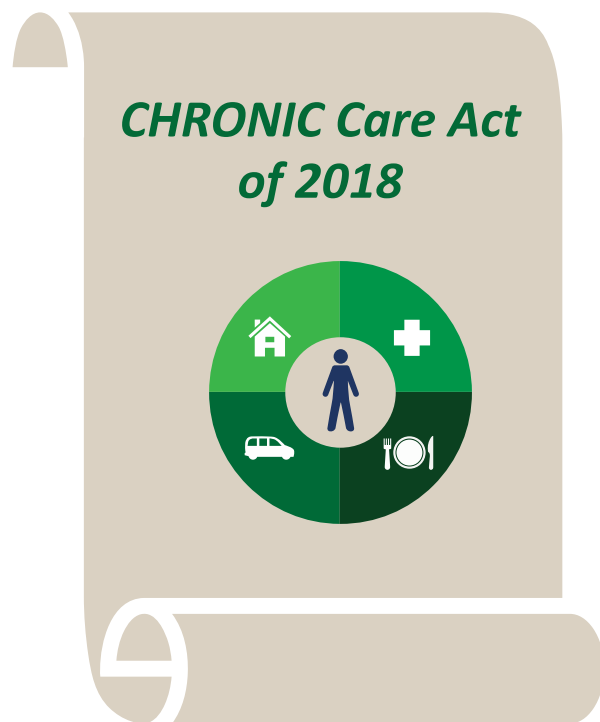


The *CHRONIC Care Act of 2018*: Advancing Care for Adults with Complex Needs

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March 2018

The *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act* was passed and signed on February 9, 2018. This brief provides a summary of key components of the law.



This new law makes significant policy changes to advance the goals of integrated, person-centered care for Medicare beneficiaries and those dually eligible for Medicare and Medicaid.

Overview

Since 2010, Medicare and Medicaid have been steadily moving toward value-based, organized care that rewards providers and health plans for improved quality and efficiency. The delivery system landscape has responded, as evidenced by the following markers:

- Medicare Advantage (MA) enrollment increased to 19 million beneficiaries, which includes 2.3 million in Special Needs Plans (SNPs).^{1,2}
- Several states are integrating Medicaid with Medicare, bolstered by growth of managed long-term services and supports now operating in 22 states.³
- Accountable Care Organizations (ACOs) serve over 10 million Medicare beneficiaries.⁴

Despite this progress, many older adults and people with disabilities continue struggling through a siloed and uncoordinated health care system that fails to meet complex needs and ignores individuals' values, preferences, and goals. To address these concerns, the Senate Committee on Finance Chronic Care Working Group published a [Policy Options Document](#), held [hearings](#), and solicited [input](#) from stakeholders.⁵⁻⁷ This feedback helped shape a new bill that makes significant policy changes to advance the goals of integrated, person-centered care for adults with complex needs who are in Medicare alone, or have both Medicare and Medicaid—the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act*. On February 9, 2018, Congress passed and President Trump signed the [Bipartisan Budget Act of 2018](#), which included the *CHRONIC Care Act*.⁸

The *CHRONIC Care Act* addresses three aspects of care for Medicare and dually eligible beneficiaries:

- 1. Encourages use of flexible new tools and strategies to better manage care for individuals with complex needs.** The new law gives MA plans greater flexibility to cover non-medical benefits for identified high-need/high-risk members, such as bathroom grab bars and wheelchair ramps. MA plans and ACOs may now offer a broader array of telehealth benefits. ACOs are able to proactively target members and provide incentives for beneficiaries to choose high-value care.
- 2. Protects and builds on key programs serving individuals with complex care needs.** The law permanently authorizes SNPs whereby managed care organizations can target and serve high-need/high-risk Medicare beneficiaries (i.e., dual eligibles, people with chronic health conditions, people living in institutions). It also extends and expands a demonstration whereby physicians serve very high-need Medicare beneficiaries in their homes to avoid institutional care.
- 3. Signals that care coordination and integration are explicit and essential purposes of SNPs.** The law requires SNPs to better integrate care by creating unified plans for dual eligible individuals, as well as a single pathway for grievances and appeals.

Major Sections of the *CHRONIC Care Act*

Below is a brief summary of key sections of the new law that advance the goals of integrated, person-centered care.⁸

Updates Medicare Advantage

- **Expands supplemental benefits to meet the needs of chronically ill Medicare Advantage enrollees:** Allows MA plans to offer an expanded set of supplemental benefits to chronically ill enrollees beginning in 2020. Rather than requiring that the benefits be primarily health-related, the law loosens this requirement to allow for supplemental benefits that have a “reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.” Further, the law allows an MA plan the flexibility to target supplemental benefits to specific chronically ill enrollees. (Section 50322)
- **Adapts benefits to meet the needs of chronically ill Medicare Advantage enrollees:** 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. MA plans in any state can participate starting in 2020. (Section 50321)

Continues Access to SNPs with Key Changes

- **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). (Section 50311)
- **Promotes integrated care in D-SNPs:**
 - 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 by 2021.
 - Provides D-SNPs three options for integrating Medicare and Medicaid long-term services and supports and/or behavioral health services by 2021.
 - Requires the Medicare Payment Advisory Commission (MedPAC), in consultation with the Medicaid and CHIP Payment and Access Commission (MACPAC), to conduct a study and report to Congress on the quality of D-SNPs.
 - Instructs the Government Accountability Office (GAO) to report on state-level integration between D-SNPs and Medicaid within two years of enactment. (Section 50311)

- **Updates C-SNPs:** C-SNPs must meet additional care management requirements starting in 2020. By 2022, and every five years thereafter, the Health and Human Services (HHS) Secretary must update the list of chronic conditions eligible for participation. The list must include HIV/AIDS, end stage renal disease, and chronic/disabling mental illness. (Section 50311)
- **Authorizes quality reporting at the plan level:** The HHS Secretary may require quality measure reporting for SNPs at the plan level (rather than the contract level), and consider this change for all Medicare Advantage plans. (Section 50311)

Enhances ACOs

- **Provides flexibility for beneficiaries to be part of an ACO:** It gives ACOs the choice to prospectively identify populations they will be managing, and allows beneficiaries who might not otherwise be assigned to an ACO to “align with” one in which their primary care provider participates. (Section 50331)
- **Eliminates barriers to care coordination in ACOs:** It 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). HHS will evaluate the program, including its impact on spending and health outcomes. (Section 50341)

Authorizes Other Delivery System Enhancements

- **Extends the Independence at Home Demonstration Program:** An “Independence at Home” practice can now participate in the demonstration for up to seven years (previously five years). It expands the total number of beneficiaries from 10,000 to 15,000, and gives practices an extra year to prove cost savings. (Section 50301)
- **Expands access to home dialysis therapy:** This section expands the ability of Medicare beneficiaries on home dialysis to receive ongoing monthly assessments through telehealth, rather than face-to-face visits. (Section 50302)
- **Expands access to telehealth services in MA, Next Generation ACOs, and for people with stroke symptoms:** Recognizing how telehealth could replace face-to-face office visits, reduce emergency room visits, and prevent hospitalizations, the law expands the types of telehealth benefits provided by both MA plans and Next Generation ACOs. It further allows Medicare reimbursement to physicians using telehealth for patients presenting with stroke symptoms regardless of geographic area. (Sections 50323, 50324, and 50325)

New Federal Studies

- GAO will issue three new studies on the following topics:
 - Feasibility of developing a payment code for longitudinal, comprehensive care planning services for Medicare beneficiaries diagnosed with serious or life-threatening illness. (Section 50342)
 - Prevalence and effectiveness of Medicare and other payer medication synchronization programs. (Section 50351)
 - Impact of obesity drugs on patient health and spending. (Section 50352)
- **HHS study on long-term Medicare cost drivers:** This new study will identify long-term risk factors for chronic conditions among Medicare beneficiaries, including obesity, tobacco use, mental health conditions, and other factors. (Section 50353)

Next Steps

The *CHRONIC Care Act* creates substantial new opportunities to transform the Medicare and Medicaid payment and delivery systems to advance the goals of integrated, person-centered care. Now is the time for federal officials – in concert with state leaders, delivery system champions, and consumer advocates – to bring this new law to life. The Administration should maximize stakeholder feedback when crafting guidance and regulation to deliver on the promise of a high-quality system of care for adults with complex needs and their family caregivers.

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