Medicare Preventive Visit Coverage Benefits & Effects of ACA Policy Changes on Older Adults with MCCs

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Today’s Speakers

Sukyung Chung, PhD  Michael Malone, MD
The Effects of ACA Policy Changes on Older Adults with Multiple Chronic Conditions

Michael L. Malone, MD
Aurora Health Care
August 3, 2017
Michael L Malone, MD has no conflict of interest to report related to this lecture.
Learning Objectives:

• Outline the ACA impact on (older) adults.
  – How the law increased coverage.
  – Those with multiple chronic conditions.
• Describe how the ACA has influenced the health care delivery system.
• Describe where the legislation stands at this point.
• Define the changes which were proposed to the ACA.
• Define the implications for those with multiple chronic conditions.
• Describe what you can do.
Background-
Older Persons with Multiple Chronic Conditions:

- Ten million older Americans with >=4 chronic health conditions who are non-institutionalized.
- Their costs of care accounts for as much as 80% of Medicare expenditures.
- Four key elements of care:
  - Comprehensive assessment, based on the patient’s values and preferences.
  - Creation, implementation, and monitoring of a comprehensive plan of care.
  - Communication and coordination of care- particularly during transitions.
  - Promotion of the patient and family caregiver’s active engagement.
Key Elements of the Affordable Care Act:

- A mandate which requires health insurance coverage for individuals - or pay a penalty.
- Medicaid expansion (28 states) entirely at federal expense to all non-elderly adults with incomes below the 133% of federal poverty level: 10.8 M. Cost = $931 B
- Provide subsidized insurance (through state exchanges or federal) health insurance market places for small businesses and individuals without access to employer-based insurance: 11.7M.
  - Costs for small business tax credits = $23 B.
  - Costs for health insurance exchanges and tax credits = $808 B.
- Adults under age 26 can access health insurance of parents: 3M.
- Prevent insurance from terminating coverage based on pre-existing conditions or becoming ill: 10 M.
- Expanded coverage/ eliminating out of pocket costs for preventative services.
The Affordable Care Act Implications:

• Since the ACA’s first open enrollment period in 2013, the number of uninsured Americans has fallen from 41 million to 27 million.

• Fewer non-elderly adults did not get care because of costs.

• Gaining insurance coverage increased the probability of a site for a usual place of care.

• Improved coverage for hospital care and emergency department care.

• Improved access to behavioral health services.

• Improved access for adults who have aged into eligibility for Medicare.


Percentage of Adults Aged 18-64 Who Are Uninsured:

- Better access to care-5 key surveys have defined the rate of uninsured Americans as 13-18%.
- Three fourths of those seeking a new appointment with a primary care provider were able to attain one within four weeks or less.
- Fewer Americans reported financial barriers to obtaining care.
Medicaid Expansion in Arkansas & Kentucky Compared to Texas:

- Improved access to primary care.
- Improved self-reported health.
- More likely to have their chronic diseases treated.
- More likely to have received screening.
- Less likely to postpone care or to take prescriptive medications because of costs.
- Reduced ED visits and increased outpatient visits.
Changes in the Health Care Delivery System in the Affordable Care Act:

- Incentives and penalties to reduce Medicare readmissions.
- Incentives to reduce hospital-acquired conditions.
- Primary Care Transformation.
- The Pay-for-Value program for hospitals and physicians.
  - In 2017, a redistribution of 2% of Medicare payments for a variety of cost & quality measures (other than readmissions and never-events).
- The bundled payment initiatives.
  - A single payment for a set of hospital, physician, and post-acute services related to a given procedure or condition.
- Health care providers were encouraged to form ACO’s.
  - To integrate/coordinate care and take responsibility for costs and quality of care for a population of Medicare beneficiaries.
  - More than 400 ACO’s serving 7 million Medicare beneficiaries as of 2015.
  - Generally improved quality measures of the Medicare Shared Savings Programs participants when compared to Medicare FFS beneficiaries.
Changes in the Health Care Delivery System in the Affordable Care Act:

- Creation of the Center for Medicare and Medicaid Innovation (CMMI) within CMS.
  - Funded at $1 Billion per year for ten years.
  - Charged with improving quality and reducing costs within Medicare and Medicaid programs.
  - If there is improved quality without increasing costs, or decreased costs without decreasing quality, the program could be disseminated without Congressional approval.
  - Program examples for older adults with multiple chronic conditions:
    - UCLA dementia care;
    - Hospital at Home at Mount Sinai in New York City;
    - OPTIMISTIC program at Indiana University.
  - Partnership for Patients.

- Improvement in the solvency of the Medicare Part A Hospital Insurance Trust Fund through 2028.
All-Cause, 30-day Hospital Readmission Rate among Medicare Beneficiaries:

Hospitals with higher than expected Medicare readmission rates have become subject to penalties.

Same data on an enlarged y axis.
Percent Change in Hospital-Acquired Conditions from 2010-2013:

- Safety improvements as a part of the Affordable Care Act.
- Hospitals that perform in the lowest quartile of hospital-acquired conditions may lose as much as 1% of their Medicare payments.
Ten Year Medicare Spending Projections

The per-beneficiary Medicare expenditures have decreased from 2010 to 2015.

Projected Medicare Spending in 2020
As of January 2010: $1,038 billion
As of March 2015: $829 billion

HEALTH POLICY REPORT
Mary Beth Hamel, M.D., M.P.H., Editor

The Affordable Care Act at 5 Years
David Blumenthal, M.D., M.P.P., Melinda Abrams, M.S., and Rachel Nuzzo, M.P.H.
Who are the older adults affected by the Affordable Care Act?

- Dual-eligible older adults.
- Those who require a disproportionate amount of Medicare spending.
- Those who live in skilled nursing facilities.
- Those who are poor.
- Those with multiple chronic health conditions—Access to Medicare Annual Wellness Visit.
- Those who need long term care.
So...What’s the problem?
The Challenges of the Affordable Care Act:

- Premiums have risen from year to year.
- Several plans have high deductibles and co-pays to keep the premium costs down.
- Some plans have restricted access to providers to control costs.
- The number of insurance marketplace products which are available in some counties has dropped, so that there is no choice.
- Requiring full coverage of multiple conditions has added costs to the health insurance companies.
  - Some carriers have limited the number of plans they sell.
- States which have chosen to expand Medicaid have new responsibility to sustain such coverage.
- Requirement for employers to provide coverage for 50 fulltime employees-
  - Some employers hired lots of part-timers.
  - Other employers have seen an increase in positions.
- The costs of the Affordable Care Act to the nation over an 11 year span: $1.76 Trillion in costs- with $567 B in new taxes and $477 B in cost savings.

http://onlinemph.berkeley.edu/affordable-care-act-six-years-later/
What happened to the legislation in the Senate?

- The Congressional Budget Office estimated that 15 million Americans would lose health insurance over a ten year period.
- Senate approved the beginning of the debate on repeal of major provisions of the ACA on July 25, 2017.
- Vote to replace the ACA failed later that evening.
- Additional repeal attempts failed on the following two days.
What was in “the skinny repeal”?

• Official name: “The Health Care Freedom Act”.
• Main Content:
  – A delay of the tax on medical devices.
  – An end to “the individual mandate” that requires people to have health insurance.
  – Cut funding for Planned Parenthood for one year.
  – Increased federal grants for community health centers.
  – Increased the limit on contributions to health savings accounts.
  – Waive federal requirements for a minimum set of benefits - e.g. maternity care and prescription drug coverage.
  – Eliminated the funding for a wide range of prevention and public health programs.
• If the bill passed, it could have:
  – Gone to conference committee to revise.
  – Been voted on in the House of Representatives.
What did the American Geriatrics Society have to say about repeal of the ACA?

- We should maintain the ACA gains in health insurance coverage for Americans.
- Any policy which is proposed to replace the ACA should be described in sufficient detail for Americans to compare to current policy.
- Repeal of the ACA would leave states with fewer resources to address the needs / discontinuation of coverage for Medicaid recipients.
- AGS opposes changes to Medicaid which would reduce access to needed services.
- The AGS supports the CMMI innovations to improve models of care, particularly those with multiple chronic conditions.
Where does this legislation stand now?

• President Trump has:
  – Described his frustrations via Twitter- “Let it fail.”
  – Encouraged Congress to try again.
  – Threatened to cut the $7 Billion federal “cost sharing reimbursements” paid to insurance companies.
  – Threatened to cut the health insurance of members of Congress.
What Can You Do?

• Read.
• Listen.
• Think.
• Go to www.KFF.org
• Champion.
• Join the AGS Public Policy Committee.
• Understand.
• Advocate.
• Write your Congressional Representative.
• Tweet.
Key Themes:

• The ACA has had major implications for access to health insurance and access to care for Americans.
• The ACA has had important and broad implications for our country’s health care delivery system.
• Congress came very close to repealing/ replacing the ACA and still might do so.
• Several important issues should be addressed to meet the challenges of the ACA.
Medicare Preventive Visit Coverage and Preventive Care among Older Adults

Sukyung Chung, PhD
Palo Alto Medical Foundation Research Institute
Medicare preventive visit coverage under ACA

- **Substantial expansion in 2011**
  
  *Welcome to Medicare Visit (WMV)*
  
  - **2005**: once lifetime, within 6 months of enrollment; $100 deductible, 20% copay
  - **2008**: once lifetime, within 12 months of enrollment; 20% copay
  - **2011**: once lifetime, within 12 months; no patient cost

*Annual Wellness Visit (AWV)*

- **2011**: annual, no patient cost
Services covered in WMV & AWV

- Medical and family **history review**
- **Biometrics** such as blood pressure and body-mass index measurement
- **Screening** for cognitive impairment, depression, functional ability, and level of safety
- Establishing a **written schedule** for recommended screening and preventive services
- Planning **end-of-life care**
- Education, counseling, and referrals for other **personalized preventive services**
Objectives

- To determine whether increases in Medicare coverage led to increased preventive visit
  - Medicare preventive visit uptake
  - Changes in the use of other preventive visits and primary care visits
- To understand how the impact of the preventive visit coverage differ among patient groups
  - Demographic differences in preventive visit utilization
  - Change in disparity after the coverage expansion
- To assess changes in the uptake of recommended preventive care associated with preventive visit
  - Comparison across preventive service types
  - Importance of preventive visit vs. frequent non-preventive visits
Setting

- Palo Alto Medical Foundation
- Multi-specialty, mixed-payer group practice in northern CA
  - >1000 physicians
  - >1,000,000 patients per year
- Electronic health records data
  - Billing information to identify visit type and preventive services
  - Other not-billable preventive services
  - Self-reported patient demographics
Patients studied

- Age 65 to 85
  - Narrower age range in some analysis
- Any insurance coverage
- Primary care patients
  - Any visit to internal medicine or family medicine in the current or previous year
- Study cohorts defined annually
  - 2007-2014

<table>
<thead>
<tr>
<th>Preventive visit</th>
<th>31.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>65-69</td>
<td>34.6%</td>
</tr>
<tr>
<td>70-74</td>
<td>24.0%</td>
</tr>
<tr>
<td>75-79</td>
<td>17.9%</td>
</tr>
<tr>
<td>80-85</td>
<td>23.6%</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>42.0%</td>
</tr>
<tr>
<td>Female</td>
<td>58.0%</td>
</tr>
<tr>
<td><strong>Race/ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>63.5%</td>
</tr>
<tr>
<td>African American</td>
<td>1.4%</td>
</tr>
<tr>
<td>Latino</td>
<td>3.3%</td>
</tr>
<tr>
<td>Asian</td>
<td>13.3%</td>
</tr>
<tr>
<td>Other</td>
<td>18.5%</td>
</tr>
<tr>
<td><strong>Primary insurance</strong></td>
<td></td>
</tr>
<tr>
<td>Medicare FFS</td>
<td>65.3%</td>
</tr>
<tr>
<td>Medicare HMO</td>
<td>17.9%</td>
</tr>
<tr>
<td>Private PPO/FFS</td>
<td>10.4%</td>
</tr>
<tr>
<td>Private HMO</td>
<td>6.4%</td>
</tr>
<tr>
<td><strong>Comorbidities (CCI no age)</strong></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>42.5%</td>
</tr>
<tr>
<td>1</td>
<td>20.5%</td>
</tr>
<tr>
<td>2</td>
<td>17.0%</td>
</tr>
<tr>
<td>3 or more</td>
<td>20.0%</td>
</tr>
</tbody>
</table>
Does the increase in Medicare coverage lead to increased preventive visit utilization?

- **Difference-in-differences analysis**
  - Differences in pre vs. post AWV period
  - Difference by insurance type: Medicare FFS vs. Medicare HMO, private FFS, private HMO
- **Trend in preventive visit and non-preventive primary-care visits**
- **Patients age 65-75; years 2007-2013**
Marked increase in the preventive visit use

Preventive Visits among Patients Age 65-75 (2007-2013)

% Received annual preventive visit

Somewhat decrease in other primary care visits
How does the impact of the preventive visit coverage differ among subgroups?

- Generalized linear models with patient random effects
- Unit of analysis: patient-year, 2007-2014
- Dependent variable: whether made a preventive visit during the year
- Control variables: patient demographic and clinical characteristics, provider characteristics
- Stratified analysis: Pre- and post-AWV periods
Predictors of increased preventive visit use

- **Positive predictors**
  - Younger age
  - Asian (ref: non-Hispanic white)
  - Post-2011
  - Medicare HMO, private insurance
  - Female provider
  - Internal medicine

- **Negative predictors**
  - Older age
  - Latino
  - Comorbidities
  - Medicare FFS
  - Frequent primary care visits
Gap in preventive visit use narrowed post-AWV

<table>
<thead>
<tr>
<th>Large reduction in the gap in preventive visit rates of older (vs. younger) seniors</th>
<th>No change in the disparity in preventive visit use based on comorbidities</th>
<th>Large reduction in the gap between Medicare FFS and other insurances</th>
</tr>
</thead>
</table>

**Graph**: Graph showing the odds ratio with 95% CI (log scale) for different age groups, number of comorbidities, and insurance types. The graph compares pre-AWV and post-AWV periods.
Does preventive visit use lead to increased uptake of recommended preventive care?

- Generalized linear models with patient random effects
- Unit of analysis: patient-year, 2011-2014
- Separately for each procedure; N= eligible individuals
- Dependent variable: recommended procedure is up to date (0/1)
- Control variables: preventive visit, non-preventive primary-care visits, patient demographic and clinical characteristics, provider characteristics
**Recommended preventive care studied**

<table>
<thead>
<tr>
<th>Category</th>
<th>Procedures</th>
<th>Eligibility criteria</th>
<th>Recommended procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Screening</td>
<td>Colorectal cancer screening</td>
<td>Adults aged 50-74 years</td>
<td>Fecal occult blood testing (annual), sigmoidoscopy (every 5 years) or colonoscopy (every 10 years)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breast cancer screening</td>
<td>Women aged 50-74 years</td>
<td>Biennial screening mammography</td>
</tr>
<tr>
<td>Management of existing conditions</td>
<td>Monitoring of persistent medications</td>
<td>Adults aged ≤18 who received ≥180 days of prescription for ACE inhibitors, ARBs or diuretics</td>
<td>At least one therapeutic monitoring for the medication</td>
</tr>
<tr>
<td></td>
<td>Coordinated diabetes care</td>
<td>Adults aged 18-75 years with type 1 or type 2 diabetes</td>
<td>Meet all of the three targets: HbA1c&lt;8.0%; blood pressure&lt;140/90mm Hg; and nephropathy monitoring</td>
</tr>
<tr>
<td>Preventative counseling</td>
<td>Smoking cessation counseling</td>
<td>Anyone who uses tobacco products</td>
<td>Discussed</td>
</tr>
<tr>
<td></td>
<td>Discussion of end-of-life care planning</td>
<td>Adults aged ≥18</td>
<td>Discussed</td>
</tr>
</tbody>
</table>
Predicted probability of being up-to-date in preventive care procedures, *by preventive visit*

<table>
<thead>
<tr>
<th>Service</th>
<th>All</th>
<th>No preventative visit</th>
<th>Made a preventative visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening</td>
<td>82</td>
<td>84</td>
<td>92</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>94</td>
<td>95</td>
<td>97</td>
</tr>
<tr>
<td>Annual Monitoring of persistent medications</td>
<td>78</td>
<td>84</td>
<td>65</td>
</tr>
<tr>
<td>Coordinated diabetes care</td>
<td>19,739</td>
<td>65</td>
<td>34</td>
</tr>
<tr>
<td>Smoking cessation counseling</td>
<td>19,303</td>
<td>34</td>
<td>65</td>
</tr>
<tr>
<td>Discussion of end-of-life care planning</td>
<td>191,308</td>
<td>15</td>
<td>34</td>
</tr>
</tbody>
</table>

N=119,191  18,381  19,303  19,739  6,805  191,308
Preventive visit vs. other primary care visits, and *preventive counseling*

Odds ratio and 95% CI presented

- For preventive counseling, frequent non-preventive primary-care visits do not offset the effect of one preventive visit.
Preventive visit vs. other primary care visits, and *preventive screening*

Odds ratio and 95% CI presented

- For up-to-date preventive screening, frequent non-preventive primary-care visits do not offset the effect of one preventive visit.
Preventive visit vs. other primary care visits, and *management of chronic conditions*

Odds ratio and 95% CI presented

- For the management of chronic conditions, the effect of 1 preventive visit is similar to 2 non-preventive primary-care visits. For those who ≥2 non-preventive primary-care visits, a preventive visit did not make a difference.
Summary of findings

- Preventive visit rate among Medicare FFS enrollees doubled with ACA’s coverage expansion, but it is still much lower than the rate among Medicare HMO enrollees.

- Seniors who are older and have more comorbid conditions are less likely to make preventive visits. Preventive visit use increased more among older seniors, reducing the age-based gap; Patients with multiple comorbidities did not utilize the coverage as much as those without, so, the gap persisted.

- Seniors who made a preventive visit were more likely to be up-to-date for recommended preventive services. The difference was prominent for time-consuming services. For these services, frequent non-preventive primary-care visits do not offset the improvement in preventive care associated with one preventive visit.
Conclusions

- Medicare’s explicit coverage of preventive visit (Annual Wellness Visit) improved the use of recommended preventive care among older adults.

- The coverage reduced gap in preventive visit rates among seniors based on age and insurance, but the difference is still substantial. The gap based on health conditions did not change.

- Among older adults who were already making frequent medical visits, a dedicated preventive visit can still improve the uptake of recommended, particularly time-consuming, preventive care services.

- Preventive care coverage should remain a priority for Medicare in order to address preventive care needs of an ageing population.
Further questions

- How does the increased preventive visit use change primary care practice?
  - Depth and breadth of issues covered during non-preventive primary-care visits, especially for seniors with multiple comorbid conditions
  - Continuity of care with own primary care provider

- Why people do not use free preventive visit service?
  - Barriers among patients
  - Practice barriers

- Does preventive visit improve patient-centered outcomes?
  - Outcomes that matter most for seniors, e.g., prevention of falls, early detection of cognitive impairment
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