

# ***The Impact of Health Reform on the High-Risk Geriatric Population***

Reducing hospital readmissions and improving outcomes through increased use of non-skilled services

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The Patient Protection and Affordable Care Act (HR 3590) is going to require health care providers to seriously change their thinking. One of the biggest thought changes will involve the use of non-skilled services. In fact, non-skilled services, which are currently underused, will play a central role under health reform. Regardless of whether your organization is a large hospital system, physician practice group or small independent provider, you need to understand how comprehensive non-skilled services will become a vital part of your continuum.

## **Hospital Overuse**

Using non-skilled services is about to become so important due to the overuse of emergency department (ED) visits and hospital readmissions for the high-risk geriatric population. People age 75 and over accounted for 60 ED visits per 100 individuals in 2006.<sup>1</sup> In addition, 20 percent of Medicare beneficiaries who were discharged from the hospital were readmitted within 30 days, according to an article in *The New England Journal of Medicine*.<sup>2</sup>

Why do ED visits and hospital readmissions continue to happen when several services could support seniors once they leave the hospital? It's because Medicare requires the majority of those services to supply a physician-certified skilled need to qualify for reimbursement. But most high-risk seniors have non-skilled needs after hospital discharge. Studies confirm that frail older people who live without help for their activities of daily living have higher rates of hospital admissions while they are living with unmet ADL needs but not after those needs are met.<sup>3</sup>

Further, if post-discharge skilled services are necessary, it's generally on a short-term basis until the skilled need is met. Then the patient is discharged from skilled care without essential non-skilled services in place, which results in declining status and an eventual visit to the hospital ED and/or unplanned hospital readmission. This pattern is continued until the patient ultimately declines to the point of needing long-term placement in a skilled care facility.

## Current State of Home and Community Based Services (HCBS)

There's a current system in place to prevent these types of hospital ED visits and readmissions. Under the Medicaid payment structure, states are federally mandated to provide certain services. Like Medicare, these mandatory state plan services don't cover the Medicaid-eligible high-risk geriatric population's non-skilled needs. To address this issue, the majority of states provide additional services through a HCBS waiver plan. But this plan isn't working the way it should for several reasons. This waiver system, because it's separate from the mandatory Medicaid state plan, is vulnerable to each state's Medicaid budget shortfalls and is therefore chronically under funded. Consequently, several Medicaid and/or dually-eligible (Medicare and Medicaid) seniors who need non-skilled services in the U.S. don't get them because of lengthy waitlists and capacity issues.

These HCBS issues mean that most high-risk seniors—those who are dependent on Medicare, Medicaid or a combination of both—don't have access to non-skilled services to the degree that is necessary. In addition, access to essential non-skilled services is almost entirely dependent upon the availability and willingness of a (usually unpaid) caregiver or on the person's ability to pay privately for services.

For example, consider adult day health care, a dramatically underused service that can address the skilled and non-skilled needs of high-risk seniors. While 21 percent of adult day health centers are based on the medical model of care, 37 percent are based on the social model of care (with no medical component) and 42 percent are a combination of both. At an average cost of \$56/day, adult day health is an extremely cost-effective model. In fact, it's a fraction of the cost of other services that provide far less daily hours of care. And yet, with 3,407 existing adult day health care centers, studies indicate that the U.S. needs an additional 5,113 centers to meet demand<sup>4</sup>. In essence, adult day health care isn't used as often because the Medicare benefit doesn't cover it; and, for Medicaid beneficiaries, the adult day health benefit is subject to restriction and capacity issues related to the HCBS waiver. In some states, the HCBS waiver doesn't cover adult day health at all. Only a small majority of states have adopted adult day health as part of their Medicaid state plan.

## HR 3590 & Other Projects

This lack of using non-skilled services to their potential is about to change, however, due to provisions in HR 3590, the Patient Protection and Affordable Care Act. To optimize payments, providers must understand how to integrate non-skilled services. The newly restructured payment methodology depends on providers leveraging the full continuum, including skilled and non-skilled services.

Several components of HR 3590—and other recent demonstration projects—also support this renewed interest in non-skilled service delivery. Consider the following information on Medicare and Medicaid programs.

1. The Medical Adult Day Care Services Demonstration. This demonstration project, based upon HR 3043 (The Medicare Adult Day Services Act of 2009), allows home health agencies (HHAs) to partner with medical adult day health facilities for a portion of home health services for Medicare beneficiaries. To date, hospitalization rates in some of the project sites have declined by as much as 47 percent<sup>5</sup>.

This project is the most significant movement between Medicare and adult day health in recent history. If passed, the legislation will signal that the government recognizes adult day health as an integral component of the continuum. HHAs could use this legislation effectively under the National Pilot Program on Medicare Payment Bundling.

2. National Pilot Program on Medicare Payment Bundling. Beginning in 2013, this voluntary five-year pilot program will provide a single payment for a bundle of services around hospital stays, three days prior and 30 days post-discharge.

Officials will select conditions based upon the opportunity to improve quality of care and reduce hospital readmissions or the high cost of post-acute expenditures. Participants must be providers of acute-care hospital(s), physician groups, skilled nursing facility and a HHA.

3. Federal Coordinated Health Care Office. The establishment of this CMS office shows an effort to improve coordination between the federal government and states. Effective March 2010, the government has charged this office with more effectively integrating Medicare and Medicaid benefits. Office staff must recommend legislation to Congress that would improve care coordination and benefits for dual-eligible people. Industry experts anticipate that this office will widely discuss and address the coverage gap for non-skilled services.
4. Independence at Home Demonstration. This Medicare demonstration, to begin in early 2012, will test physician and nurse practitioner directed home-based primary care and care coordination across all treatment settings. Medicare intends for it to help reduce preventable hospital admissions, improve health outcomes and reduce the costs of health care services. If providers can show a 5 percent cost savings by reducing preventable hospitalizations and readmissions for qualifying Medicare beneficiaries, they'll receive payment incentives under Medicare Part B. To qualify, beneficiaries must have two or more chronic conditions and two or more functional dependencies.
5. Medicare Shared Savings Program. Non-skilled service providers, either directly or through contractual relationships, will likely be essential components of models such as the Accountable Care Organization (ACO). Becoming part of an ACO allows providers to participate in the permanent Medicare Shared Savings Program. To qualify for shared savings, ACOs must meet certain criteria and exceed more than some minimum level of Medicare savings and quality.
6. Medicaid Community First Choice Option. Beginning in late 2011, this state plan option will provide home- and community-based attendant (non-skilled) services and supports to people who need an institutional level of care. This includes assistance with ADLs, instrumental activities of daily living (IADLs) and health related tasks. States participating in this program will receive a 6 percent federal matching rate (FMAP).
7. Medicaid State Balancing Incentives Payments Program. Effective October 2011, states with less than 25 percent total Medicaid long-term care spending on HCBS will get a 5 percent FMAP increase to get to 25 percent. And states with 25-49 percent total Medicaid long-term care spending on HCBS will get a 2 percent FMAP increase to get to 50 percent. The program aims to help states balance their long-term care supports and services away from institutional and toward HCBS, of which non-skilled services are a critical component.

All of these projects, along with HR 3950, are putting renewed emphasis on skilled services. If you haven't done so already, start looking for more ways to use HCBS. Understanding how HCBS fits into the continuum now will help you succeed in the new era of health reform.

## References

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