



# Medicare Advantage Supplemental Benefits, 2015-2019

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UNIVERSITY OF  
MARYLAND

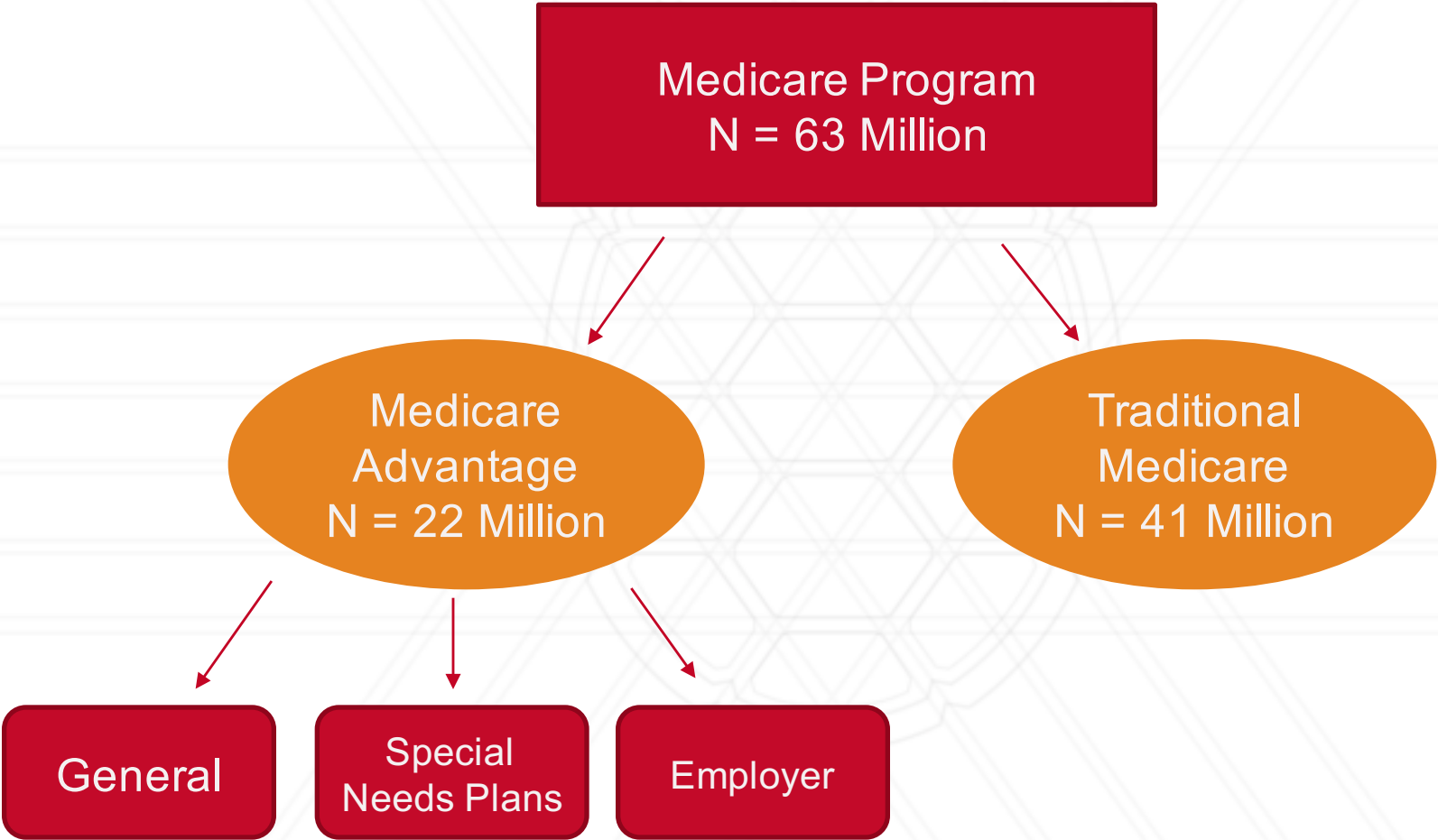
# Acknowledgements and Disclosures

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- Funding
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- Disclosures
  - Speaker fees from ZimmerBiomet unrelated to this project (2018)

# Background

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# Traditional Medicare vs Medicare Advantage

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

# Medicare Advantage

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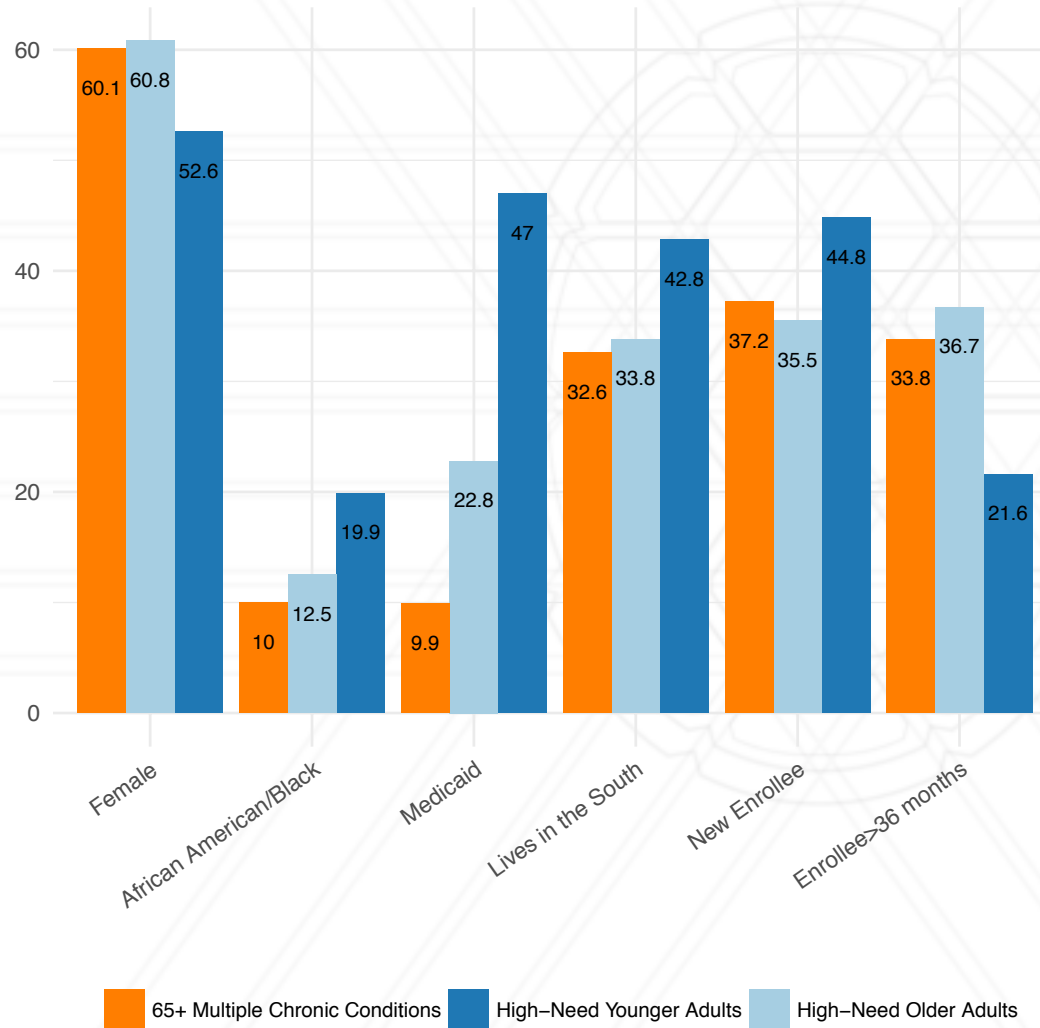
- MA Plans are private health plans (e.g., Aetna, UnitedHealthCare) that offer Medicare covered services
- Enrollment in MA varies by state.
  - In Colorado, ~37% are enrolled in MA
  - In Maryland, ~16% are enrolled in MA
- MA Plans are paid by Medicare based on the risk of their enrollees AND the quality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

# CHRONIC Care Act

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

# Characteristics of Medicare Advantage enrollees



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

Source: E. H. DuGoff, W. Buckingham, A.J. Kind, S. Chao and G. F. Anderson. Targeting High-Need Beneficiaries in Medicare Advantage: Opportunities to Address Medical and Social Needs. Issue Brief (Commonwealth Fund) 2019;2019:1-14.

# Supplemental Benefits Cover a Wide-Range of Services

Dental	Vision	Hearing	Clinical	Preventive Health	Auxiliary
<p><b>Preventive</b></p> <ul style="list-style-type: none"> <li>Dental x-ray</li> <li>Oral exam</li> <li>Dental cleaning (prophylaxis)</li> <li>Fluoride</li> </ul> <p><b>Comprehensive</b></p> <ul style="list-style-type: none"> <li>Prosthodontics, maxillofacial surgery</li> <li>Non-routine services</li> <li>Diagnostic services</li> <li>Restorative services</li> <li>Endodontics, periodontics, extractions</li> </ul>	<p><b>Eye exam</b></p> <p><b>Eyewear</b></p> <ul style="list-style-type: none"> <li>Upgrades</li> <li>Contact lenses</li> <li>Glasses: lenses and frames</li> <li>Glasses: lenses only</li> <li>Glasses: frames only</li> </ul>	<p><b>Hearing aids</b></p> <p><b>Hearing exam</b></p> <ul style="list-style-type: none"> <li>Fitting and evaluation for hearing aid</li> <li>Routine hearing exam</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic maintenance care Routine foot care</li> <li>Acupuncture</li> <li>Other alternative therapies</li> <li>Residential substance abuse treatment</li> </ul>	<ul style="list-style-type: none"> <li>Health education</li> <li>Nutrition counseling</li> <li>Enhanced smoking cessation counseling</li> <li>Gym membership</li> <li>Enhanced disease management</li> <li>Telemonitoring</li> <li>Remote access technology<sup>1</sup></li> <li>Bathroom safety devices</li> <li>Counseling services</li> <li>In-home safety assessments</li> <li>Personal emergency response systems</li> <li>Medical nutrition therapy</li> <li>Post-discharge in-home medication reconciliation</li> <li>Weight management program</li> <li>Annual physical exam</li> <li>Enhanced screening EKG<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>Emergency coverage abroad</li> <li>Nonemergency transportation</li> <li>Meals</li> <li>Wigs for hair loss related to chemotherapy</li> <li>Over-the-counter drugs/items</li> </ul>

Source: AARP Public Policy Institute analysis of the 2017 "Plan Benefit Package" file.

<sup>1</sup> Web-/phone-based or nursing hotline.

<sup>2</sup> EKG = electrocardiogram





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

Benefit Type	Plans % offering	Beneficiaries % in plans offering
<b>Dental</b>	68	62
Preventive dental	67	61
Comprehensive dental	47	45
<b>Vision</b>	84	79
Eyewear	67	61
Eye exam	83	78
<b>Hearing</b>	68	66
Hearing exam	67	65
Hearing aids	55	57
<b>Clinical services</b>	42	45
<b>Preventive health</b>	86	78
<b>Auxiliary</b>	86	80

Source: AARP Public Policy Institute analysis of the December 2017 MA/Part D Contract and Enrollment "Monthly Enrollment by Plan" file and of the 2017 "Plan Benefit Package" file.

# Objective and Key Questions

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

Key Questions:

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

Type of Benefit	Exemplar Service
Dental	Oral exams, extractions, x-rays
Vision	Eye Glasses, Eye exams
Hearing	Hearing exam, hearing aids
Transportation	Plan-approved locations
Waiver of 3-day Hospital Stay for SNF	
Meals	

# Sample and Data Sources

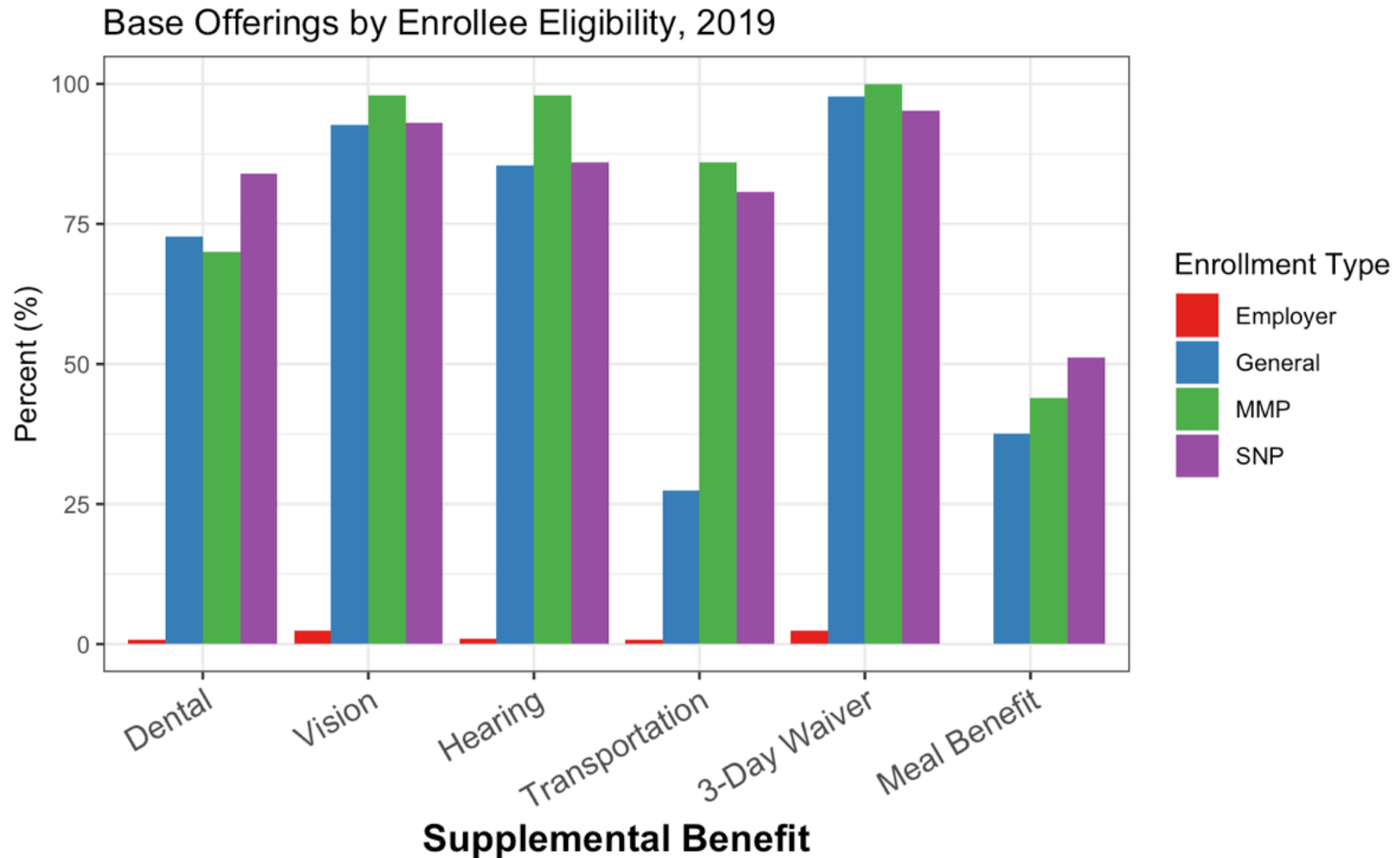
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## Sample:

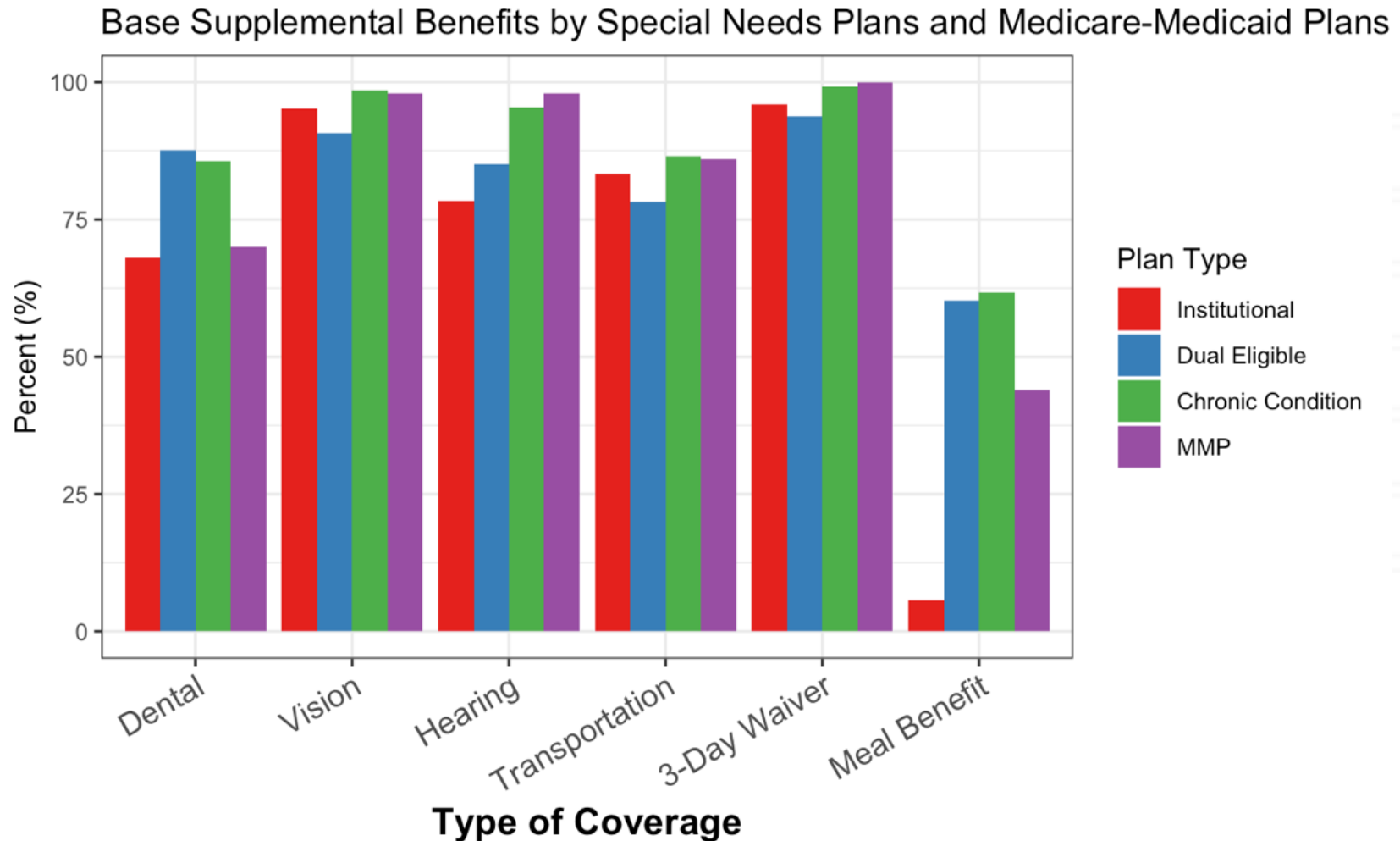
- HMO, PPO, PFFS, SNP, or Medicare-Medicaid Plan with positive enrollment in the July monthly enrollment file
  - Employer plans are excluded unless noted
  - Demonstration plans are includes unless noted

Data	Years	Variables
Medicare plan benefit files	2015-2019	<ul style="list-style-type: none"><li>• Dental, Vision, Hearing, Transportation, SNF 3-day Waiver, Meals</li><li>• Part B premium</li><li>• Type of Plan</li></ul>
Monthly Plan Enrollment	July, 2015-2019	<ul style="list-style-type: none"><li>• Enrollment</li></ul>
Directory File	2015-2019	<ul style="list-style-type: none"><li>• Non-Profit/For-Profit</li></ul>

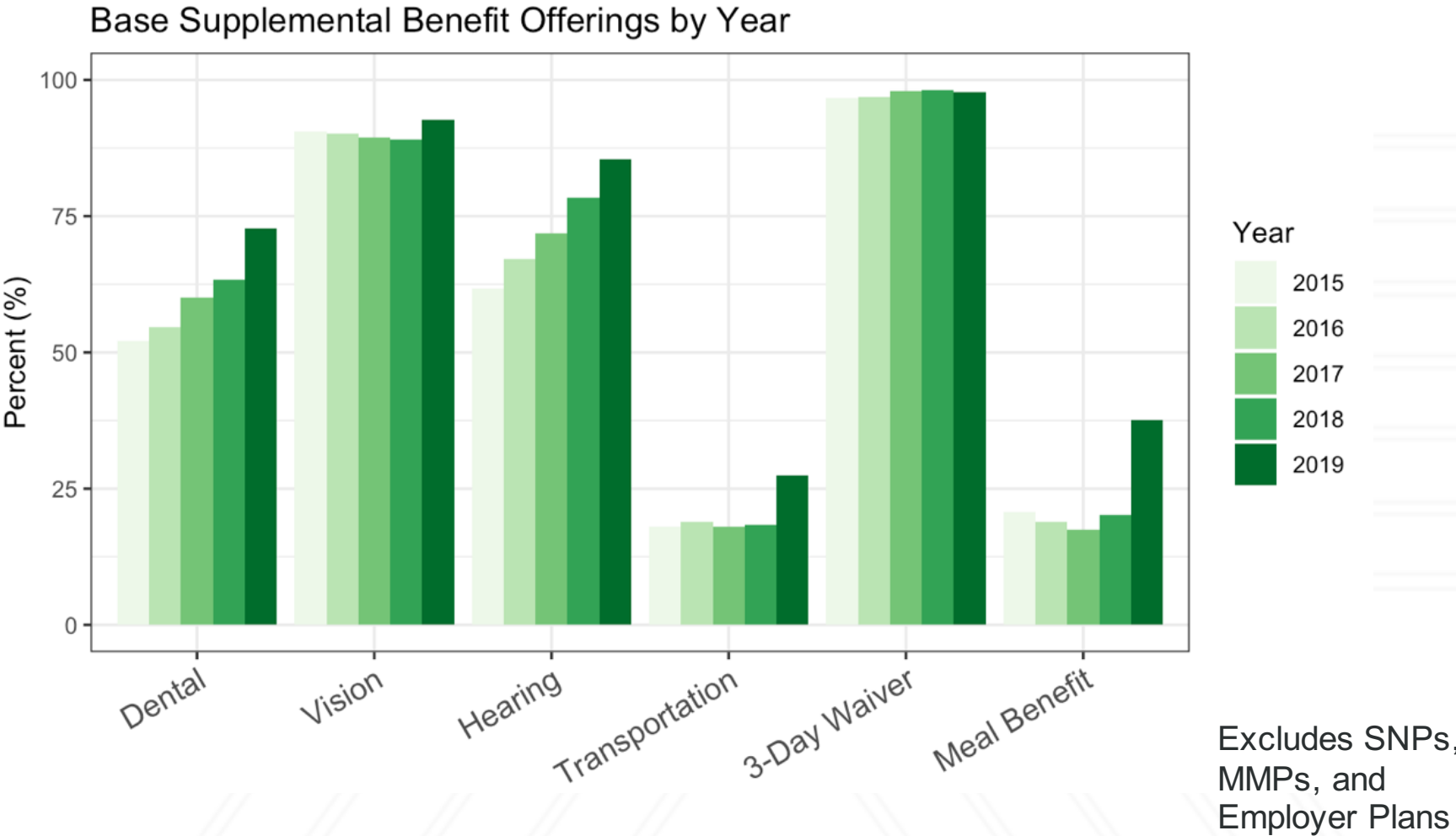
# Supplemental Benefit Offer Rates, 2019



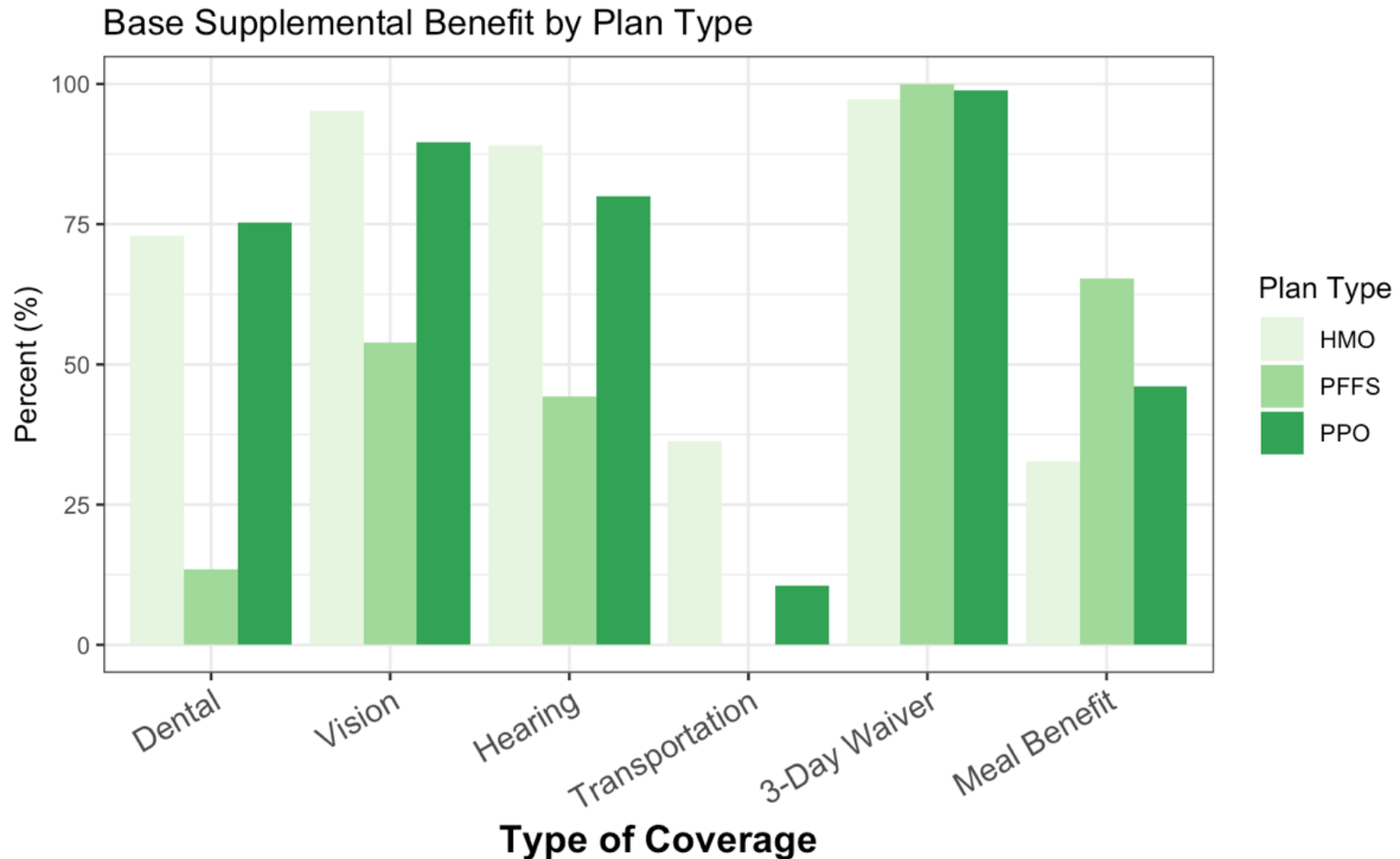
# Closer Look at SNPs and MMPs: Offer Rates Vary, 2019



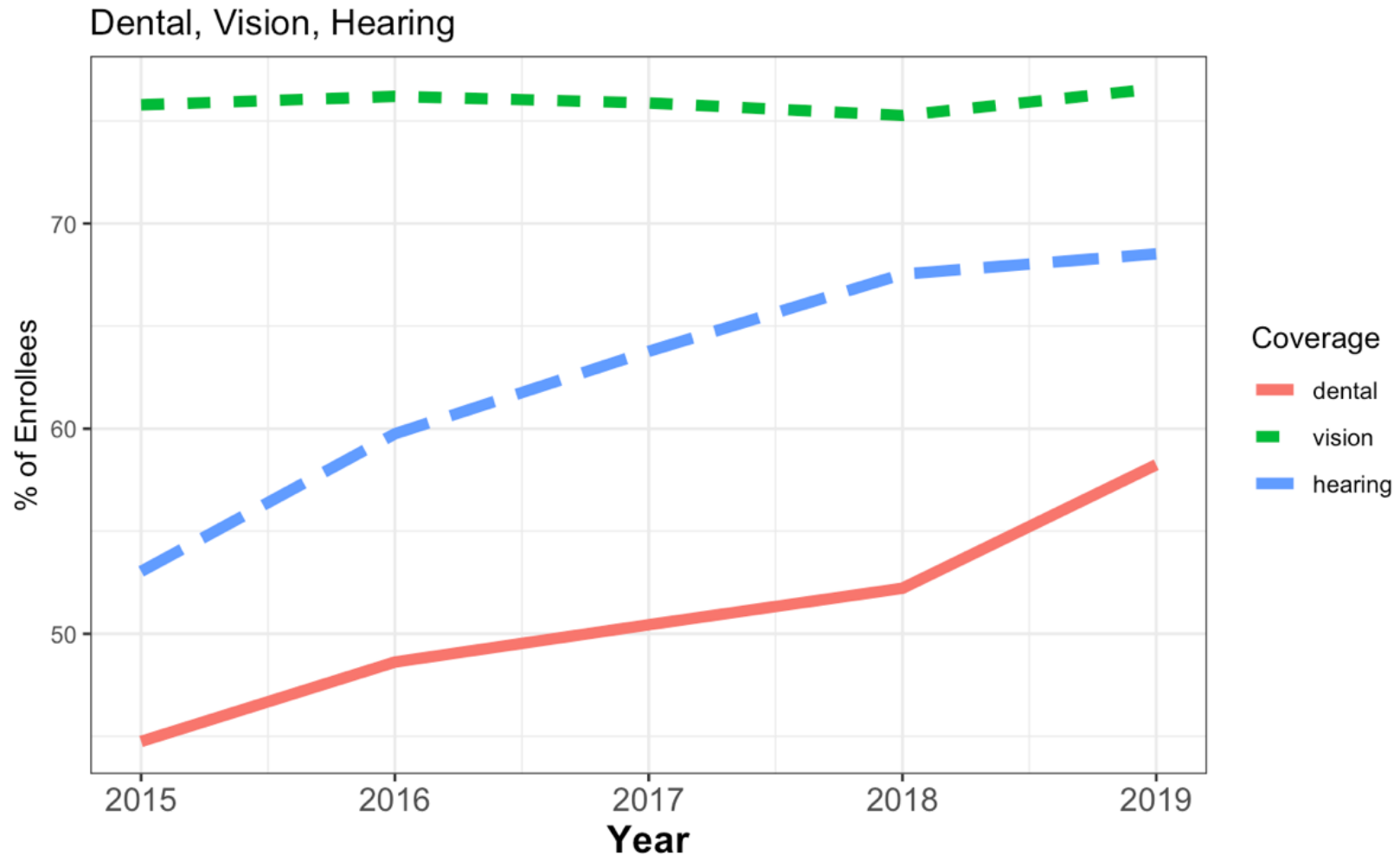
# Program-Wide Offer Rates, 2015-2019



# Supplemental Benefits Offerings Vary Among HMO, PPO, and PFFS

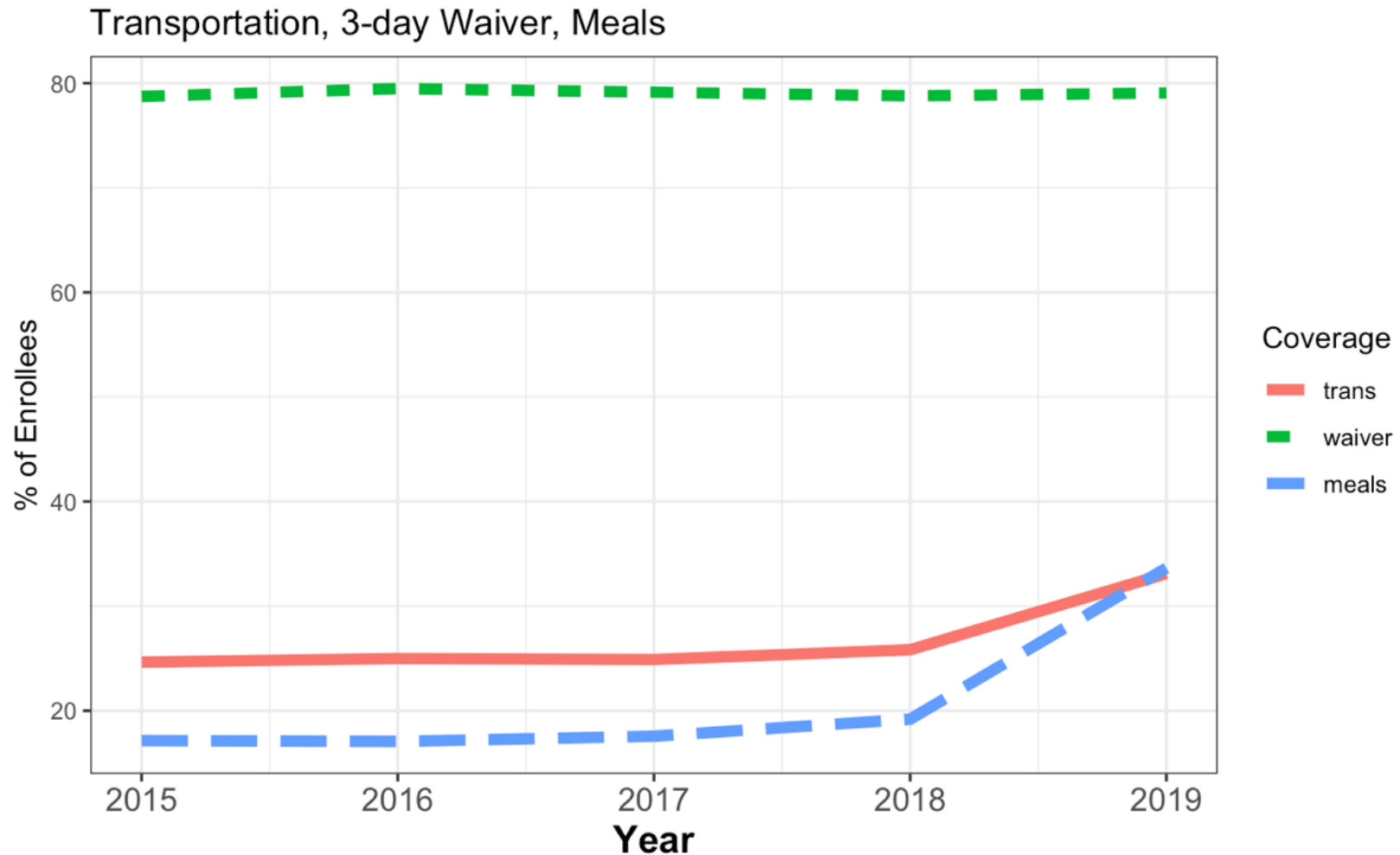


# Beneficiary Access to Dental, Vision, and Hearing Benefits Are Increasing



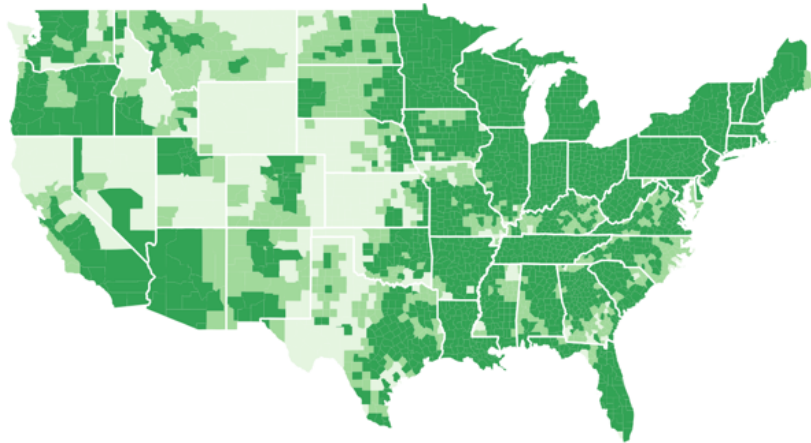


# Beneficiary Access to Transportation, and Meal Benefits Increased in 2019



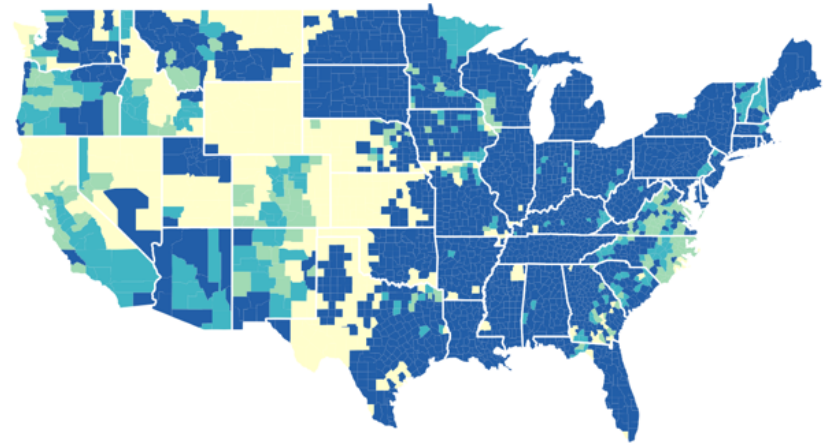
# Geographic Variation in Access to Dental Coverage

Number of Plans Per County Offering Benefit



Number of Options 0 1-4 5+

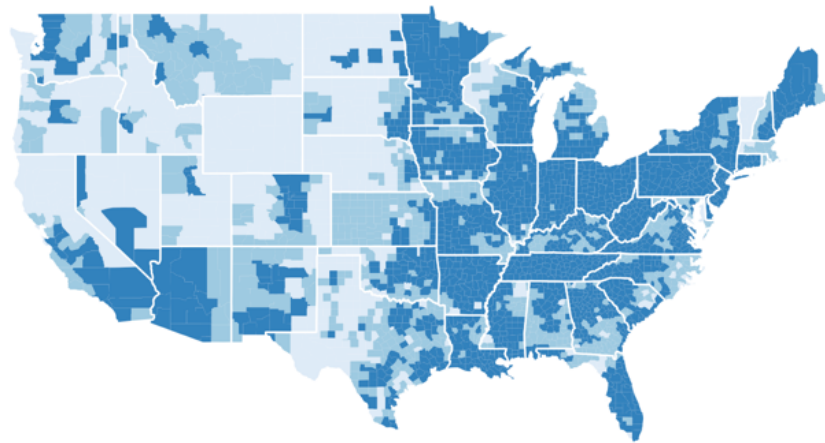
% of Enrollees Per County with Benefit



% of Enrollees 0 1-25 25-50 50+

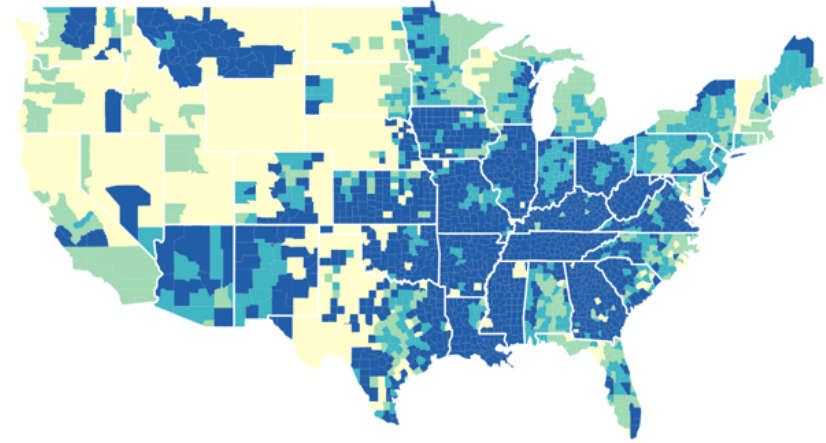
# Geographic Variation in Access to Meal Benefit

Number of Plans Per County Offering Benefit



Number of Options 0 1-4 5+

% of Enrollees Per County with Benefit



% Enrollees 0 1-25 25-50 50+

# Summary of Key Finding

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

## Next Steps

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



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# Medicare Advantage: New Options for Supplemental Benefits

August 29, 2019

# TODAY'S DISCUSSION

- 1. Introduction***
- 2. Medicare and Medicaid Funding***
- 3. Factors Driving Need for Change***
- 4. State and Federal Initiatives***
- 5. CHRONIC Care Act***
- 6. Implications for Stakeholders***
- 7. Opportunities and Questions to Consider***



# INTRODUCTION

## **Dr. Jay Bulot**

Vice President for State Markets  
WellSky Corporation

## **Brief Bio**

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

# MEDICARE AND MEDICAID FUNDING

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

# FACTORS DRIVING CHANGE

Growing Costs

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graph TD; A[Growing Costs] --> B[Attempts at Integration]; B --> C[Chronic Care Act – the Game Changer];
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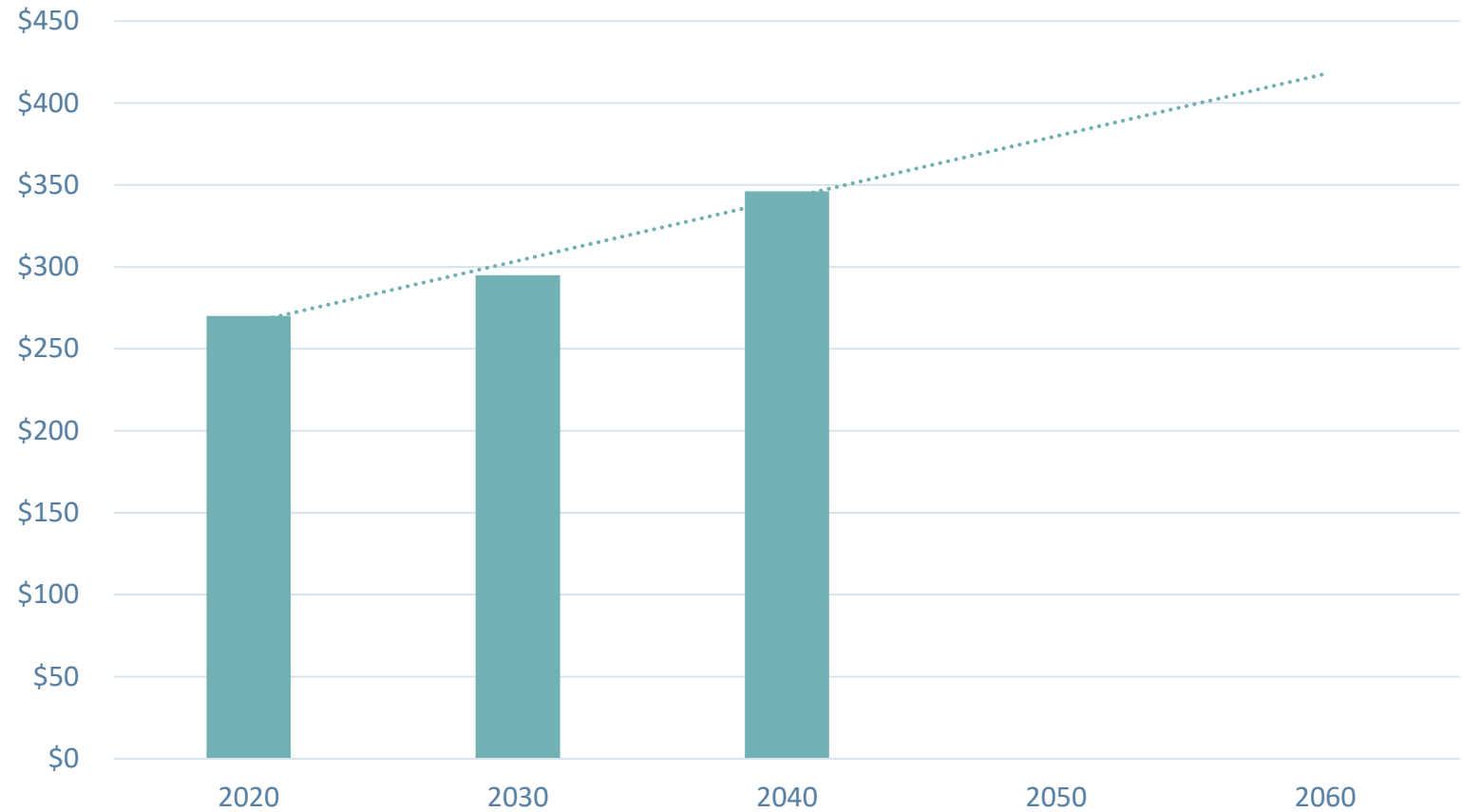
Attempts at Integration

Chronic Care Act – the  
Game Changer

# 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**.

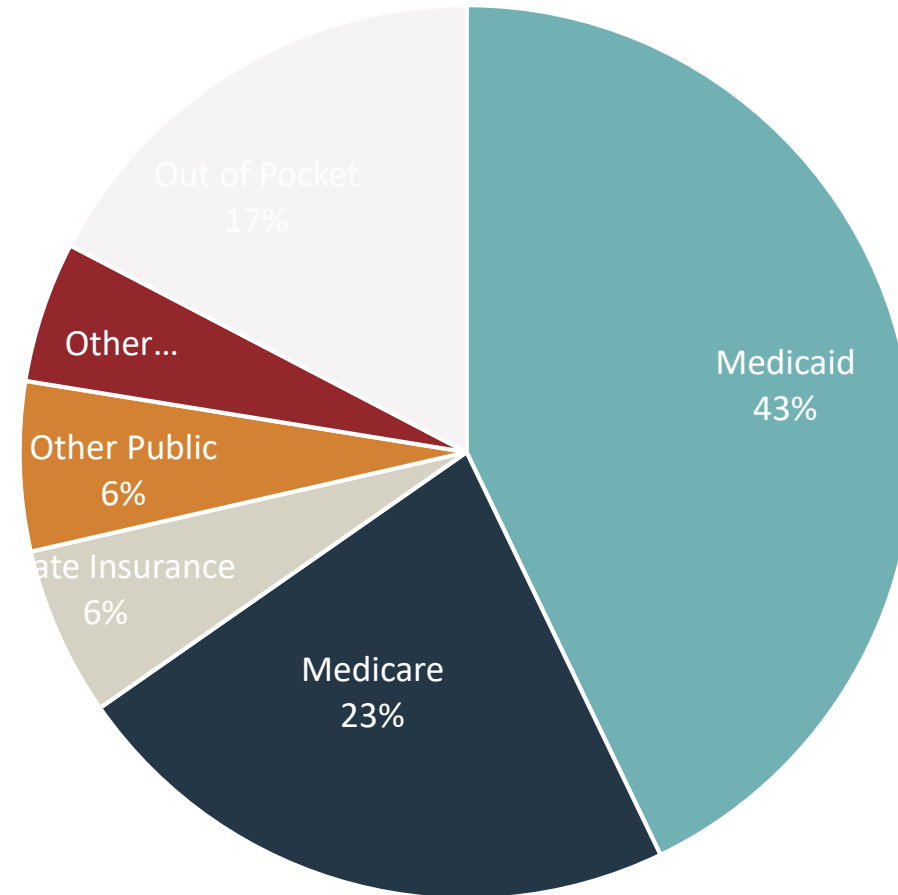
LTSS Expenditure Estimates in Billions



# 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



## OTHER ECONOMIC DRIVERS

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

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

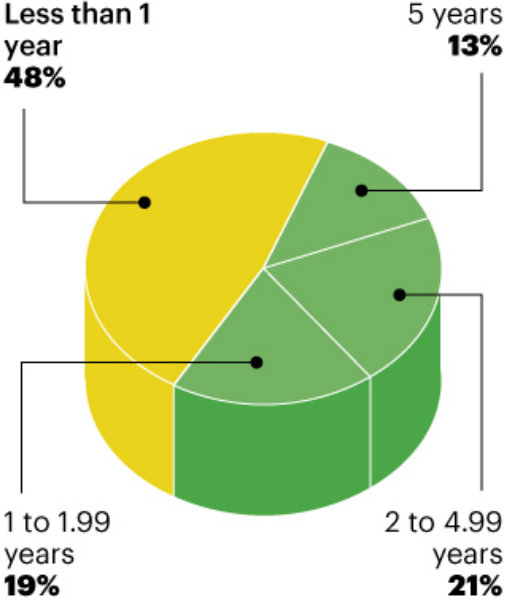
**Medicare is in even worse shape. Its Part A is already spending more each year than payroll taxes cover and is projected to be depleted in 2026.**

# INCREASING NEED + INCREASING COST + DECREASING INCOME/BENEFITS=NEED FOR CHANGE

## The Unpredictability of Long-Term Care

### HOW LONG ...

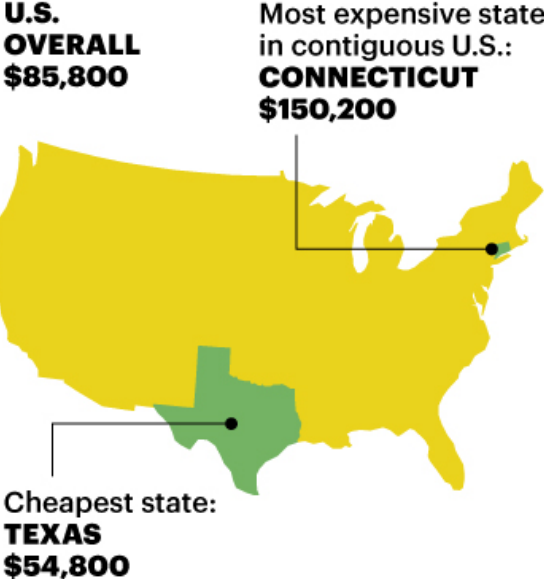
The duration of paid care among 65-year-olds who will need it someday varies widely, but for many it is under one year.



PERCENTAGES EXCEED 100% BECAUSE OF ROUNDING. SOURCE: DEPARTMENT OF HEALTH AND HUMAN SERVICES

### HOW MUCH ...

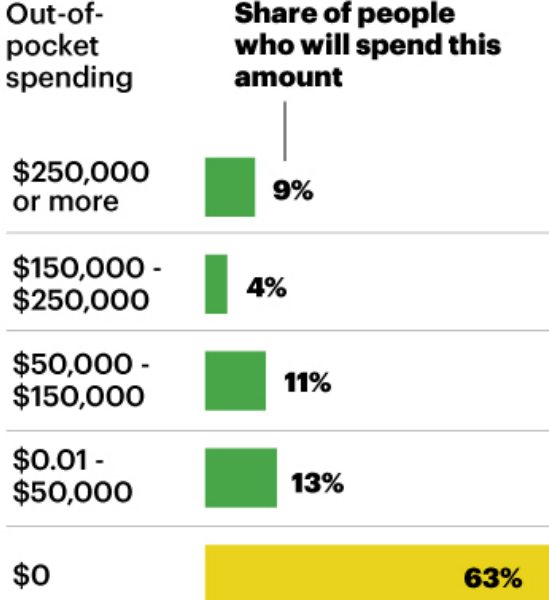
The median annual cost of nursing home care depends on your state.



PRICES ARE FOR A SEMIPRIVATE ROOM. THE MEDIAN ANNUAL COST IN ALASKA IS \$292,000. SOURCE: GENWORTH

### YOUR COSTS

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



SOURCE: DEPARTMENT OF HEALTH AND HUMAN SERVICES



## REALITY CHECK - NEVER HAVE I EVER....

- **Had Long Term Care Insurance?**
- **Spent \$50,000, out of pocket, for healthcare expense?**



# REALITY CHECK

## 2.4% OF ADULTS HAVE LTC INSURANCE

- **Private long-term care (LTC) insurance:** Typically inaccessible to anyone with current or future care needs due to high premium prices
  - (LTC) insurance, which began as nursing facility insurance, has been available for about 30 years, the market for this insurance product is relatively small (estimated 7 – 9 million purchasers)
  - Paying for private LTC insurance can be burdensome for individuals and families with limited incomes
- **Out-of-pocket:** Few individuals can afford to pay out-of-pocket for needed long-term services and supports, especially those living on fixed incomes with limited personal savings and assets
  - A person's ability to pay for current LTSS needs and/or save for future potential LTSS needs depends on many factors, including, but not limited to, health status, employment status and history, household income, debt and asset levels, and the availability of natural supports (such as a family caregiver)

# FOCUSING ON PERSON CENTERED CARE MAY ALSO YIELD COST SAVINGS

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

## 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

# GROWTH OF OPPORTUNITIES TO EXPAND ACCESS TO LTSS

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

Older American  
Act

Medicaid  
Waivers

Money Follows  
the Person

Balancing  
Incentive  
Program

Risk Based  
MLTSS

Dual  
Demonstrations

ACOs/Medicaid  
ACOs

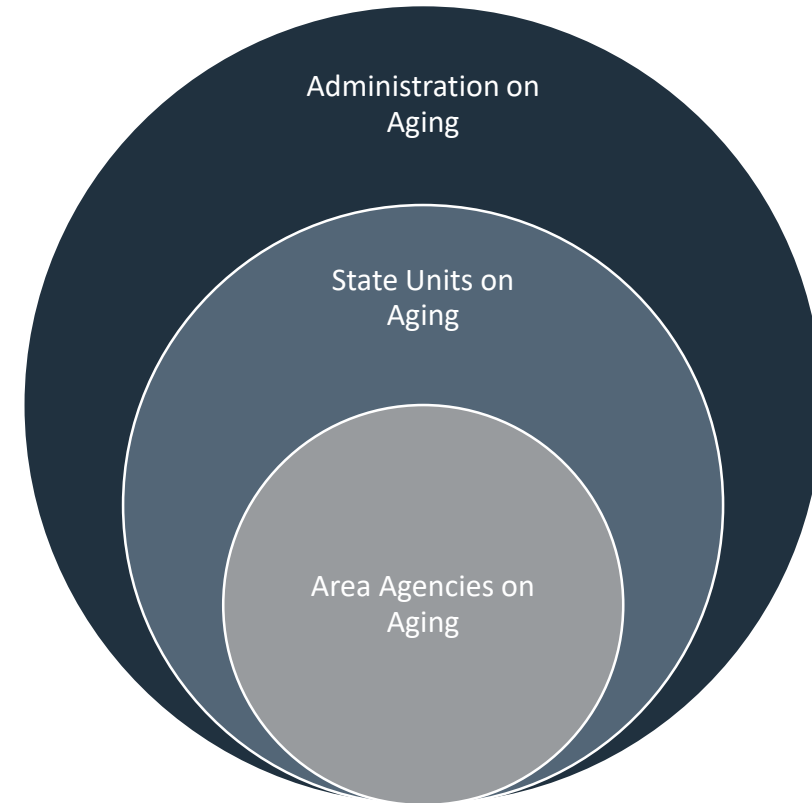
Medicare  
Advantage  
(CCA)

# OLDER AMERICANS ACT

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

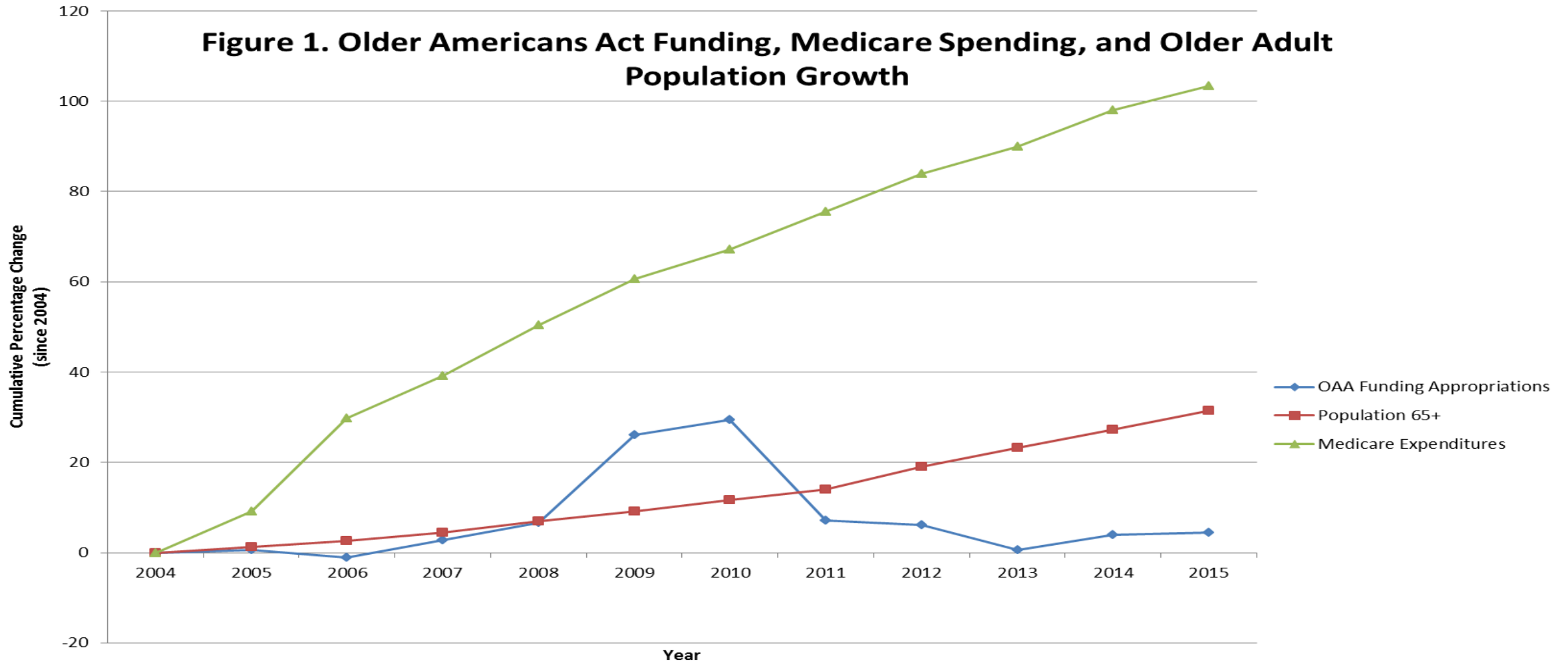
Created the National Aging Network which provides funding - based primarily on the percentage of an area's population 60 and older for:

- Nutrition and supportive home and community-based services,
- Disease prevention/health promotion services
- Elder rights programs
- National Family Caregiver Support Program
- Native American Caregiver Support Program

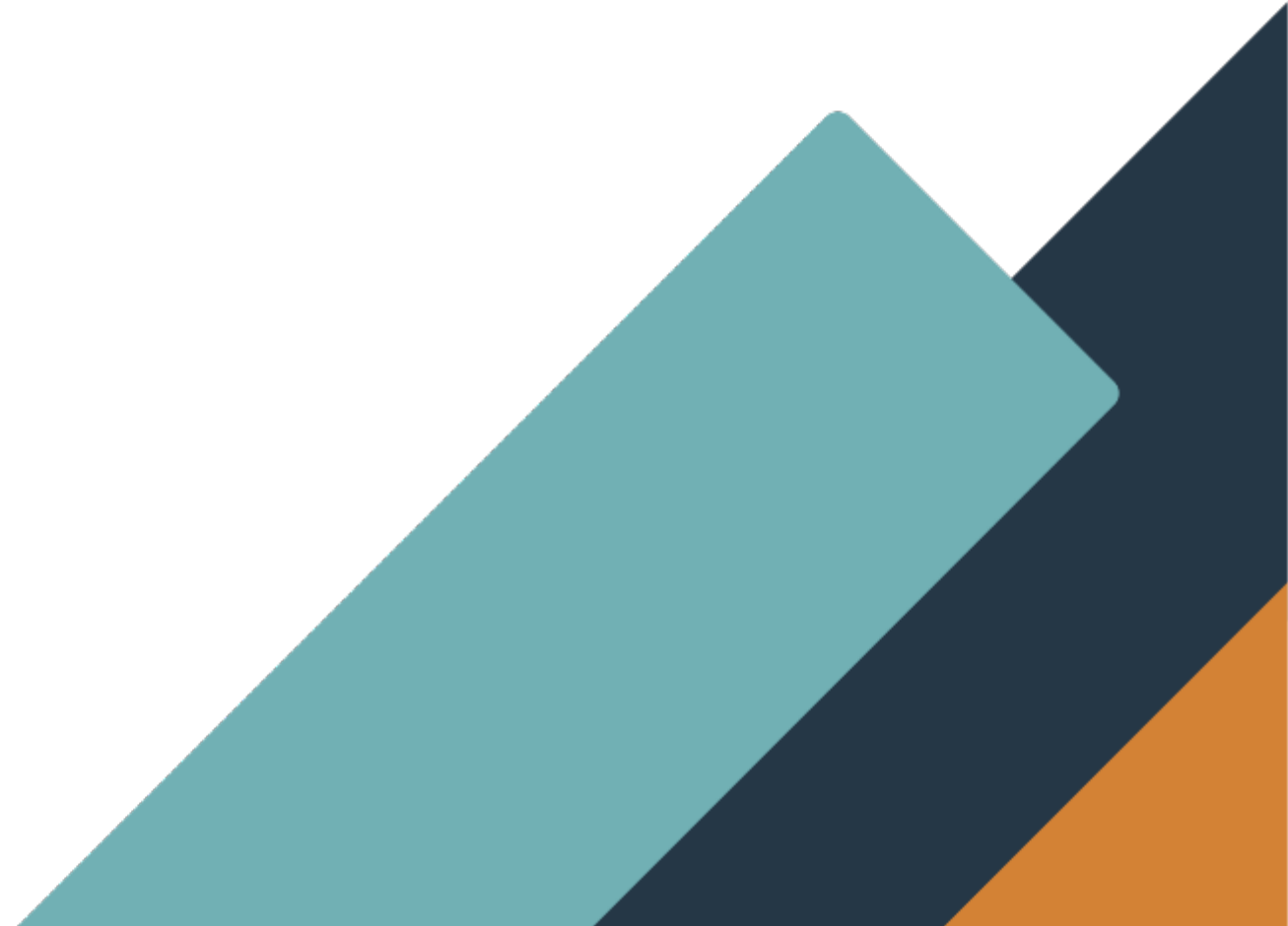


# GROWING AGING POPULATION PLACES TREMENDOUS STRAIN ON PUBLIC FUNDING

**Figure 1. Older Americans Act Funding, Medicare Spending, and Older Adult Population Growth**



# Chronic Care Act



# CHRONIC CARE ACT

- The recently passed federal budget law incorporated the “Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care (CHRONIC) Care Act” which makes significant policy changes to **advance the goals of integrated, person-centered care for Medicare beneficiaries and those dually eligible for Medicare and Medicaid**
- The CHRONIC Care Act is meant to address the siloed uncoordinated health care system that fails to meet complex needs and ignores individuals’ values, preferences, and goals.

# CHRONIC CARE ACT: KEY COMPONENTS

## Encourages Flexibility

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



# 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

# 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

# EXPANSION OF MEDICARE ADVANTAGE SERVICES

- The Chronic Care act will allow Medicare Advantage plans to cover non-medical expenses ***that can help enrollees improve their health such as:***
  - Paying for transportation to help people get to doctors' appointments
  - Healthy food delivered to home-bound MA enrollees
  - In-home safety modifications such as bathroom grab bars
- The new rule will also allow MA plans to **offer different benefits to different groups**
- These tools are being offered to MA insurers but not to users of original Medicare, which includes Parts A and B of Medicare

Health Experts,  
Aging Agencies,  
SDOH Researchers  
and other HCBS  
Advocates have  
long argued that  
spending money  
on such items can  
reduce overall  
Medicare spending

# EXPANSION OF MEDICARE ADVANTAGE SERVICES

## 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.

# Implications for Stakeholders



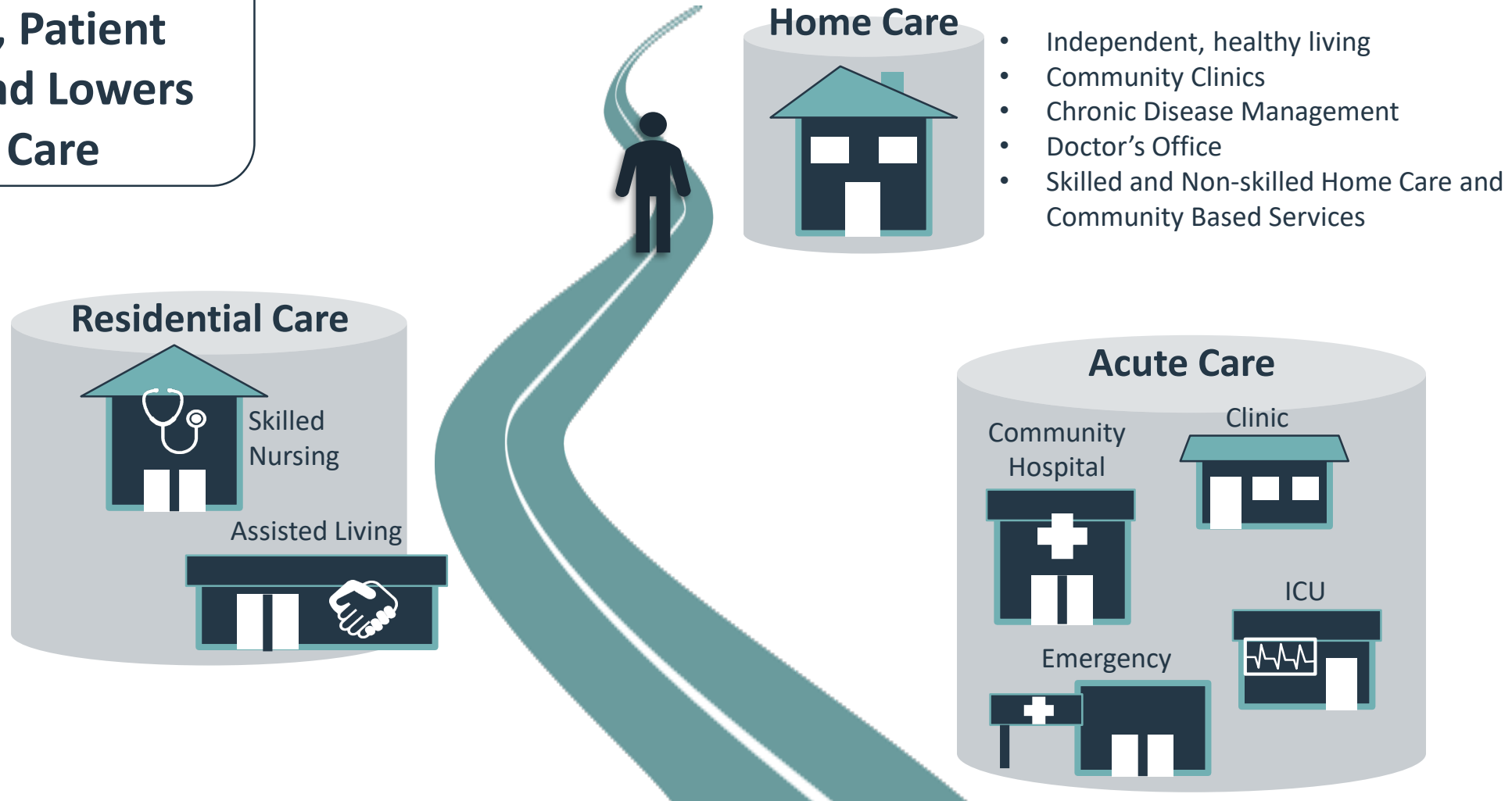
# CCA STAKEHOLDERS AND INTEREST VARY

- CMS
- Medicare Advantage Plans
- **State Units on Aging**
- **State Medicaid Agencies**
- **Area Agencies on Aging**
- HCBS Service Providers
- Local and Regional Hospitals
- Health Systems and Physician Practices
- Medicare Home Health Providers
- Community Based Organizations.



# MA PLANS WILL NEED TO INTEGRATE CARE TO BE SUCCESSFUL

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



# MA PLANS WILL NEED TO DETERMINE HOW TO PROVIDE TRADITIONAL HCB SERVICES

## Own (Buy or Build)

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

## Partner

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

# MA SERVICE EXPANSION WILL REQUIRE A NEW SKILL SET TO FILL GAPS IN CARE

Care managers will lead the team for coordination/management of services, such as:

- Transportation
- Medication coverage
- Keeping provider appointments
- Housing
- Coverage for social concerns
- Food
- Financial assistance
- Discharge planning
- And probably much much more....

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

# MEDICAID AND STATE UNITS ON AGING

- Both have extensive experience funding and developing policy around how to most effectively deliver non-medical, community-based long-term care.
- Medicaid Agencies can leverage their financial relationship with Medicare Advantage plans to encourage coordination of service, common definitions and requirements, while encouraging the use of the existing statewide infrastructure.
- SUA Administers OAA services (which are very similar to new many of the new MA benefits) and are required to have statewide coverage for services.

**States who fail to lead these discussion risk having their traditional OAA and Medicaid LTSS program negatively impacted.**

# SUA AND AAA: SELECT CROSS-OVER SERVICES

SERVICES	OAA FUNDED SERVICES	MA PLANS (CCA)
Adult day care services	X	X
Meal Delivery	X	X
Grocery Shopping	X	X
Food and Produce	*	X
Pest Control	*	X
Self Direction	*	*
Community or Social Clubs	X	X
Respite Care	X	X
Caregiver Support	X	X
Home Modifications	X	X
Legal Assistance	X	X
Homemaker Services	X	X

# AREA AGENCIES ON AGING

- AAA may have more opportunities to work directly with Medicare Advantage Plans, hospitals and Home Health Agencies, as they have a long history of already coordinating and delivering relevant in-home services like:
  - home modifications
  - Transportation
  - Nutritional assistance
  - Respite
  - Case Management
- Other opportunities exist for AAAs to expand their impact by offering to supplemental support with evidence-based programs including Care Giver Support and Chronic Disease Self-Management Programs.
- Those with demonstrable experience may also be able to leverage their care transition programs (Hospital Care Transitions, Nursing Facility Care Transitions, etc)

# AREA AGENCIES ON AGING

- AAA, if they have not already done so, should be reaching out to any Medicaid Managed Care Organizations and Medicaid Advantages operating in their regions; as well as hospitals and other health care facilities.
- Many most don't have active partnerships with MA plans, nor do they know how to reach out.
- State Medicaid Agencies may be able to facilitate, through MIPPA Plans.

**AAA who fail to develop these relationships risk Medicare Home Health Agencies usurping their role as the primary provider/coordinator of non-medical HCBS Services**

# Questions to Consider





# QUESTIONS TO CONSIDER

- How will MA plans coordinate and pay for services for members who are receiving other state-coordinated HCBS services?
- How or will the differences in how CMS defines the services for the CCA and how states have defined them impact care coordination and service delivery?
- What effect will MA-coordinated HCBS services have on service delivery for existing HCBS programs (OAA and Waiver Services)?
- What other opportunities exist or can be leveraged to ensure adequate coordination across payors (Medicare Advantage, OAA Services and Waivers)?

# Questions

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# About WellSky

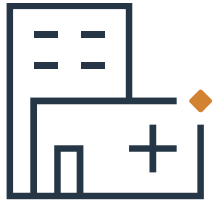
WellSky is a technology company advancing human wellness worldwide. Our software and professional services address the continuum of health and social care — helping businesses, organizations, and communities solve tough challenges, improve collaboration for growth, and achieve better outcomes through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

## We are committed to

- Serving our customers to ensure they can serve their communities
- Anticipating provider needs in an ever-changing care landscape
- Using data and applied insights to elevate and intelligently scale care

Together, we are realizing care's potential and building communities that thrive.

# We partner with organizations across the care spectrum



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



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



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



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



## Hospital

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



## Home

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



## Practices & Facilities

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



## Community

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- Payers
- IDD Payers
- Aging & Disability
- Protective Services
- Incident Management
- Information & Referral
- Community-Based Organizations
- Housing & Homelessness
- Blood Centers



## Hospital

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



## Home

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



## Practices and Facilities

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- +50 million blood donor tests annually
- +22 million rehab treatments in 12 months
- +2.3 million rehab patients served in 12 months
- +135 medication management facilities (including 34 correctional health facilities)



## Community

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