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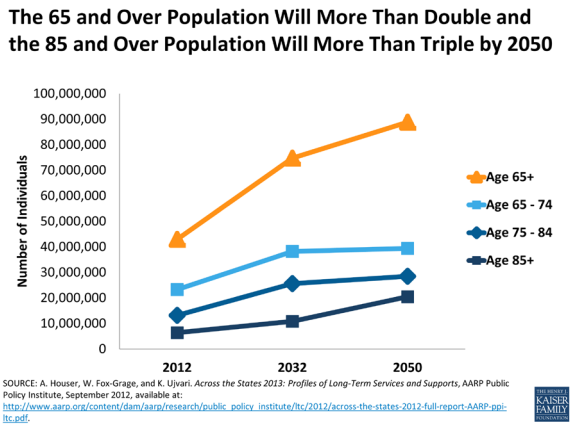
Aging in Place: Senior Care Options Plans and the Dual-Eligible Population in Massachusetts

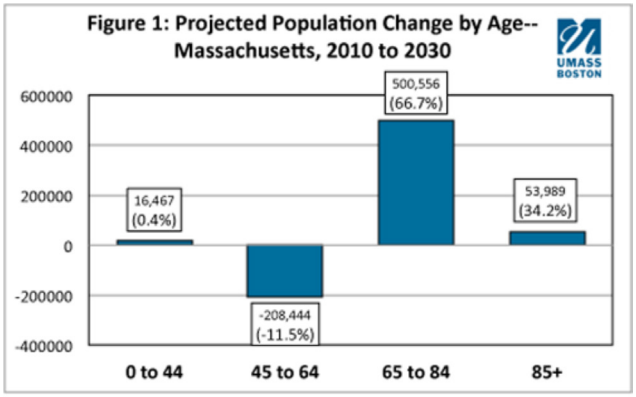
In Massachusetts and across the nation, advances in assistive and medical technology and greater access to health care coverage and services have contributed to longer life spans and more opportunities for seniors to age in place — to live in their own homes and communities safely, independently, and comfortably, regardless of age, income, or ability level.[1] Over the next 30 years, the population of US residents over 65 years of age will increase significantly. The population age 65 and older will nearly double, those age 80 and older will nearly triple, and the number of people in their 90s and 100s will quadruple.[2] In Massachusetts, the number of seniors is expected to grow by 61% by 2030, indicating that the state's population is aging faster than the US population overall.[3]

National



SOURCE: A. Houser, W. Fox-Grage, and K. Ujvari. *Across the States 2013: Profiles of Long-Term Services and Supports*, AARP Public Policy Institute, September 2012, available at: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf.

Massachusetts

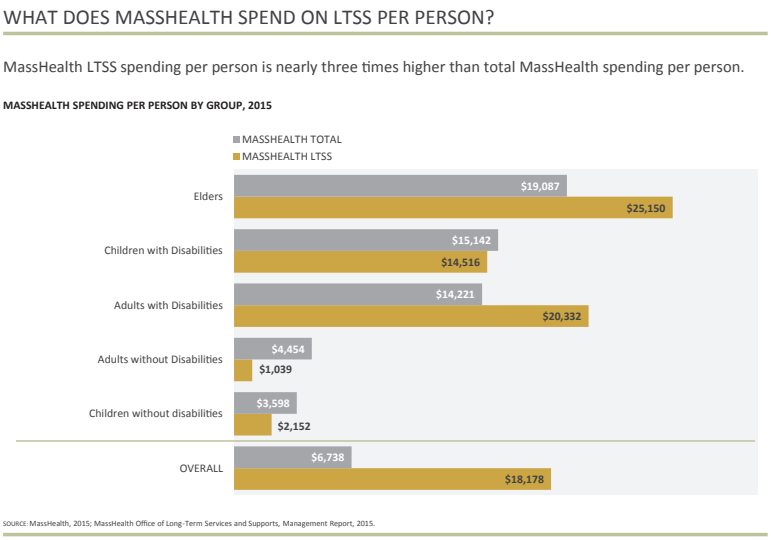


Source: U.S. Census, Interim Projections, 2005.

As the population ages, the number of individuals eligible for Medicare will grow, increasing both total and per capita Medicare spending, raising deep concerns about the sustainability of the Medicare program without programmatic or funding interventions. The very advances that allow individuals to be more independent and live longer, combined with the aging population, will likely result in an increased need for long-term services and supports (LTSS) over the coming decades. Studies from the Congressional Budget Office estimate that population aging is expected to account for a significant portion of spending growth on the nation's major health care programs, including increases in Medicaid spending largely attributable to the cost of LTSS not covered by Medicare.[4,5] To meet the needs of an aging population and curb health care spending growth, state and federal policymakers will need to focus on ways to improve coordination of care for high-need, high-cost patients. Policymakers across the nation can learn from the Massachusetts Senior Care Options (SCO) demonstration, now a permanent program serving dual-eligible individuals over 65 years of age.

Who Are the Dual-Eligibles?

Dual-eligibles are individuals who qualify for both Medicare and Medicaid. They are eligible for Medicaid because of their low incomes and limited assets, and they qualify for Medicare by either meeting the age requirement or receiving Social Security Disability Insurance, usually due to a disability. Medicare is the primary payer for acute and post-acute care services, while Medicaid covers services not included in the Medicare benefit package. Medicaid may also provide varying levels of assistance with Medicare premiums and cost sharing for individuals who meet certain income requirements.



Today, there are more than 10.7 million people in the United States who are dually eligible for both Medicare and Medicaid coverage,[6] and they include some of the sickest, frailest, and most vulnerable populations covered by either program. Dual-eligibles are more likely than other Medicare beneficiaries to have multiple chronic conditions, report poorer health status, and have more limitations with regard to their activities of daily living. Because of their acuity, dual-eligible beneficiaries account for a disproportionate share of Medicare fee-for-service (FFS) expenditures, despite being a fraction of the Medicare FFS population. Nationally, dual-eligibles accounted for 18% of the Medicare FFS population in 2012 but represented nearly 31% of aggregate Medicare FFS spending.[7]

In Massachusetts, the dual-eligible population accounts for nearly one third of all MassHealth spending, with MassHealth serving as the largest payer of LTSS in the state. In 2015 alone, LTSS spending accounted for $4.5 billion or 12% of the entire state budget and approximately 33% of the entire Medicaid budget. National estimates project the rate of spending growth for Medicaid LTSS to be more than three times that of Medicaid overall.[8]

As the population in Massachusetts ages, programs that offer expert coordination of care by trained professionals to manage essential skilled and unskilled services are fundamental to ensuring individuals are able to age in place and receive high-quality, necessary care.

Facing the Challenge: Community First While Curbing Costs

In 2004, Massachusetts launched its SCO program, a demonstration for dual-eligible individuals that has since become a permanent program. SCO is available to Massachusetts residents age 65 and older who are covered by MassHealth Standard alone or MassHealth Standard and Medicare. SCO plans are managed care plans that provide comprehensive health care coverage for all of the services normally paid for by Medicare and MassHealth, including care coordination and specialized geriatric support services, along with respite care for families and caregivers. Massachusetts has long sought to enable elders and persons with disabilities to live with dignity and independence in the community by expanding, strengthening, and integrating systems of community-based long-term supports that are person-centered and provide optimal choice. The *Community First Plan*, based on the federal *Olmstead Community Decision* was finalized in 2008 and is the Commonwealth's mechanism for implementing the *Olmstead* decision. The *Community First Plan* seeks to maximize the extent to which elders and persons with disabilities can successfully live in their homes and communities through the provision of choice.[9] However, a central challenge of the community first policy is ensuring that those who are dual-eligible can access the appropriate home- and community-based services and supports needed to keep them healthy and in the community.

The SCO program is one approach to meet that challenge, and today, 14 states are participating in the Centers for Medicare & Medicaid Services' Financial Alignment demonstrations based on the SCO model.[10] Members access services through the SCO plan and its network of providers. SCO plans are financed by bringing together both the Medicare and Medicaid capitated payments at the plan level, and SCO plans operate at full risk under this capitated payment model that is fully integrated from the member's perspective. A SCO member has a single health plan with a single card through which they can access a wide range of integrated services traditionally offered through separate Medicare and Medicaid fee-for-service reimbursement. In addition, SCO members receive benefits not offered in the traditional FFS program, including the elimination of cost-sharing for Medicaid and Medicare Services, comprehensive dental coverage for adults when not covered by MassHealth, and coordination of and payment for transportation services for members to get to medical appointments.

The integrated financial model of the SCO program enables the SCO plans to operate a high-touch care management model, through which the plans seek to improve quality of care, reduce or avoid hospitalizations and institutional care, and decrease care duplication and poor medication management for their members. The overarching goals of the SCO program and the integrated financial model are to support individuals living in the community in the safest and most appropriate setting; SCO plans are able to assist their members in delaying or avoiding entering a nursing facility, and for those who are already in nursing facilities, SCO plans are able to assist their members in avoiding acute admissions to the emergency room or hospital. The flexibility to manage within the combined capitation rate provides SCO plans with incentives to invest in robust care management, ensure access to a broad network of providers, and offer the whole-person care needed for Massachusetts elders living in the community and in institutions.

Nationally, policymakers and stakeholders have identified essential elements of effective care models for dual-eligible populations. In 2010, the Center for Health Care Strategies detailed nine core program design elements that are critical for achieving high-quality, patient-centered, and cost-effective care for dual-eligibles, which align closely with the key elements of the Massachusetts SCO program.[11]

Core Elements of Integrated Care Programs

1. Comprehensive assessment to determine needs;
2. Personalized (person-centered) plan of care;
3. Multidisciplinary care team;
4. Family caregiver involvement;
5. Comprehensive provider network;
6. Strong home- and community-based options;
7. Adequate consumer protections;
8. Robust data-sharing and communications systems; and
9. Financial incentives aligned with integrated, quality care.

It should be no surprise then that studies confirm the value of the SCO program from the members' perspectives and from a financial perspective. Multiple studies have shown high member satisfaction with the SCO program. In an early evaluation of the program, the Center for Health Policy and Research at the University of Massachusetts Medical School interviewed SCO members, and nearly all respondents agreed that they trusted their SCO plan to help them get the help they needed, and indicated they were "quite happy with the program, the services they received, and the personnel who provided them."[12] The Massachusetts SCO plans are consistently highly ranked in the Medicare Star Ratings, with high marks for member satisfaction.[13]

In addition, several studies have illustrated the financial benefits accrued from nursing facility avoidance as a result of the care coordination services offered by SCO plans.[14,15] A 2013 JEN Associates study commissioned by the Commonwealth compared community-dwelling Massachusetts residents enrolled in a SCO plan and a control group of beneficiaries covered under the traditional FFS Medicaid and Medicare programs and found that SCO enrollment is associated with a 16% overall reduction in the risk of long-stay nursing facility admission, a 23% reduction in end-of-life nursing facility entry risk, and a 17% reduction in mortality risk.[16] Data from an earlier 2008 JEN Associates study suggested that SCO enrollees who enter nursing facilities are assessed with greater functional impairments and at much higher stages of frailty upon entry, confirming the successes of the SCO program in avoiding or delaying nursing home admissions. Nursing facility care is significantly more expensive than community-based services. In 2016, the median annual cost of semiprivate nursing facility services was $135,050 versus the $57,200 annual median cost of a full-time home health aide.[17] In 2015, Health Management Associates (HMA) modeled the potential cost savings to MassHealth attributable to SCO interventions to reduce the risk of nursing facility entry, estimating $65.9 million in annual costs avoided for nursing facility admissions. HMA further estimated that MassHealth could potentially avoid another $45.1 million annually if the nursing-home-certifiable population currently receiving services through the FFS system was enrolled in SCO.[18]

Recommendations

As the state embarks on new integrated care models for the non-duals population, stakeholders in Massachusetts and across the country should continue to look to the SCO program for best practices, including:

1. Integration of the Medicare and Medicaid Funding Streams

The heart of the SCO program is the integration and alignment of incentives between Medicare and Medicaid. This unique payment model is comprised of separate capitated risk-adjusted per member payments for Medicare Part A and B covered services and for Medicare Part D prescription drug coverage, paired with separate capitated monthly payments from MassHealth, allowing SCO plans to use those funds to support their members' needs regardless of the payer. The payment structure incentivizes SCOs to provide members with lower-cost community-based alternatives, and allows members to age in place with the help of an integrated care team.

2. Person-Centered Care Coordination

Members enrolled in SCO plans have 24-hour access to care and active involvement in their care planning. As part of the SCO program, members have a multidisciplinary Primary Care Team, which often includes the member, the primary care physician, a Geriatric Support Services Coordinator, and a nurse practitioner, registered nurse, or physician's assistant. The care team has experience in geriatric practice, and coordinates medical, behavioral health, and long-term services and supports for the member. The strong care coordination model used by the SCO plans ensures evaluation and monitoring of members' individual needs and addresses disease, acute and behavioral health care services, and social determinants of health, all while ensuring the member's input is central to the care plan.

3. Steady Enrollment Growth While Preserving Program Integrity

Since its inception in 2004, the SCO program has seen steady growth in enrollment and market penetration. There are currently six SCO plans operating in Massachusetts, offering full or partial geographic coverage across a majority of the state. While there are over 50,000 members enrolled across all six plans, more than 88,000 additional MassHealth members have access to at least one SCO plan but are not enrolled.

SCO Total Enrollment by Plan As of 1/1/18	
BMC HealthNet Plan	529
Commonwealth Care Alliance	9,223
Fallon Community Health Plan SCO	6,451
Senior Whole Health	14,462
Tufts Health Plan	4,179
United SCO	19,043
Total:	53,887

The SCO program stands apart from other managed care programs in Massachusetts as a voluntary enrollment program for those individuals who are dual-eligible. However, MassHealth has begun "passive enrollment" for Medicaid-only SCO-eligible individuals. Individuals who are enrolled by the state into the SCO program with the option to opt out of the program are considered "passive enrollees." While in the early stages of passive enrollment for this population, SCO plans have seen two waves of enrollment with strong member retention and member engagement in their care plans. Massachusetts should continue to be a leader for this population, and should continue efforts to increase participation in integrated care models, move SCO-eligible individuals from the highly siloed FFS program into a model of care that rewards value over volume, and explore options, like passive enrollment for dual-eligible individuals, for growing the SCO program while preserving program integrity.

Conclusion

As the population ages and an increasing number of elders in Massachusetts seek to receive care in their homes, communities, or skilled nursing facilities, it is especially important that the state foster efficient ways to provide high-quality community first care while curbing health care costs. The Massachusetts SCO program has been a nationwide leader in coordinating, case managing, and integrating elder care, with evidence and data that demonstrates its success in fostering linkages to community services for some of the Commonwealth's most complex and medically compromised residents. The benefits of SCO are multifold: a single point of care management, integration of acute care needs with long-term services and supports, coverage of behavioral health services, and comprehensive pharmacy, vision, and dental benefits with $0 co-pays, all while supporting each individual's choice of care setting. Through fully integrated, capitated care programs, like SCO, Massachusetts is well-positioned to face the challenges of an aging population.

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