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- **Johns Hopkins Team**
  - Amber Willink
  - Karen Davis
- **Disclosures**
  - Speaker fees from ZimmerBiomet unrelated to this project (2018)
Background

Medicare Program
N = 63 Million

Medicare Advantage
N = 22 Million

Traditional Medicare
N = 41 Million

General
Special Needs Plans
Employer
## Traditional Medicare vs Medicare Advantage

<table>
<thead>
<tr>
<th>Feature</th>
<th>Traditional Medicare</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited Physician Network</td>
<td>X</td>
<td>Yes</td>
</tr>
<tr>
<td>Copays</td>
<td>80/20</td>
<td>Varies</td>
</tr>
<tr>
<td>Prior Auth/Step Therapy</td>
<td>X</td>
<td>Probably</td>
</tr>
<tr>
<td>Out-of-Pocket Cap</td>
<td>X</td>
<td>$6,000 in-network</td>
</tr>
<tr>
<td>Disease Management</td>
<td>X</td>
<td>Probably</td>
</tr>
<tr>
<td>Dental/Vision/Hearing</td>
<td>X</td>
<td>Probably</td>
</tr>
<tr>
<td>Pay for Performance</td>
<td>Value-Based Modifier, ACOs, PCMH, VBP</td>
<td>5-Star Rating</td>
</tr>
</tbody>
</table>

*Note: X indicates feature is included in Traditional Medicare, while blank indicates feature is included in Medicare Advantage.*
Medicare Advantage

- MA Plans are private health plans (e.g., Aetna, UnitedHealthCare) that offer Medicare covered services
- Enrollment in MA varies by state.
  - In Colorado, ~37% are enrolled in MA
  - In Maryland, ~16% are enrolled in MA
- MA Plans are paid by Medicare based on the risk of their enrollees AND the quality of care delivered
CHRONIC Care Act

• Passed as part of the Bipartisan Budget Act in 2018
• Allows MA plans to target supplemental benefits to high cost, high need populations
  • Can include standard medical benefits (e.g., lower copays and non-medical benefits such as dental or long term care services and supports)
  • Through regulation, CMS allowed plans to start targeting benefits in 2019 as well as through Value Based Insurance Design demo
• 55 plans from 9 MA contracts took advantage of the uniform flexibility to target patients with cardiovascular disease, diabetes, COPD, and substance use disorder
  • The majority of these tackled diabetes by reducing copays for physician and podiatry visits
Characteristics of Medicare Advantage enrollees

- 37% of MA enrollees in large health plans are complex: multiple chronic conditions and functional limitations or <65

Supplemental Benefits Cover a Wide-Range of Services

<table>
<thead>
<tr>
<th>Dental</th>
<th>Vision</th>
<th>Hearing</th>
<th>Clinical</th>
<th>Preventive Health</th>
<th>Auxiliary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive</td>
<td>Eye exam</td>
<td>Hearing aids</td>
<td>Chiropractic maintenance care</td>
<td>Health education</td>
<td>Emergency coverage abroad</td>
</tr>
<tr>
<td>• Dental x-ray</td>
<td>• Upgrades</td>
<td>• Fitting and evaluation for</td>
<td>• Routine foot care</td>
<td>Nutrition counseling</td>
<td>Nonemergency transportation</td>
</tr>
<tr>
<td>• Oral exam</td>
<td>• Contact lenses</td>
<td>hearing aid</td>
<td>• Acupuncture</td>
<td>Enhanced smoking</td>
<td>Meals</td>
</tr>
<tr>
<td>• Dental cleaning (prophylaxis)</td>
<td>• Glasses: lenses and frames</td>
<td></td>
<td>• Other alternative therapies</td>
<td>cessation counseling</td>
<td>Wigs for hair loss related to</td>
</tr>
<tr>
<td>• Fluoride</td>
<td>• Glasses: lenses only</td>
<td></td>
<td>• Residential substance abuse</td>
<td>Gym membership</td>
<td>chemotherapy</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>• Glasses: frames only</td>
<td></td>
<td>treatment</td>
<td>Enhanced disease</td>
<td>Over-the-counter drugs/items</td>
</tr>
<tr>
<td>• Prosthodontics, maxillofacial</td>
<td></td>
<td></td>
<td>• Health education</td>
<td>management</td>
<td></td>
</tr>
<tr>
<td>surgery</td>
<td></td>
<td></td>
<td>• Nutrition counseling</td>
<td>Telemonitoring</td>
<td></td>
</tr>
<tr>
<td>• Non-routine services</td>
<td></td>
<td></td>
<td>• Enhanced smoking cessation counseling</td>
<td>Remote access technology</td>
<td></td>
</tr>
<tr>
<td>• Diagnostic services</td>
<td></td>
<td></td>
<td>• Gym membership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Restorative services</td>
<td></td>
<td></td>
<td>• Enhanced disease management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Endodontics, periodontics,</td>
<td></td>
<td></td>
<td>• Telemonitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>extractions</td>
<td></td>
<td></td>
<td>• Remote access technology</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Personal emergency response systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Medical nutrition therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Post-discharge in-home medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>reconciliation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Weight management program</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Annual physical exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Enhanced screening EKG</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


1 Web/phone-based or nursing hotline.

2 EKG = electrocardiogram
### AARP: Over half of MA beneficiaries have access to some Dental, Vision, and Hearing Services, 2017

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Plans % offering</th>
<th>Beneficiaries % in plans offering</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive dental</td>
<td>67</td>
<td>61</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>47</td>
<td>45</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyewear</td>
<td>83</td>
<td>78</td>
</tr>
<tr>
<td><strong>Hearing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing exam</td>
<td>68</td>
<td>66</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>55</td>
<td>57</td>
</tr>
<tr>
<td><strong>Clinical services</strong></td>
<td>42</td>
<td>45</td>
</tr>
<tr>
<td>Preventive health</td>
<td>86</td>
<td>78</td>
</tr>
<tr>
<td><strong>Auxiliary</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Objective and Key Questions

Objective: How have supplemental benefits changed over the last 5 years?

Key Questions:
1. What percent of plans with access to standard supplemental benefits?
2. What percent of beneficiaries have access to supplemental benefits?
3. Are there geographic variations in access to supplemental benefits?

<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>Exemplar Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>Oral exams, extractions, x-rays</td>
</tr>
<tr>
<td>Vision</td>
<td>Eye Glasses, Eye exams</td>
</tr>
<tr>
<td>Hearing</td>
<td>Hearing exam, hearing aids</td>
</tr>
<tr>
<td>Transportation</td>
<td>Plan-approved locations</td>
</tr>
<tr>
<td>Waiver of 3-day Hospital Stay for SNF</td>
<td></td>
</tr>
<tr>
<td>Meals</td>
<td></td>
</tr>
</tbody>
</table>
Sample and Data Sources

Sample:
- HMO, PPO, PFFS, SNP, or Medicare-Medicaid Plan with positive enrollment in the July monthly enrollment file
  - Employer plans are excluded unless noted
  - Demonstration plans are included unless noted

<table>
<thead>
<tr>
<th>Data</th>
<th>Years</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare plan benefit files</td>
<td>2015-2019</td>
<td>• Dental, Vision, Hearing, Transportation, SNF 3-day Waiver, Meals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Part B premium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type of Plan</td>
</tr>
<tr>
<td>Monthly Plan Enrollment</td>
<td>July, 2015-2019</td>
<td>• Enrollment</td>
</tr>
<tr>
<td>Directory File</td>
<td>2015-2019</td>
<td>• Non-Profit/For-Profit</td>
</tr>
</tbody>
</table>
Supplemental Benefit Offer Rates, 2019

Base Offerings by Enrollee Eligibility, 2019

Supplemental Benefit

- Dental
- Vision
- Hearing
- Transportation
- 3-Day Waiver
- Meal Benefit

Enrollment Type
- Employer
- General
- MMP
- SNP

Percent (%)
Closer Look at SNPs and MMPs: Offer Rates Vary, 2019

Base Supplemental Benefits by Special Needs Plans and Medicare-Medicaid Plans

- **Dental**
- **Vision**
- **Hearing**
- **Transportation**
- **3-Day Waiver**
- **Meal Benefit**

**Plan Type**
- Institutional
- Dual Eligible
- Chronic Condition
- MMP

**Type of Coverage**

**Percent (%)**

0 25 50 75 100
Program-Wide Offer Rates, 2015-2019

Base Supplemental Benefit Offerings by Year

Excludes SNPs, MMPs, and Employer Plans

Percentage (%)

Year
- 2015
- 2016
- 2017
- 2018
- 2019

Benefits
- Dental
- Vision
- Hearing
- Transportation
- 3-Day Waiver
- Meal Benefit
Supplemental Benefits Offerings Vary Among HMO, PPO, and PFFS

Base Supplemental Benefit by Plan Type

Type of Coverage

Plan Type
- HMO
- PFFS
- PPO

Percent (%)
Beneficiary Access to Dental, Vision, and Hearing Benefits Are Increasing
Beneficiary Access to Transportation, and Meal Benefits Increased in 2019

Transportation, 3-day Waiver, Meals

% of Enrollees

Year

Coverage
- trans
- waiver
- meals
Geographic Variation in Access to Dental Coverage

Number of Plans Per County Offering Benefit

% of Enrollees Per County with Benefit
Geographic Variation in Access to Meal Benefit

Number of Plans Per County Offering Benefit

% of Enrollees Per County with Benefit

Number of Options: 0, 1-4, 5+

% Enrollees: 0, 1-25, 25-50, 50+
Summary of Key Finding

- Access to Dental, Vision, Hearing, Meal benefits are increasing in the Medicare Advantage program
- Nearly all Medicare Advantage plans take advantage of the 3-day hospital stay waiver for SNFs
- Beneficiaries in West and Mid-West are less likely to have access
Next Steps

- Research needed to identify which types of beneficiaries benefit from supplemental benefits using Medicare approved data sources (ICD-10s, episodes of care)
- Take-up rates for these supplemental benefits are unknown
Medicare Advantage: New Options for Supplemental Benefits

August 29, 2019
1. Introduction
2. Medicare and Medicaid Funding
3. Factors Driving Need for Change
4. State and Federal Initiatives
5. CHRONIC Care Act
6. Implications for Stakeholders
7. Opportunities and Questions to Consider
Dr. Jay Bulot
Vice President for State Markets
WellSky Corporation

Brief Bio
• PhD Gerontology
  - Public Policy, Research Methods and Statistics
• Tenured Professor, Department Head, Associate Dean
• Executive Director of LA Governor’s Office of Elderly Affairs
• Director, Georgia Division of Aging Services
• Navigant Associate Director, LTSS
• ADvancing States, Past President, Vice President, Secretary and Treasurer
• ADvancing States Board Member since 2008
MEDICARE AND MEDICAID FUNDING

• Medicaid and Medicare each fund about half of total public spending, distribution of spending by program varies considerably by type of service
  – Medicare pays for short-term post-hospital SNF stays and physician services
  – Medicaid pays for long-term nursing facilities and alternative home-and community-based services
• Medicare and Medicaid goals may be different with regard to long-term care
  – Costs of avoidable hospitalizations fall on Medicare, so Medicaid has few incentives to invest in programs to reduce hospitalizations
  – For example, nursing facilities benefit if duals are hospitalized and return after three days at the higher Medicare SNF rate
FACTORS DRIVING CHANGE

Growing Costs

Attempts at Integration

Chronic Care Act – the Game Changer
Conservative CBO estimates suggest total long-term care expenditures will increase at a rate of 2.6 percent per year above inflation to $195 Billion in 2020, and a staggering $270 Billion in 2030.
Medicaid is the primary payer for formal LTSS, covering about 43 percent ($146 Billion) of all LTSS spending.

- In 2014, **$81 Billion (53 percent)** of Medicaid spending went to home- and community-based care (HCBS)
- **$71 Billion (47 percent)** to institutional LTSS
- Institutional care counts for **59 percent** of LTSS spending for older people and adults with physical disabilities

Social Security Trustees reported in April that “Social Security’s total cost is projected to exceed its total income (including interest) in 2020 for the first time since 1982.” The annual shortfall is expected to continue “throughout the remainder” of their foreseeable projections.

By 2035, the trust fund’s reserves are expected to be depleted.

Medicare is in even worse shape. Its Part A is already spending more each year than payroll taxes cover and is projected to be depleted in 2026.
INCREASING NEED + INCREASING COST + DECREASING INCOME/BENEFITS = NEED FOR CHANGE

The Unpredictability of Long-Term Care

HOW LONG...
The duration of paid care among 65-year-olds who will need it someday varies widely, but for many it is under one year.

- Less than 1 year: 48%
- 1 to 1.99 years: 19%
- 2 to 4.99 years: 21%
- 5 years: 13%

HOW MUCH...
The median annual cost of nursing home care depends on your state.

- U.S. OVERALL: $85,800
- Most expensive state in contiguous U.S.: CONNECTICUT: $150,200
- Cheapest state: TEXAS: $54,800

YOUR COSTS
One in four people now age 65 will face over $50,000 in lifetime out-of-pocket long-term care expenditures.

- Out-of-pocket spending
  - $250,000 or more: 9%
  - $150,000 - $250,000: 4%
  - $50,000 - $150,000: 11%
  - $0.01 - $50,000: 13%
  - $0: 63%

Prices are for a semiprivate room. The median annual cost in Alaska is $292,000. Source: Genworth

Source: Department of Health and Human Services

• Had Long Term Care Insurance?

• Spent $50,000, out of pocket, for healthcare expense?
Private long-term care (LTC) insurance: Typically inaccessible to anyone with current or future care needs due to high premium prices

- (LTC) insurance, which began as nursing facility insurance, has been available for about 30 years, the market for this insurance product is relatively small (estimated 7 – 9 million purchasers)
- Paying for private LTC insurance can be burdensome for individuals and families with limited incomes

Out-of-pocket: Few individuals can afford to pay out-of-pocket for needed long-term services and supports, especially those living on fixed incomes with limited personal savings and assets

- A person’s ability to pay for current LTSS needs and/or save for future potential LTSS needs depends on many factors, including, but not limited to, health status, employment status and history, household income, debt and asset levels, and the availability of natural supports (such as a family caregiver)
FOCUSING ON PERSON CENTERED CARE MAY ALSO YIELD COST SAVINGS

89 percent of Americans over the age of 50 wish to stay in their homes for as long as possible

<table>
<thead>
<tr>
<th>Consumer Savings</th>
<th>Medicaid Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Out of pocket spending is much higher for institutional than non-institutional care</td>
<td>• HCBS waivers result in a national average public expenditure savings of $43,947 per participant for that year</td>
</tr>
<tr>
<td>• Assistance for activities of daily living expenses were $554 and $1,065 for non-institutional and institutional services</td>
<td></td>
</tr>
</tbody>
</table>

Source: huduser.gov/portal/periodicals/em/fall13/highlight2.htm
In the last decade, the federal government has provided funding and flexibility for states to implement LTSS reforms:

- Older American Act
- Medicaid Waivers
- Money Follows the Person
- Balancing Incentive Program
- Risk Based MLTSS
- Dual Demonstrations
- ACOs/Medicaid ACOs
- Medicare Advantage (CCA)
OLDER AMERICANS ACT

Passed in 1965 as the first federal level initiative aimed at providing comprehensive services for older adults

Created the National Aging Network which provides funding - based primarily on the percentage of an area's population 60 and older for:

- Nutrition and supportive home and community-based services,
- Disease prevention/health promotion services
- Elder rights programs
- National Family Caregiver Support Program
- Native American Caregiver Support Program
GROWING AGING POPULATION PLACES TREMENDOUS STRAIN ON PUBLIC FUNDING

Figure 1. Older Americans Act Funding, Medicare Spending, and Older Adult Population Growth
Chronic Care Act
The recently passed federal budget law incorporated the “Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care (CHRONIC) Care Act” which makes significant policy changes to advance the goals of integrated, person-centered care for Medicare beneficiaries and those dually eligible for Medicare and Medicaid.

The CHRONIC Care Act is meant to address the siloed uncoordinated health care system that fails to meet complex needs and ignores individuals’ values, preferences, and goals.
CHRONIC CARE ACT: KEY COMPONENTS

Encourages Flexibility

- Allows flexibility to cover non-medical benefits, such as bathroom grab bars and wheelchair ramps, for identified high-need/high-risk members
- MA plans and ACOs may now offer a broader array of telehealth benefits
- ACOs will be able to identify and proactively reach out to potential members and provide incentives for beneficiaries to choose an ACO as their main service point
- Adapts benefits to meet the needs of chronically ill Medicare Advantage enrollees and expands testing of the Value-Based Insurance Design (VBID) model, which allows MA plans to experiment with different types of benefit packages to meet the needs of chronically ill beneficiaries

Source: http://www.asaging.org/blog/chronic-care-act%E2%80%94-path-better-care-older-adults
Leverages Existing Programs

- Authorizes SNPs to be a **permanent part of Medicare**, whereby managed care organizations can proactively identify and serve high-need/high-risk Medicare beneficiaries
  - Permanently authorizes three types of SNPs: D-SNP (dual eligibles), C-SNP (those with severe or disabling chronic conditions), and I-SNP (those in institutions)
- Formalizes the Medicare-Medicaid Coordination Office as the dedicated point of contact for states to assist with integration efforts
- Establishes a unified grievance and appeals process across Medicare and Medicaid for D-SNPs
- Provides D-SNPs three options for integrating Medicare and Medicaid long-term services and supports and/or behavioral health services by 2021

Source: http://www.asaging.org/blog/chronic-care-act%E2%80%94-path-better-care-older-adults
CHRONIC CARE ACT: KEY COMPONENTS

Leverages Existing Programs

- Establishes the new ACO Beneficiary Incentive Program whereby eligible ACOs can make incentive payments to beneficiaries for receiving primary care services (up to $20 per service)

- Extends and expands the Independence at Home program—a Medicare program that provides primary care in the homes of Medicare beneficiaries with chronic disorders
  - Medical professionals visit patients’ homes to accommodate travel expenses
  - IAH will expand its course to offer this home-based service to 15,000 people nationwide through September 2019

- Expansion of Telehealth by allowing Medicare Advantage plans more flexibility to design telehealth programs

Source: http://www.asaging.org/blog/chronic-care-act%E2%80%94-path-better-care-older-adults
EXPANSION OF MEDICARE ADVANTAGE SERVICES

• The Chronic Care act will allow Medicare Advantage plans to cover non-medical expenses **that can help enrollees improve their health such as:**
  - Paying for transportation to help people get to doctors’ appointments
  - Healthy food delivered to home-bound MA enrollees
  - In-home safety modifications such as bathroom grab bars

• The new rule will also allow MA plans to **offer different benefits to different groups**

• These tools are being offered to MA insurers but not to users of original Medicare, which includes Parts A and B of Medicare

Health Experts, Aging Agencies. SDOH Researchers and other HCBS Advocates have long argued that spending money on such items can reduce overall Medicare spending.
### EXPANSION OF MEDICARE ADVANTAGE SERVICES

<table>
<thead>
<tr>
<th>Adult day care services</th>
<th>Home-based palliative care</th>
<th>In-home support services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Services provided outside the home such as assistance with ADLs/IADLs, education to support performance of ADLs/IADLs, physical maintenance/rehabilitation activities, and social work services targeted to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization&lt;br&gt;• Recreational or social activities or meals that are ancillary to primarily health-related services and items may also be provided, but the primary purpose of adult day care services must be health-related and provided by staff whose qualifications and/or supervision meet state licensing requirements. Transportation to and from the adult day care facility may be provided and should be included&lt;br&gt;</td>
<td>• Home-based palliative care services to diminish symptoms of terminally ill members with a life expectancy of greater than six months not covered by Medicare (e.g., palliative nursing and social work services in the home not covered by Medicare Part A)&lt;br&gt;• Medicare covers hospice care if a doctor and/or the hospice medical director certify the patient is terminally ill and has six months or less to live&lt;br&gt;</td>
<td>• In-home support services to assist individuals with disabilities and/or medical conditions in performing ADLs and IADLs within the home to compensate for physical impairments, ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization. Services must be provided by individuals licensed by the state to provide personal care services, or in a manner that is otherwise consistent with state requirements.</td>
</tr>
</tbody>
</table>
### Respite support for caregivers of enrollees
- Respite care provided through a personal care attendant or the provision of short-term institutional-based care, as appropriate, to ameliorate the enrollees’ injuries or health conditions, or reduce the enrollees’ avoidable emergency and health care utilization.
- Respite care should be for short periods of time (e.g., a few hours each week, a two-week period, a four-week period) and may include services such as counseling and training courses for caregivers of enrollees.

### Medically approved non-opioid pain management
- Medically approved non-opioid pain treatment alternatives, including therapeutic massage furnished by a state licensed massage therapist.
- The non-opioid pain management item or service must treat or ameliorate the impact of an injury or illness (e.g., pain, stiffness, loss of range of motion).

### Stand-alone memory fitness benefit
- Memory fitness benefit may be incorporated as a component of a health education benefit and/or offered as a standalone benefit.
- The benefits and activities must be primarily for the prevention, treatment, or amelioration of the functional/psychological impact of injuries or health conditions.
## Home and bathroom safety devices and modifications
- Non-Medicare-covered safety devices to prevent injuries in the home and/or bathroom. Plans may also offer installation.
- The benefit may include a home and/or bathroom safety inspection conducted by a qualified health professional, in accordance with applicable state and Federal requirements, to identify the need for safety devices and/or modifications, as well as the applicability of the device or modification to the specific enrollee’s needs and home.

## Transportation
- Transportation to obtain non-emergent, covered Part A, Part B, Part D, and supplemental benefit items and services to accommodate the enrollee’s health care needs.
- For example, transportation for physician office visits.
- Transportation must be arranged, or directly provided, by the plan and may not be used to transport enrollees for purposes that are not health related.

## Over-the-counter health-related items and medications
- Health-related items and medications that are available without a prescription, and are not covered by Medicare Part A, Part B, or Part D.
Implications for Stakeholders
CCA STAKEHOLDERS AND INTEREST VARY

• CMS
• Medicare Advantage Plans
• State Units on Aging
• State Medicaid Agencies
• Area Agencies on Aging
• HCBS Service Providers
• Local and Regional Hospitals
• Health Systems and Physician Practices
• Medicare Home Health Providers
• Community Based Organizations.
MA PLANS WILL NEED TO INTEGRATE CARE TO BE SUCCESSFUL

Person Centered Care, That Drives Quality, Patient Engagement, and Lowers the Cost of Care

- Residential Care
  - Skilled Nursing
  - Assisted Living

- Home Care
  - Independent, healthy living
  - Community Clinics
  - Chronic Disease Management
  - Doctor’s Office
  - Skilled and Non-skilled Home Care and Community Based Services

- Acute Care
  - Community Hospital
  - Clinic
  - ICU
  - Emergency
MA PLANS WILL NEED TO DETERMINE HOW TO PROVIDE TRADITIONAL HCB SERVICES

Own (Buy or Build)
- Must consider resources to add service offerings and administrative modifications
- By owning the services, health systems can control the type and quality of care their patients receive, integrate the information into their EHR systems, and better manage care from a population health perspective.
- Must consider scale, expertise, and capital requirement considerations to be made.

Partner
- Relationships can take different forms e.g., leasing beds, and/or preferred referral networks
- Possibly identifying the high performers with quality care, patient satisfaction, and low readmissions and developing relationships that encourage accountability and high-quality outcomes
- Examples:
  - Post-Acute Care: Many established partnerships use their relationship as a platform to focus on quality initiatives for post-acute care. These efforts often focus on care transitions, augmenting clinical staffing, broadening the medical director role, reducing readmissions, developing patient-centered models, and enhancing clinical staff education.
  - Home Health Providers: May provide an additional role to health systems or plans by providing and opportunity for real time patient information (using technology) to flag potential health problems, signaling the right medical professionals, decreasing unnecessary readmissions
MA SERVICE EXPANSION WILL REQUIRE A NEW SKILL SET TO FILL GAPS IN CARE

Care managers will lead the team for coordination/management of services, such as:
• Transportation
• Medication coverage
• Keeping provider appointments
• Housing
• Coverage for social concerns
• Food
• Financial assistance
• Discharge planning
• And probably much much more....

Filling these gaps will decrease readmissions, hospital ED visits and overall costs
Both have extensive experience funding and developing policy around how to most effectively deliver non-medical, community-based long-term care.

Medicaid Agencies can leverage their financial relationship with Medicare Advantage plans to encourage coordination of service, common definitions and requirements, while encouraging the use of the existing statewide infrastructure.

SUA Administers OAA services (which are very similar to new many of the new MA benefits) and are required to have statewide coverage for services.

States who fail to lead these discussion risk having their traditional OAA and Medicaid LTSS program negatively impacted.
## SUA AND AAA: SELECT CROSS-OVER SERVICES

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>OAA FUNDED SERVICES</th>
<th>MA PLANS (CCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult day care services</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Meal Delivery</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Grocery Shopping</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Food and Produce</td>
<td>*</td>
<td>x</td>
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<tr>
<td>Pest Control</td>
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<td>x</td>
</tr>
<tr>
<td>Self Direction</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Community or Social Clubs</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Respite Care</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Caregiver Support</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Home Modifications</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Legal Assistance</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Homemaker Services</td>
<td>X</td>
<td>x</td>
</tr>
</tbody>
</table>

AREA AGENCIES ON AGING

• AAA may have more opportunities to work directly with Medicare Advantage Plans, hospitals and Home Health Agencies, as they have a long history of already coordinating and delivering relevant in-home services like:
  • home modifications
  • Transportation
  • Nutritional assistance
  • Respite
  • Case Management

• Other opportunities exist for AAAs to expand their impact by offering supplemental support with evidence-based programs including Care Giver Support and Chronic Disease Self-Management Programs.

• Those with demonstrable experience may also be able to leverage their care transition programs (Hospital Care Transitions, Nursing Facility Care Transitions, etc)
• AAA, if they have not already done so, should be reaching out to any Medicaid Managed Care Organizations and Medicaid Advantages operating in their regions; as well as hospitals and other health care facilities.
• Many most don’t have active partnerships with MA plans, nor do they know how to reach out.
• State Medicaid Agencies may be able to facilitate, through MIPPA Plans.

AAA who fail to develop these relationships risk Medicare Home Health Agencies usurping their role as the primary provider/coordinator of non-medical HCBS Services.
Questions to Consider
QUESTIONS TO CONSIDER

- How will MA plans coordinate and pay for services for members who are receiving other state-coordinated HCBS services?

- How or will the differences in how CMS defines the services for the CCA and how states have defined them impact care coordination and service delivery?

- What effect will MA-coordinated HCBS services have on service delivery for existing HCBS programs (OAA and Waiver Services)?

- What other opportunities exist or can be leveraged to ensure adequate coordination across payors (Medicare Advantage, OAA Services and Waivers)?
Questions
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About WellSky

WellSky is a technology company advancing human wellness worldwide. Our software and professional services address the continuum of health and social care — helping businesses, organizations, and communities solve tough challenges, improve collaboration for growth, and achieve better outcomes through predictive insights that only WellSky solutions can provide.
We are committed to

• Serving our customers to ensure they can serve their communities

• Anticipating provider needs in an ever-changing care landscape

• Using data and applied insights to elevate and intelligently scale care

Together, we are realizing care’s potential and building communities that thrive.
We partner with organizations across the care spectrum

Hospital: Ensuring hospitals can focus on delivering superior patient care safely and efficiently

Practices & Facilities: Enhancing providers’ abilities to streamline operations and focus on the delivery of care

Home: Empowering providers to deliver exceptional care while focusing on improving outcomes

Community: Supporting dynamic communities of care with our diverse set of human services solutions
Hospital

- Blood Transfusion
- Hospital Donor Program
- Biotherapy Clinics
- Inpatient Rehabilitation
- Outpatient Rehabilitation
- Acute Respiratory & Rehabilitation
- Enterprise Scheduling
- Medication Management
- International Medication Management

Home

- Home Health
- Hospice
- Home Infusion
- Specialty Pharmacy
- Home Medical Equipment
- Private Duty
- Home Health Therapy
- OASIS Review & Coding
- Billing & Revenue Cycle Services
- DDE & Payer Connection

Practices & Facilities

- Behavioral Health & IDD Providers
- Donor Testing Services
- Biotherapy Labs
- Private Practice Rehabilitation
- Scheduling
- Long-Term Care
- Correctional Medication Management

Community

- Payers
- IDD Payers
- Aging & Disability
- Protective Services
- Incident Management
- Information & Referral
- Community-Based Organizations
- Housing & Homelessness
- Blood Centers
Practices and Facilities
• +50 million blood donor tests annually
• +22 million rehab treatments in 12 months
• +2.3 million rehab patients served in 12 months
• +135 medication management facilities (including 34 correctional health facilities)

Community
• +35,000 daily users
• + 3,000 agencies providing services
• Used by majority of Area Agencies on Aging
• Used by majority of HUD Continuums of Care
• Customer organizations in 50 US states, Washington D.C., and Canada

Hospital
• FDA 510(k) cleared system for blood banks
• The blood compliance solution for U.S. Department of Defense facilities worldwide
• + 450 transfusion sites worldwide
• + 20,000 cord blood and tissue donors registered

Home
• +4,500 home health and hospice agencies
• +34 million billable visits in 12 months
• +$11 billion Medicare claims processed
• +200,000 care tasks every day

WellSky