Contracting with Primary Care to Reimburse Older Adult Non-Clinical Services

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Primary Care Providers (PCPs) and Care Transitions Organizations (CTOs) are required to link high risk low income, underserved and rural older adults into a wide array of non-clinical social programs and services to improve quality of care and reduce healthcare costs.

A unique funding opportunity through the Centers for Medicaid and Medicare is targeting high risk individuals utilizing HEART Funds (Health Equity Advancement Resource and Transformation Payment).

The Wisconsin Area Deprivation Index (ADI) is a tool utilized to identify rural and underserved populations who may need a wide array of non-clinical services and programs. https://www.neighborhoodatlas.medicine.wisc.edu/
INITIAL EFFORTS TO CONNECT HIGH-RISK INDIVIDUALS WITH NON-CLINICAL SERVICES BEGAN ON MARYLAND’S LOWER EASTERN SHORE

Initial contracts began in July 2022 with one Maryland PCP clinic. Additional clinics and a large CTO began referrals in the following months.

- Diverse services for reimbursement include:
  - Social Determinants of Health (SDoH) screenings and connection to resources
  - Enrollment in evidence-based behavior change and falls prevention programs
  - Link to advance care planning
  - Medication management
  - Home-delivered meals
  - Assistance with utility bills
  - Transportation
The initiative was first piloted on the lower eastern shore. Today multiple additional locations in central Maryland are linking falls risk older adults to assessments and falls prevention evidence-based programming.

Invoicing of up to $110.00 per month per individual is invoiced monthly for screenings, services and programs delivered.

Documentation of services and their impact on improving older adult health and quality of life are submitted to Maryland’s Health Information Exchange - Chesapeake Regional Information System of Patients (CRISP).
OPPORTUNITIES AND CHALLENGES

- HEART Funds have been available in Maryland since January 2022 and will be available through 2025. The funds were NOT accessed by providers until LWCE began contracting.
- There are significant shortages across healthcare professions and staff turnover has challenged clinicians’ ability to screen and refer clients.
- LWCE plays a key role in assisting to train new clinical staff about community-based programs and services, and how to refer clients via the HIE.
- LWCE accesses CRISP to receive referrals, document services and programs completed and sends status reports back to the referring provider.
OUTCOMES

- LWCE receives around 50 referrals for HEART patients monthly (billed quarterly through Medicare)
- An additional 50 physician and local hospital monthly referrals are received for social services and programs for non-HEART patients.
- Under a separate contract, 230 referrals were received from 8 primary care practices for enrollment in the Stepping On falls prevention evidence-based program.
- CMMI (Centers for Medicare and Medicaid Innovation) plans to post interviews with HEART patients on the benefits of receiving social services and evidence-based programs on their website.
Barbara was out gardening for about 2 hours, and she decided was done for the day because she knew she couldn’t be out there for too much longer due to her previous experience. She was able to get up from her low seat without much difficulty. Because she was in a row that was narrow and was also uneven and soft, she had to step sideways for about 15 feet to remove herself from the row. She felt her side-step exercises from Stepping On helped her to accomplish this and feel stable doing it. (Her previous fall was due to being out in the garden for 4 hours. She did not ask for help. She fell when she was walking up the stairs, as her legs gave out from under her. Even though she was holding on to the railing, she fell and ended up with a slight concussion.)

Julia is receiving rides through HEART funds to Stepping On. She feels that the exercises are helping her catch herself better and her balance is improved. She said she feels less wobbly since starting Stepping On.

Philmore is receiving rides to Stepping On, and enjoying the company of attending class regularly. He lost his wife 5 months ago, and he feels it is helping him being around people. He still struggles with doing the exercises on his own because of his grief, but said it is helping when he does them in class.
LWCE’S goal is to document significant healthcare cost savings AND improved quality of life for individuals receiving HEART funds.

Ongoing activities are focused on communicating the critical impact of social services in maintaining/improving the lives of older adults and people with disabilities.

LWCE is able to submit data and print reports on changes in a client’s health status and changes in hospitalization emergency department utilizations, as well as the cost-savings occurring as a result of non-clinical services.

Currently, meetings at the national level are underway to maximize linking of non-clinical services and documentation on impact of those services across Maryland.
WHAT HAS BEEN THE CHALLENGE OR BENEFIT FOR YOUR ORGANIZATION IN DOCUMENTING REDUCED HEALTH CARE COSTS AS A RESULT OF PROVIDING NEEDED SOCIAL SERVICES?