Integrating Clinical and Home and Community Based Services

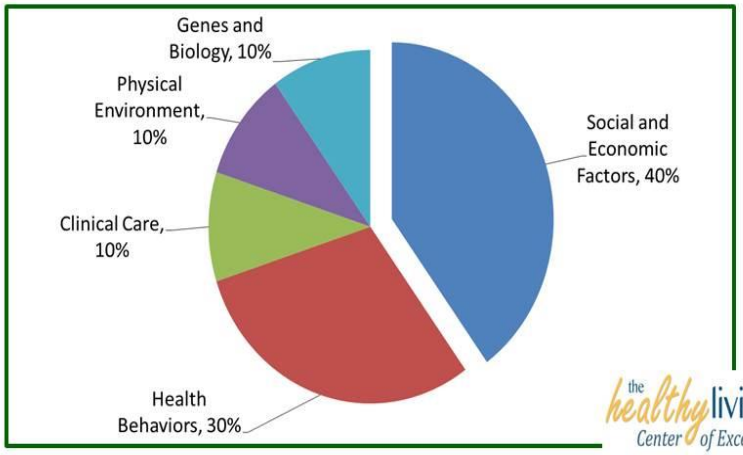
National Alzheimer's Project Act (NAPA) Advisory Committee

October 19, 2018

Presenters

- Becky A. Kurtz, J.D., Moderator
  - NAPA Advisory Committee Member
  - Director, Area Agency on Aging, Atlanta Regional Commission
- Tim Engelhardt
  - Director, CMS Office of Medicare and Medicaid Coordination
- Debra L. Cherry, PhD
  - NAPA Advisory Committee Member
  - Executive Vice President, Alzheimer's LA
- Kathy Velsey
  - President/CEO, Bay Aging dba VAAACares
- Marisa Scala-Foley
  - Director, Aging and Disability Business Institute, n4a

Public Policy Framework for Improving Population Health



the healthy living Center of Excellence

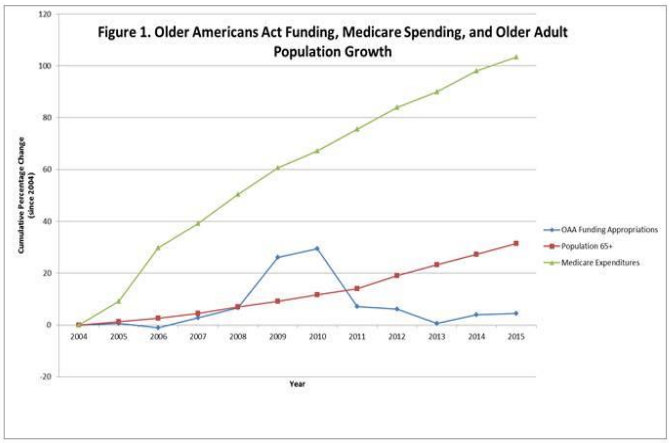
Tarlov AR. Public policy frameworks for improving population health. *Ann N Y Acad Sci* 1999; 896: 281-93.

"The United States is spending an extraordinary amount on health care as defined by the OECD. But the United States is not spending as much as other industrialized countries on fortifying crucial social services that help make people healthy."

Elizbeth H. Bradley and Lauren A. Taylor

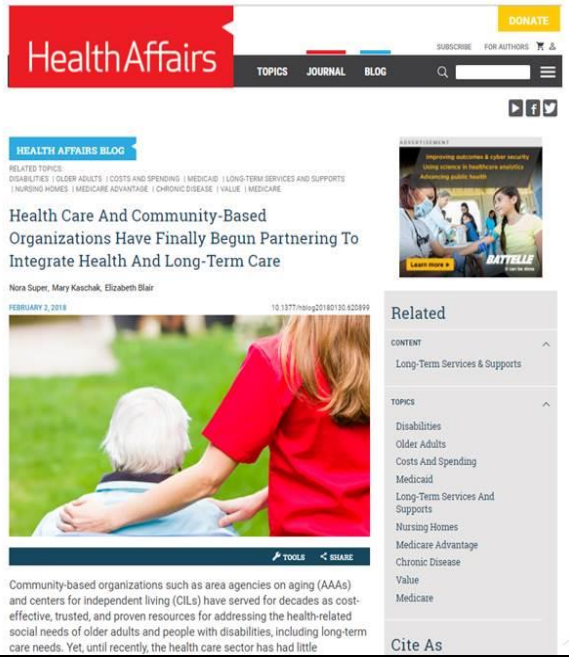
The American Health Care Paradox: Why Spending More is Getting Us Less (2013) at p. 14

Older Americans Act Funding, Medicare Spending, And Older Adult Population Growth



Source: Adapted from Parikh RB, Montgomery A, Lynn J. The Older Americans Act at 50—community-based care in a value-driven era. N Engl J Med. 2015;373(5):399-401. Values have not been adjusted for inflation.

https://www.healthaffairs.org/do/10.1377/hblog20180130.620899/full/



The National Plan

- Released by HHS Secretary Sebelius on May 15, 2012 during International Research Summit at NIH
- Balance work on treatments with care needed by people with the disease and their families now
- National Plan, not just a federal plan: Requires engagement of public and private sector stakeholders
- Long-term goals, strategies to achieve those goals, and immediate actions
- Transparent reporting on progress:
  - Implementation timeline is appendix
  - Bi-annual reporting on progress to Advisory Council
- Plan Iterations occur annually
  - Final Plan released May 2012: http://aspe.hhs.gov/daltcp/napa/NatlPlan.shtml
  - 2013 Update released June 2013
  - 2014 Update released April 2014 http://aspe.hhs.gov/daltcp/napa/NatlPlan2014.shtml

Panel Discussion

Tim Engelhardt, Director, CMS Office of Medicare and Medicaid Coordination
Debra Cherry, PhD, Advisory Council Member
Kathy Vesley-Massey, CEO, VAAA Cares
Marisa Scala-Foley, Dir., Aging and Disability Business Institute, n4a

Moderator: Becky Kurtz

Better Serving Dually Eligible Individuals with Dementia through Integrated Care

Tim Engelhardt, Director
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services

Dually eligible beneficiaries

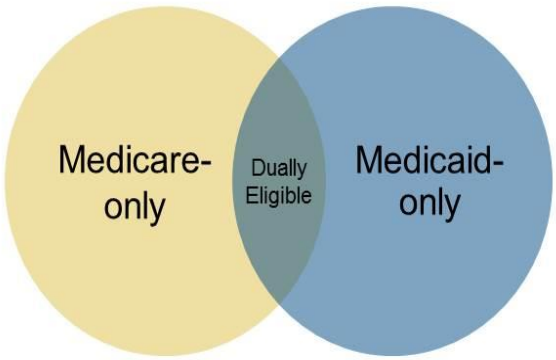
The dually eligible population

- Higher incidence of chronic conditions, disability
  - 41% have at least one mental health dx
  - 41% eligible for Medicare due to disability (vs. 8% for non-dual Medicare beneficiaries)
  - About half use long term services and supports
  - 19% have Alzheimer's or related dementia

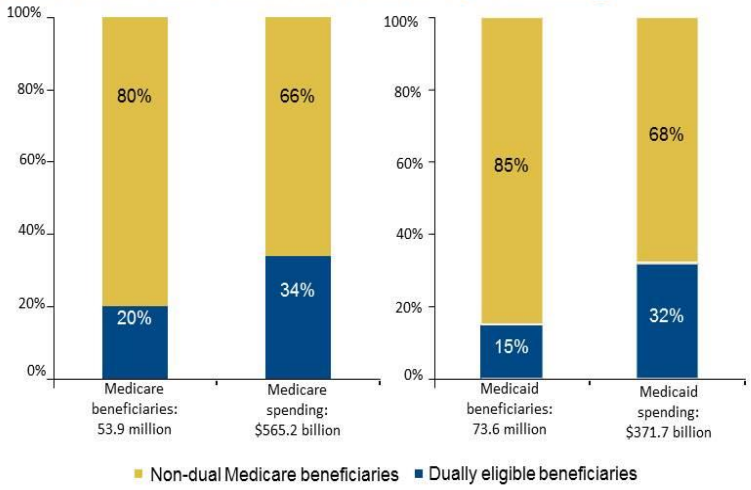
How it works

- Duals navigate two separate programs:
  - Medicare for the coverage of most preventive, primary, and acute health care services and drugs.
  - Medicaid for the coverage of long-term care supports and services, certain behavioral health services, and for help with Medicare premiums and cost-sharing.
  - Where benefits overlap, Medicare is primary payer.

12 million individuals are simultaneously enrolled in Medicare and Medicaid



Dually eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending



Note: *Charts include all dually eligible beneficiaries (FFS, managed care, and ESRD). Medicaid spending amounts exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Source: MedPAC-MACPAC Data Book 2018*

Dual eligibility correlates to poorer outcomes in Medicare programs

Program	ASPE findings for dually-enrolled vs. non-dually-enrolled beneficiaries
Hospital Readmissions Reduction Program	- 10-31% higher risk-adjusted odds of readmission
Hospital-Acquired Conditions Reduction Program	- Higher safety event rates for 4/8 individual events; lower for 2/8
Hospital Value-Based Purchasing Program	- 5-14% lower risk-adjusted odds of mortality - 4% higher risk-adjusted spending per episode
Medicare Advantage	- Performance worse on 17/20 quality measures
Medicare Shared Savings Program	- 18% higher risk-adjusted odds of readmission - 16% higher age/gender-adjusted odds of COPD admission - 14% lower age/gender-adjusted odds of HF admission
Physician Value-Based Payment Modifier	- 11-20% higher risk-adjusted odds of readmission - 80-230% higher risk-adjusted odds of preventable admission - $725-$2,979 higher risk-adjusted costs
ESRD Quality Incentive Program	- Performance worse on 5/5 quality measures
Skilled Nursing Facility Readmissions	- 4% lower risk-adjusted odds of readmission
Home Health Readmissions and ED Use	- 9% higher risk-adjusted readmission rates - 18% higher risk-adjusted ED use rates

ASPE Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. December 2016.
https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.

Misaligned incentives

Critical point: Misaligned incentives across states and CMS

- State investments in Medicaid services to improve care for dually eligible beneficiaries (e.g. enhanced behavioral health, LTSS) may result in savings that accrue to Medicare from lower acute care utilization – or vice versa.
- Historically, states have either:
  - Shouldered the burden of such investments without sharing in the acute care savings,
  - Carved out dually eligible beneficiaries of their care management programs, and/or
  - Passively (and sometimes actively) shifted costs to Medicare.
- Integrated care holds promise for realigning incentives.

Current Approaches to Integrated Care

Programs of All-Inclusive Care for the Elderly (PACE)

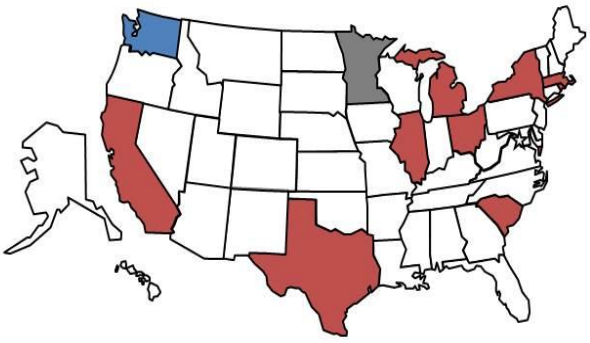
- PACE is a unique capitated managed care benefit for the frail elderly.
- PACE features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

Dual Eligible Special Needs Programs (D-SNPs)

- Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are entitled to both Medicare and Medicaid. D-SNPs are Medicare Advantage plans that are specifically designed to provide targeted care and limit enrollment to special needs individuals. When paired with a Medicaid MCO operated by the same organization, a beneficiary can receive all of her services from one place.

Overview of the Financial Alignment Initiative

- **Background**
  - A longstanding barrier to coordinating care for the dually eligible population is the financial misalignment between Medicare and Medicaid. That is, investments or disinvestments in one program may result in savings or costs to the other program.
    - Individuals with Alzheimer's and related dementias among populations that may feel that financial misalignment most acutely
  - CMS is testing models to integrate the service delivery and financing of both Medicare and Medicaid through federal-state demonstrations to better serve the population.
- **Goal**
  - Reduce expenditures while preserving or enhancing quality of care
  - Increase access to quality, seamlessly integrated services for the dually eligible population.



Capitated financial alignment demonstration (9 states)
Managed FFS financial alignment demonstration (1 state)
Administrative alignment demonstration (1 state)

[1] CMS and NY operate two separate capitated demonstrations, both in the New York City area.

Cal MediConnect

- Financial Alignment Initiative demonstration in California
- 10 Medicare-Medicaid plans serving 115,000 beneficiaries
- Leverage three-way contract provisions to identify, document, and support beneficiaries with dementia diagnosis
  - Health risk assessments and care plans
  - Caregivers
  - Dementia care specialists
- Alzheimer's of Greater Los Angeles estimates almost 200,000 dually eligible beneficiaries in California and 71,000 in Los Angeles county have Alzheimer's or a related dementia.

The Dementia Cal MediConnect Project

Presentation to the NAPA Advisory Council on Research, Care and Services
October 19, 2018

Debra L Cherry, PhD

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Funding

This project was supported, in part, by grant numbers 90DS2002-01-00 and 90DS2017-01-00, from the Administration on Aging, U.S. Administration for Community Living, Department of Health and Human Services and the California Department of Aging.

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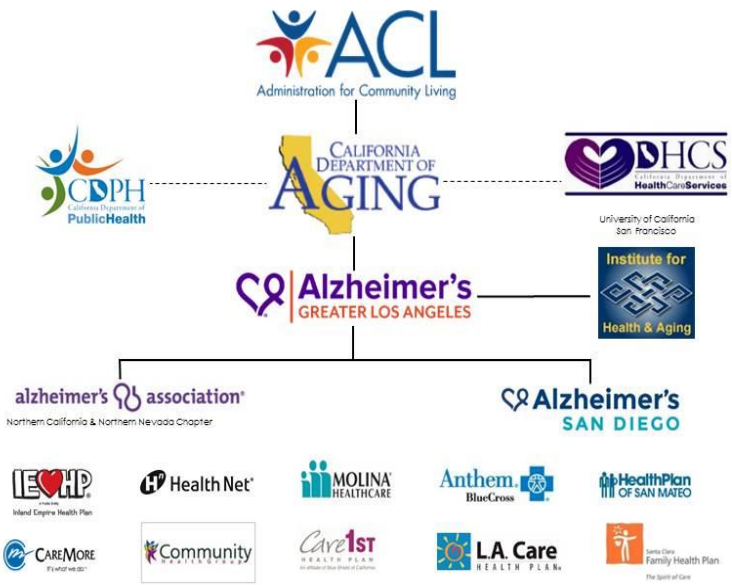
- The Allergan Foundation
- The Rosalinde and Arthur Gilbert Foundation



Policy Levers for DCMC Project

- 3 Way Contracts – Dementia Care Specialists
- Guidance on Identifying a Caregiver
- Informational Bulletin on Dementia

Dementia Cal MediConnect Project Goal: Creating Dementia-Capable Systems of Care

- Better detection & documentation of patients with dementia
- Better identification, assessment, support and engagement of family/friend caregivers
- Better partnerships with community-based organizations

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The Dementia Cal MediConnect Project: Key Components

- Advocacy with health plans, state and CMS - Making the case for focusing on dementia care
- Care manager training and support
- Health plan technical assistance
- Support services for patients and caregivers through the health plans and/or through referrals to local Alzheimer's organizations for:
  - Disease education
  - Caregiver support
  - Care planning
  - I & R
  - Respite

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Indicators of a Dementia Capable System

1. Better detection of patients with dementia

- Include cognitive impairment questions in the HRA and other assessments
- Adopt a validated screening tool
- Document cognitive assessment in the e-medical record
- Establish a follow-up protocol if the cognitive screen is positive

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Indicators of a Dementia Capable System

2. Better identification, assessment, support and engagement of family/friend caregivers

- Identify caregiver and document him/her/them in the eMR
- Assess the caregiver's needs
- Provide or arrange for disease education and support
- Engage the patient, as appropriate, and the caregiver in care planning
- Develop a care plan based on person- and family-centered needs

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Indicators of a Dementia Capable System

3. Better partnership with Community-Based Organizations

Adoption of a proactive referral tool to connect families to LTSS like:

- Respite
- Meals on Wheels
- Support groups
- Caregiver education
- Care counseling
- Disease education

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Care Manager Training

Care manager training (8 hours)

- 10 health plans plus PPGs and contracted LTSS organizations
- Nearly 500 care managers

Dementia Care Specialist trainings (12 hours)

- 9 health plans
- 109 specialists trained to date

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Dementia Care Manager Training Content

- Fundamentals of Cognitive Impairment, Alzheimer's Disease and Related Dementias
  - **AD8 Screening**
- Practical Dementia Care Management
  - **IDEA! Behavior Management Approach**
  - **Caregiver Tip Sheets on Behaviors**
  - **Best Practice Care Plans**
- Caring for the Caregiver
- Resources/Support Services
  - **ALZ Direct Connect**

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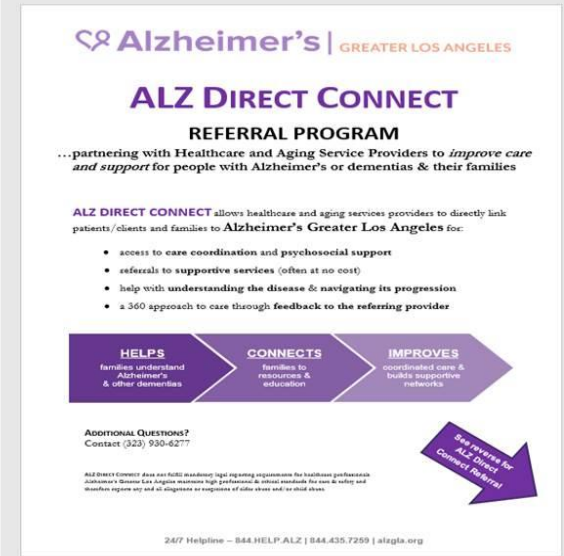
www.alzheimersla.org/professionals

Tool to Facilitate Warm Referrals



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ALZ DIRECT CONNECT

REFERRAL PROGRAM

…partnering with Healthcare and Aging Service Providers to *improve care and support* for people with Alzheimer's or dementias & their families

ALZ DIRECT CONNECT allows healthcare and aging services providers to directly link patients/clients and families to **Alzheimer's Greater Los Angeles** for:

- access to **care coordination** and **psychosocial support**
- **referrals** to **supportive services** (often at no cost)
- help with **understanding the disease** & **navigating its progression**
- a 360 approach to care through **feedback to the referring provider**

HELPS families understand Alzheimer's & other dementias

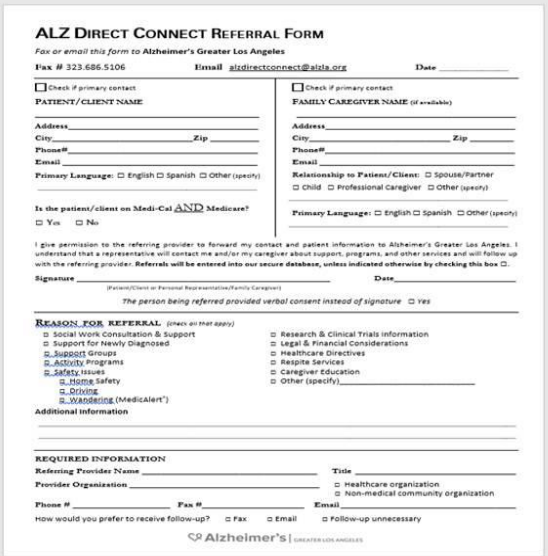
CONNECTS families to resources & education

IMPROVES coordinated care & builds supportive networks

ADDITIONAL QUESTIONS? Contact (323) 930-6277

See reverse for ALZ Direct Connect Referral

24/7 Helpline – 844.HELP.ALZ | 844.435.7259 | alzgla.org



ALZ DIRECT CONNECT REFERRAL FORM

Fax or email this form to **Alzheimer's Greater Los Angeles**

Fax # 323.686.5106 **Email** alzdirectconnect@alzla.org **Date** _____

☐ Check if primary contact

PATIENT/CLIENT NAME

Address_____

City_____ Zip _____

Phone#_____

Email_____

Primary Language: ☐ English ☐ Spanish ☐ Other (specify)

Is the patient/client on Medi-Cal AND Medicare?

☐ Yes ☐ No

☐ Check if primary contact

FAMILY CAREGIVER NAME (if available)

Address_____

City_____ Zip _____

Phone#_____

Email_____

Relationship to Patient/Client: ☐ Spouse/Partner ☐ Child ☐ Professional Caregiver ☐ Other (specify)

Primary Language: ☐ English ☐ Spanish ☐ Other (specify)

I give permission to the referring provider to forward my contact and patient information to Alzheimer's Greater Los Angeles. I understand that a representative will contact me and/or my caregiver about support, programs, and other services and will follow up with the referring provider. **Referrals will be entered into our secure database, unless indicated otherwise by checking this box ☐.**

Signature _____ **Date**_____

(Patient/Client or Personal Representative/Family Caregiver)

The person being referred provided verbal consent instead of signature ☐ *Yes*

REASON FOR REFERRAL *(check all that apply)*

- ☐ Social Work Consultation & Support
- ☐ Support for Newly Diagnosed
- ☐ Support Groups
- ☐ Activity Programs
- ☐ Safety Issues
  - ☐ Home Safety
  - ☐ Driving
  - ☐ Wandering (MedicAlert®)
- ☐ Research & Clinical Trials Information
- ☐ Legal & Financial Considerations
- ☐ Healthcare Directives
- ☐ Respite Services
- ☐ Caregiver Education
- ☐ Other (specify)_____

Additional Information

REQUIRED INFORMATION

Referring Provider Name _____ Title _____

Provider Organization _____ ☐ Healthcare organization ☐ Non-medical community organization

Phone # _____ **Fax #**_____ **Email**_____

How would you prefer to receive follow-up? ☐ Fax ☐ Email ☐ Follow-up unnecessary

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Keeping Home Safe

People with Alzheimer's or dementia may have trouble knowing what is dangerous or making safe decisions. By helping him or her feel more relaxed and less confused at home, you can help stop accidents.

WHAT CAN YOU DO?

Keep Things Simple
- make sure rooms are neat
- place "often used" items in the same place
- remove things that might break and aren't needed

Look at the Floor
- remove small rugs, rugs that are thick, or rugs that might slide on floors
- don't shine or wax floors
- keep items off floors... cords, books, toys, bags, boxes, etc.
- make sure bathroom and kitchen floors are kept dry and avoid walking with wet feet
- use tables and chairs that are stable enough to lean on

Remove Dangerous Items
- keep all medicines... vitamins, aspirin, prescriptions... in a locked box, cabinet, or drawer
- place knives, scissors, guns, sharp tools, matches, and lighters out of sight or in a locked area
- move all cleaning supplies to a high shelf or lock them away
- take off knobs from the stove and oven

Don't Leave Him or Her Alone
- in the kitchen with the stove or oven on
- in the bathroom with water running
- anywhere with burning cigarettes, cigars, or pipes
- near an open or unlocked door or gate

WHY DOES THIS HAPPEN?

People with Alzheimer's or dementia might:
- trip because of changes in balance or trouble walking
- have problems seeing clearly due to poor eyesight
- forget to turn off water, burners, ovens
- forget how to use knives, etc. or where to safely place burning objects

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24/7 Helpline
844.HELP.ALZ
alzgla.org

Plain Language Caregiver Tip Sheets

- Anger and Fighting
- Bathing
- Getting Lost
- Medications
- Hallucinations
- Paranoia
- Sundowning

- And more…

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- Sample HRA Questions
- Training Curricula for Care Managers
- ALZ Direct Connect Form (for adaptation)
- Dementia Care Management Toolkit
- AD8 Dementia Screening Tool and others
- Caregiver Identification Tool
- Benjamin Rose Caregiver Stress and Strain Scale and others
- Care Needs Assessment Tool
- *IDEA!* Strategy for Managing Challenging Behaviors
- Best Practice Care Plans
- Plain Language Caregiver Tip Sheets

Tools Available

Download at: www.alzheimersla.org/professionals

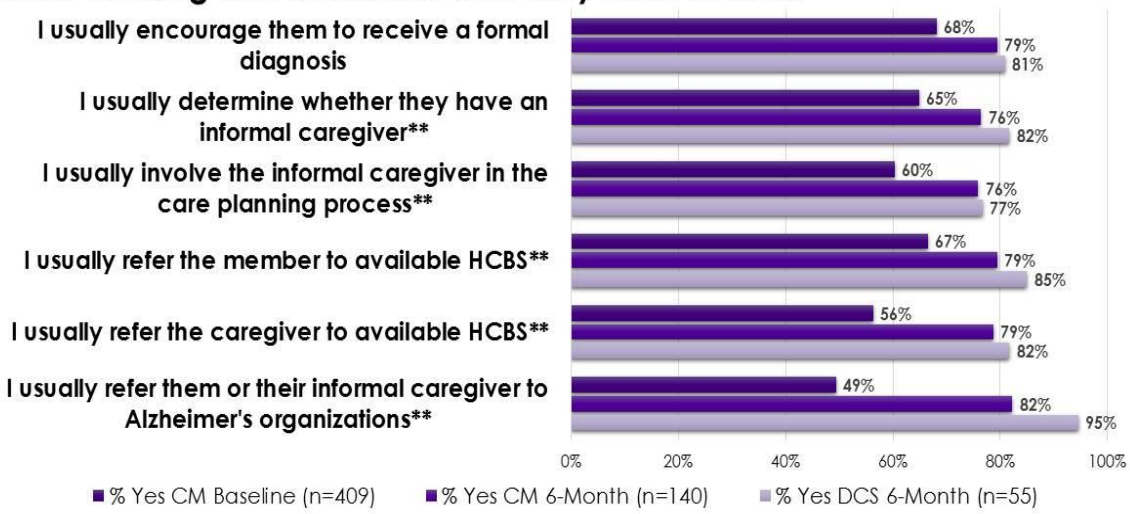
Evaluation

Evaluation Design

- **Care Manager training outcomes**
  - Knowledge of ADRD
  - Practice change
  - Systems change
  - Pre-, post- and 6-months post surveys
- **Systems Change Tracking**
  - Tracking indicators of dementia capable systems of care
  - Staff report and key informant validation

What can we say about CM practice change?

When working with a member who may have ADRD…



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Health Plan Systems Change Results (n=10)

Screening and Diagnosis

- 10 have at least one question in HRA regarding cognitive issues
- 6 have adopted a validated screening tool into their assessment processes
- 5 have protocols to refer members to PCP if screen is positive

Caregiver Identification, Assessment, and Involvement

- 9 report documentation of caregivers in EHR
- 10 plans report engaging caregivers in care planning and ICTs
- 4 adopted validated measure of caregiver stress and strain, and 2 integrated into EHR
- 7 offer or arrange for respite
- 10 plans offer or arrange for caregiver education (group or 1:1)

Referrals to HCBS

- 7 plans encourage the use of *ALZ Direct Connect*
- 10 plans make referrals to local Alzheimer's organizations

Dementia Cal MediConnect Project Team

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Integrating Clinical Care and Social Supports: An Area Agency on Aging Model

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VAAACares® is

- A Statewide collaboration of the Virginia Network of Area Agencies on Aging (AAAs).
- A subsidiary of Bay Aging; it serves as the 'one-stop-shop' for healthcare providers and payers to access community-based services.
- AAAs are Aging & Disability Resource Centers (ADRCs) for persons 18 and older.
- Previously the Eastern Virginia Care Transitions Partnership, it serves as the Hub for care transitions, chronic care management, and behavioral health integration across the State of Virginia.

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Evolution of the EVCTP to VAAACares®

- **2013**: EVCTP's full launch under the CMS CCTP demo for CTI with 5 health systems, 69 skilled nursing facilities, and 5 Area Agencies on Aging – covering 20% of the state
- **2015**: Bay Aging Initiated development of VAAACares® statewide for contract opportunities with Duals Demonstration - CTI and Care Coordination.
- **2016**: Based on Medicare savings and improved health outcomes, the VA General Assembly awarded funding to Bay Aging/EVCTP to demonstrate impact in Medicaid.
- **2017**: Success in Duals Demo led to MLTSS contracts for CTI and Care Coordination
- **2018**: VAAACares® emphasizes services for MCOs and ACOs, and is working to leverage new Medicare Advantage opportunities.

VAAACares®

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VAAACares® Evidence-Based, Care Transitions Intervention (CTI)©

- 30 – 90 Day intervention targeted to patients with one or more acute hospital admissions – based on a modified Coleman CTI model
- VAAACares® places embedded care coordination staff at participating hospitals.
  - Participants are targeted based on high utilization rates
  - The intervention becomes part of the hospital discharge process
- A person-centered intervention plan is developed based on assessment findings.
  - Discharge Planning Assessment
  - In-Home Assessment
  - Medication / Reconciliation post-discharge /Management Plan
  - Caregiver needs are high priority with some interventions geared to them.

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Past Performance

CMS – CMMI funded Community Care Transitions Provider: Eastern Virginia Care Transitions Partnership (EVCTP)

EVCTP: Year 2 Performance Analysis:

- Visited 90% of chronically ill target group (high utilizer) patients from partner hospitals in their homes
- Total Home Visits to all Hospital Patients 25,655
- Target Group Readmission Reductions (Hospital Data)
  - **2010 Baseline 23.4%**
  - **Enrollee Readmission Rate 9.1%**
  - **Reduced ED Utilization of "Self Insured"**
  - **Increased PCP Utilization**

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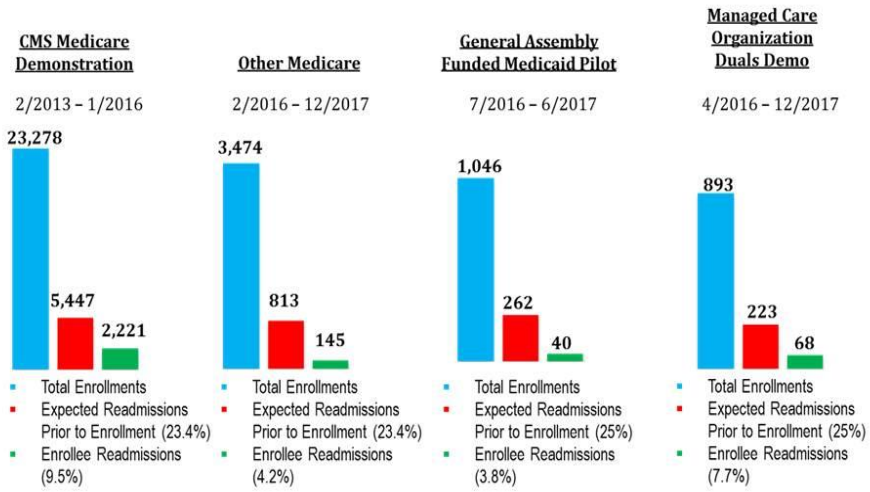
Eastern Virginia Care Transitions Partnership (now d/b/a VAAACares®) Outcomes and Cost Savings



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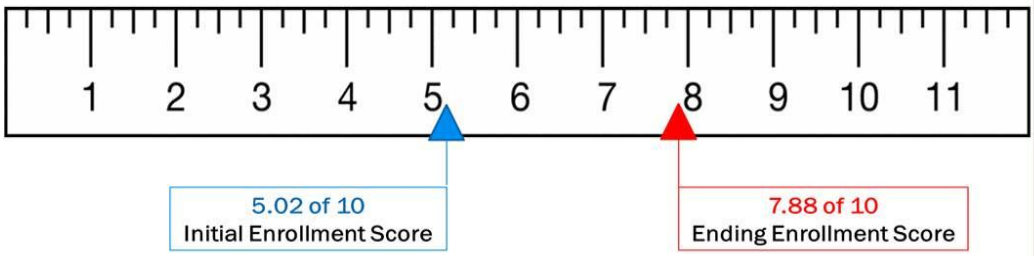
PATIENT EMPOWERMENT

When given the opportunity to gain insight and skills, engaged patients are better equipped to manage their conditions, remain at home longer, and are more likely to use fewer healthcare services, thereby reducing healthcare costs.



Confidence Question: *On a scale of 1 to 10, with 1 being not at all confident and 10 being completely confident, consider the following:*

I am confident that I can manage and control most of my health problems.

Value Adds from AAAs

Assessment and home stabilization strategy
Available to Caregiver and Patient

Components	• Assessment • Medication Reconciliation and Self-Management • PCP Appointment Adherence • Red Flags • Patient Centered Record
Incorporate	• Chronic Disease Self-Management Education • Fall Prevention • Diabetes Self-Management Education • Healthy Ideas / PHQ9 • Advance Care Planning • Telehealth / Tele-education
Other Services	• Information about ADRC services • Transportation • Nutrition / Meals on Wheels • Personal and Companion Care • Emergency Services i.e. fuel assistance • Environment Home Modifications & Repair • Adult Day Services • Caregiver Support

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Customizable:

30-Day Traditional Intervention

- Inclusion Criteria-Examples
  - Patient with one or more chronic conditions and/or a recent hospital admission or ED encounter
  - CHF, COPD, Diabetes, Septicemia, AMI, Pneumonia, and other high utilizers
  - Patients with "social" needs for community based services
- Other Inclusion Criteria – Examples
  - Individuals with dementia or Alzheimer's Disease or serious mental health issues with an active caregiver
  - Usually patients in hospice or living in long term care facilities are not included.

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Customizable:
Extended 90-Day Model for Higher-Risk Populations

- Blended Care Transitions and Case Management
- Inclusion Criteria-Examples are the same as 30-Day Model but patients have more complex needs
- Some payers include:
  - Medicare Advantage
  - Medicare high-risk
  - Dual-Eligible
- Support from Administration for Community Living (ACL) for the opportunity to develop and participate in demonstrations and third-party payer models
- Third-Party Payer
  - Utilizing TCM and CCM codes ordered by physician group and/or hospitalist

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Success Story: The Millers

About:

- 82 year old male discharged from the hospital with a diagnosis of pneumonia. Prior recent diagnosis of dementia.
- Mrs. Miller, his caregiver, had no local support or knowledge of how to care for Mr. Miller given his current condition and how his dementia would progress.
- Mr. Miller was in denial of his condition and did not want to discuss what might happen if his wife fell ill and could no longer care for him.
- His dementia progressed rapidly and other physical conditions surfaced:
  - Incontinence
  - Wandering off
  - No caution of situations that should be considered frightening
  - Constant intolerance and agitation.

VAAACares

BAY AGING
DIGNITY AT EVERY AGE

Success Story: The Millers

Outcomes:

- Enrollment in our Care Transitions Intervention program and participation in the telehealth patient monitoring program to assist Mrs. Miller in tracking her husband's vital signs for 90 days.
- Frequent visits with a VAAACares® Health Coach to determine needs and support.
- Referred Mrs. Miller to an Alzheimer's support group and set up respite care during her absence.
- The coach was able to build a relationship with Mr. Miller during these sessions providing Mrs. Miller the necessary time to focus on herself.

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Success Story: The Millers

Outcomes:

- Enrollment in a pilot program called FAMILIES (Family Access to Memory Impairment and Loss Information, Engagement and Supports), which connected Mrs. Miller to a Clinical Psychologist who provided counseling services via a WebEx connection that the coach provided.
  - These sessions helped her:
    - Increase her knowledge for managing her husband's dementia and how it may progress
    - Develop a care plan that works for her
    - Identify coping strategies to reduce stress and the changes in her husband's personality and behavior

The Millers are able to live in their home and frequent hospitalizations subsided

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Thank you!

Questions?

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Integrating Clinical Care with Home & Community-Based Care: New Opportunities under Medicare Advantage

NAPA Advisory Council Meeting
October 19, 2018

Marisa Scala-Foley
Director, Aging and Disability Business Institute
n4a

Aging and Disability
BUSINESS INSTITUTE

The "Business Institute"

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

www.aginganddisabilitybusinessinstitute.org

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Aging and Disability BUSINESS INSTITUTE

Our Funders

Our Partners

Bipartisan Budget Act of 2018 & CHRONIC Care Act

- New tools and strategies to address the needs of people with Medicare who have complex care needs
- Permanently authorizes Special Needs Plans (SNPs) which target high-need/high-risk Medicare beneficiaries (i.e., dual eligibles [D-SNPs], people with chronic health conditions [C-SNPs], people living in institutions [I-SNPs])
- Promotes integration in D-SNPs, and reduces barriers to care coordination in ACOs
- Extended and expanded the Independence at Home Demonstration, through which comprehensive primary care services are delivered at home to Medicare beneficiaries with multiple chronic conditions
- Expanded access to telehealth in Medicare Advantage plans and ACOs

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Opportunities – Medicare Advantage (MA)

- Expansion of Medicare Advantage supplemental benefits
  - Includes flexibility to offer some types of long-term supports and services (LTSS)
- Changes in the following areas:
  - Uniformity requirements
  - Targeting of beneficiaries
  - Definition of "primarily health-related"

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Changes for 2019

	Old Rules	New Rules
Benefit uniformity	Plans must offer the same benefits to all enrollees of the same plan	Now allowed to target benefits to groups of enrollees who share
Supplemental benefits	Supplemental must be "primarily health-related" which means, in part, not for the purpose of "daily maintenance"	Broader definition of the term "primarily health-related"

Source: Tumlinson & Johnson. (2018). *CHRONIC Care Act: Making the Case for LTSS in Medicare Advantage Supplemental Benefits.* LTSS Summit, Sacramento, CA, The SCAN Foundation, 2018.

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Defining "primarily health-related"

- Benefits must:
  - Diagnose, prevent or treat an injury;
  - Compensate for physical impairments;
  - Act to ameliorate the functional/psychological impacts of injuries or health conditions; OR
  - Reduce avoidable emergency or health care utilization
  - ***Cannot be*** *"solely or primarily used for cosmetic, comfort, general use, or social determinant" purposes*
- Benefits must be recommended by a licensed professional as part of a care plan

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Examples of allowable types of supplemental benefits

- Adult day care services
- Home-based palliative care
- In-home support services
- Respite care
- Transportation (to doctor's visits)
- Home modification (e.g., safety devices and modifications like grab bars, shower stools, stair treads)
- Support for caregivers
- *(Meals excluded for 2019)*

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Further changes in 2020

- Expands supplemental benefits to allow benefits that "with respect to a chronically ill enrollee, 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."
- The Secretary may waive uniformity requirement for supplemental benefits to chronically ill enrollees

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Opportunities (and Advice) for Community-Based Organizations

- Define your value proposition in terms of how the services you offer address the plan's pain points
- Results, results, results
- Think about approaching MA plans with your existing health care partners
- If you have contracts with Medicaid/duals plans, approach their MA plans
- Don't underestimate the value of retention

Resources

- https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html (select "2019 Announcement")
- https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2018/07/Policy-Spotlight-Integrated-Care-print.pdf
- https://www.thescanfoundation.org/sites/default/files/chronic_care_act_brief_030718_final.pdf

Questions?

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Discussion