THE CHANGING LANDSCAPE OF LONG-TERM SERVICES AND SUPPORTS (LTSS): MEDICAID, OLDER AMERICANS ACT (OAA), AND NOW MEDICARE?

2018 NASUAD HCBS CONFERENCE

BALTIMORE, MD

NAVIGANT

AGENDA

4:15 – 4:25	Growing Costs of Long Term Services and Supports (LTSS)
4:25 – 4:35	History of Addressing LTSS
4:35 – 4:45	Policies and Programs reforming the Provision of LTSS
4:45 – 5:20	Implications for Stakeholders
5:20 – 5:30	Closing Remarks, Q & A

GROWING COSTS OF LONG TERM SERVICES AND SUPPORTS

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Rising costs of everything from home ownership to higher education are making it harder than ever for Americans to save for retirement and the LTSS that more and more people require…With demand for LTSS likely doubling over the next 30 years, ***the time for action and forward-facing reforms is now.***

- AMA Board Member Stephen R. Permut, M.D., J.D

Growing Costs

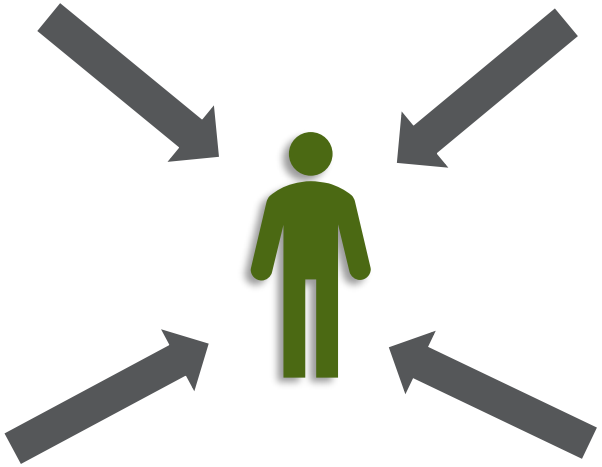
Attempts at Integration

Chronic Care Act – the Game Changer

NAVIGANT LTSS AND MEDICARE ADVANTAGE SOLUTIONS

Home Health Providers
- Medicare Advantage Service Expansion
- Post Acute Care Network Strategy

Health Systems & Hospitals
- Continuum Care Management Design
- Discharge Planning Process Redesign
- Post-Acute Care Network Strategy
- Episode Payment Model Readiness and Implementation Support
- Readmission Prevention

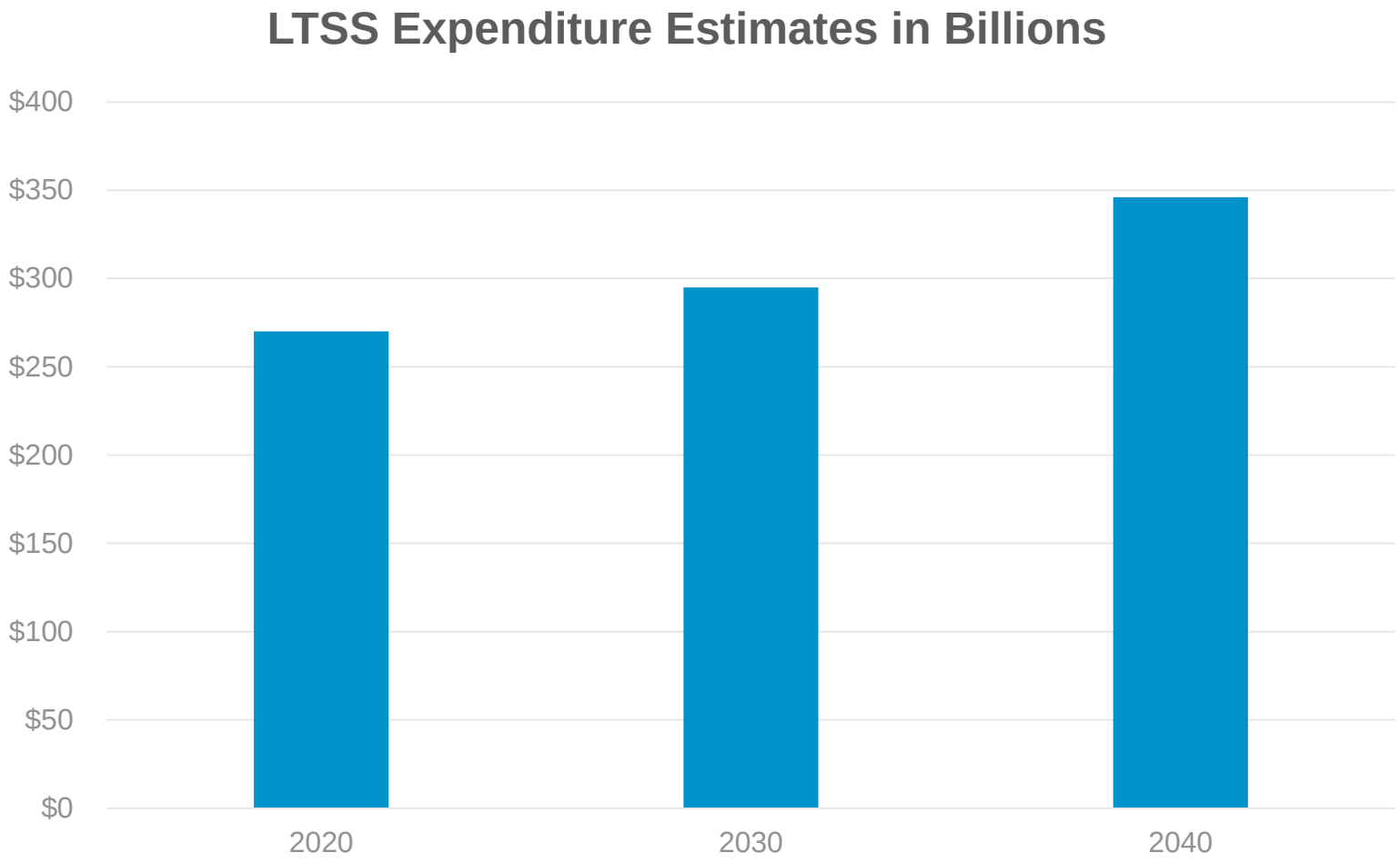


Health Plans
- Care Coordination
- Proposal Development
- DNSP/MA Experience

Government
- HCBS Waiver Redesign
- MLTSS Program Design
- LTSS Monitoring and Oversight
- Procurement Support
- Readiness Review

ARE WE GOING TO HAVE THE RESOURCES TO PROVIDE THESE SERVICES IN THE FUTURE?

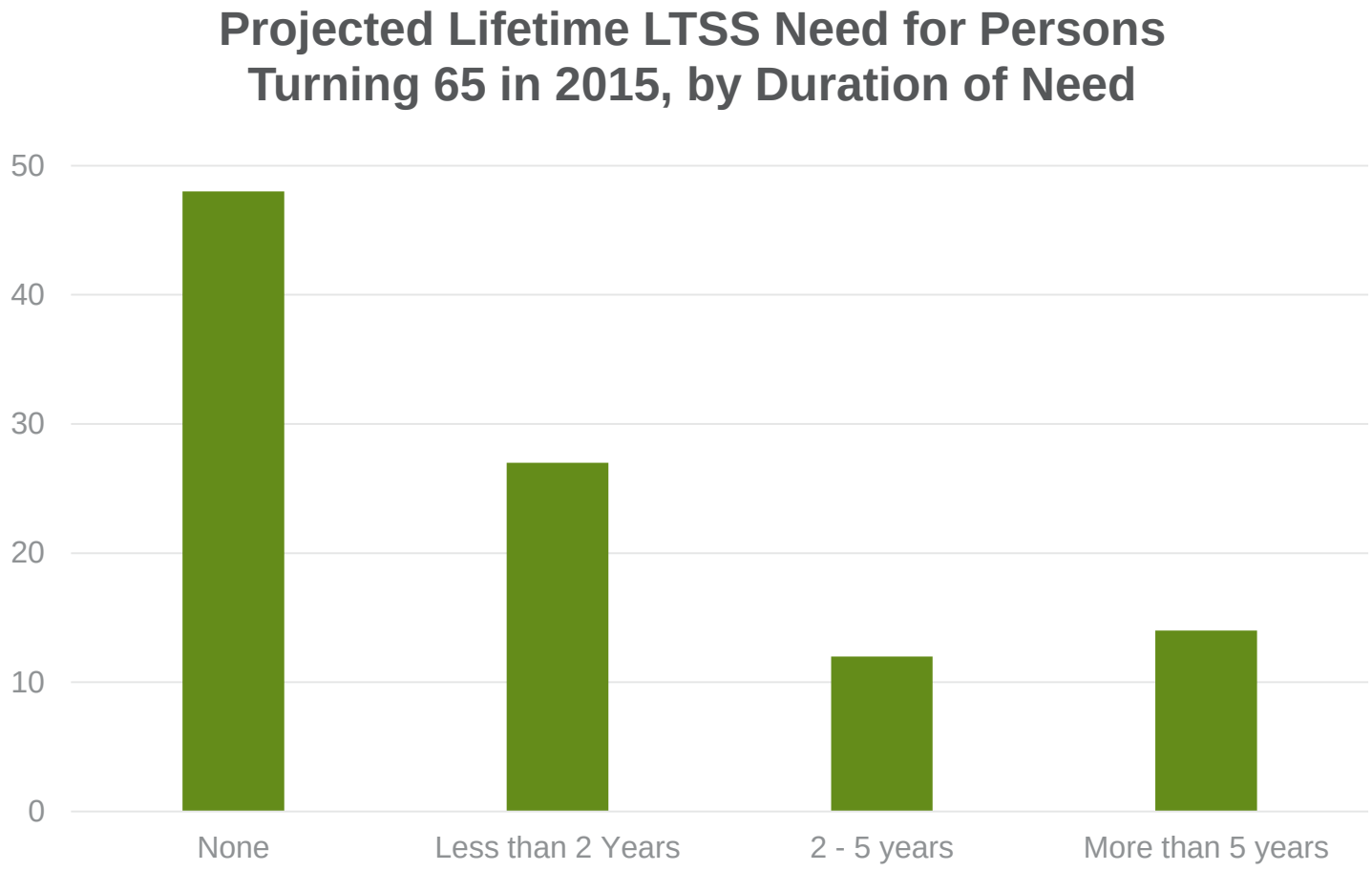
Conservative CBO estimates suggest total long-term care expenditures will increase at a rate of 2.6 percent per year above inflation to $195 Billion in 2020, and a staggering $270 Billion in 2030



LONG TERM SERVICES AND SUPPORTS IMPACTS OVER 12 MILLION

12 Million People as of 2017	
Aging and Physical Disabled	Disabled (ID/DD)
Institutional	Community Based

- Most people will need some form of LTSS in their lifetime, including assistance with daily activities such as bathing and dressing, because of a physical impairment or a cognitive impairment
- 18 percent of all seniors will require more than one year in a nursing facility



AGING PROJECTIONS – THE SILVER TSUNAMI IS COMING

In 2011, the oldest Baby Boomers (defined by those born between 1946 and 1964) began celebrating their 65th birthdays and **each day through 2029, 10,000 more will cross that threshold nationwide**

According to the latest population projections, **adults 65 and older will outnumber children** for the first time in U.S. history by the year 2035

The Census Bureau projects a **200 percent increase in the number of people 85 and older** between now and 2060

Senior population is estimated to **reach 92 Million by 2030**

Source: https://www.aarp.org/content/dam/aarp/ppi/2017-01/Fact%20Sheet%20Long-Term%20Support%20and%20Services.pdf

ACUITY CREEP AND AN OLDER, HEALTHIER POPULATION

The US population is healthier, living longer and feeling better at more advanced ages

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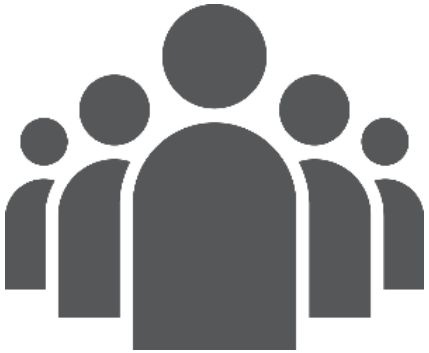


Older seniors want to age in place → Delay need for LTSS → Require LTSS at more advanced ages, with multiple chronic conditions → Higher costs of care results in Medicaid or private coverage for LTSS

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

Consumer Savings

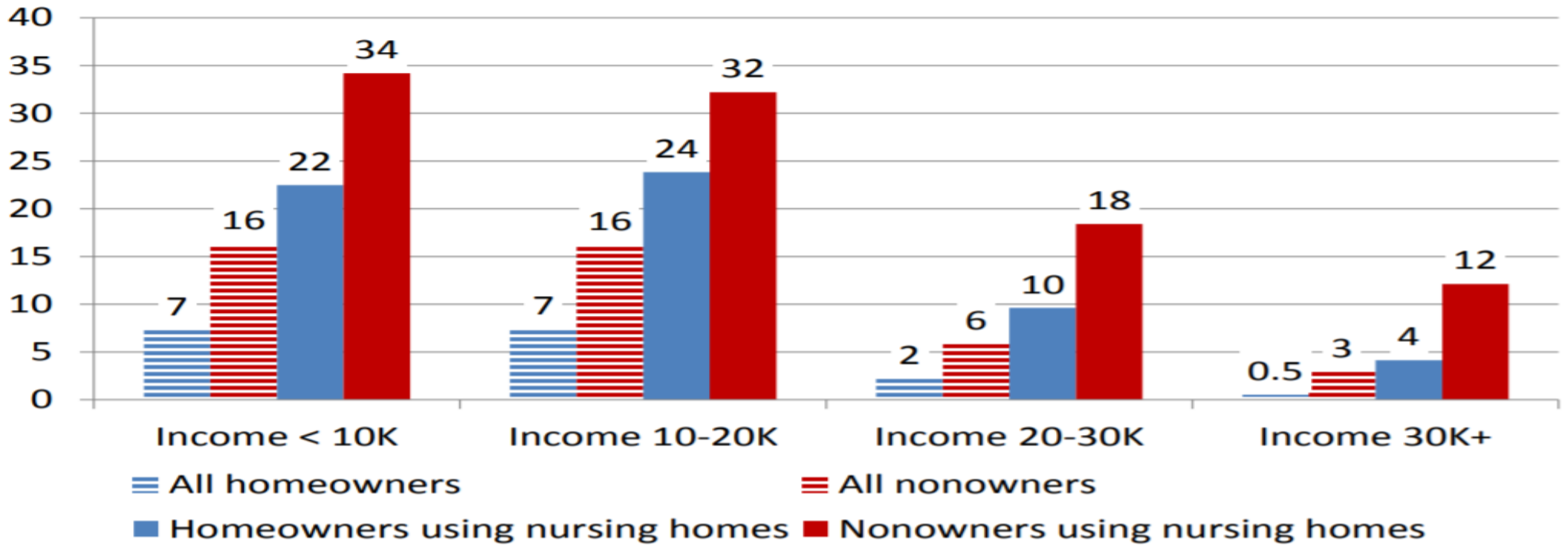
- Out of pocket spending is much higher for institutional than non-institutional care
- Assistance for activities of daily living expenses were $554 and $1,065 for non-institutional and institutional services

Medicaid Savings

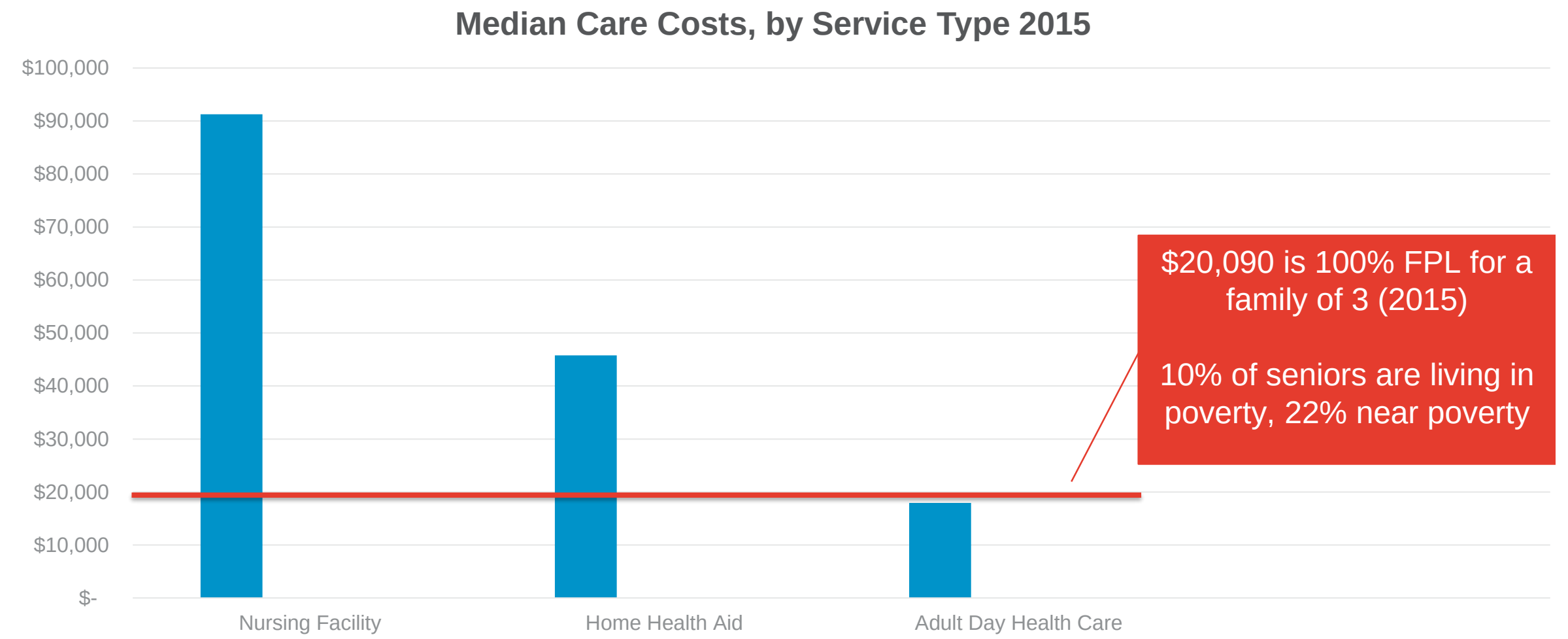
- HCBS waivers result in a national average public expenditure savings of $43,947 per participant for that year

Source: huduser.gov/portal/periodicals/em/fall13/highlight2.htm

Predicted Medicaid transition rate over 4 years by income, home ownership, and nursing home use

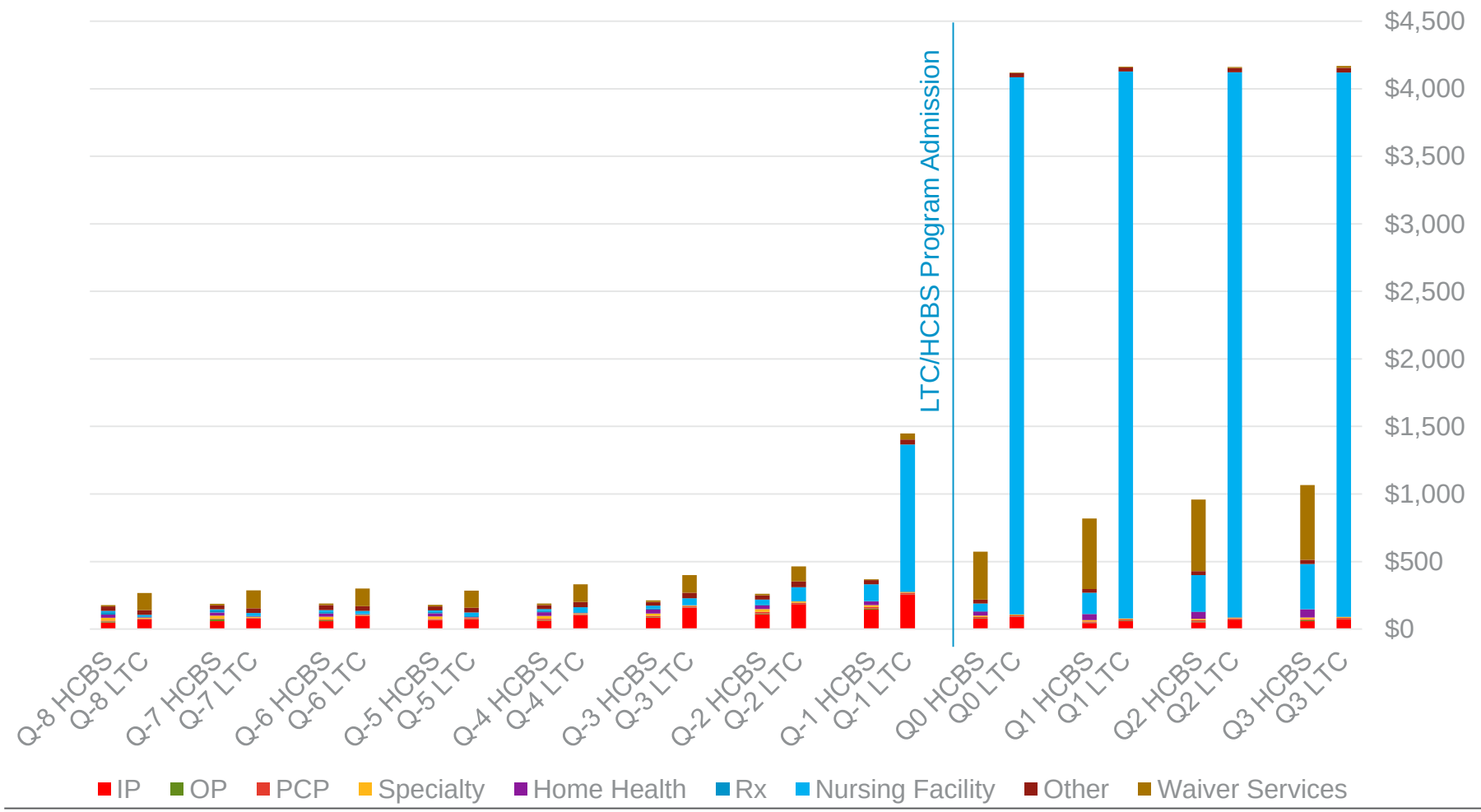


LTSS EXPENSES EXCEED WHAT MOST FAMILIES CAN AFFORD



Source: Genworth Cost of Care Survey, 2015

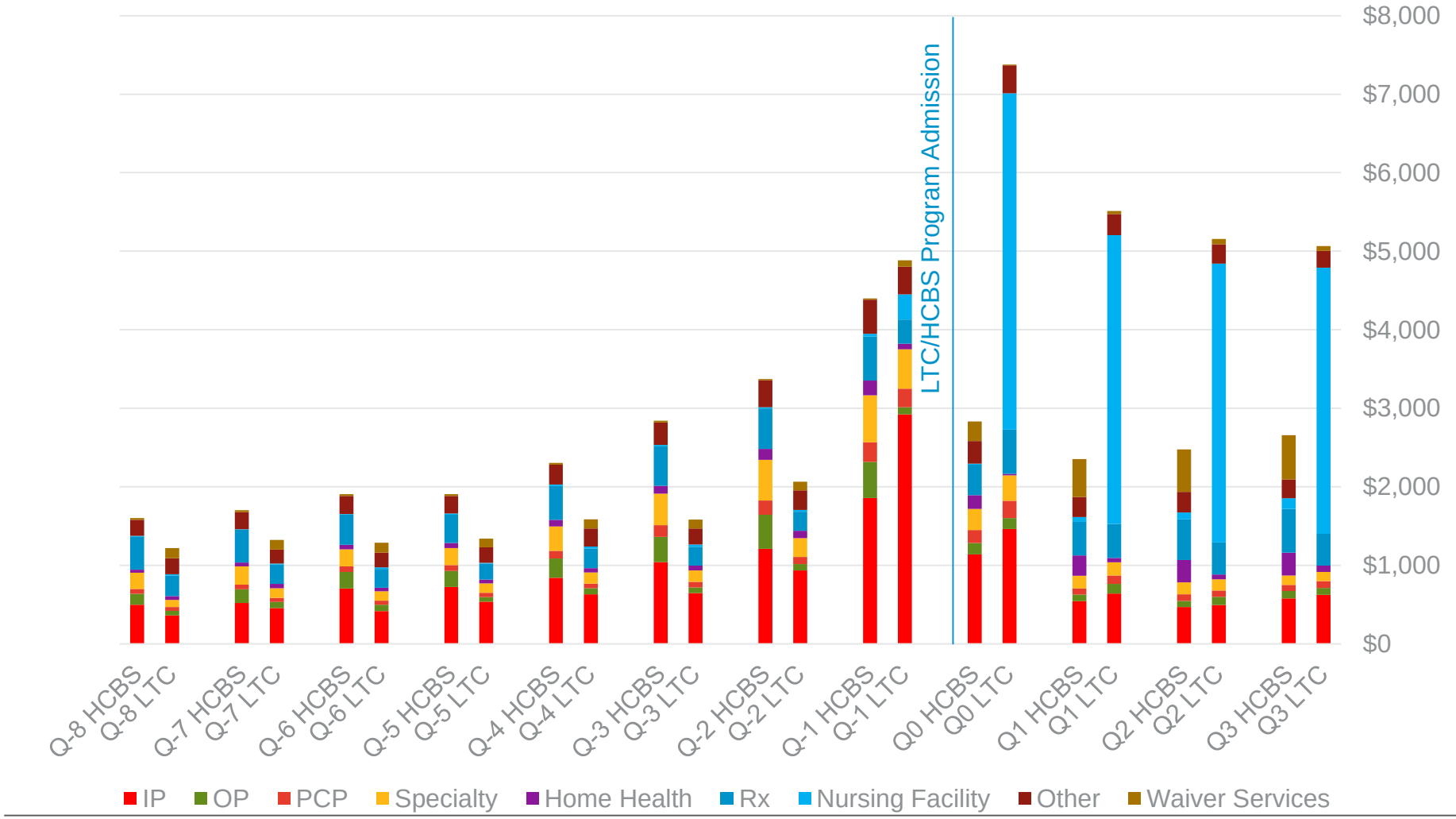
DUAL LTC AND WAIVER UTILIZATION/EXPENDITURE PMPM



Key Findings

1. Similar healthcare utilization prior to admission to program for pre HCBS and Pre LTC groups
2. Substantial cost differential for individuals utilizing LTC vs HCBS
3. Significant potential for serving individual in most integrated setting based on prior utilization

NON-DUAL LTC AND WAIVER UTILIZATION/EXPENDITURE PMPM



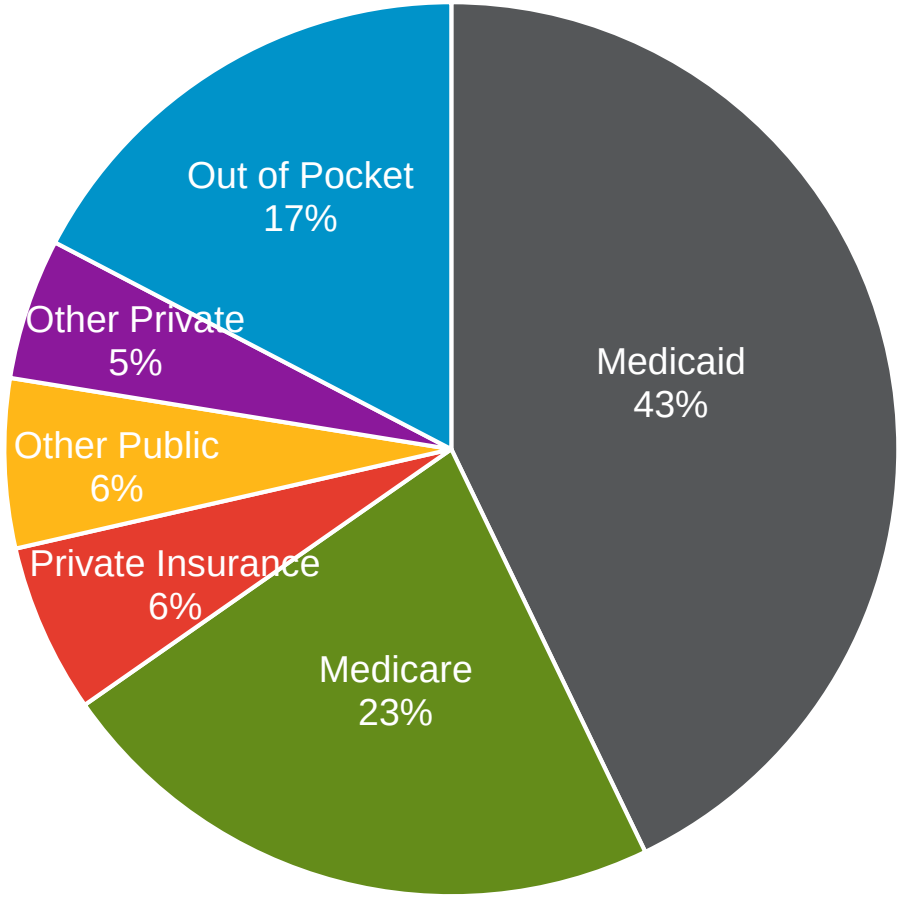
Key Findings

1. Pre-HCBS group has higher healthcare utilization than Pre-LTC group
2. Substantial utilization of IP services
3. Appears to be little care coordination or involvement of a PCP
4. Similar healthcare utilization prior to program admission
5. Substantial cost differential for individuals utilizing LTC vs HCBS

PAYING FOR LTSS SERVICES

- 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

National Spending for LTSS, by Payor



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 3, 2013.

PRIVATE LTSS COVERAGE

- **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)

PUBLIC COVERAGE FOR OPTIONS

Medicaid

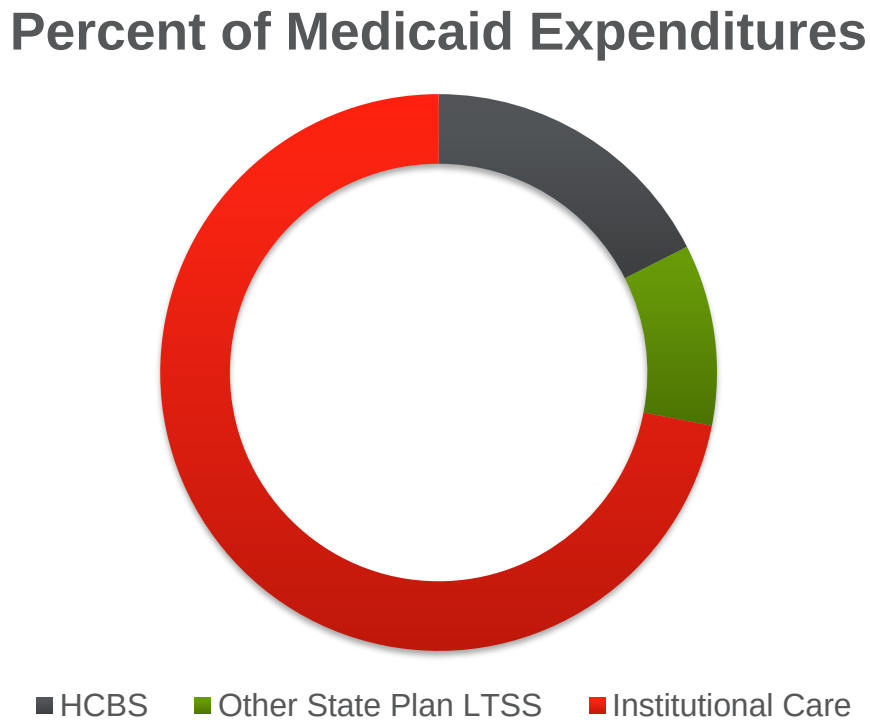
- States have flexibility in coverage of LTSS but generally must provide nursing facility and home health services to adult beneficiaries
- All other LTSS, particularly most HCBS, are optional for states. Examples of Medicaid HCBS include homemaker/home health aide services, personal care or attendant services, adult day health services, case management, habilitation, respite care, home modifications, and home delivered meals
- Over the last thirty years, there has been a shift toward serving more people in the community rather than institutions due in large part to the growth in beneficiary preferences for HCBS and states' obligations under the Supreme Court's Olmstead decision
- Individuals with extensive medical and LTSS needs may require around-the-clock care that is provided in an institutional setting
- Almost all states (46 states in both fiscal year (FY) 2015 and 2016) continue to focus on expanding beneficiary access to Medicaid HCBS services

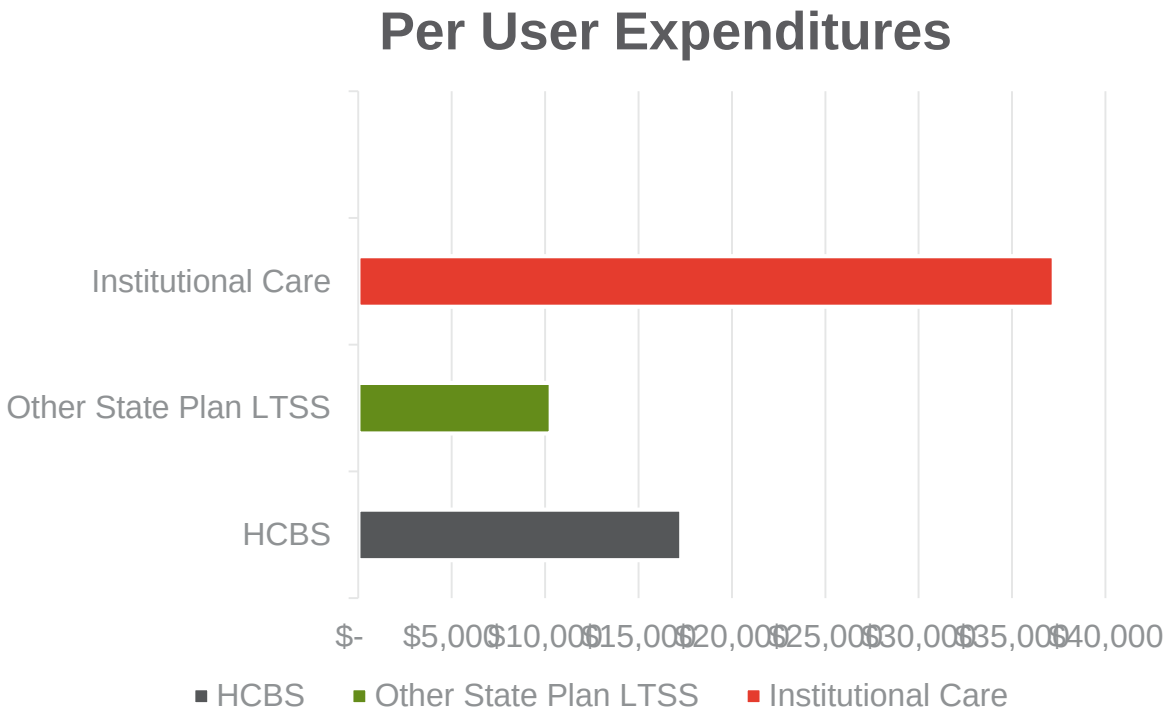
Medicare

- Medicare coverage of long-term services and supports for seniors, nonelderly people with disabilities, and people with certain chronic conditions is limited
- Medicare covers both acute care and post-acute services for people who have a qualifying work history and are:
  - Age 65 or older
  - Are under age 65 and have been receiving Social Security Disability Insurance for more than 24 months
  - Have end-stage renal disease or Amyotrophic Lateral Sclerosis.
- Home health services are only covered for beneficiaries who are homebound, and personal care services are not covered by Medicare
- Post-acute nursing facility care is covered for up to 100 days following a qualified hospital stay

LTSS IS EXPENSIVE
Institutional Care Drives Costs

Institutional care accounts for a large portion of the $57 Billion in LTSS Medicaid expenditures for the 2.1 million enrollees *over age 65*



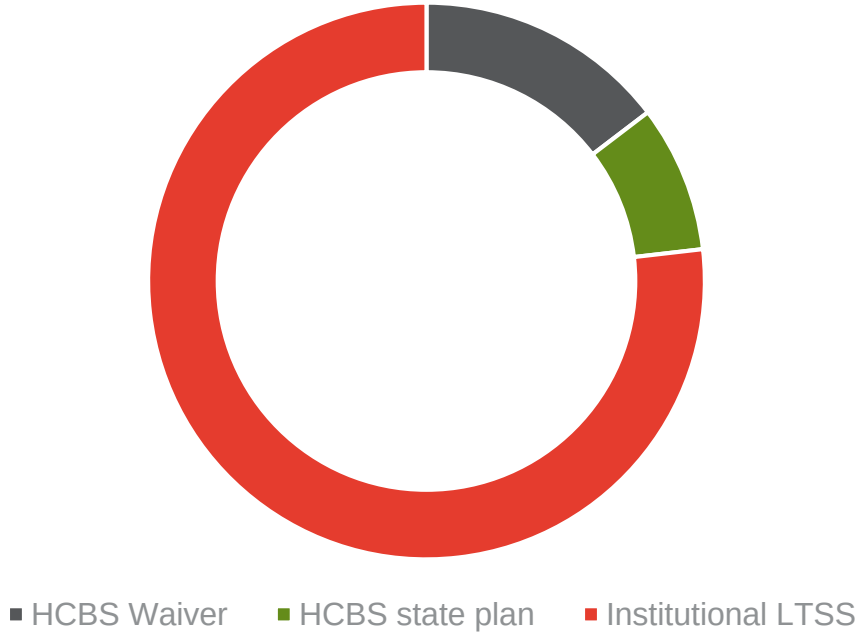


https://www.openminds.com/market-intelligence/executive-briefings/big-medicaid-spend-65-population/

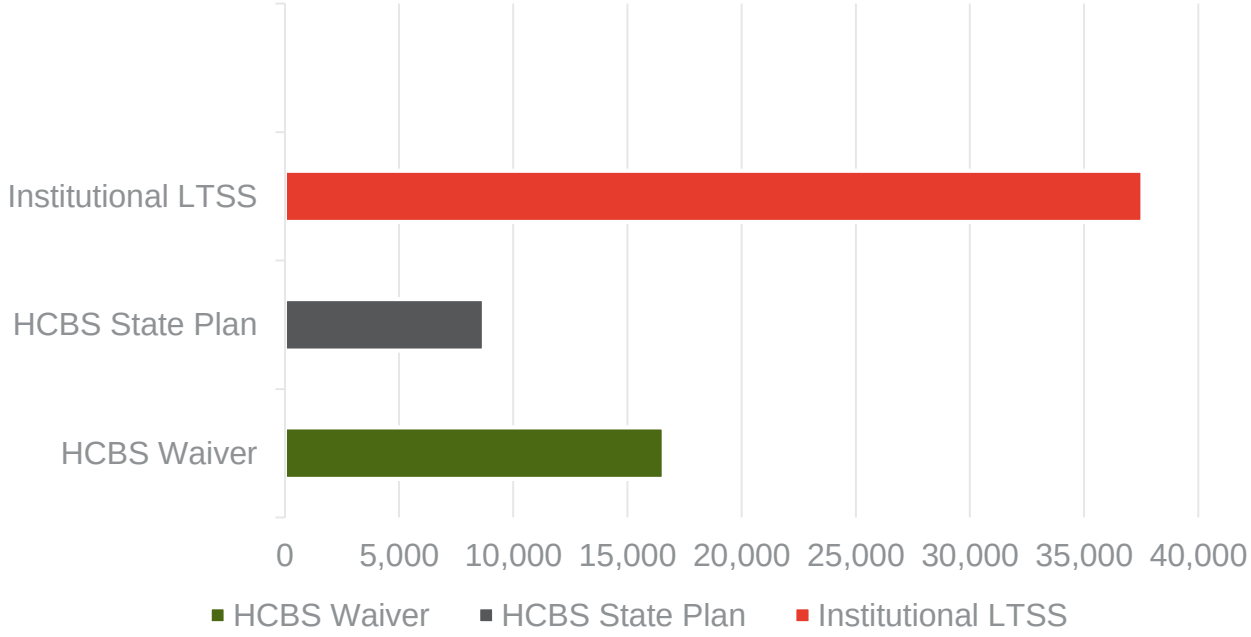
LTSS IS EXPENSIVE
Dual Eligibles Drive Costs

Intuitional care accounts for a large portion of Medicaid spending for the 10 Million individuals
dually-eligible for Medicare and Medicaid

Percent of Medicaid Spending



Dual Eligible Per User Expenditures



Source:https://markets.businessinsider.com/news/stocks/managed-ltss-health-plan-association-applauds-congress-and-president-for-passage-of-legislation-to-improve-medicare-medicaid-coordination-1015769926

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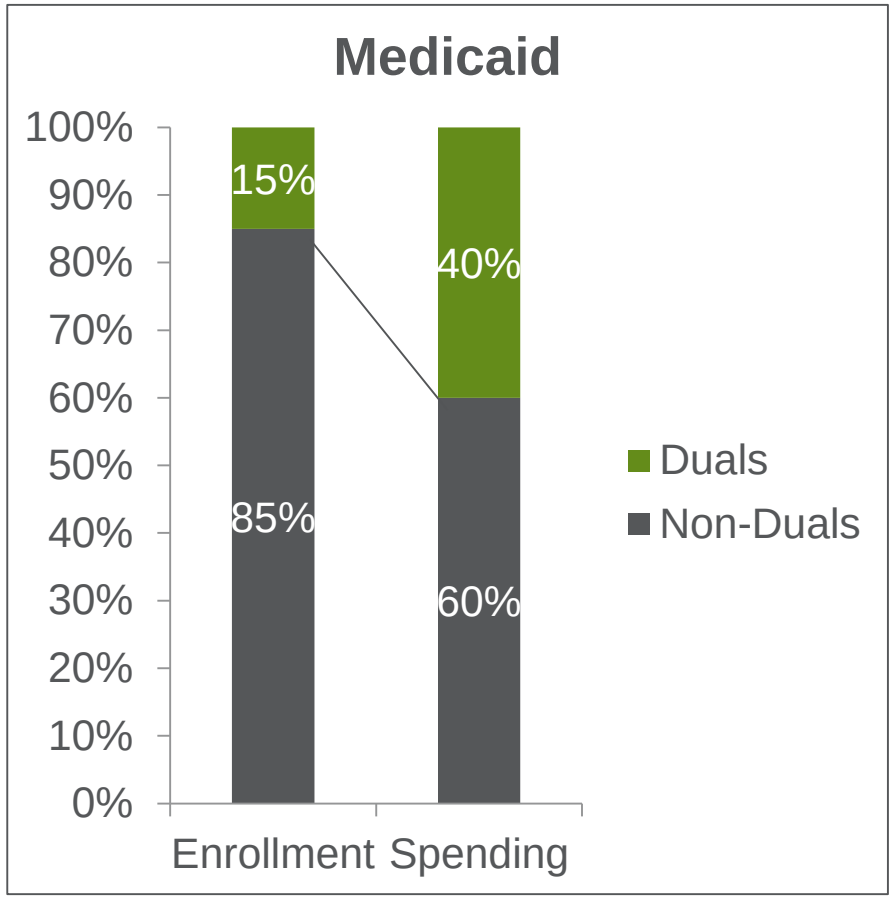
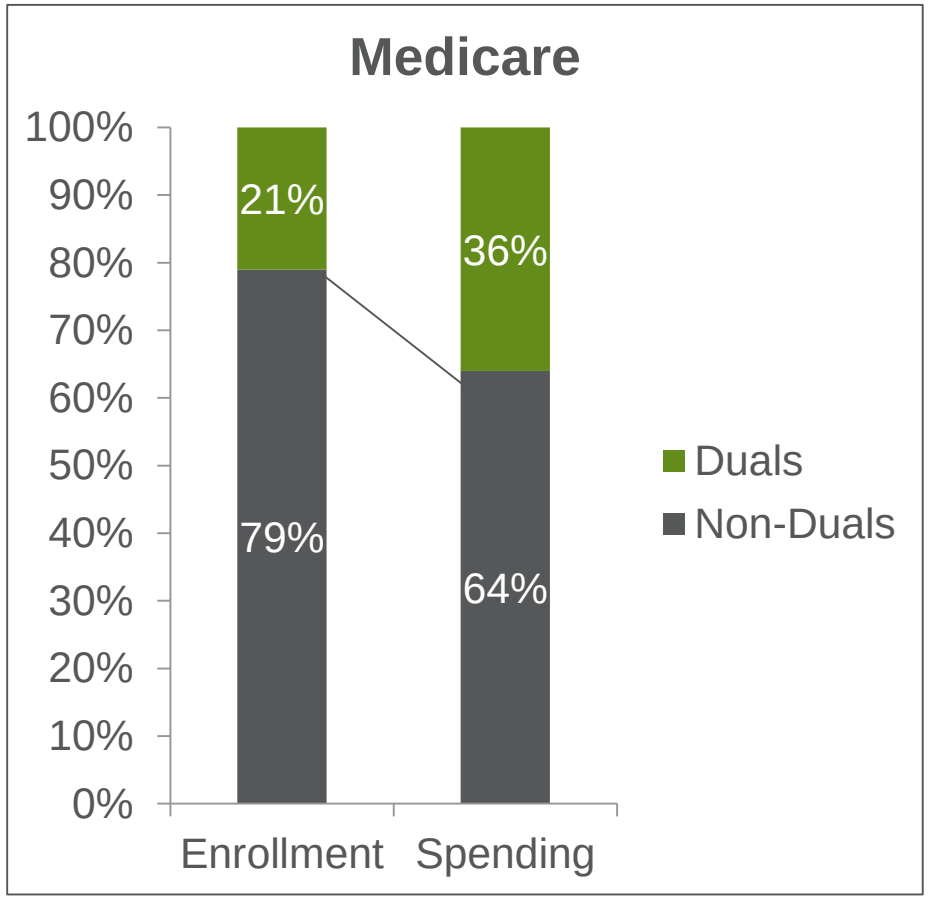
COST OF CARE IS HIGHER FOR DUAL ELIGIBLES





CARE OPPORTUNITIES TAILORED TO SPECIFIC SEGMENTS OF THE DUAL POPULATION

Identify people who are likely to be nearing the end of life and provide intense palliative services for a relatively fixed period of time.	• Many Duals require intensive services for short periods near the end of life • Among high-cost dual eligibles ages sixty-five and older, nearly half die and one-quarter revert to lower spending levels by the end of the following year, leaving only about 30 percent persistently high cost • High-cost community-dwelling dual eligibles younger than sixty-five, two-thirds of whom remain high cost
Reduce reliance on acute care settings through increased use of home and community-based services	• 57 percent of high-cost dual eligibles reside in the community and not in nursing homes • Within the community-dwelling group, the older high-cost dual eligibles use fewer home and community-based long-term services and supports than younger dual eligibles
Expand medical services and psychiatric care and improve care transitions to improve care and reduce the need for acute hospitalization	• High-cost dual eligibles often use costly inpatient settings, including all types of acute care hospitals (medical, psychiatric, and rehabilitation) and inpatient long-term services and supports settings, in addition to nursing homes • Among high-cost dual eligibles residing in nursing homes, spending in Medicare exceeds Medicaid nursing home spending

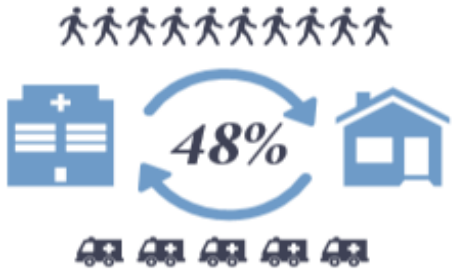
DISCONNECT BETWEEN MEDICARE AND MEDICAID FUNDING

- 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

DISCONNECTS LEAD TO POOR QUALITY

DUAL-ELIGIBLE BENEFICIARIES HAVE A HIGHER RISK OR RE-HOSPITALIZATION

1/2 of all Medicare patients with chronic obstructive pulmonary disease and congestive heart failure are hospitalized at least once during the year,



2x but of these patients, dual-eligible individuals are about two times as likely to return to the hospital multiple times during the year.

DUAL-ELIGIBLE BENEFICIARIES FACE BARRIERS TO RECEIVING INTEGRATED CARE

2–5 Enrollment cards

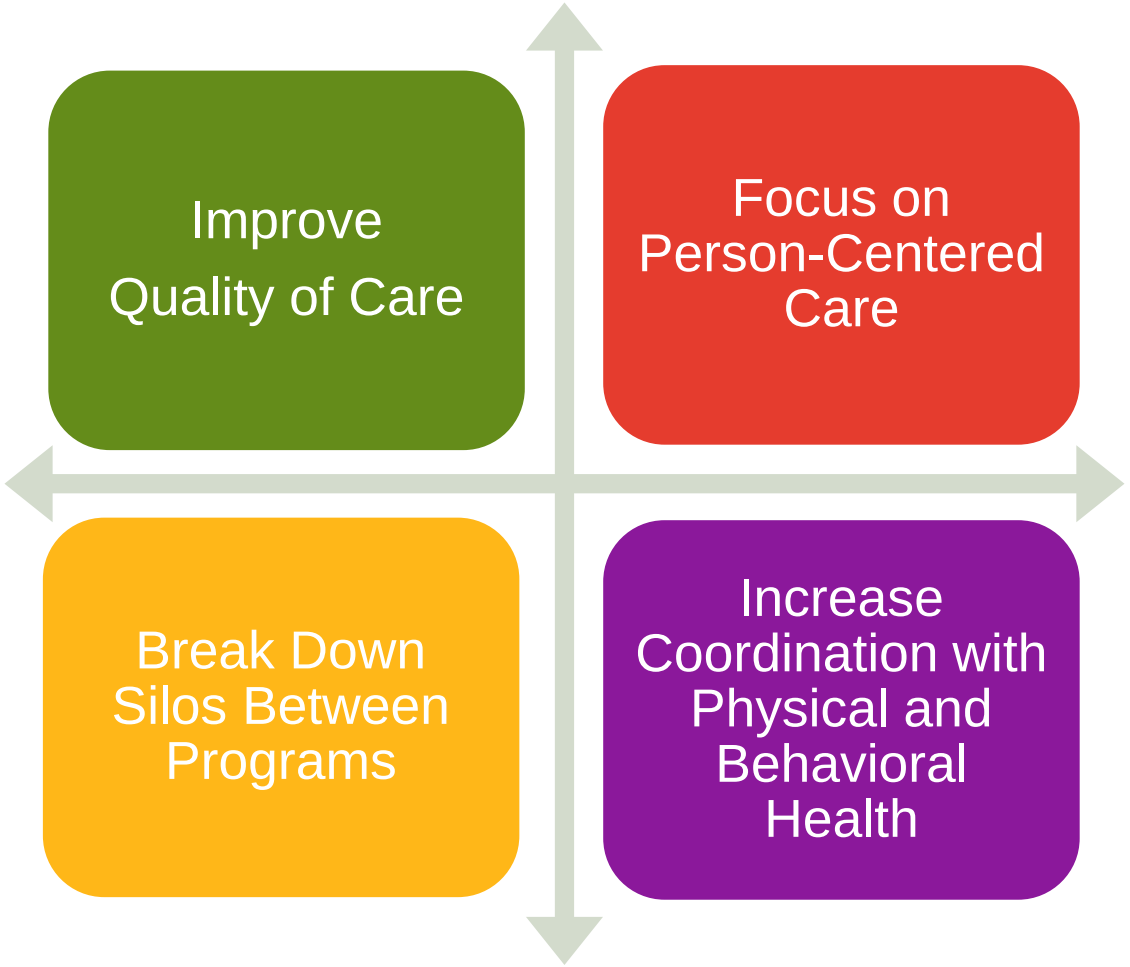
2 Processes & Contact Numbers for Coverage Appeals

2+ Sets of Rules for Benefits & Cost-Sharing

2 Enrollment Periods & Deadlines for Applications

CAN WE ACHIEVE SUCCESS BEYOND COST SAVINGS?

Improved Quality, Increased Person-Centeredness



PUBLIC PAYORS ARE RESPONDING TO THE NEED FOR MORE INTEGRATED CARE

Since 2010, Medicare and Medicaid have been steadily moving towards more integrated value-based, organized care that rewards providers and health plans for improved quality and efficiency

- Medicare Advantage (MA) enrollment increased to 19 million beneficiaries, which includes
- 2.3 million in Special Needs Plans (SNPs)
- Several states are integrating Medicaid with Medicare, bolstered by growth of managed long-term services and supports now operating in 22 states
- Accountable Care Organizations (ACOs) serve over 10 million Medicare beneficiaries

HISTORY OF ADDRESSING LTSS THROUGH INTEGRATION

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STATES HAVE ANTICIPATED THESE PRESSURES AND PURSUED OPPORTUNITIES TO REFORM MEDICAID LTSS

Over the last decade, the federal government has provided funding and flexibility for states to implement LTSS reforms

- Older American Act
- Money Follows the Person
- Balancing Incentive Program
- Dual Integration

OLDER AMERICANS ACT

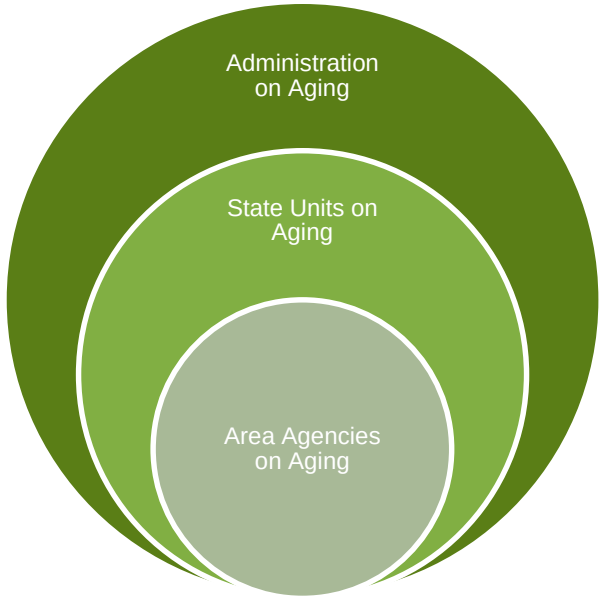
OLDER AMERICANS ACT

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

In 2016, Congress reauthorized the Act in its entirety, effective through FY 2019



MONEY FOLLOWS THE PERSON

THE MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION GRANT

MFP

- Authorized under the Deficit Reduction Act of 2005
- 43 states and the District of Columbia participate in the program
- Over 75,151 people with chronic conditions and disabilities have transitioned from institutions back into the community through MFP programs as of December 2016
- Goals:
  - Increase the use of home and community-based services (HCBS) and reduce the use of institutionally-based services
  - Eliminate barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice
  - Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
  - Put procedures in place to provide quality assurance and improvement of HCBS

Source: https://www.healthmanagement.com/blog/dual-eligible-financial-alignment-demonstration-enrollment-update/

Source: https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html

THE MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION GRANT

MFP

- The Affordable Care Act of 2010 strengthens and expands the MFP program to more states:
  - Extends the MFP program through September 30, 2016 and appropriates an additional $2.25 billion ($450 million for each fiscal year (FY) 2012-2016). Any funds remaining at the end of each fiscal year carry over to the next FY, and can be used to make grant awards to current and new grantees through FY 2016
  - Grant awards are available to states for the fiscal year they receive the award, and four additional fiscal years after. Any unused grant funds awarded in 2016 can be used through FY 2020
  - Expands the definition of who is eligible for the MFP program to include people that live in an institution for more than 90 consecutive days. (Exception: days that a person was living in the institution for the sole purpose of receiving short-term rehabilitation services reimbursed by Medicare don't count toward this 90-day period)

Source: https://www.healthmanagement.com/blog/dual-eligible-financial-alignment-demonstration-enrollment-update/

Source: https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html

MFP PROGRAM RESULTS

MFP Transitioned Over 63,000

- Number of beneficiaries transitioning through MFP increased each year from 2008 to 2015
- In 2015, states transitioned 11,661 participants
- States encountered challenges, including:
  - Insufficient supply of affordable and accessible housing
  - Staff shortages (e.g., transition coordinators and case managers)
  - Low numbers of referrals from nursing facilities

Estimated $978 Million in Savings from 2008 to 2013

- In the first year after transitioning, monthly Medicaid expenditures per beneficiary declined by an average of:
  - $1,820 (23 percent) for older adults,
  - $1,783 (23 percent) for individuals with physical disabilities, and
  - $4,013 (30 percent) for individuals with intellectual or developmental disabilities.

Evidence MFP Participants Had Positive Outcomes

- MFP participants were less likely than a comparison group to be readmitted to an institution in the year after transition
- Quality of life surveys showed improvement in satisfaction with care and living arrangements, and fewer reports of barriers to community integration

BALANCING INCENTIVE PROGRAM

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BALANCING INCENTIVE PROGRAM (BIP)

BIP

- Developed under ACA
- Goals:
  - Improve access to Medicaid LTSS in community settings by giving states an increased federal matching rate for community-based services
- 18 states received BIP funding and were required to:
  - Implement a “no wrong door” system, core standardized assessment, and conflict-free case management
  - Use the funds to improve access to LTSS in the community
  - Spend a certain percentage of total LTSS funds on community LTSS

https://www.milbank.org/wp-content/uploads/2017/12/Strengthening-LTSS-Toolkit_120717.pdf

BALANCING INCENTIVE PROGRAM (BIP)

BIP

- Based on states' reports, the no wrong door system had the largest impact on access to community LTSS by increasing entry points, streamlining the referral process, and improving awareness of services
  - States that spent less than half of their total LTSS dollars on community LTSS in 2009 receive a two percent enhanced federal match rate, while states that spent less than a quarter receive a five percent enhanced match
  - Under BIP, 18 states received a total of $2.4 billion in grant funding to increase access to new or expanded services and infrastructure

https://www.milbank.org/wp-content/uploads/2017/12/Strengthening-LTSS-Toolkit_120717.pdf

STRATEGIES TO EXPAND HCBS

Strategies Used to Expand HCBS as a Share of Total LTSS Expenditures	Number of States Employing Strategy (*n* = 20)
Increase HCBS Provider Rates	11
Increase Scope or Amount of HCBS Benefits to Current Users	11
Expand Mental Health Services	12
Support Transitions from Institutions to Community	5
Expansion of HCBS to Serve More People, New Populations	11
Reduce HCBS Waitlists	4
Increase HCBS Waiver Slots	14
Other Strategies	5

BIP RESULTS

1. States engaged in a **wide range of activities** to achieve the required BIP expenditure and infrastructure goals.

2. States **combined activities and funding from a range of Medicaid programs** to achieve goals of the Balancing Incentive Programs. All states used MFP and 1915(c) waivers to help achieve the expenditure goals and used other Medicaid programs, such as State Plan options and 1115 demonstration programs, to help increase the use of HCBS.

3. States **targeted activities to different populations**. Most states addressed activities to each of the four key populations (people with I/DD, people with physical disabilities, people age 65 and older, and people with SMI/SUD), and did so in various ways. Efforts to increase access were more common than were strategies to increase payments.

4. States also **made progress toward optional goals**. As part of their application, states had the opportunity to identify optional goals. For example, expanding waiver slots or eliminating waiting lists for waivers was an optional goal of 14 states. Most optional state goals also helped to increase the share of LTSS expenditures for HCBS.

DUALS INTEGRATION

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HISTORY OF COORDINATING SERVICES FOR THE DUALLY ELIGIBLE:

LOTS OF ACTIVITY, BUT WHERE EXACTLY ARE WE GOING?

1990s

PACE

- First waiver option for states to pursue in for integrating Medicare and Medicaid for dually eligible beneficiaries.

2006

D-SNPs

- Demonstrations transitioned into state contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), a new Medicare health plan option that combines Medicare and Medicaid benefits for dually eligible beneficiaries.
- Only allow states to achieve a certain level of integration based, in part, on the requirement to have two separate contracts with the health plan (one with Medicare and one with Medicaid).

2010/2011

Duals Demonstrations

- ACA established the Medicare-Medicaid Coordination Office (MMCO) and MMCO launched the federal Financial Alignment Initiative (i.e., “duals demonstrations”)

PACE

- Capitated voluntary benefit for frail elderly authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing
- Eligibility
  - Age 55 or older…
  - Living in the service area of a PACE organization
  - Eligible for nursing home care
  - Be able to live safely in the community
- PACE services include, but are not limited to, all Medicare and Medicaid services and additional services: e.g., social work, drugs, nursing facility care, etc.

DUAL ELIGIBLE SPECIAL NEEDS PLANS

- Special needs plans (SNPs), including dually-eligible special needs plans (D-SNPs), were set to expire but were permanently authorized to allow MA plans to provide benefits that are more responsive to the needs of chronically-ill enrollees, and will improve the coordination between Medicare and Medicaid for dually-eligible individuals

- **D-SNPs are required to have contracts with all states in which they operate (as required by the Medicare Improvements for Patients and Providers Act of 2008 and amended by the ACA) States can use this contracting authority to control Medicare-Medicaid integration**

Duals Demonstration

- Part of the Financial Alignment Initiative, a series of demonstrations launched in 2011 by the Medicare-Medicaid Coordination Office (MMCO) and the Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS)
- Designed to test new approaches to contracting and reimbursement for Medicare and Medicaid dually eligible population
- As of November 2017, more than 400,000 dually eligible individuals were enrolled in a demonstration plan across the ten states
- So far, enrollment in these ten states represents nearly 32 percent of the potential enrollment of more than 1.25 million across all ten capitated demonstration states

Source: https://www.healthmanagement.com/blog/dual-eligible-financial-alignment-demonstration-enrollment-update/

DUAL DEMONSTRATION PARTICIPANT PERSPECTIVES

Overall, participants' **satisfaction with the demonstration varied by State** and across focus groups, and was influenced by their experience with the benefits and services they used as well as ease of access and cost

Some participants observed that the under the demonstration it became **easier to navigate the system to obtain needed services, and the cost of these services had decreased**

Some participants were not as satisfied with the demonstration, pointing to **difficulties with finding a provider or specialist who contracted with the participant's plan**, or services and benefits that were not covered

Participants described **mixed experiences with the assessment process**; some indicated that assessments occurred regularly, whereas others indicated that assessments occurred only as needs arose

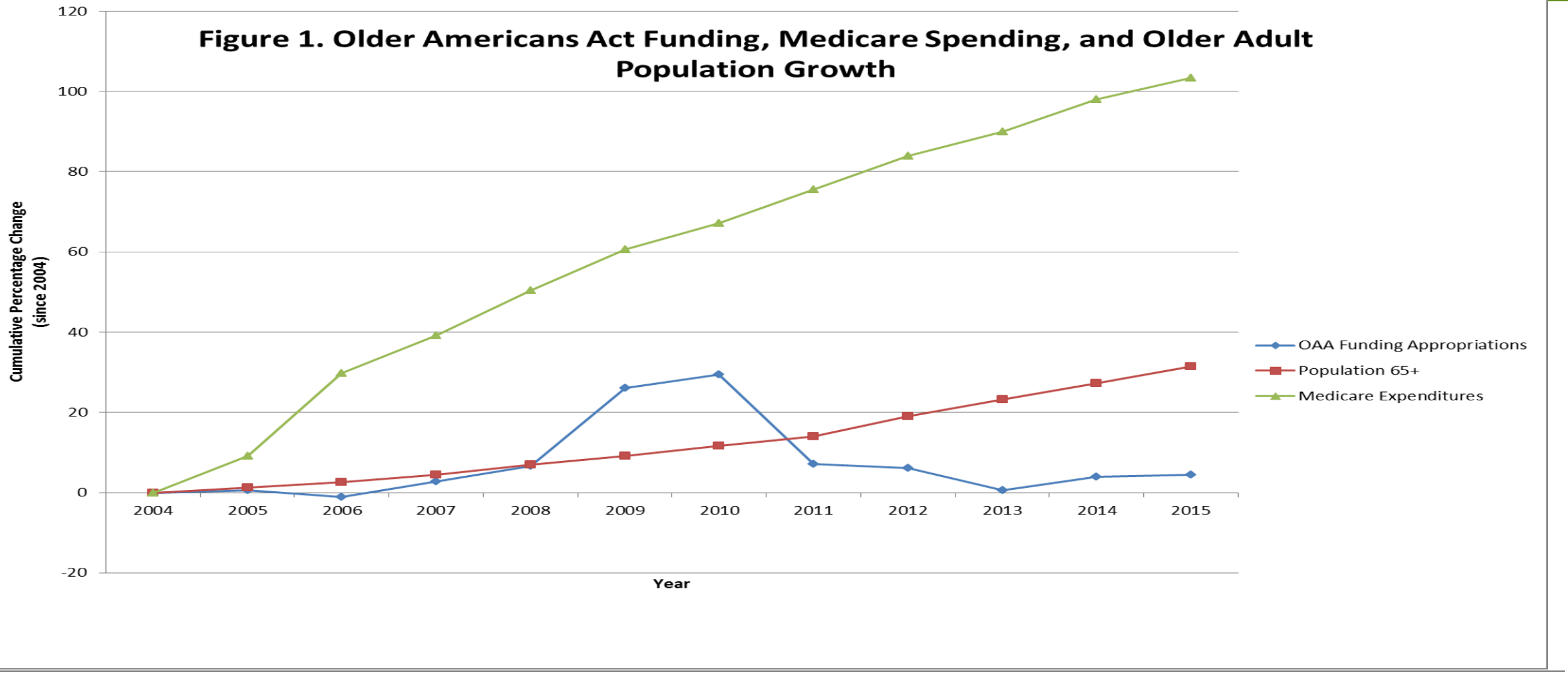
Participants expressed **positive experiences related to goal setting**

Many participants reported that their **care coordinators improved coordination across providers and improved their access to needed services**, but some noted lack of follow-up, heavy caseloads, and high turnover among care coordinators.

POLICIES AND PROGRAMS REFORMING THE PROVISION OF LTSS

CHRONIC CARE ACT

GROWING AGING POPULATION PLACES TREMENDOUS STRAIN ON PUBLIC FUNDING



Source: OAA Funding Appropriations: Congressional Research Service; Medicare Expenditures: the Centers for Medicare and Medicaid Services; Population: U.S. Census Bureau.

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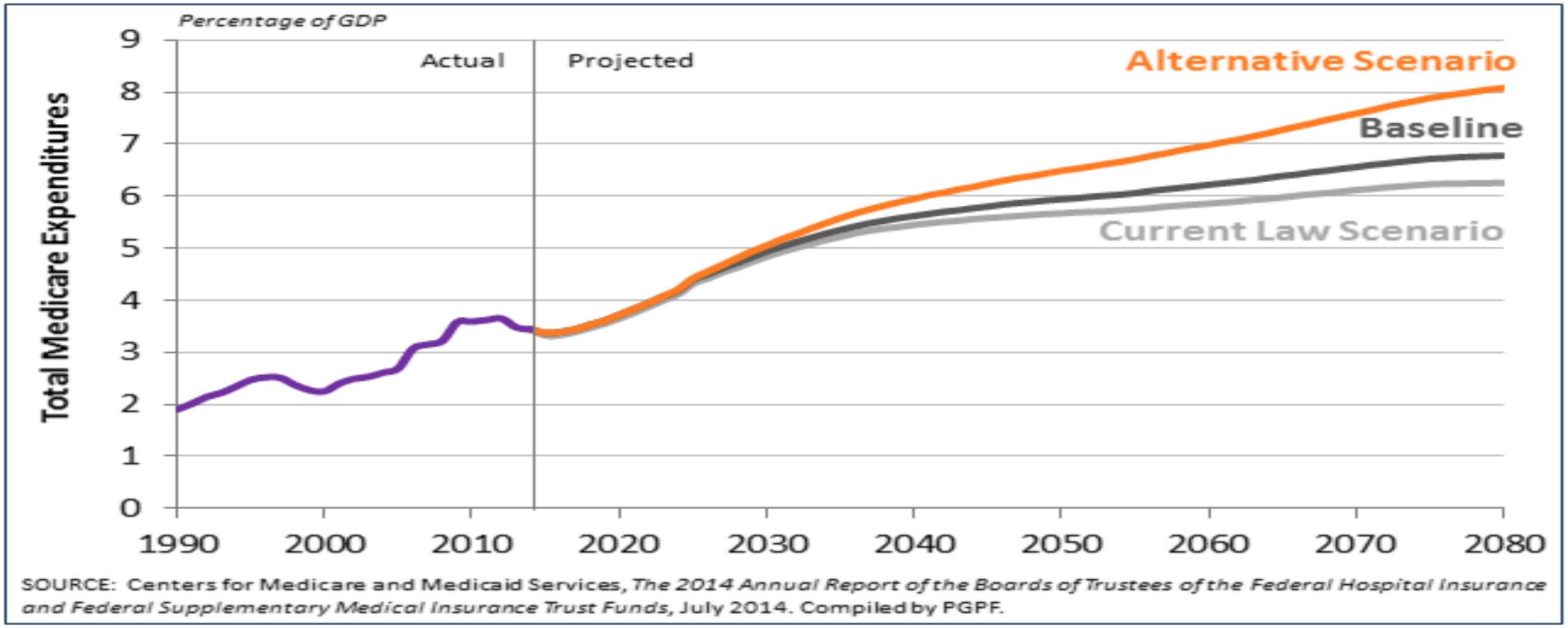
GROWING AGING POPULATION PLACES TREMENDOUS STRAIN ON PUBLIC FUNDING



SOURCE: Centers for Medicare and Medicaid Services, *The 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 2014. Compiled by PGPF.

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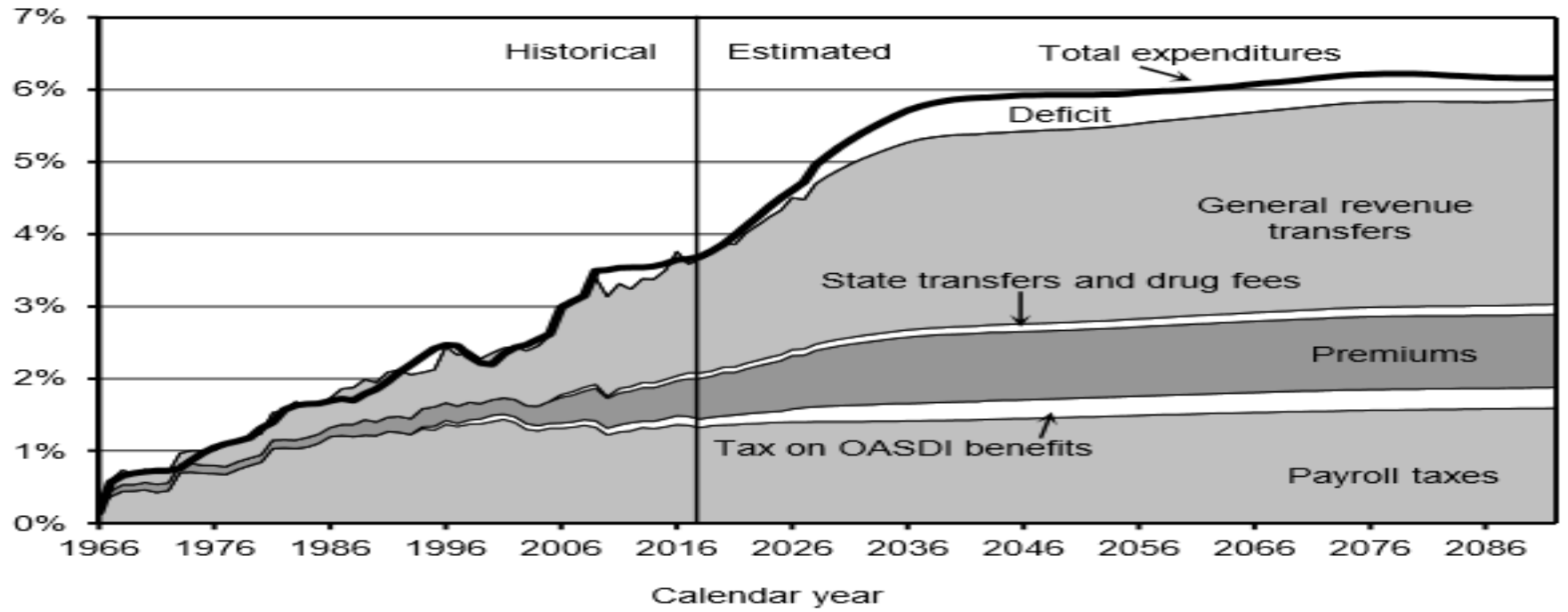
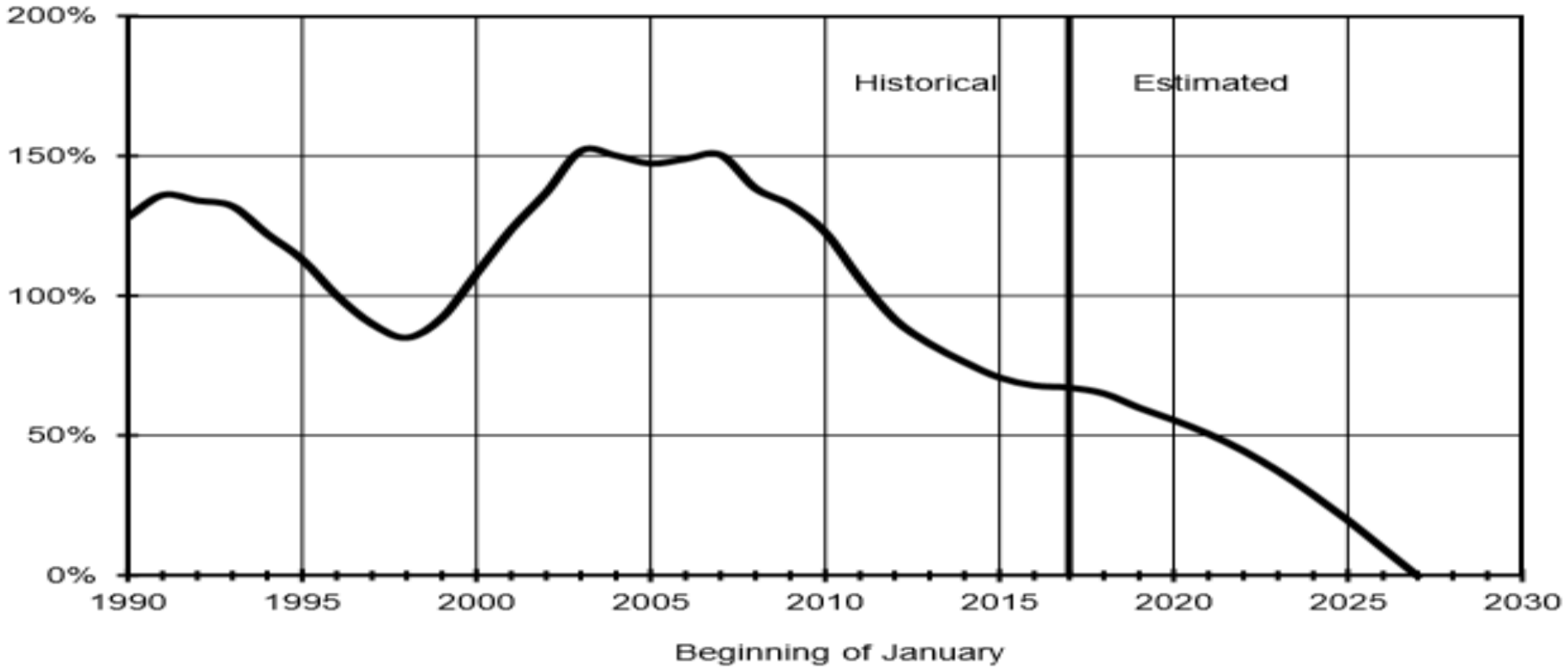
Figure II.D2.—Medicare Sources of Non-Interest Income and Expenditures as a Percentage of the Gross Domestic Product

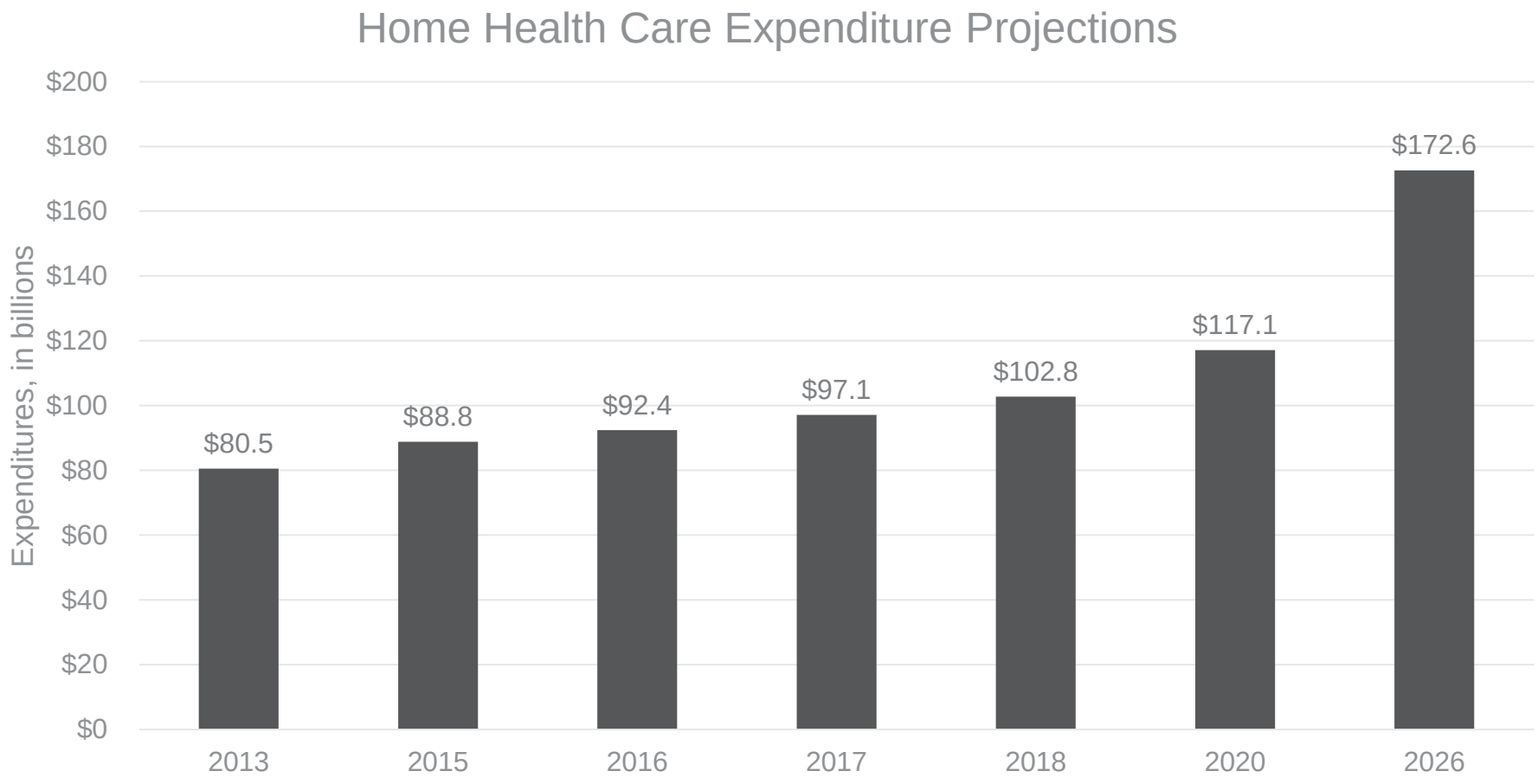


Note: Percentages are affected by economic cycles.

Figure II.E1.—HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures



NATIONAL HEALTH EXPENDITURES – HOME HEALTH CARE



Source: Home Health Care News

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.

- CMS notes their intent to interpret these benefits more broadly going forward but has tightened the definition of the chronically ill population

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

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

CHRONIC CARE ACT
Key Components

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

CHRONIC CARE ACT

Requires Integration

- Requires SNPs to better integrate care by creating unified plans for dual eligible individuals
- These plans must actively incorporate Medicare and Medicaid benefits and provide a single pathway for grievances and appeals, across these two complex programs

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

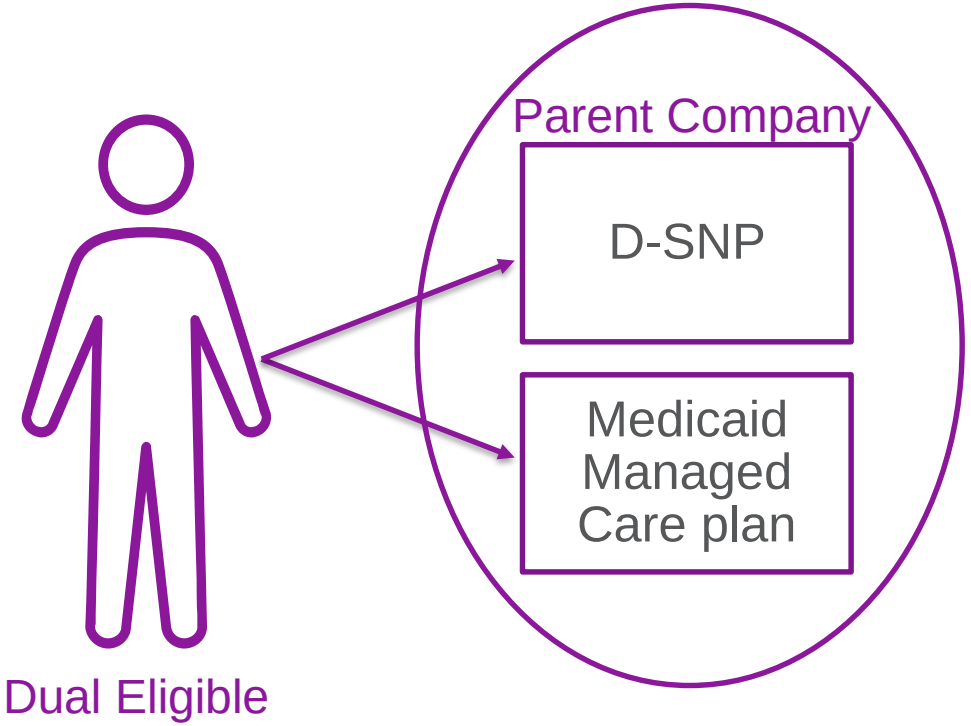
HOW DOES THE CHRONIC CARE ACT AFFECT PATIENTS?

- Medicare beneficiaries will have an **easier time getting needed services**
    - Accountable Care Organizations (ACOs) can offer monetary incentives for patients to receive primary care, making it more attractive for providers to offer services and easier for patients to seek care
- 15,000 **more people will be eligible for home-based services**
    - *Expansion of the Independence at Home program which provides primary care in the homes of Medicare beneficiaries with chronic disorders will allow more people to receive needed services*

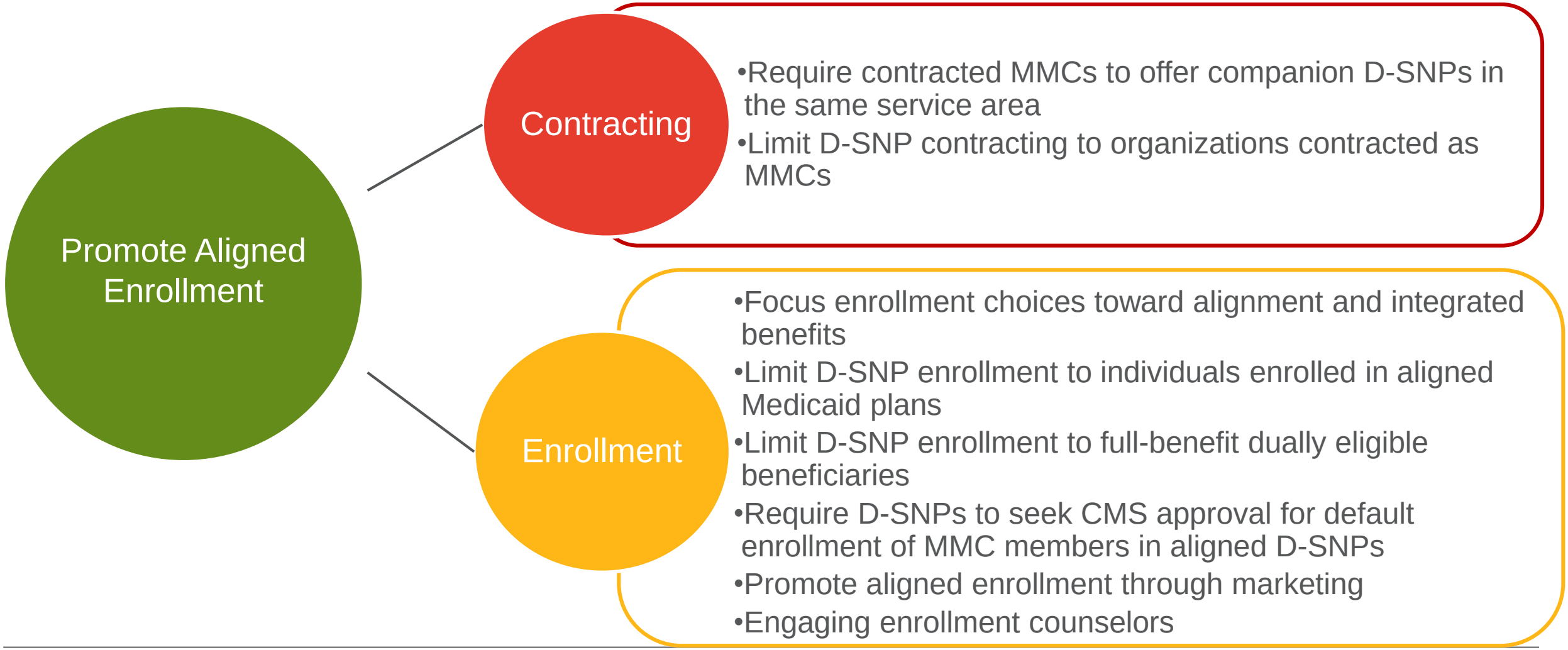
SPECIAL NEEDS PLANS

ALIGNED D-SNPS

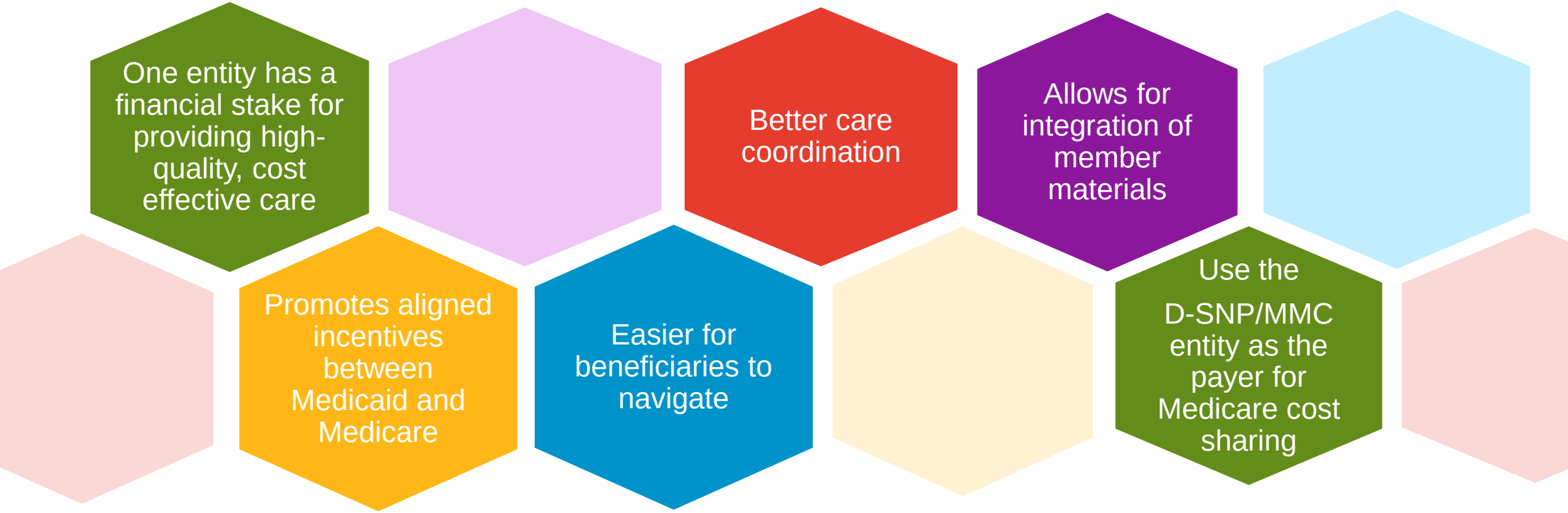
States may consider integrating care for dual eligibles by using contracting strategies that maximize **aligned enrollment for D-SNPs and Medicaid managed care.** States can use Medicaid managed care contracting to drive overall quality goals and set priorities.



STATE OPPORTUNITIES TO ENCOURAGE ALIGNMENT



ADVANTAGES OF ALIGNED ENROLLMENT



FULLY INTEGRATED DUAL ELIGIBLE SNPs

- Some D-SNPs can operate as Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP)
  - D-SNPs must meet certain requirements and get CMS approval to achieve FIDE SNP status
  - Must cover Medicaid LTSS under their contract with the state, have an aligned Medicare and Medicaid care management model, and align certain administrative functions
    - Align Medicaid and Medicare processes and materials
    - May offer supplemental benefits not typically covered by Medicare
  - FIDE SNPs that serve a high proportion of frail, high-risk beneficiaries may also be eligible for Medicare Advantage incentive payments to encourage plans to participate

As of November 2017, there were eight states operating FIDE SNPs, serving 153,101 beneficiaries

MEDICAID ADVANTAGE SERVICES

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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

Health experts have long argued that spending money on such items can reduce overall Medicare spending

- 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

EXPANSION OF MEDICARE ADVANTAGE SERVICES

Adult day care services

- 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
- 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

Home-based palliative care

- 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)
- 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

In-home support services

- 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.

EXPANSION OF MEDICARE ADVANTAGE SERVICES

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

EXPANSION OF MEDICARE ADVANTAGE SERVICES

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.

OTHER OPTIONS TO LEVERAGE SERVICES PROVIDED UNDER MEDICARE

- Minnesota is considering an option to provide a home care benefit similar to that provided under Medicaid under the Medicare program
  - The benefit would be included in all Medicare supplement plans and Medicare Advantage plans
- Allow Medicare beneficiaries the ability to purchase supplemental LTSS benefit services which could include HCBS services

IMPLICATIONS FOR STAKEHOLDERS

And Opportunities for Coordinating to Drive Quality and Reduce Costs

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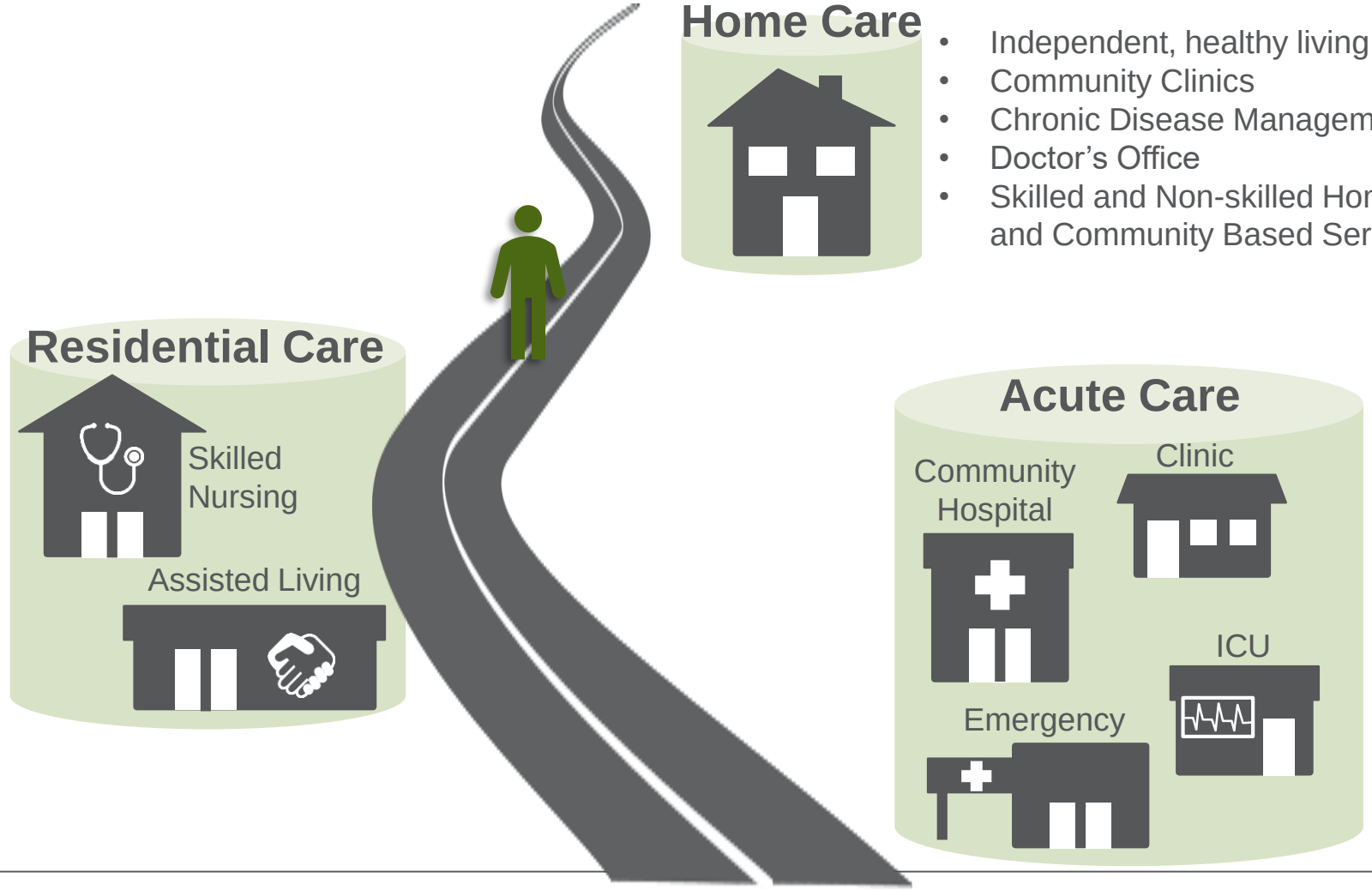
PERSON CENTERED CARE THAT DRIVES QUALITY, PATIENT ENGAGEMENT, AND LOWERS THE COST OF CARE

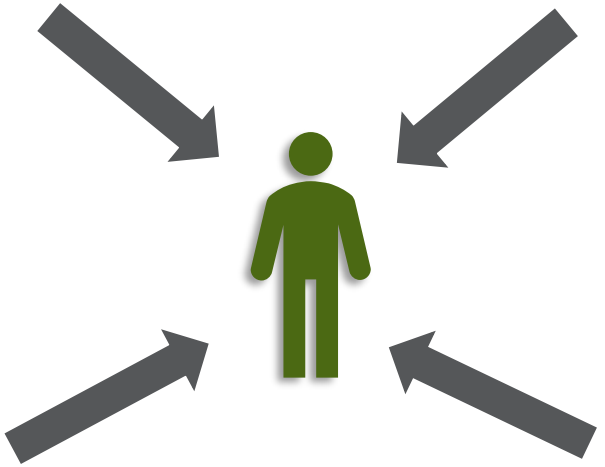


- Independent, healthy living
- Community Clinics
- Chronic Disease Management
- Doctor's Office
- Skilled and Non-skilled Home Care and Community Based Services

NAVIGANT LTSS AND MEDICARE ADVANTAGE SOLUTIONS

Home Health Providers
- Medicare Advantage Service Expansion
- Post Acute Care Network Strategy

Health Systems & Hospitals
- Continuum Care Management Design
- Discharge Planning Process Redesign
- Post-Acute Care Network Strategy
- Episode Payment Model Readiness and Implementation Support
- Readmission Prevention



Health Plans
- Care Coordination
- Proposal Development
- DNSP/MA Experience

Government
- HCBS Waiver Redesign
- MLTSS Program Design
- LTSS Monitoring and Oversight
- Procurement Support
- Readiness Review

MEDICARE ADVANTAGE PLANS PREPARE TO PROVIDE ADDITIONAL SERVICES

Many Medicare Advantage plans already offer some health benefits not covered by traditional Medicare, such as eyeglasses, hearing aids, dental care and gym memberships

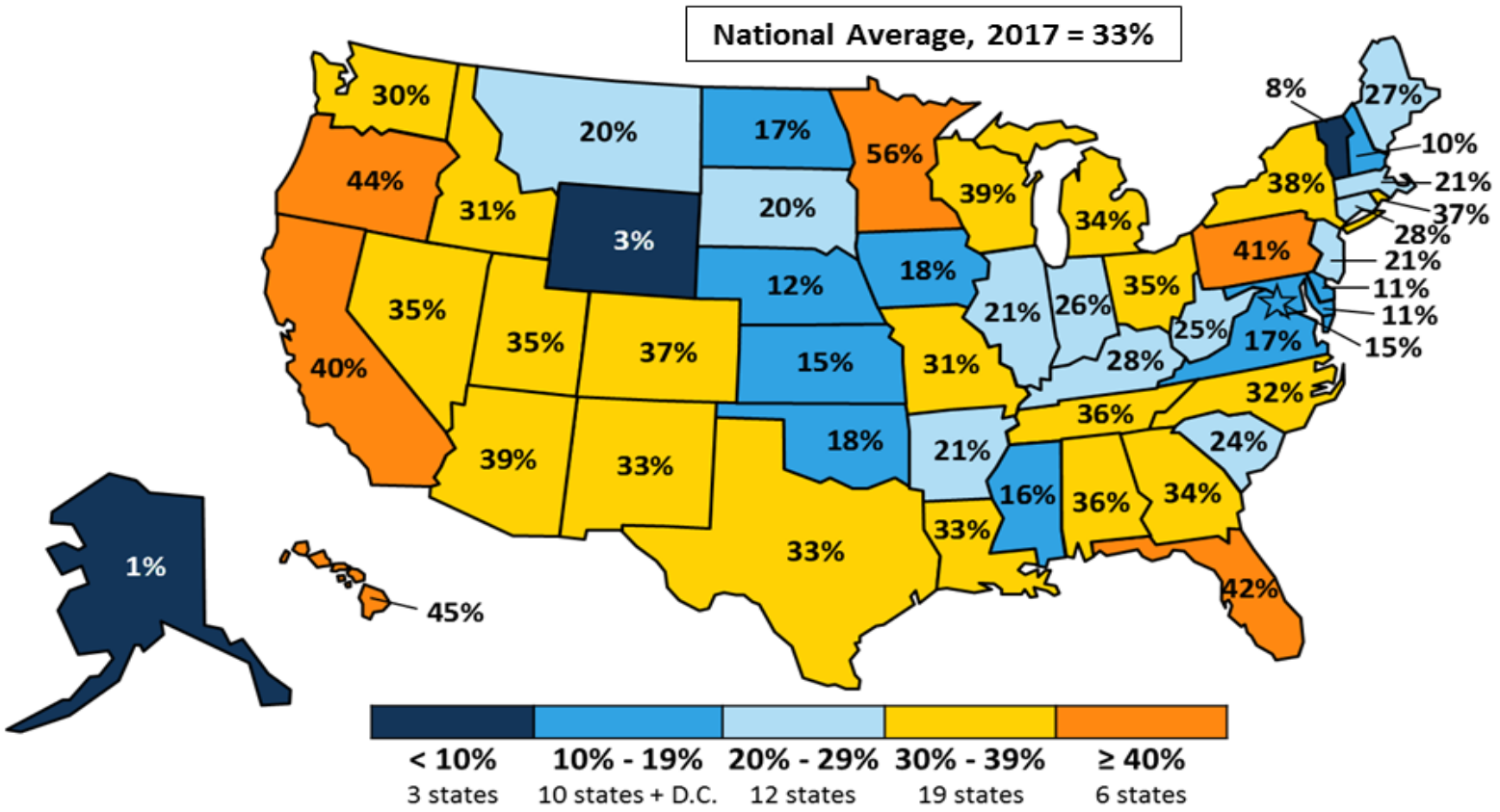
But the new rules, which the industry sought, will expand that significantly to items and services that may not be directly considered medical treatment

The details of the 2019 Medicare Advantage benefit packages must first be approved by CMS and will be released in the fall, when the annual open enrollment begins

While these benefits are not required to be included in MA plans, plans are provided the latitude to include them if they choose and may very well change the reimbursement landscape for personal care agencies around the country

MEDICARE ADVANTAGE PLAN PENETRATION
Supplemental Coverage will Vary Across the Country

Share of Medicare Beneficiaries Enrolled in Medicare Private Health Plans, by State, 2017



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS State/County Market Penetration Files, 2017.

THE HENRY J. KAISER FAMILY FOUNDATION

Supplemental benefits are not required to be included in MA plans so benefit packages may vary by plan to plan and region to region

Supplemental benefits are not required in fee-for-service Medicare

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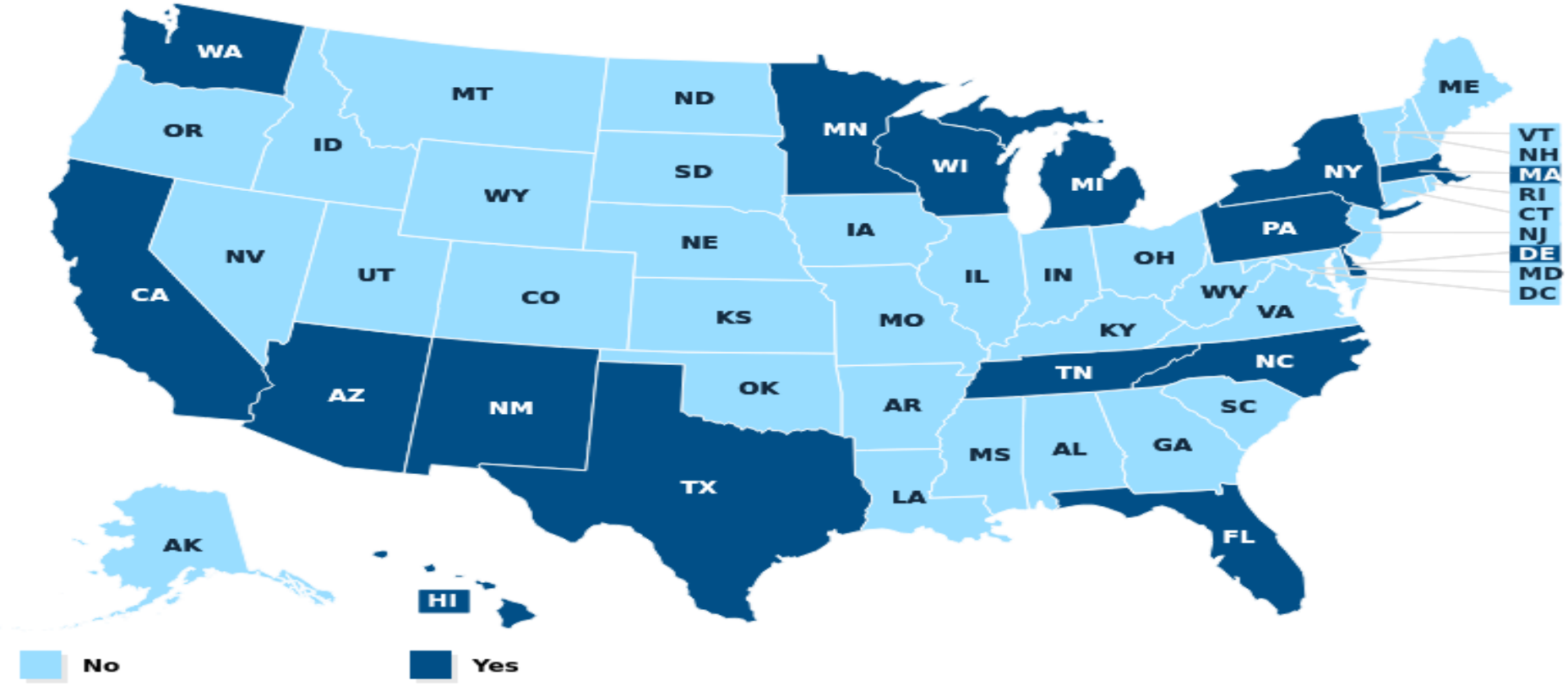
MEDICAID ENROLLMENT IN MLTSS

Total Medicaid Enrollment in Managed Long-Term Services and Supports (MLTSS): MLTSS Program in Place, 2012

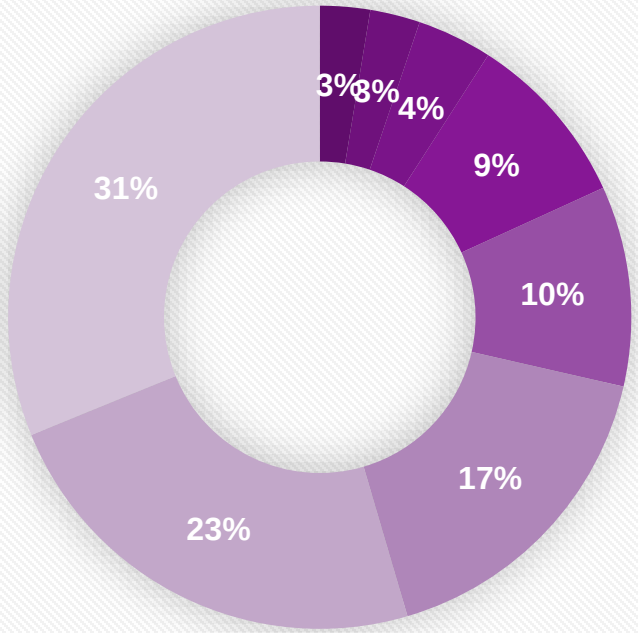


SOURCE: Kaiser Family Foundation's State Health Facts.

MEDICARE ADVANTAGE PLANS
Medicare Enrollment Concentration

- Medicare Advantage enrollment tends to be highly concentrated among a small number of firms

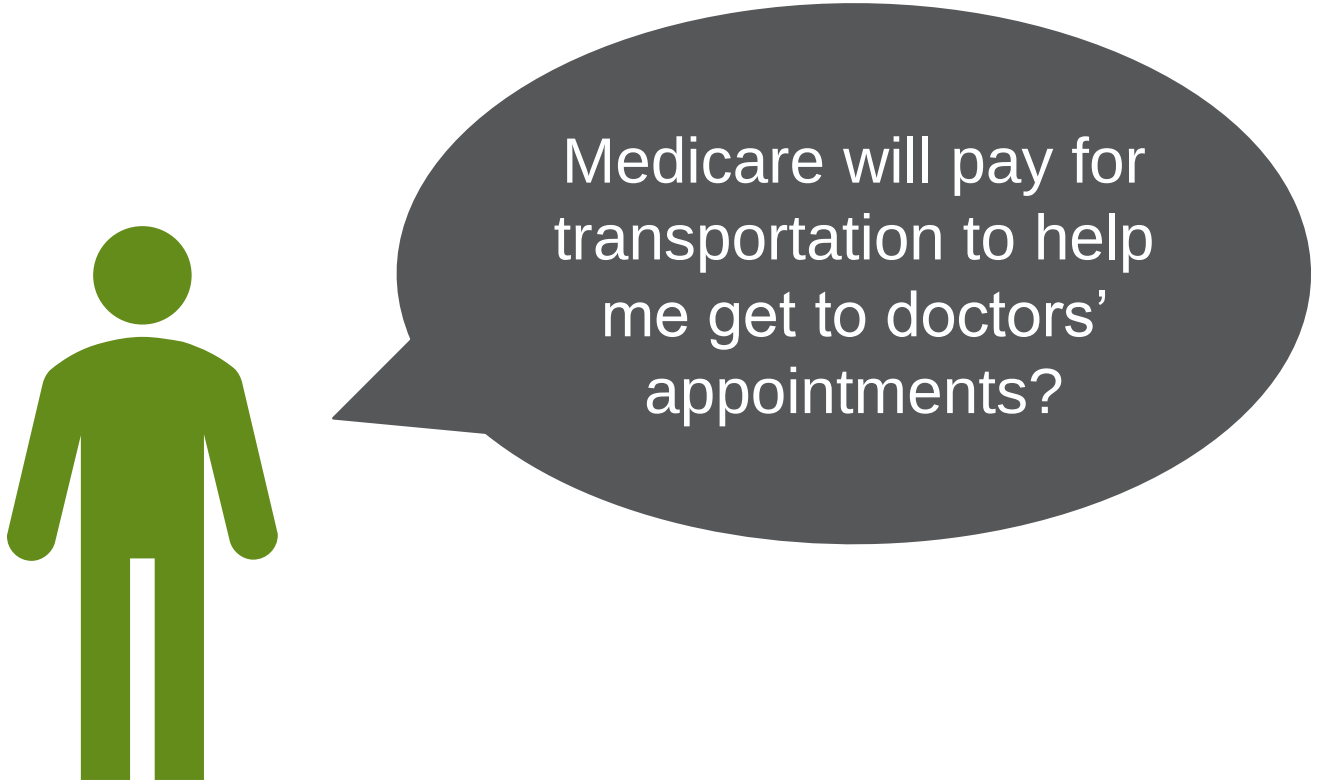
- Enrollment in UnitedHealthcare's plans grew more than any other firm, increasing by more than 800,000 beneficiaries between 2016 and 2017.



HOME HEALTH PROVIDERS

Expand Medicare Advantage Services

The Health Related Supplemental Benefits for 2019 Medicare Advantage will allow Medicare to cover non-medical expenses that can help Medicare enrollees improve their health.



HOME HEALTH PROVIDERS HAVE A KEY ROLE IN IMPROVING HEALTH OUTCOMES AND CONTROLLING HEALTHCARE COSTS

Recent changes signal policymakers awareness that behavioral, environmental and social factors, as well as functional status, contribute significantly to health and health care spending

Home health providers are experienced in the delivery of supplemental services

Partnerships between MA plans and home health providers to provide supplemental social services and intensified case management to targeted beneficiaries could significantly improve health and quality of life for this population, while also reducing costs for the plan

Medicare beneficiaries with 4 or more chronic conditions

Accounted for 76 percent of total Medicare spending

Account for 92 percent of readmissions

77 percent of these readmissions were for 15 percent of Medicare beneficiaries 6 or more chronic conditions.

https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2018/04/Policy-Spotlight-Integrated-Care-high-res-proof-4-17-2.pdf

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HOW DO SENIORS AFFORD CARE?

Unpaid Caregivers Provide Most Services

- Unpaid caregivers (e.g., family members and friends) currently provide most LTSS services:
  - 82% care for 1 adult
  - 15% care for 2 adults
  - 3% care for 3+ adult
- The average age of caregivers is 49.2. However, by including adult children as well as spousal caregivers (who tend to be considerably older), the average age is 62.3 years old.

49 percent felt that they had no choice in taking on this role

- Six out of 10 family caregivers are women
  - One in three female caregivers provide more than 20 hours of care per week
- It is estimated that the economic value of unpaid care was $470 Billion in 2013

Source: http://www.nasuad.org/sites/nasuad/files/NASUAD%20Caregiver%20Infographic.pdf
https://www.apa.org/pubs/journals/releases/amp-a0040252.pdf

PROVIDING CARE IS DRAINING ON UNPAID CAREGIVERS

- 60 percent of female caregivers who were employed had to make sacrifices at work to accommodate caregiving responsibilities.

- Unpaid caregivers incur costs of providing services and lost wages and benefits.

  - $28+ Billion in lost productivity for full/part-time employed
  - 17.9 Billion hours of unpaid care for people with Alzheimer's & related Dementias

20 percent of female caregivers report high levels of physical strain

41 percent report high levels of emotional stress as a result of caregiving

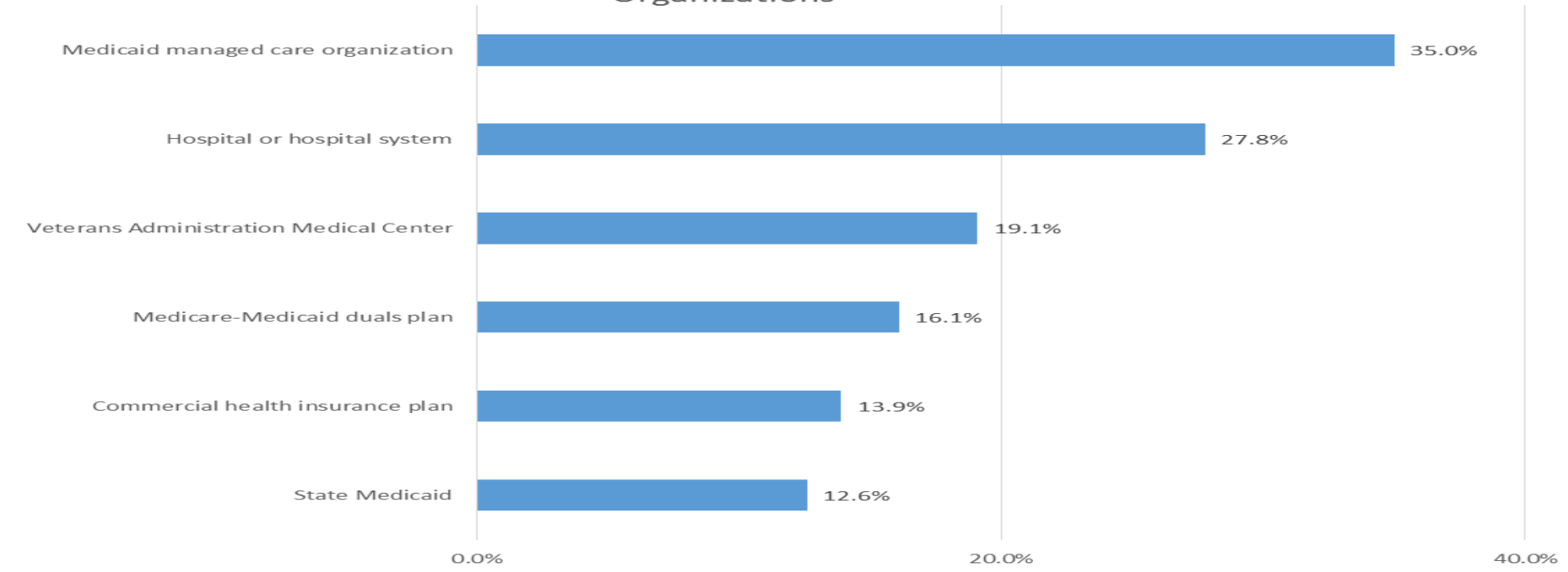
Source: http://www.nasuad.org/sites/nasuad/files/NASUAD%20Caregiver%20Infographic.pdf
https://www.aarp.org/content/dam/aarp/ppi/2017-01/women-and-long-term-services-and-supports.pdf

HOW WILL NEW POLICIES AFFECT HOME HEALTH PROVIDERS

- Humana is in the process of acquiring a 40% stake in Kindred at Home.
- Humana indicated that Kindred can help manage costs and care for its Medicare Advantage population..

- Homewatch CareGivers provided about 6.4 million hours of non-medical care in 2016, through about 200 locations run by 106 franchise partners
- It is now engaging with Medicare Advantage providers with a goal of becoming a preferred provider within MA plans.
- Must consider the trade-off between lower rates and higher volume

Figure 2. Most Common Health Care Partners Engaged with Community-Based Organizations



Data Source
2017 data: Kunkel, S.R., Straker, J.K., Kelly, E.M., & Lackmeyer, A.E. (2017). Community-based organizations and health care contracting: Research brief. Scripps Gerontology Center, Oxford, OH.

MA SERVICE EXPANSION WILL ALLOW HEALTH SYSTEMS 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

Filling these gaps will decrease readmissions, hospital ED visits and overall costs

HEALTH SYSTEMS LEADERS WILL NEED TO DETERMINE HOW TO PROVIDE ADDITIONAL SERVICES

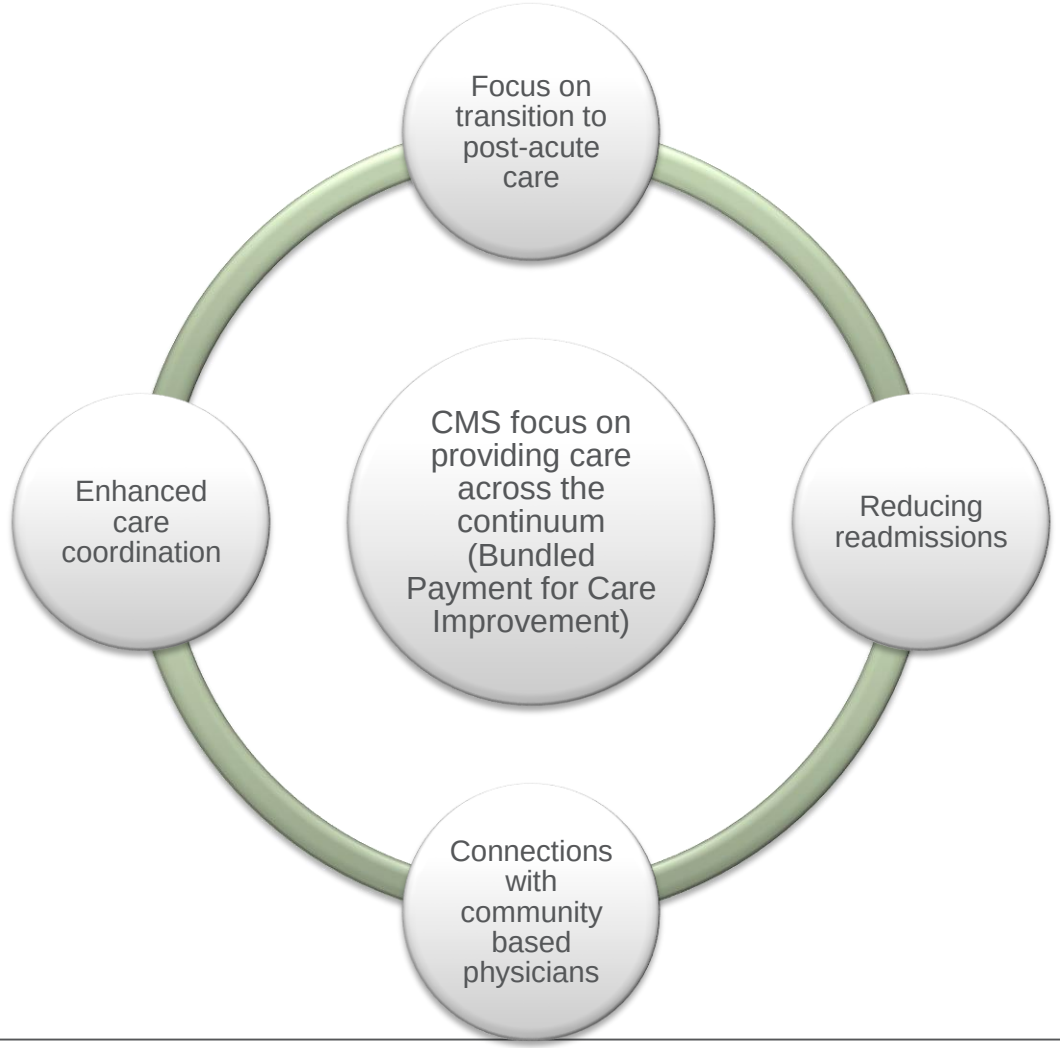
Own (Buy or Build)

- 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

CMS SHIFTS AIMS TO BREAK DOWN SILOS
MA Plan Shift Focus



DISCUSSION

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