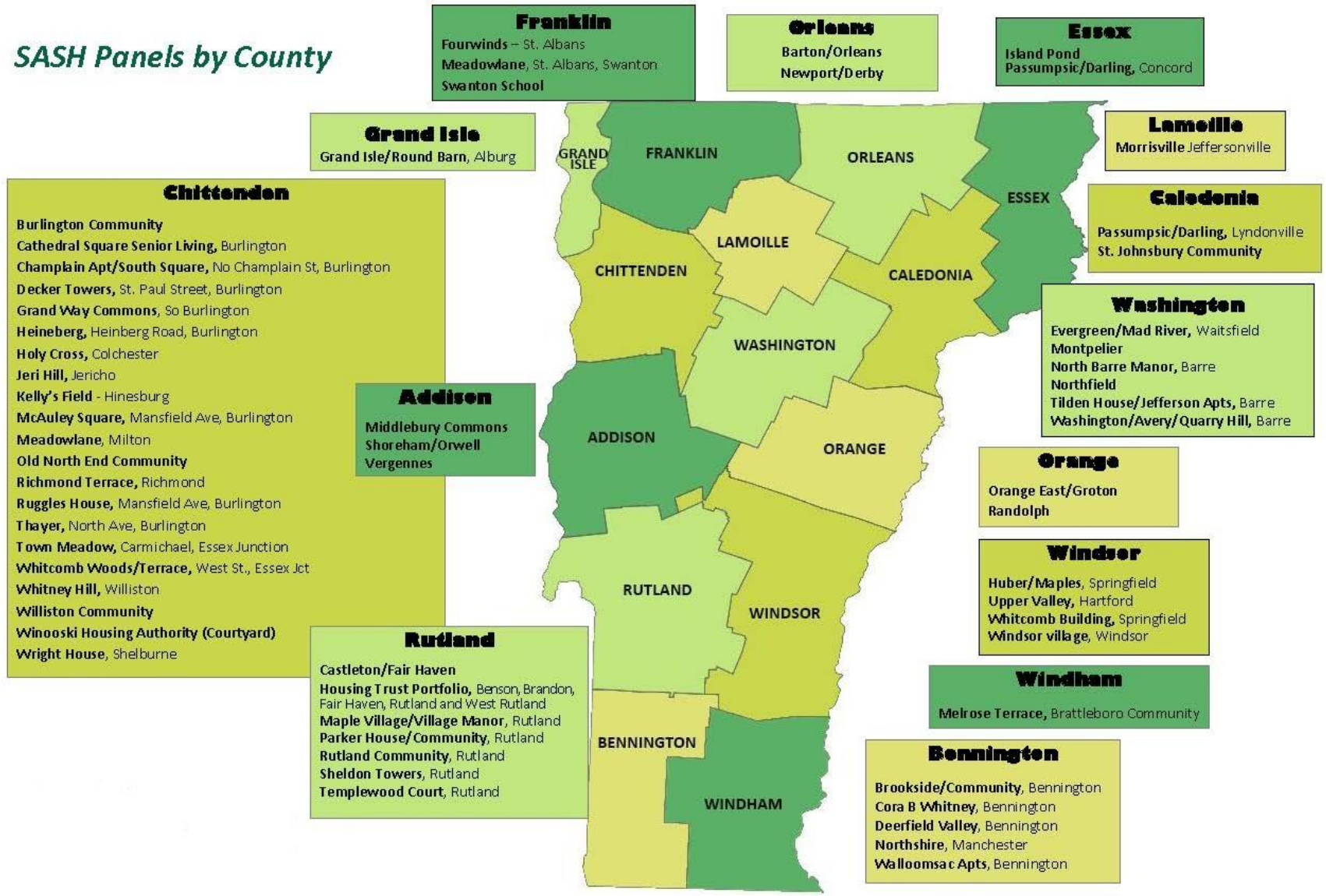
SASH Keeps “Katie” in the Driver’s Seat

SASH Staff = Trusted Guides

Consistent presence of SASH staff and SASH team builds knowledge and trust.


WRIGHT
HOUSE

SASH at 118 Locations Statewide

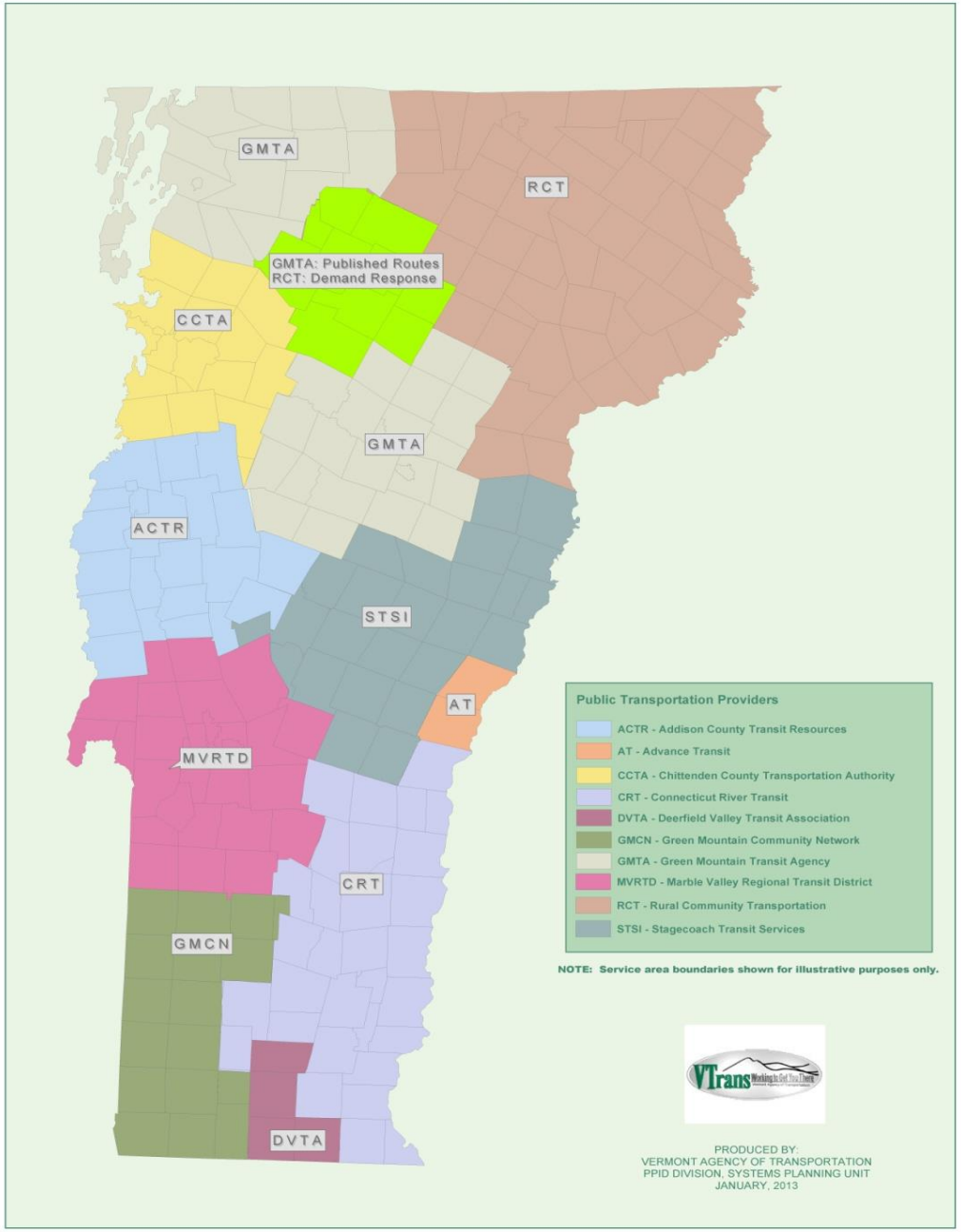


Building the System's Infrastructure

WHAT TRANSIT DO WE HAVE IN VERMONT?

- It all depends on where you live and what you're willing to do to ride.
- Transit of various types covers all of Vermont
- City buses, fixed route
- Intercity buses, fixed route
- Commuter routes
- Demand Response
- Volunteers

Vermont's Public Transportation Providers



WHERE DOES THE MONEY COME FROM?

- There are approximately 8 sources of money for transit in Vermont.

  - 1. The Vermont Agency of Transportation receives money from the Federal Transit Administration (DOT) to distribute.
  - 2. The Vermont Agency of Transportation budgets tax money for the transit providers through it's yearly approval process from the legislature.
  - 3. The Agency of Human Services (AHS) DVHA program (health access – Medicaid) purchases transportation for its members for appointments.
  - 4. The AHS various departments purchase transportation for a variety of their programs.
  - 5. Various businesses and institutions contribute large sums of money to ensure their areas get transportation.
  - 6. Local municipalities contribute funds to their local service providers.
  - 7. Various social service groups pay for transportation for their clients.
  - 8. Many riders make contributions or pay fares to assist with the cost.

WHAT IS VTRANS DOING TO PROVIDE MOBILITY TO VERMONT?

- Established transit providers in each region with routes that are regional.
- Funding for multiple modes of transit, volunteers, demand response, fixed route, commuter runs, go!Vermont, intercity
- Information service to answer questions and connect people to answers,
  - go!Vermont info line 800-685-RIDE (7433)
  - go!Vermont website www.connectingcommuters.org
  - State website publictransit.vermont.gov/providers#buses

- A “one-click/one-call” clearinghouse for all efficient transportation options in Vermont
  - Carpool Matching,
  - Single ride matching
  - Vanpool program
  - Links to bus schedules
  - Park and Ride locations
  - Drive electric Vermont
  - Call Center Assistance 1-800-685-RIDE (7433)
  - Web-based program

SOME IDEAS TO MAKE IMPROVE PUBLIC TRANSIT ACCESS

- A planning tool so people can optimize how to get where they want to go.
  - UVM is collaborating with VTrans to create an individual planning process which will be easily available on the web and perhaps even an app.
- A way to pay for service
  - Perhaps a personal account which resolves the need for paying cash or needing to qualify for each ride in order to obtain it.
  - A statewide fare card system
- A training program that allows people to practice riding various systems to determine which ride works best for them for which purpose.

- ***Public Transportation Policy***
- http://www.leg.state.vt.us/statutes/sections.cfm?Title=24&Chapter=126
- § 5081 Definition
- § 5082 Findings and declarations
- § 5083 Declaration of policy
- § 5084 Public Transit Advisory Council
- § 5088 Definitions
- § 5089 Planning
- § 5090 Human service transit
- § 5091 Funding
- § 5092 Reports
- § 5093 Rules
- § 5094 Powers of Secretary of Transportation
- Full text of Chapter 126.

Chap[illegible] 126: PUBL[illegible] TRAN[illegible]PORTATION

THE [illegible]ERMONT STAT[illegible]TES
TITLE [illegible]24:
MUN[illegible]IPAL AND COU[illegible]TY GOVE[illegible]RNMENT

§ 5083. DECLARATION OF POLICY, PUBLIC TRANSIT GOALS

- (1) Provision for basic mobility for transit-dependent persons, as defined in the public transit policy plan of January 15, 2000, including meeting the performance standards for urban, suburban, and rural areas. The density of a service area's population is an important factor in determining whether the service offered is fixed route, demand-response, or volunteer drivers.
- (2) Access to employment, including creation of demand-response service.
- (3) Congestion mitigation to preserve air quality and the sustainability of the highway network.
- (4) Advancement of economic development objectives, including services for workers and visitors that support the travel and tourism industry. Applicants for "new starts" in this service sector shall demonstrate a high level of locally derived income for operating costs from fare-box recovery, contract income, or other income.