Title: Access to Home-and-Community-Based Services among Duals with Alzheimer's Dementia: Does Plan Integration Matter?

Authors: Eric Slade, PhD
Quan Qi, PhD
Quincy Samus, PhD
Karen Shen, PhD
Mark Meiselbach, PhD
Tamar Rodney, DNP PhD
Daniel Polsky, PhD

Institution: Johns Hopkins University

ABSTRACT

Background: Alzheimer's dementia and Alzheimer's related dementias (ADRD) account for a growing share of health care spending among dually eligible Medicare-Medicaid enrollees (i.e., among duals). Approximately 400,000 Medicare beneficiaries with diagnosed ADRD are dually eligible for Medicaid benefits. Duals account for a third of all ADRD diagnosed beneficiaries in Medicare but nearly half of the $250 billion that Medicare and Medicaid spend annually on services for persons with dementia. Medicare and Medicaid are each responsible for a separate component of care needed by duals with dementia; Medicare covers medical care, including home health and durable medical equipment, while Medicaid covers social supports individuals need once their functioning becomes too impaired to perform instrumental activities of daily living. The separate administration of duals' Medicaid and Medicare benefits, respectively, often results in fragmented care coordination among duals and in a misalignment of financial incentives between duals' Medicare and Medicaid plans. This study tests whether access to Medicare and Medicaid services needed by many duals with ADRD is improved by enrolling in a special category of Dually Eligible Special Needs Plans (D-SNPs) that brings together duals' Medicare and Medicaid coverage under integrated Medicare-Medicaid health plans operated by one managed care organization (MCO).

Conceptual Framework. Dually Eligible Special Needs Plans (D-SNPs). D-SNPs are Medicare Advantage plans that enroll only duals. Integrated D-SNPs in this project are D-SNPs that offer

aligned and integrated plan enrollment, which means: (i) that everyone in the D-SNP is also enrolled in the same state Medicaid plan; and (ii) one MCO operates both plans and integrates their benefit plans and care coordination functions. In our conceptual framework, integrated D-SNPs' integration of duals Medicare and Medicaid benefits would be expected to result in their enrollees having greater access to services that support people with ADRD who are living in community residences, and not in nursing home institutions. The reasoning behind this hypothesis is the misalignment of financial incentives that is inherent to non-integrated D-SNPs, wherein Medicaid long-term care services are not a covered benefit and must be separately coordinated. In this scenario, the Medicare provider organization has no financial incentive to prevent unnecessary nursing home stays or to ensure access to needed Medicaid Home and Community-Based Services (HCBS). Common Medicaid services in this category include personal care services (e.g., housekeeping), non-medical transportation, adult day care, and nursing home care for those who need 24-hour staffed institutional care. Meanwhile, Medicaid does not pay for duals' hospital care and consequently duals' Medicaid insurer has weak financial incentives to avert transfers to hospitals for emergency or acute inpatient care.

Data and Sample. Administrative Medicare and Medicaid data were obtained for duals with full Medicaid coverage who had an ADRD diagnosis in the 2021 Master Beneficiary Summary File. The sample was limited to duals residing in one of six states where both integrated and non-integrated D-SNPs were being offered (California, Florida, New York, Tennessee, Virginia, and Wisconsin). The final data sample contained N=31,297 observations, n=2,562 in integrated D-SNPs and n=28,375 in non-integrated D-SNPs. Using this 6-state sample, we applied entropy balancing to construct inverse probability weights that balanced individual and county characteristics between the integrated and non-integrated D-SNP groups, respectively. Covariates used in balancing included demographics, chronic conditions, ADRD diagnosis year, Medicare plan type in 2020, area type, inpatient hospital utilization in 2020, and county-level measures that included urbanicity, nursing home bed supply, and home health workforce size.

Measures. We compared access to needed Medicaid HCBS and Medicare GUIDE-model medical care coordination services between integrated and non-integrated D-SNPs. Study outcomes were binary indicators of any service use during 2021 in the following categories: Medicaid-funded supports for community living including daily living supports, home health devices/equipment/modifications, skilled home healthcare, day/respite care, and residential care;

and Medicare-funded medical care management services including wellness visit, depression screen, advance care planning, chronic care management, transitional care management, and oversight of home health/hospice.

Results. In weighted analyses that compared service use between the integrated and non-integrated D-SNP groups, beneficiaries enrolled in integrated D-SNPs had greater use of home health devices/equipment/modifications (34.5% vs 23.6%; *p*-value<.001) and chronic care management (11.2% vs 8.8%; *p*-value<.001), and lower use of annual wellness visits (36.6% vs 43.1%; *p*-value<.001). Use of other types of services did not differ by plan integration. sensitivity analysis that was restricted to beneficiaries residing in counties where integrated D-SNPs were offered found similar results. Results were also robust to alternative model specifications (e.g. adding covariates and using state-level clustered standard errors) and adjustment for multiple comparisons.

Conclusions: Findings indicate that among duals with ADRD, integrated D-SNPs resulted in greater use of home health equipment and chronic care management services and lower use of wellness visits. These effects suggest that integration of duals' Medicare and Medicaid benefits under one MCO resulted in improved access to services associated with medical management and community-based in-home supports.

Keywords: Alzheimer's disease and related dementias; Integrated Dual Eligible Special Needs Plans; Home and community-based care; Medical care management; Medicare and Medicaid

Acknowledgements: This work was supported by the National Institutes of Health (NIH) under Grant R01AG089597-01. The authors have no financial or non-financial conflicts of interest to report. The views expressed are those of the authors and do not necessarily reflect the views of the Johns Hopkins University or NIH.