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White paper

The promise and potential of the

CHRONIC Care Act

for community-based agencies

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About the author

Dr. Bulot is considered a national expert on aging and disability services, long-term services and supports (LTSS), health policy and assistive technology. Prior to joining WellSky, he was an Associate Director at Navigant. He also served under three governors as the State Director for Aging and Adult Services where he was responsible for Older Americans Act, Public Guardianship, Protective Services and Medicaid 1915c waiver programs. Jay is also a past President of the National Association of State Units on Aging and Disability, and a tenured Associate Professor, Department Head and Research Institute Director.

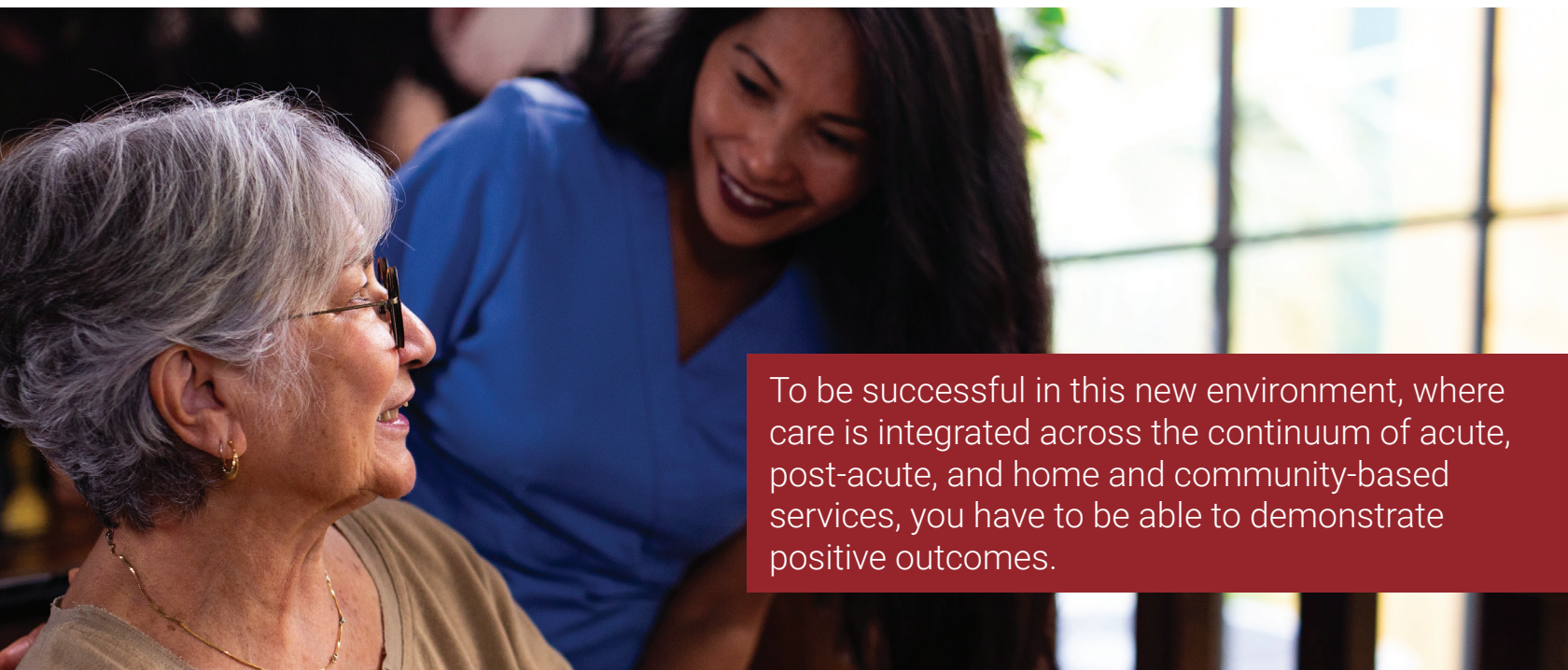
Dr. Bulot has worked closely with state and federal leadership on developing performance benchmarking data for recipients of HCBS services. Jay has over 10 years of experience leading the development and implementation of state programs such as 1915c waivers, No Wrong Door/Single Entry Point for LTSS, Balancing Incentive Program, Money Follows the Person, and administration of Home and Community-Based Services (HCBS). He develops, promotes and maintains relationships with leaders at health systems, government agencies, universities and associations to drive better understanding of the need to integrate health, social and behavioral supports. He has taught graduate level courses in health care administration, aging and disability services networks, long-term care administration, research methods, and statistics.

The promise and potential of the CHRONIC Care Act for community-based agencies

The evolution from fee-based services to value-based health care is now making its way to the human services landscape. As WellSky has shared in previous posts and webinars, value-based programs focus on coordinated care and accountability for long-term outcomes, creating efficiency in costs and care.

The Centers for Medicare and Medicaid Services (CMS) began emphasizing value-based care in 2008, and the Affordable Care Act, implemented in 2010, authorized a number of value-based programs. These changes have forced traditional health care providers to adapt rapidly. Value-based purchasing initiatives, pilot alterative payment models, and Accountable Care Organizations (ACOs), as well as Medicaid Managed Care have forced providers to invest in technologies and analytics to identify opportunities for creating greater value, controlling cost, and improving health outcomes across acute and post-acute care markets.

The trend toward value-based care and quality management inherently increases the importance of data. To be successful in this new environment, where care is integrated across the continuum of acute, post-acute, and home and community-based services, you have to be able to demonstrate positive outcomes. In fact, we've seen instances across the U.S. where financially at-risk providers are willing to pay significantly more if a community-based provider is able to help it achieve its performance or contractual goals.



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For example, hospitals have invested billions to modernize their data systems; and physician practices have been installing electronic medical records (EMR) and patient portals (in some cases, multiple systems) to improve patient engagement and treatment adherence. This paradigm shift has contributed to improved health care for all Americans, especially those who receive Medicare and Medicaid services. However, few of these investments were driven, or even informed, based on the need to coordinate non-medical care outside of clinical settings. As a result, the shift to value, quality, and accountability are new in the human services field. At WellSky, we believe this requires our human and social services customers to adapt and change to be competitive and deliver on these new objectives.

A timely vehicle to facilitate the change is the CHRONIC Care Act (CCA), which became law in 2018. Driven by patients, physicians, advocacy, and various health care professionals, the CCA represents a potentially seismic shift in how Medicare Advantage plans can coordinate care for their members. The acronym CHRONIC stands for Creating High-Quality Results and Outcomes Necessary to Improve Chronic (care). Medicare does a lot of good for older adults who suffer from chronic illnesses, such as arthritis, cancer, and diabetes, but it often fails to address the non-medical needs that many of these older adults deal with on a daily basis. The CCA tries to resolve this shortcoming by allowing MA plans to expand the services and supports available to the more than 12 million chronically ill people in the United States.

Beneficiaries who may benefit the most are those who have at least one co-morbid condition that is medically complex. These conditions either have to be life-threatening or severely limiting to the overall health of the enrollee. The chronic condition will also have a high chance of leading to hospitalization or similarly adverse outcomes. Finally, the chronic condition(s) has to require intensive care coordination. Diabetes and cancer are two of the most common chronic illnesses. They are clearly identified in the CCA and present a massive opportunity for improving outcomes and saving money. It is no accident that quality, outcomes, and results are all a part of the CCA.

The CCA allows Medicare Advantage (MA) plans to offer frail and chronically ill beneficiaries a broader range of non-medical services and support than what was previously allowed under the old MA rules. The goal is to help prevent further decline in health, and improve care coordination across medical and non-medical home and community-based services (HCBS). While each plan is responsible for its own offerings, an array of services has already been considered, including: meals, transportation, homemaker, personal care, adult daycare, vision and hearing aids, and home modifications.

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With the CCA, the CMS will allow supplemental benefits that are used to "diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health-care utilization." Targeted benefits will be medically relevant to the status of each enrollee or to their state of disease.

The CCA defines supplemental benefits as benefits that "have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health-related benefits." With this broader definition, the CCA also allows the uniformity requirement for supplemental benefits to be waived.

The benefit of these changes is that supplemental benefits can now be more tailored to the beneficiary.

There is great similarity between these new "covered services" by MA plans and the services traditionally provided through state administered LTSS Programs – primarily the Older Americans Act and Medicaid HCBS waiver programs. As such, state agencies should begin to consider how Medicare Advantage plans offering community-based services could potentially impact the services for which they have traditionally coordinated – through policy and payment. WellSky currently works with more than 40 state agencies. We know how similar and different each state's service delivery network operates – from statewide funding to local service delivery.

From this perspective, some questions to consider for state policy makers include the following.

Are there differences in how CMS defines the services for the CCA and how states have defined them?

The CMS Memo dated April 2017 "Medicare Advantage Organizations and Section 1876 Cost Contract Plans" provides some reinterpretation of the term "primarily health related" and provides additional guidance to MA plans on new services, including, but not limited to: Adult Day Care Services, In-Home Support Services, Support for Caregivers of Enrollees, Stand-Alone Memory Fitness Benefits, Home & Bathroom Safety Devices & Modifications and Transportation.

States should examine their policies and taxonomy of services to determine which specific services may be potentially impacted. For example, if an MA plan requires more intensive certification or training for an in-home support service provider than is currently required by OAA and/or Medicaid HCBS Waiver Services, will this impact cost to deliver this service in the future – given the lack of providers statewide?

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

A large number of MA plan recipients in a state may be dually eligible for both Medicare and Medicaid. Of these, many are also likely receiving Medicaid HCBS waiver services. State Medicaid Agencies have long had a legal obligation to pay Medicare cost-sharing for dual eligible members, and this extends to Medicare Advantage Plans. However, how exactly this works is not well understood, and there is likely significant variation across states with little uniformity in methodology.

States may need to consider whether these expanded benefits are subject to cost sharing; how their policies may need to be modified to encompass Medicare Advantage; and how processes might need to change to accommodate these services for dually eligible members. State agencies administering Older Americans Act (OAA) or state funded-only HCBS programs may need to evaluate policies and taxonomy to determine whether there is duplication of services and how services should be coordinated.

What effect does MA-coordinated HCBS services have on service delivery for existing programs?

When working with multiple states on their HCBS service definitions and service-delivery structure, there are often similar and/or identical services paid for through multiple funding streams (OAA, Medicaid, Social Services Block Grants, Community Services Block Grant, etc.). In some instances, when a new provider enters a market and the rate is insufficient to cover the full cost, providers may attempt to cost shift the losses from one funding stream to another.

For example, many OAA home-delivered meal (HDM) providers also provide home-delivered meals to Medicaid HCBS recipients. While the Medicaid HDM statewide rate is set by the state, each Area Agency on Aging (AAA) must request bids from HDM providers for their geographic region. Generally, these are often the same providers. Anecdotally, when the Medicaid rate is insufficient to cover the full cost of the meal production and delivery, providers who are able, cost shift these losses into their bid responses for the AAA contracts. In instances such as these, AAAs are essentially subsidizing the Medicaid program and diverting already scarce dollars from those most in need.

However, if for example, Medicaid rules a higher level of staffing, licensing, or training for in- home workers or community-based services, these requirements increase the cost to deliver these services. If MA plans require certification or additional training/licensing above what is required by the State, providers will need to upgrade their staff skills, thus increasing the total state-wide expenditures necessary to maintain the same level of services. Some states have addressed these risks through coordinated purchasing as well as ensuring Medicaid and non-Medicaid HCBS policies are aligned.

What are the opportunities for coordination?

The range of stakeholders impacted by the CCA is large: CMS, Medicare Advantage plans; State Units on Aging; State Medicaid Agencies; Area Agencies on Aging; HCBS Service Providers; local/regional hospitals; health systems and physician practices; and Medicare home health providers, to name just a few. Each one of these stakeholders presents an opportunity and different perspective for how to achieve coordination. The state Aging and Medicaid Agency has extensive experience funding and developing policy around how to most effectively deliver non-medical, community-based long-term care. States can leverage their financial relationship with Medicare Advantage plans to encourage coordination of service definitions and requirements, while encouraging the use of the existing statewide infrastructure.

Meanwhile, Community Based Organizations (CBOs) are going to have more opportunities to work directly with Medicare Advantage Plans, hospitals and Home Health Agencies, as they have a long history of delivering relevant in-home services like home modifications, transportation, and nutritional assistance. CBOs should also be reaching out to any Medicaid Managed Care Organizations operating in their regions, as well as hospitals and other health care facilities. At least right now, most don't have active partnerships with MA plans, but this could change.

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

The range of stakeholders impacted by the CHRONIC Care Act include:

- 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

Human Services

These help reduce stress and caregiver burden, as well as Emergency Department use and hospital spending. CBOs have long offered evidence-based self-management programs, and these represent ideal opportunities to begin discussions with MA plans.

There are also implications for HCBS providers. For the first time, on a wide-scale, the door is open for CBOs to partner with MA plans to deliver services in which they have significant expertise. By partnering with MA plans, community-based health care organizations can provide, and get paid for, more efficient and better-quality care to people who are chronically ill. The emphasis is on value, not quantity. However, providers may need to upgrade the skills of the work force and may need to consider how best to manage service delivery across different payors (Medicaid, OAA, Private Pay and now Medicare Advantage).

It is a good time for state agencies, area agencies on aging, large HCBS providers, and others in the aging and disability services network to begin to start conversations with MA plans. However, they should also begin (if they haven't already) to consider ways to help meet all the different needs of beneficiaries on Special Needs Plans, Fee for Service (Medicaid and Private Pay), and Medicaid Managed LTSS.

Considering the CHRONIC Care Act, policy makers, state leaders and providers must start developing working relationships with MA plans – to both strengthen the existing HCBS delivery network as well as ensuring community-based services are available, accessible and easier to coordinate across payors and settings.

References

1. Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, P. 208
2. "Senate Passes CHRONIC Care Act," policymed.com, May 4, 2018
3. Specific references to payments related to Medicare HMOs and Medicare Advantage plans are found in State Medicaid Manual §3490.12, and appeared as early as 1991.

WellSky

WellSky is a technology company that delivers software and services to transform an ever-growing range of care services worldwide. We leverage our broad experience in health care and human services to empower payers and non-profit community-based organizations to play an even greater role in protecting the wellness, safety, and stability of the most frail and at-risk members of our community.

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