




Perspectives  
of a Health  
and Aging  
Policy Fellow  
2020/21



## 2012 o4a Annual Conference for Aging and Disability Networks

October 20 & 21 , 2021

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Hilton Columbus East @ Easton

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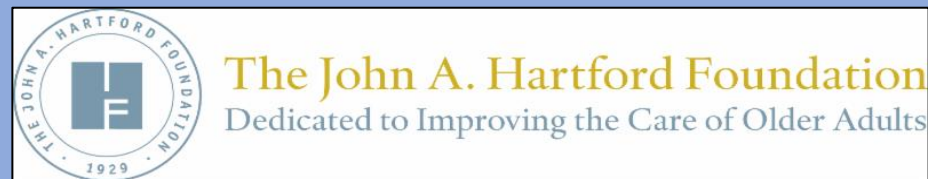
# Health and Aging Policy Fellowship

The Health and Aging Policy Fellows Program provides a unique opportunity for professionals in health and aging to gain the experience and skills necessary to make a positive contribution to the development and implementation of health policies that affect older Americans.

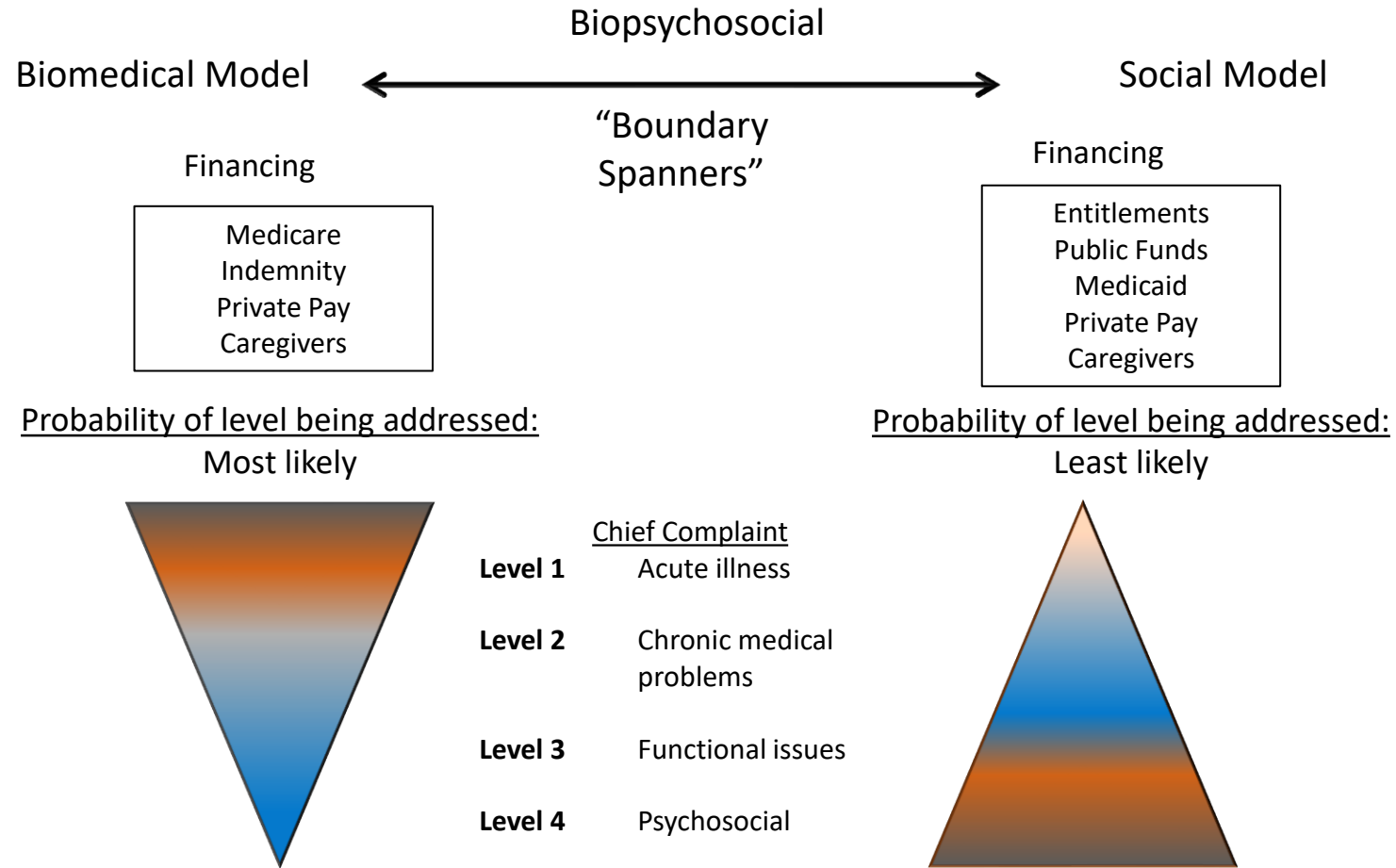
<https://www.healthandagingpolicy.org>

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 **westhealth**



# Boundary Spanning: Integrated Care Delivery





HEALTH AND AGING  
POLICY FELLOWS

# Aligning Healthcare and Social Services: Boundary Spanning Top Down and Bottom Up

**Kyle R. Allen DO, AGSF**

HAPF 2020/2021 Placements  
Center for Medicare & Medicaid Care Coordination Office  
Administration for Community Living

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**The John A. Hartford Foundation**  
Dedicated to Improving the Care of Older Adults



# Fellowship Goals

- Gain broader and more in depth understanding of policy and regulatory background of Medicare and Medicaid Integration including barriers and challenges to integration for social services and community-based organizations
  - Why did the Community Based Care Transitions CMS Demonstration not become a permanent model ?
- Participate as a seasoned professional and “boundary spanner” with community experience integrating social and medical organizations at the community, health system, and health plan interface
- Network Development with key leaders and subject matter experts



# A Grand Opportunity

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“Life is what happens to you while you’re busy making other plans” – John Lennon

**John Lennon** lyric from “Beautiful Boy” on his last album **Double Fantasy**, with **Yoko Ono**



# HAPF 2020/2021 Placements

- Original plan was to work with state and federal offices but not feasible to develop during PHE COVID 19
- 50% of placement effort at Center for Medicare and Medicaid Services (CMS), Medicare and Medicaid Coordination Office (MMCO)
- 50% of placement effort at the Administration for Community Living (ACL)
- A unique opportunity to “**boundary span**” between two of the largest federal divisions responsible for health care and social services for older adults working as a fellow within the Health and Human Services (HHS) organization, i.e. CMS and ACL



# Administration for Community Living (ACL)

<https://acl.gov>

- Mission: maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers
- Guiding principle: people with disabilities and older adults should be able to live where they choose, with the people they choose, and participate fully in their communities

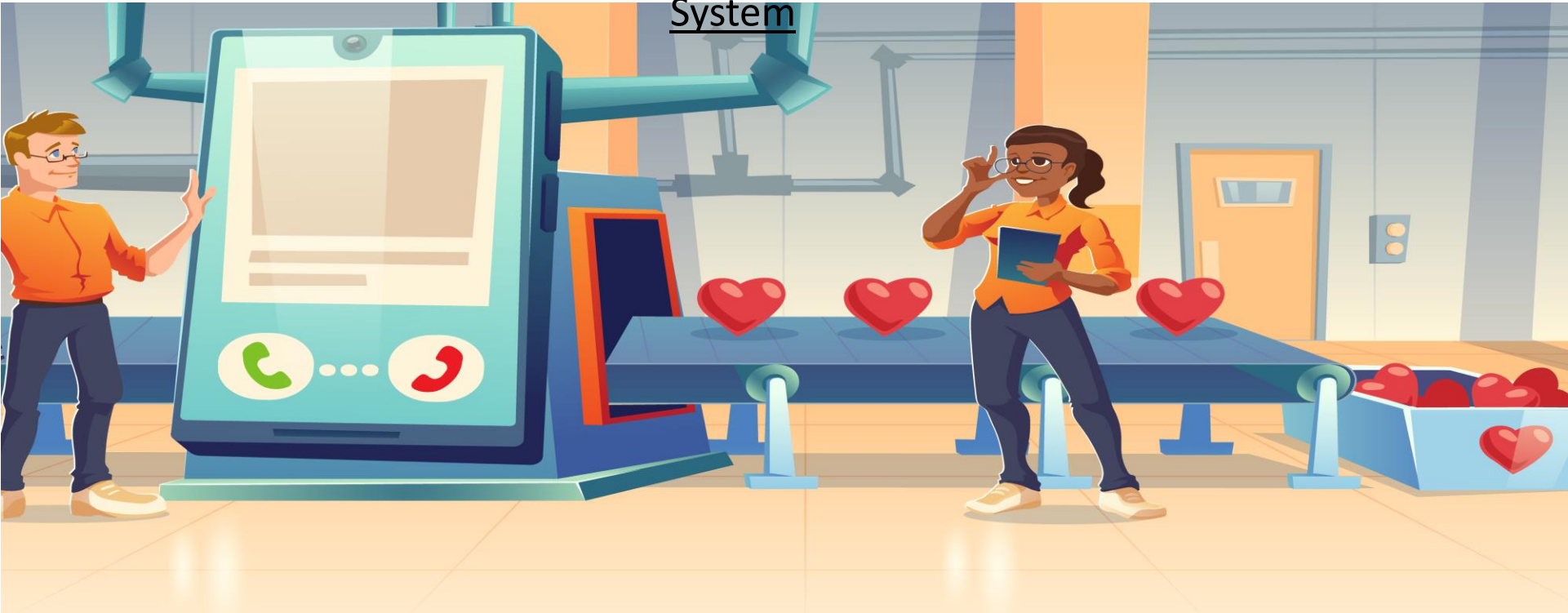




# Core Competencies and Services Offered by Aging and Disability Networks

- Acute focus on high cost, high need populations
- Robust planning and assessment, expert knowledge/navigation of complex social services system
- Core services include:
  - Assessment for SDOH needs
  - Benefits eligibility and financial resource coordination
  - Care transitions
  - Case management
  - Housing assistance (eviction prevention, supportive services, home mods)
  - Information and referral
  - Nutrition assistance (home-delivered and congregate meals, access to SNAP benefits, food banks, etc.)
  - Social isolation support
  - Transportation assistance

## Project GOAL: Creating a Sustainable SDOH Intervention Delivery System



Develop the infrastructure to support the growth of viable, sustainable, and locally governed networks of community-based organizations (CBOs) to deploy interventions that address social determinants of health (i.e., community integrated health networks)

# Key Roles

## Team:

- **Kelly Cronin**, Deputy Administrator, Center for Innovation and Partnership, HHS Administration for Community Living, ACL
- **Joseph Lugo**, Director, Office of Network Advancement, ACL
- **Kristie Kulinski, MSW**, Team Lead/Aging and Disability Program Coordinator: Office of Network Advancement & Center for Innovation and Partnership, ACL
- **Len Nichols PhD**, Non-resident Fellow Urban Institute, Consultant to ACL
- **Tim McNeil, RN, MPH**, Consultant to ACL

## My Major roles:

- Advisor, reviewer, reference gatherer, networking coordinator, meeting participant, thought leader, subject matter expert
- Member of large stakeholder group with leaders of national health plans, lead Community Based Organizations, Foundations, Associations working on a vision and plan to create a scalable and replicable model for Community Health Integrated Networks (CHIN-HUB)
- This group evolved into national Planning Group seeking to develop a proposal for planning grant funding to be submitted to leading philanthropic organizations, health systems foundations as well as health plans foundations
- The primary goal is to create the organization, processes, and entity to facilitate more integrated social and health care sector partnerships to address SDOH and improve outcomes



To Be a Leader,  
Let Them First  
Become A Bridge



## Other tasks and accomplishments

### “Boundary Spanning”

- ✓ Organized and chaired an ACL presentation to the MMCO monthly staff meeting “**Aligning Health Care and Social Services through the Growth of Sustainable, Locally Governed CBO Networks**”
- ✓ Introduced and helped to organize a presentation to the **Special Needs Plan Alliance** (SNP-Alliance <https://snpalliance.org>): “**Aligning Health Care and Social Services through the Growth of Sustainable, Locally Governed CBO Networks.**” This will lead to SNP Alliance Fall Conference Symposium
- ✓ Invited to join **Virginia Secretary of Health Stakeholder Group** regarding the creation of an independent State Office on Aging in Virginia
- ✓ Worked with **Ohio Association of Area Agencies on Aging and AAA** as an advisor regarding contracting with Social Health Assessment Referral Platforms (SHARPS)
- ✓ Presented and worked with **Indiana Department of Aging** regarding issues of CBO Integration with Duals Special Needs Plans and Managed Long-term Services and Supports
- ✓ Networking phone calls and meetings with numerous national leaders and individuals representing foundations (e.g., SCAN, Archstone) gerontology research and policy centers (Scripps Gerontology Center, SCAN) regarding this work

# Dually Eligible Individuals and the Medicare-Medicaid Coordination Office (MMCO)

Tim Engelhardt, Director

Sara Vitolo, Deputy Director

June 2021



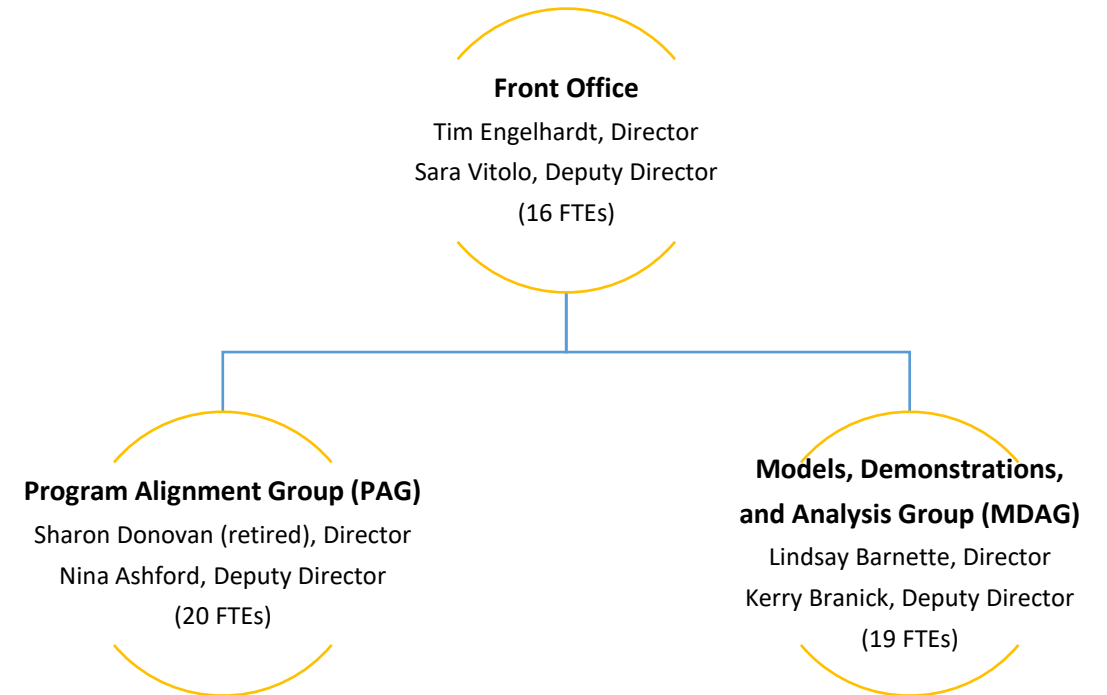
# Medicare-Medicaid Coordination Office structure

## The Affordable Care Act created MMCO in 2010 to focus on dually eligible individuals:

- Statute refers to the Federal Coordinated Health Care Office, but office formally goes by the Medicare-Medicaid Coordination Office
- Statutory purpose is “To bring together officers and employees of the Medicare and Medicaid programs at [CMS] in order to – ”
- “more effectively integrate benefits under the Medicare program...and the Medicaid program...”
- “improve the coordination between the federal government and the states for individuals eligible for benefits under both such programs...”

## The Bipartisan Budget Act of 2018 also charged MMCO with:

- Developing regulations and guidance related to the integration or alignment of policy and oversight under Medicare and Medicaid regarding Medicare Advantage dual eligible special needs plans (D-SNPs), and
- Serving as the single point of contact for states on D-SNP issues.

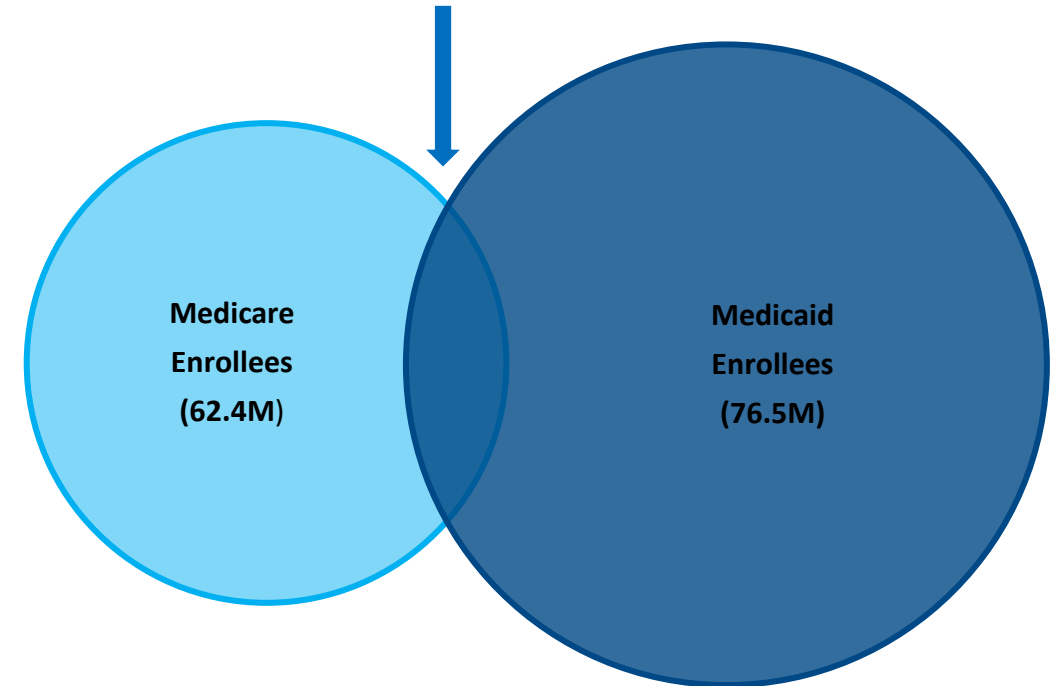


# Dually Eligible Individuals

## How it works

- Dually eligible individuals may either be enrolled first in Medicaid by virtue of income or disability and then qualify for Medicare on the basis of age, or vice versa
- Dually eligible individuals navigate two separate programs:
  - Medicare for the coverage of most preventive, primary, and acute health care services and drugs
  - Medicaid for the coverage of certain behavioral health services and long-term care supports and services (LTSS) – about half of dually eligible individuals use LTSS
  - Medicaid for help with Medicare premiums and cost-sharing through the Medicare Savings Programs
  - Where benefits overlap, Medicare is primary payer

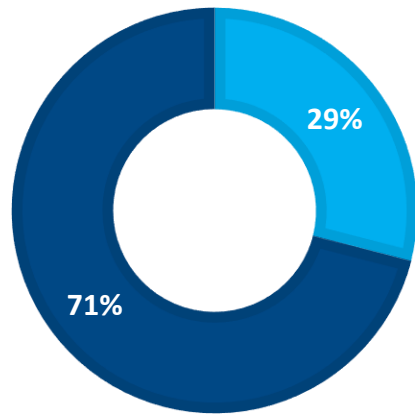
**12.3 million individuals are simultaneously enrolled in Medicare and Medicaid**



# Dually Eligible Individuals

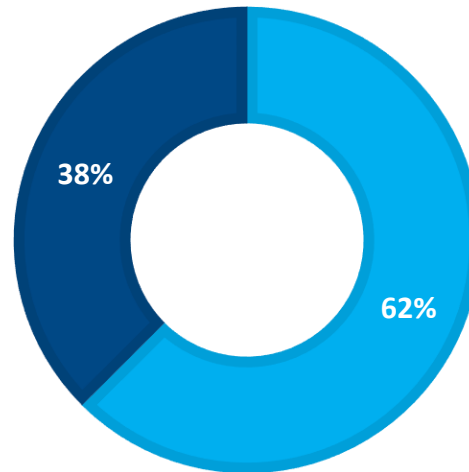
By Type of Medicaid Benefit

■ Partial-benefit ■ Full-benefit



By Initial Medicare Eligibility

■ Age ■ Disability



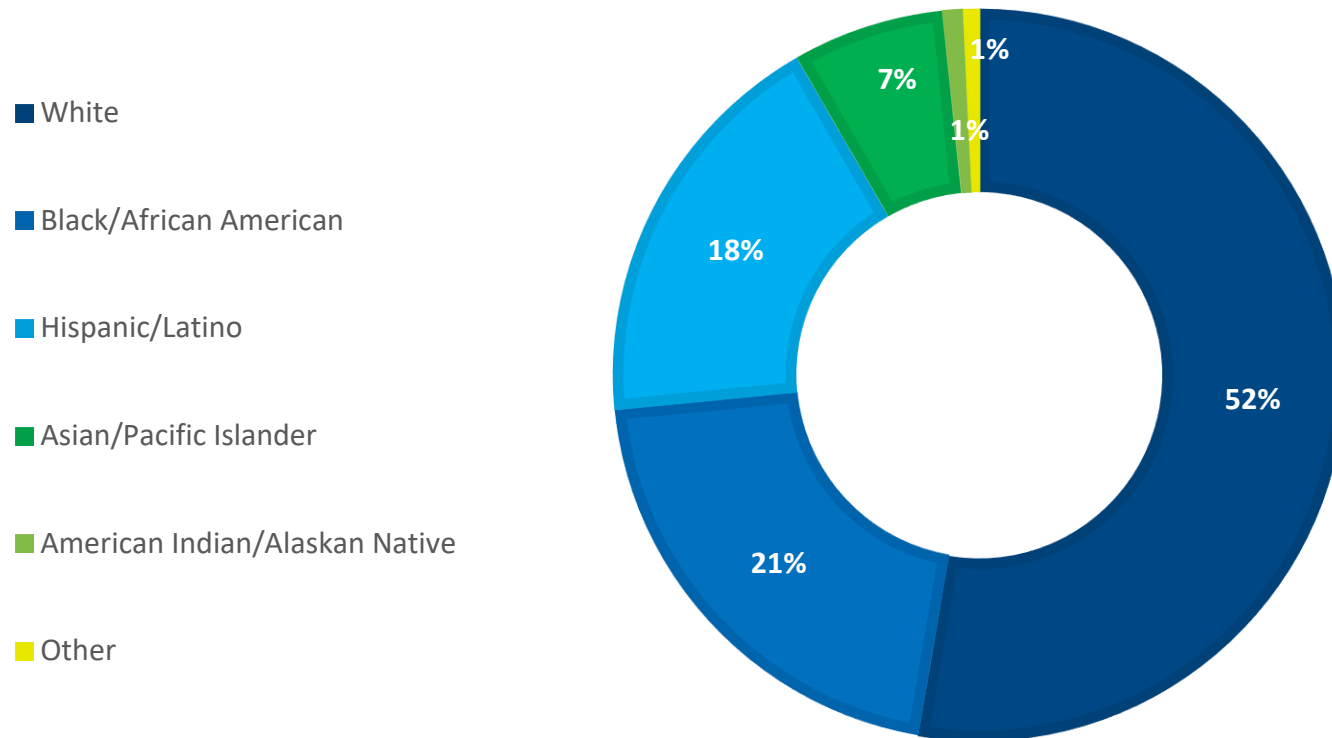
## Dually eligible individuals are not a homogenous group

- Includes older adults and younger people with physical disabilities, serious mental illness, and/or intellectual and developmental disabilities.
- Almost 30% of dually eligible individuals receive “partial benefits,” which means they receive assistance only with Medicare premiums and, in most cases, cost sharing. They do not qualify for the full range of Medicaid services covered in their state.

[2019 CMS Medicare-Medicaid Dual Enrollment Data Brief](#)

# Dually Eligible Individuals

Proportion of Dually Eligible Individuals by Race/Ethnicity, 2019



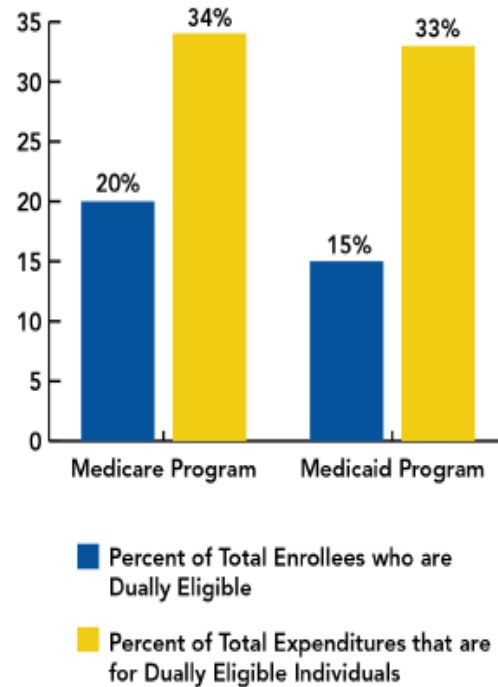
**Almost half of dually eligible individuals are from racial/ethnic minority groups (48 percent)**

- This proportion is growing over time, up 7 percentage points since 2006
- In comparison, the proportion of Medicare-only beneficiaries from racial/ethnic minority groups is 22 percent, up 5 points since 2006
- Improving care for dually eligible individuals requires addressing racial/ethnic disparities, and vice versa

# High Cost and Integration Trend Growing

**FIGURE 2**

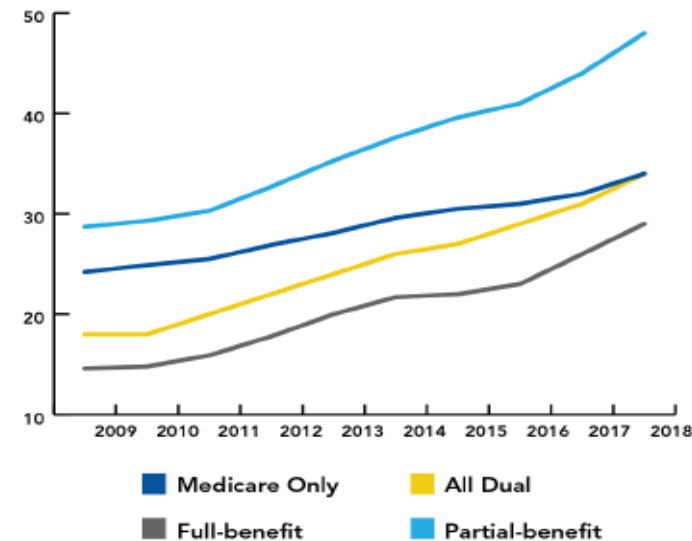
**Share of Medicaid and Medicare Enrollment and Costs Associated with Dually Eligible Individuals<sup>6</sup>**



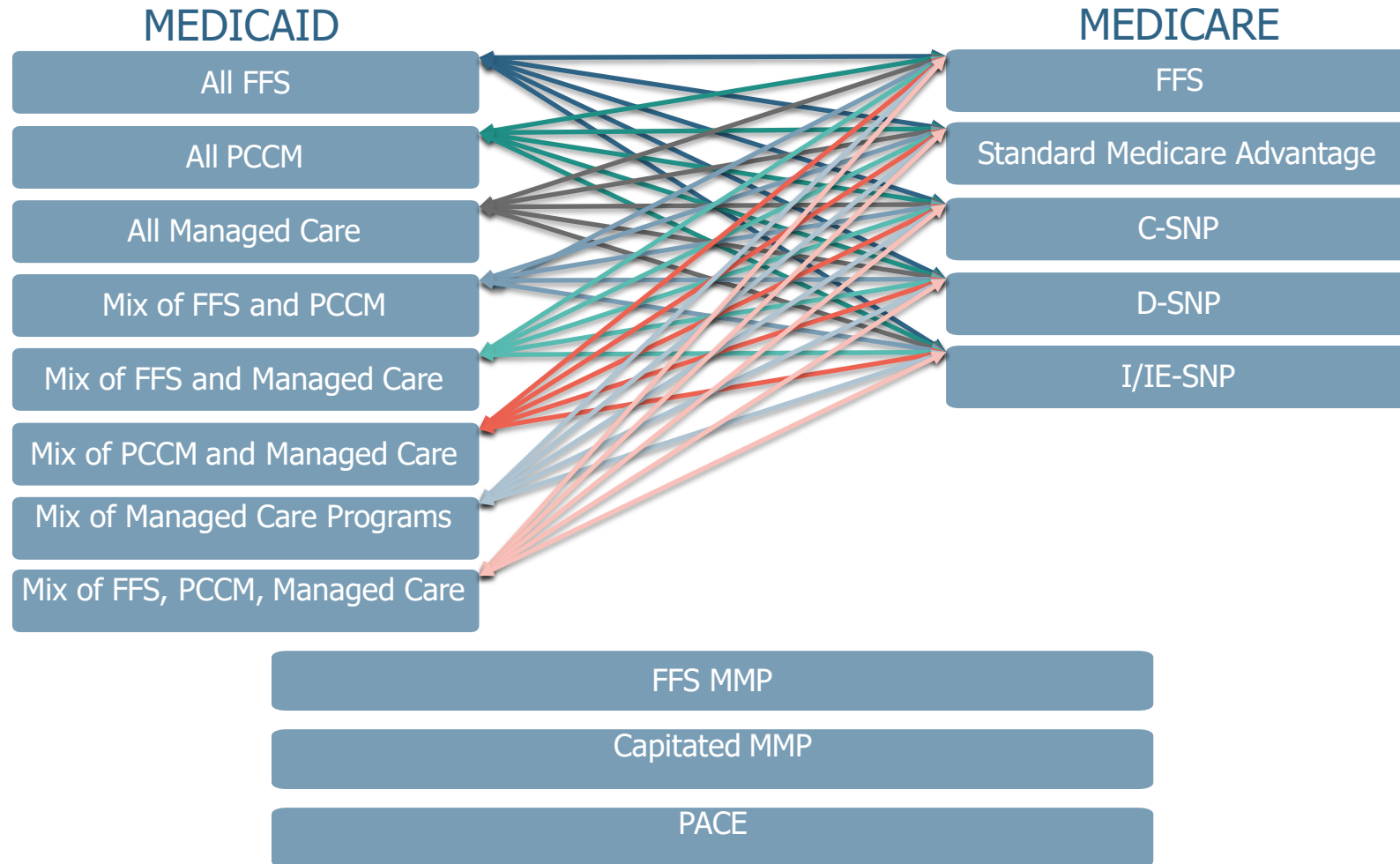
**FIGURE 4**

**Medicare Managed Care<sup>8</sup>**

Among dually eligible individuals (full- and partial-benefit) 37 percent were enrolled in Medicare managed care in 2018, up from 18 percent in 2009.



# At Least 43 Medicare-Medicaid Coverage Combinations Nationwide





# Key Roles

- As HAPF fellow was integrated into all operations groups at MMCO including Program Alignment Group, Special Needs Plans Operations Group, and Demo Team/Analytics Operations work groups
- Major roles:
  - ✓ “Paid learner “ that had to navigate new a vocabulary and plethora of abbreviations and regulations. A humbling complexity
  - ✓ Clinical advisement, MMP perspectives as CMO, Geriatrician clinical perspectives
  - ✓ Content areas : Health Risk Assessments, SDOH discussions, Patient/Member Advisory Committee review, Quality Assurance Care Plan reviews, ESRD and Transplant Part D Coverage, etc. .

# Challenges and Solutions to COVID 19 Vaccination of Homebound Dual Eligible Beneficiaries

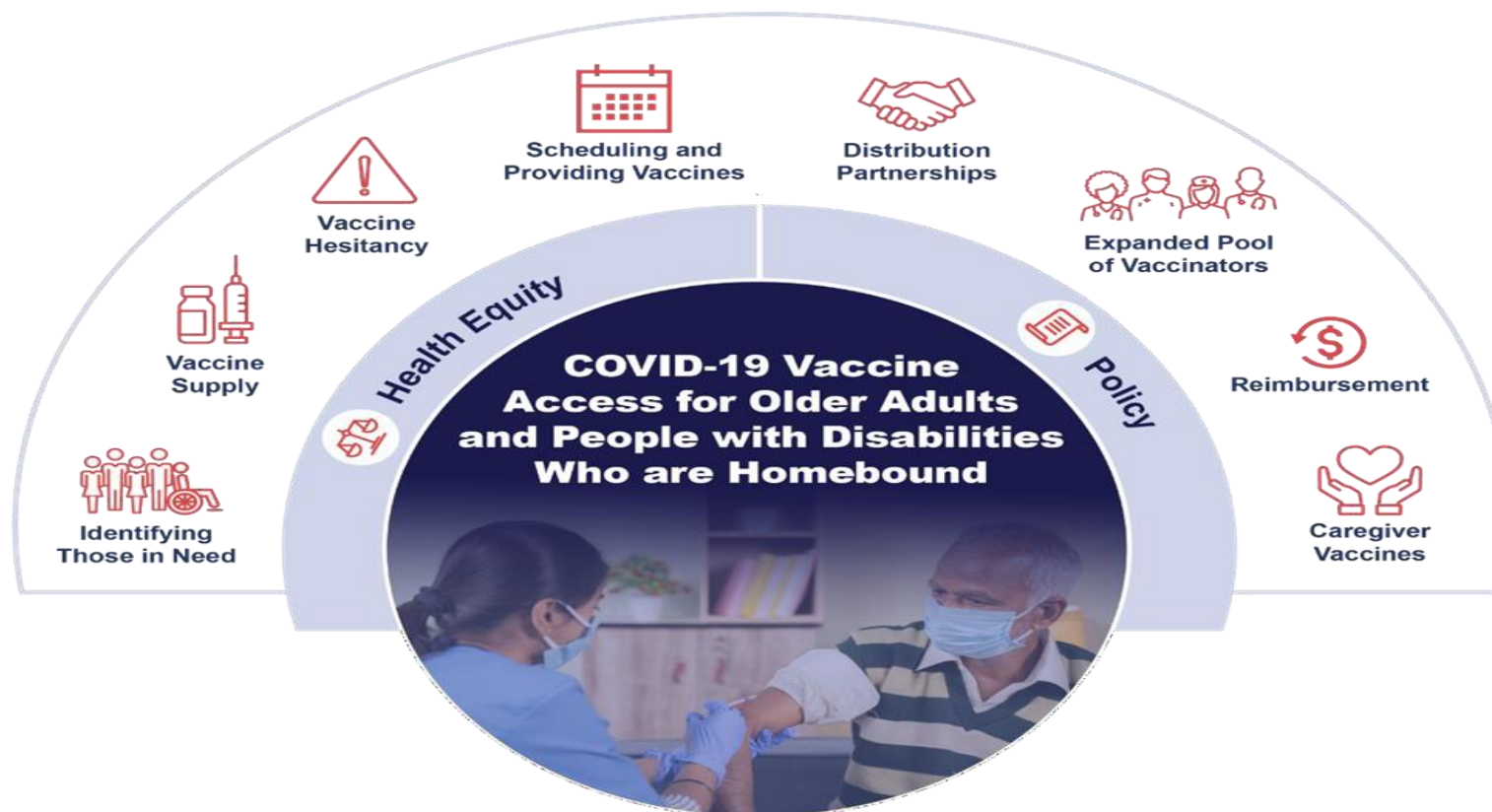
KYLE ALLEN , DO AGSF

HEALTH AND AGING POLICY FELLOW 2020-2021

HAPF FELLOW @ ADMINISTRATION FOR COMMUNITY LIVING AND MEDICARE  
AND MEDICAID COORDINATION OFFICE

[KYLE.ALLEN@CMS.HHS.GOV](mailto:KYLE.ALLEN@CMS.HHS.GOV)

# Challenges for Those Who are Homebound



# COVID-19 disproportionately impacts dually eligible individuals

Preliminary Medicare COVID-19 Data Snapshot:  
Medicare Claims and Encounter Data: January 1, 2020 to March 20, 2021, Received by April 16, 2021

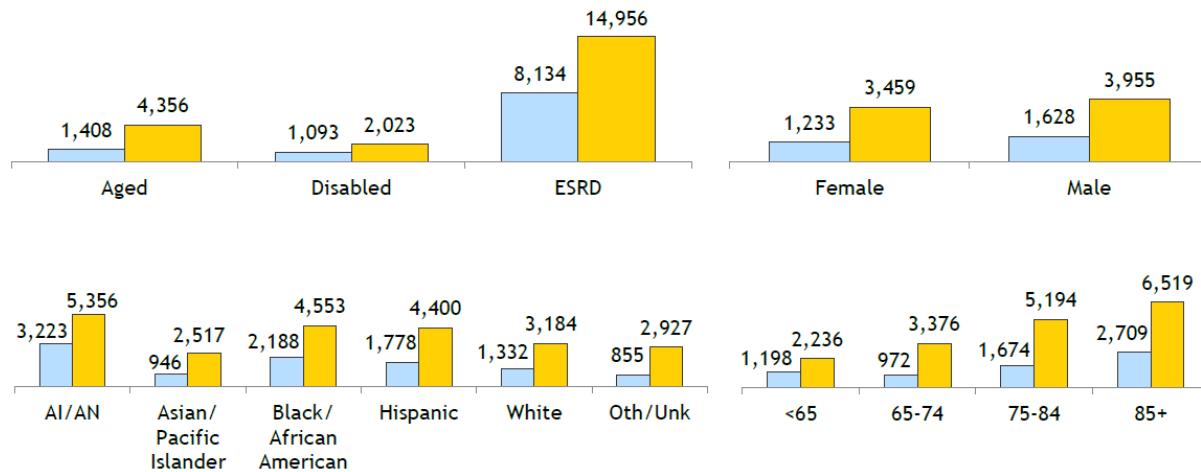
## COVID-19 Hospitalizations

**1,141,592** Total COVID-19 Hospitalizations **1,825** COVID-19 Hospitalizations per 100k

### COVID-19 Hospitalizations per 100K by Beneficiary Characteristics

-Medicare Only vs. Dual Medicare and Medicaid Eligibility-

■ Medicare Only ■ Dual Medicare and Medicaid



[CMS COVID-19 Data Snapshot](#)

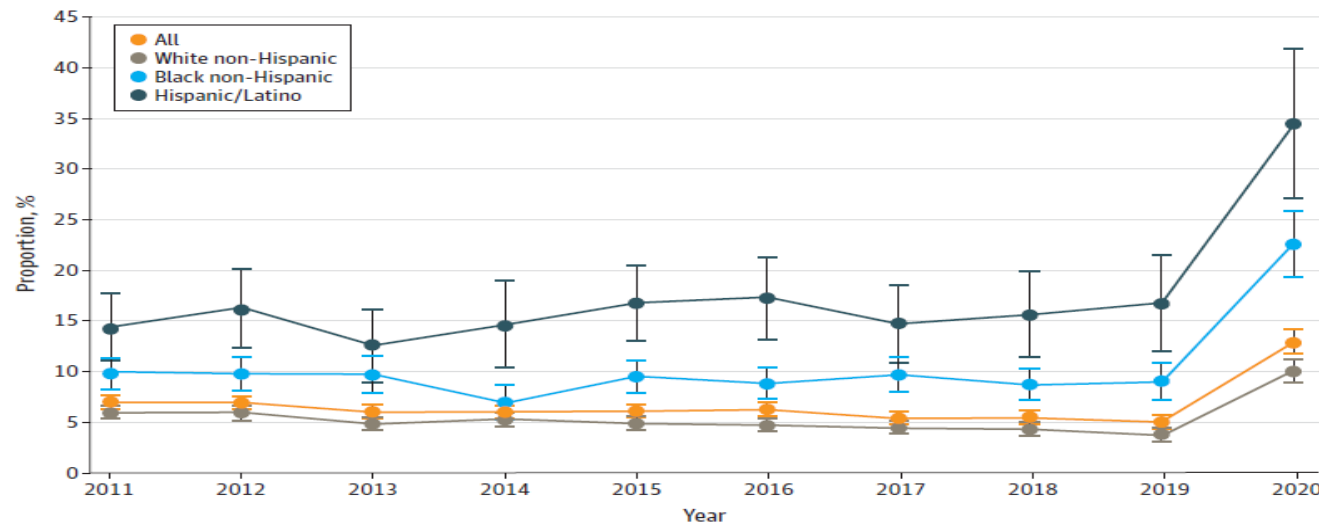
**Dually eligible individuals are far more likely to be hospitalized for COVID-19 than their Medicare-only counterparts**

- Partly related to much higher proportion of nursing facility residents among dually eligible individuals
- Despite disparate impact, maximizing uptake of COVID vaccine among dually eligible individuals in the community will be a challenge

# Prevalence & Characteristics Homebound Older Adults 2020-2021

- ▶ Homebound 70+ increased due to COVID 19 and public health recommendations to “stay at home.” **Increased from 1.6 million (2019) to 4.2 million (2020)**

Figure. Proportion of Community-Dwelling Older Homebound Adults Aged 70 Years or Older, 2011-2020



## Prevalence 2011-2020 :

- All - 5%- 13%
- Hispanic/Latino- 12.6%-35%
- Black; 7%- 23%
- White 4% - 10%

## Characteristics:

28% no phone  
51% no computer  
52% no email use

Ankuda, C. K., Leff, B., Ritchie, C. S., Siu, A. L., & Ornstein, K. A. (2021). Association of the COVID-19 Pandemic With the Prevalence of Homebound Older Adults in the United States, 2011–2020. *JAMA Internal Medicine*. Retrieved from <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2783103?questAccessKey=1c10d2ce-9dd8-4feb-beaf->

# Major MMCO Project: COVID 19 Homebound Vaccination Deep Dive Questionnaire and Report

- COVID 19 Vaccination major priority for CMS and MMCO
- Literature search and national environmental scan done regarding homebound vaccination efforts, challenges and innovations
- Developed 16-item question to learn what were the challenges, innovations, and best practices being used by the Medicare/Medicaid Health Plans (MMP) to address vaccination of homebound membership
- Personally participated and led 35/39 phone calls to MMP to review answers, collect additional information, and address any concerns
- Collected, collated, developed summary report of findings and report out
- Final report and technical assistance paper being published by Resources for Integrated Care (RIC - <https://www.resourcesforintegratedcare.com>)
- RIC will share this report with the MMP through publication and upcoming calls
- Comprehensive archive report developed for MMCO of findings and best practices



# Key Lessons Learned from MMP July Homebound Vaccine Review

- ▶ COVID 19 caused many plans to re-evaluate their screening, targeting, analytics, and care management operations.
- ▶ In general, MMPs were challenged to begin to see the need for a “homebound registry” and are in process to develop.
- ▶ Many MMP stated that the “definition of “homebound” needs more standardization. Almost all plans expanded their view of “homebound” to more broadly include home restricted due to psychosocial issues, BH Issues, IDD issues, SDOH vulnerability.
- ▶ Many but not all MMP began to modify their analytics and move to a predictive analytics model adding broad set of CPT, ICD 10 codes, prior authorization/authorization codes,

# Key Challenges Learned from MMP July Homebound Vaccine review

- ▶ Data integration systems with state, Medicare, Medicaid, public health and community-based organizations that permitted accurate accounting of vaccination status were often delayed. Causes undue burden and effected vaccination strategies.
- ▶ Highly variable across states and MMP, but not having in place pre-COVID 19 PHE strong community partnerships with community organizations i.e. Area Agency on Aging etc. Some states do have this and it was reported how valuable this was to address vaccine access, vaccination rates, and vaccine hesitancy.
- ▶ Vaccine access and availability.
- ▶ Vendors for in home vaccination.
- ▶ Prolonged timeline by states for getting health plan staff certified for home bound vaccination (e.g. nurse practitioners).

# Key Innovations & Best Practice Learned from MMP July Homebound Vaccine review

- ▶ Formation of collaborative coalition for MMP, MCO, MLTSS, AAA/CBO, Public Health and State.
- ▶ MMP with active and formed partnerships (formed pre-COVID) with CBO and Public Health were described as “invaluable” and permitted greater ability to pivot to home bound member needs, vaccine access, in home vaccination, and coordination.
- ▶ MMP reported AAA/CBO “more trusted” and felt they could address vaccine hesitancy and were able to coordinate local services to meet needs.
- ▶ CMO engagement (internal and external) for education, engagement, trusted expert, and leadership. CMO in some plans did ZOOM town hall meetings with members which was described as beneficial to address questions and permit peer to peer relations of vaccinated and vaccine hesitant.

## Key Innovations & Best Practice :

### OHIO AAA and MMP Best Practice !

- Formation of collaborative coalition for MMP, MCO, MLTSS, AAA/CBO, Public Health and State.
- MMP with active and formed partnerships (formed pre-COVID) with CBO and Public Health were described as “invaluable” and permitted greater ability to pivot to home bound member needs, vaccine access, in home vaccination, and coordination.
- MMP reported AAA/CBO “more trusted” and felt they could address vaccine hesitancy and were able to coordinate local services to meet needs.
- CMO engagement (internal and external) for education, engagement, trusted expert, and leadership. CMO in some plans did ZOOM town hall meetings with members which was described as beneficial to address questions and permit peer to peer relations of vaccinated and vaccine hesitant.

These totals represent activities from **April 1, 2020 – March 31, 2021**

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Number of unique visitors accessing website	# applications - Medicaid LTSS	# functional assessments - Medicaid LTSS programs	Number of people receiving PCC	Number of people transitioned from nursing home	Number of unduplicated people served	Total number people served (Age 60+)	Total number people served (Aged 21-59)	Total number people served (Age 20 and below)
68,149	1,200	105,256	49,267	321	85,799	64,624	11,483	326

## Ohio: Providing Vaccinations to Homebound Residents: A Resource for Partners

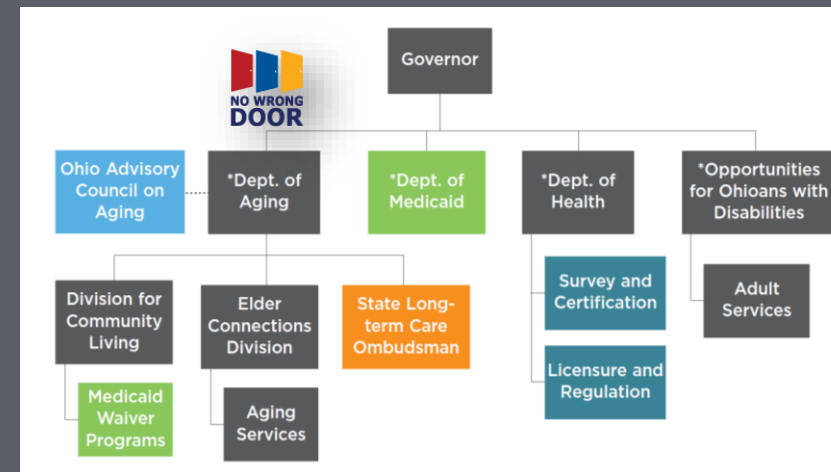
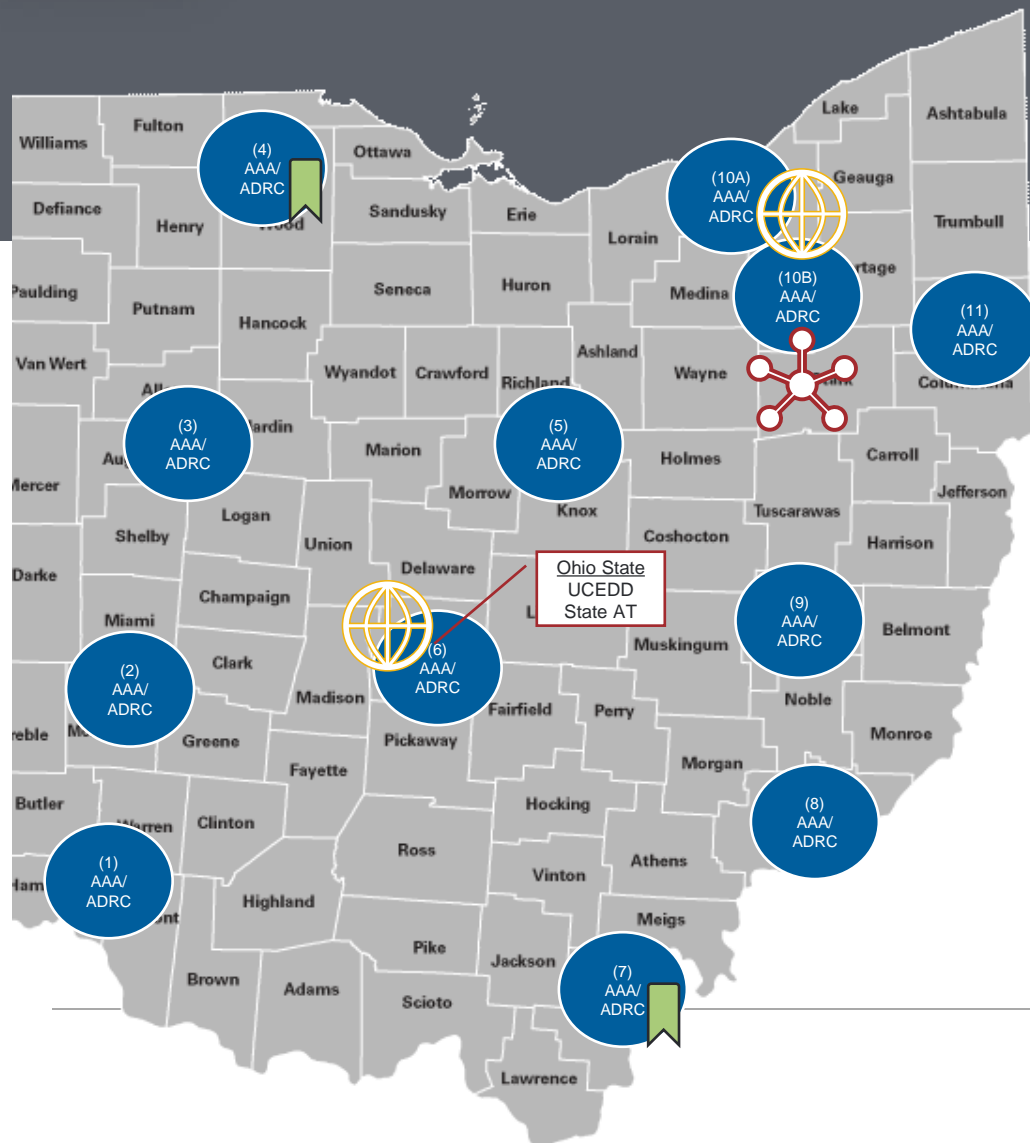
**Description:** The Regional Rapid Response Assistance Program (R3AP) builds upon existing service delivery structures by committing teams of regional experts to provide vaccine access. The program leverages partnerships with local Aging and Disability Resource Network (ADRN) entities that identify and connect with homebound individuals. This playbook can be utilized to plan vaccinations for those who need additional support.

**Click here to access the resource:** <https://coronavirus.ohio.gov/static/vaccine/homebound-vaccinations-playbook.pdf>

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- **State Lead Contact:**
- **Kimberly Mobley** [kmobley@age.ohio.gov](mailto:kmobley@age.ohio.gov)
- Access & Integration Manager, Ohio Department of Aging, Division for Community Living



### Additional NWD Entities:

- CareStar
- Access Center for Independent Living
- Catholic Social Services
- Easter Seals of Northern Ohio
- Mansfield/Richland County First Call 2-1-1
- Linking Employment Abilities and Potential (LEAP)
- Services for Independent Living



**AAA/ADRC**



*NLE - Direction Home, LLC*  
*CIHN - Statewide*



**Veteran Directed  
Care (VDC)**



**Benefit Enrollment  
Center (BEC)**



Network Lead Entity:	Direction Home, LLC		
Address:	1550 Corporate Woods Parkway Uniontown, Ohio 44685-8797		
Contact:	330.896.9172 ; <a href="mailto:info@dhad.org">info@dhad.org</a>		
Contract Types in Existence			
Does the network have a statewide, regional or multistate contract with:	Yes		Detail (e.g. services offered in contract, health plans involved, start up funding, etc.)
Medicare Advantage	Yes	Statewide	Contract with NCOA to implement Aging Mastery with MA plans in the State. Benefit is considered a patient engagement and marketing initiative.
ACOs	Yes	Statewide	Direction Home is negotiating with Aetna, Paragon Health Plan, and United Healthcare for supplemental benefits.
State Medicaid			
Medicaid MCOs	Yes	Statewide	AAAs have contracts with D-SNPs and Medicaid LTSS plans for case management services
Medicare Fee for Service			
Commercial Health Insurance	Yes	Statewide	Current contract with Ground Game Health is only for Commercial members. This has hampered the success of the contract since the commercial market is generally working persons which does not fit the AAA delivery model. Direction Home wants to revise the arrangement with Ground Game Health to implement services for the Anthem Medicare Advantage population.
Hospital or Health System	Yes	Regional	Local contracts with health systems for evidence-based programs.
Other	Yes	Statewide	o4a established a LLC by the name of Direction Home to support Statewide contracting

# Thoughts and Next Steps

- Very smart, dedicated, and talented public servants at both ACL and MMCO
- Humbling complexity looking through a clinical and provider lens
- Create a Joint Clinical SME Technical Advisory Panel for ACL and MMCO that includes CBO and Providers
- Need to continue policy efforts for more integration between social and medical ecosystems, maybe a CMMI demonstration that is aimed and top down and bottom-up integration of the CBO and social sectors
  - Example: The **Better Care Better Jobs Act Proposal for New \$400 Billion in Federal Medicaid Home and Community-Based Services** does not have provisions to integrate medical care or strengthen interface with medical ecosystem
- However, the Social Network Enterprise must connect as “valued partner” and avoid being “absorbed” by the Industrial Medical Enterprise System. Preserve the mission, vision and trust.
- Two major policy frameworks being developed at Bipartisan Policy Center and the Leavitt Group (Dual Eligible Coalition) that aims to work towards state and federal integration for dual eligible beneficiaries. Long road to travel but this work is being informed by the MMCO Demonstrations

