POLICY ANALYSIS PAPER

The Six Pillars Framework for Advancing Health Policy

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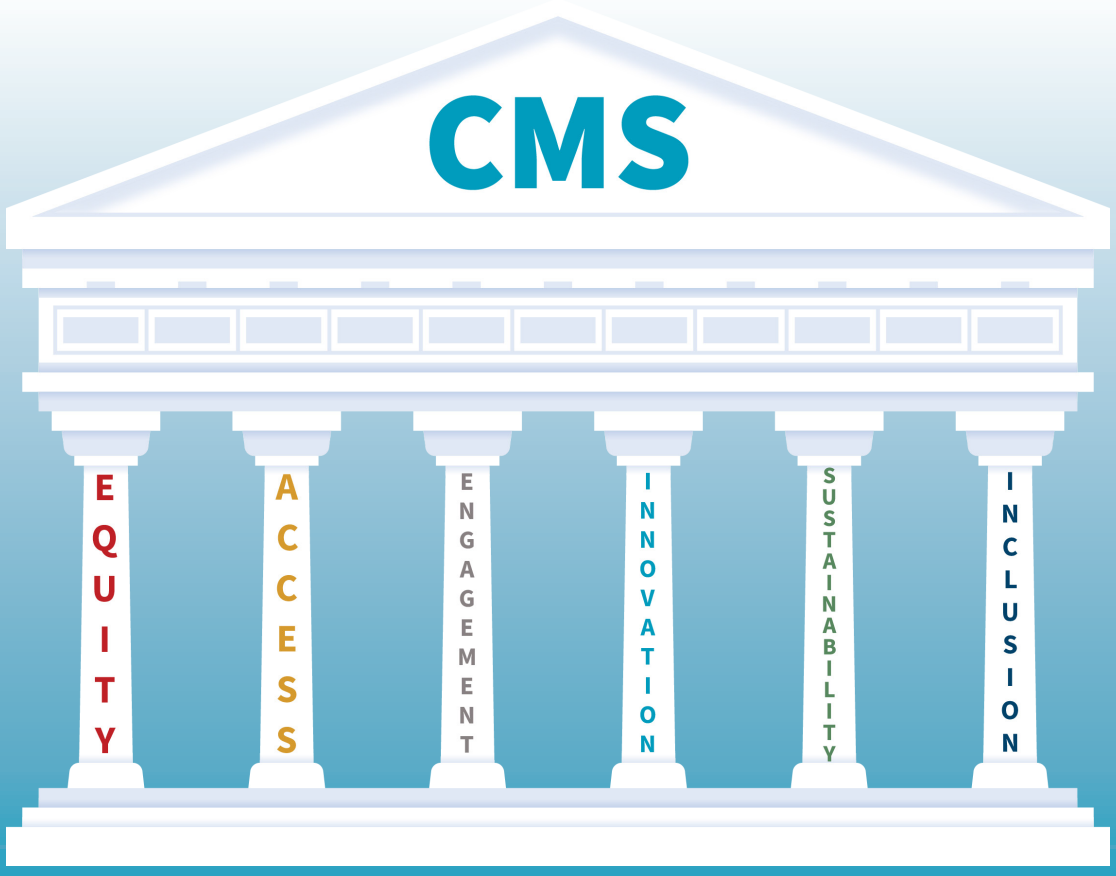

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About the Author

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Introduction

With the dizzying array of evolving news focused on health issues, Covid-19, health equity, and new federal funding to address challenges in health care delivery, it is difficult to track and sort through how developments and innovations – at the national, state, and provider levels – all fit together. In previous decades, health policy issues could all be distilled into a three-legged framework of health care access, cost, and quality. Now, in a more complex world with actively engaged public and private health sectors, an expanded framework is warranted.

The Centers for Medicare and Medicaid Services (CMS) is now structuring its innovations and policy directions into six pillars[1]:

1. Advance health equity by addressing the health disparities that underlie our health care system.
2. Build on the Affordable Care Act and expand access to quality, affordable health coverage, and care.
3. Engage our partners and the communities we serve throughout the policymaking and implementation process.
4. Drive innovation to tackle our health system challenges and promote value-based person-centered care.
5. Protect our programs' sustainability for future generations by serving as a responsible steward of public funds.
6. Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS' operations.

The Value of Six Pillars

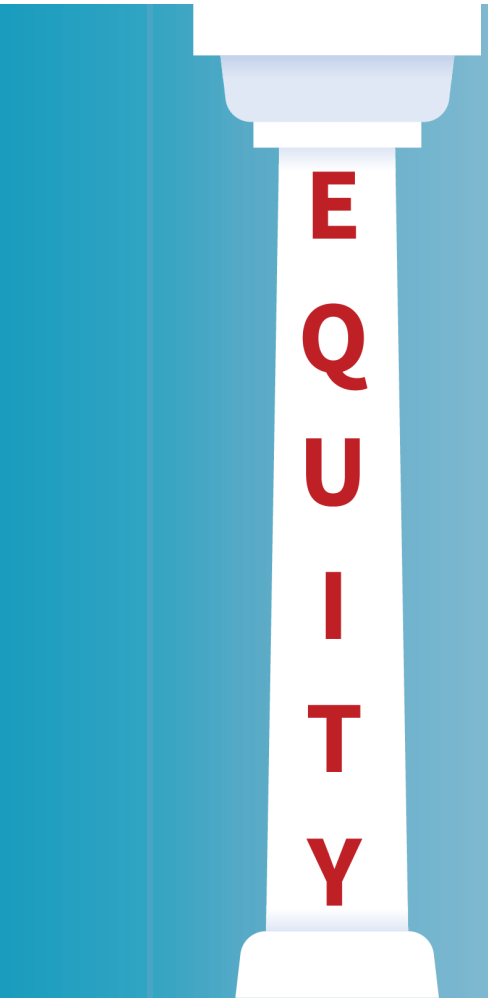
A six-pillar framework anchors federal health priorities and provides a coherent structure for engaging CMS' state and provider partners. The conceptualization provides a way to organize the myriad of federal policies, programs, and developments into a coherent framework of action and accountability. This structure aligns all the legal, regulatory, financing, and distributive tools in the federal domain that are essential for advancing executive and legislative objectives. It places ongoing operations and emerging accomplishments into a priority framework within CMS.

[1] Chiquita Brooks-LaSure, "My First 100 Days and Where We Go From Here: A Strategic Vision for CMS." www.cms.gov September 9, 2021.

The six-pillar framework provides a way to communicate to states and CMS' many health care stakeholders in a consistent, coherent, and mutually reinforcing way. As a communication tool, it suggests to states and providers how to focus and organize their health policy efforts, as it is important that thousands of initiatives and ongoing work align and reinforce each other. This six-pillar reinforcement, for example, can provide clarity among the states, and even provider organizational advocacy, in budget hearings, legislative testimony, communication about Medicaid waivers, regulatory communication, and so forth.

Thus, the six pillars hold together the overall goal of CMS, which is to foster a U.S. health care system that is better, smarter, and healthier – to improve care, spend health care dollars more wisely, and make our communities healthier.

A summary of how individual pillars are being addressed follows:



Advance Health Equity

The concept of "health equity" is front and center of current and robust health care discussions, and perhaps the most exciting development across the U.S. health landscape. As there is much to consider about health equity, the topic will be further expanded in a subsequent MediSked resource.

The ongoing Covid-19 pandemic laid bare disturbing truths about health care inequity in America. Significant barriers to health care access at both the individual and system levels continue to threaten the lives of millions of people. Characteristics such as individuals' race, low-income status, occupation, health insurance status, formal education level, and special needs (physical or mental disability) can undermine equitable access to needed care and services. Furthermore, it is the distributive practices in the U.S. medical care system – such as geographically unavailable health facilities or underfunded public clinics and hospitals – that further limit access

for those who are poor or those who live in rural areas. These disparities generally lead to worse health outcomes and lower quality of care than the general population. Finally, history reminds us that racial inequalities run deep in the U.S. health care system. Ensuring everyone – regardless of race or zip code – can receive health care and achieve their full health potential remains a preeminent and not easily attainable goal.

Thus, it is no surprise that among the six pillars, the commitment to advance the nation's health equity by addressing health disparities that underly our health care system is most significant. Health care leaders, in both public and private sectors, understand they must look at everything they do now through a health equity lens. Fostering equity is no longer a tangential concern of health care leaders as inequity impacts vulnerable individuals with complex health care needs as well as those with high burdens of disease and social needs who fall through the cracks.

CMS' organizing framework to strategically address the overarching equity goal includes three elements:

1. **Increasing understanding and awareness of disparities;**
2. **Developing and disseminating solutions to achieve health equity; and**
3. **Implementing sustainable actions to achieve health equity.**

Rates of maternal mortality and morbidity and pre-term birth have been rising in the US; and people of color are at increased risk for poor maternal and infant health outcomes.[2] To address the national crisis in maternal health, CMS has proposed a multi-pronged approach. Under the American Rescue Plan Act, twelve months of post-partum coverage can be provided to pregnant women enrolled in Medicaid and CHIP via a temporary Medicaid State Option. The Administration has proposed "Birthing Friendly" hospitals designed to drive improvements in perinatal health outcomes. The designation would identify hospitals that provide perinatal care, are participating in a maternity care quality improvement collaborative, and have implemented recommended patient safety practices. The information would be posted on CMS' website Care Compare.

Medicare, the nation's largest health program and the bedrock of our health care system, is taking steps at the system- and community-levels to improve operations and achieve better equity in Medicare services. These steps are important as they influence how the nation's health care system operates overall. After reviewing six years of progress,[3] approaches are being "refreshed" to implement policies that will improve accessibility to health care, technology, and devices.

Priorities for action now include:

- Expand standardized data collection, reporting, and analysis to pinpoint disparities and track improvement;
- Integrate equity solutions across CMS programs;
- Develop and disseminate promising approaches to reduce health disparities;
- Increase ability of the healthcare workforce to meet the needs of vulnerable populations;
- Improve communication and language access, making information more understandable and culturally appropriate; and
- Increase physical accessibility of health care facilities.

Much of this equity work (both ongoing and new) is accomplished through CMS' vast network of quality improvement partners, including state and local governments, tribal organizations, health providers, and community groups.

[2] Kaiser Family Foundation. Issue Brief: Racial Disparities in Maternal and Infant Health: An Overview. November 10, 2020.

[3] Centers for Medicare and Medicaid Services, Office of Minority Health. Paving the Way to Equity: A Progress Report, 2015-2021, 2022.

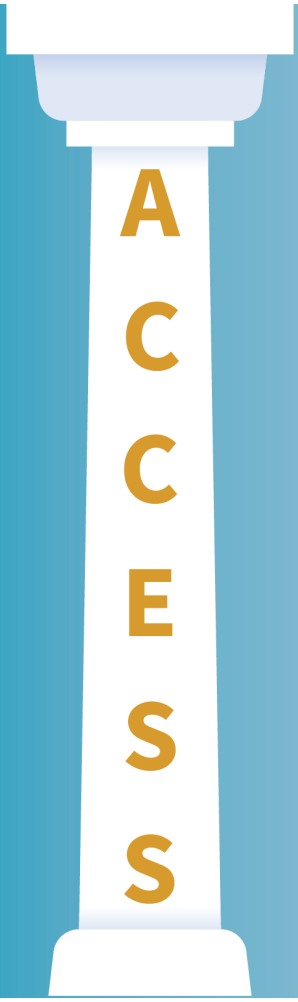
Equity strategies also include implementing new and targeted payment policies in traditional Medicare, such as value-based payments and accountable care structures. As Medicare Advantage is growing (almost half of all Medicare beneficiaries are now enrolled in Medicare Advantage plans), enhanced quality measures are being considered to account for some social risk factors, and then holding plans accountable for addressing social isolation, food insecurity, lack of transportation, etc. among their members.

The Medicaid program, operated by states within a federal framework, has long supported a stronger health care safety net for vulnerable and low-income populations. **Again, Covid-19 illuminated significant disparities in care and often racism in how Medicaid services are delivered.** To address disparity gaps in Medicaid states, often in partnership with contracted managed care organizations (MCOs), are reviewing provider network composition and reimbursement, utilization management, prior authorization, and the creative application of medical necessity criteria.[4] Many states have started to require expanded quality performance measures and demographic data that are separated by race and ethnicity.

State Medicaid leaders are also looking to the MCO procurement process to identify opportunities for closing health care and health outcomes disparity gaps. Options may include requiring of MCOs detailed equity plans and that MCOs contract with community-based organizations; the application benchmark tools and targets for improved chronic disease management among specific populations; and altering payment mechanisms to expand provider networks in some underserved neighborhoods and for disadvantaged groups. Finally, some states and plans are seeking to include communities of color in membership handbook development, as the consumer voice is increasingly recognized as essential to the provision of fair, transparent, and usable information.

Major health care organizations and their national associations are also being driven to ensure that improved health equity becomes part of their core missions. The question of how to embed racial and social justice into the culture of organizations and remove obstacles to care is being debated and determined among board members, C-suite executives, and private investors. They are considering how processes, infrastructure, technology, and the health care workforce can all advance pathways for better health care and health outcomes among historically disadvantaged groups who are served by their organizations. Health equity officers are being hired by many providers to coordinate the important equity work underway in their institutions so that structural barriers in patient care are reduced, communication and training is improved, performance is advanced, and evidence-based policies to maximize health and well-being are forged.

[4] Raslevich and Mustaine. "Advancing Health Equity through Medicaid: Opportunities for States' Managed Care Plans," Health Affairs blog March 3, 2022.



Expand Access to Quality, Affordable Care

It's important to understand that the Biden Administration's strategy for expanding affordable coverage is to build on the 2010 Affordable Care Act (ACA), and not try to replace it with a Medicare for All-type program. About 21 million people are covered by the law, including protections for Americans with pre-existing conditions. In addition to building upon the ACA and improving how Marketplaces function, CMS is continually reviewing the Medicare and Medicaid programs to determine how better and more affordable health coverage can be generated through existing tools and approaches. This piecemeal approach to expanding affordable and meaningful coverage, while practical in a political sense, leaves large number of individuals vulnerable and often without health insurance protection because they cannot afford private plans and don't meet eligibility criteria for public programs, such as Medicaid.

Yet, a record-breaking 14.5 million people signed up for 2022 health coverage through Marketplaces established under the Affordable Care Act. And more than 2.5 million Americans were able to enroll in federal and state Marketplaces this year because of the Special Enrollment Period instituted by the Administration. The American Rescue Plan lowered health care premiums for most Marketplace consumers and their families and increased enrollment to record levels. HealthCare.gov consumers experienced a drop in their average monthly premiums, falling by 23% compared to 2021 enrollment period.[5] Equally significant, the uninsured rate for the U.S. population dropped to 8.9% (Q3 2021), down from 10.3% (Q4 2020), corresponding to

UNINSURED RATE OF U.S. POPULATION

10.3%

Q4 2020

↓

8.9%

Q3 2021

Estimated 4.6 Million additional people with coverage

[5] www.cms.gov press release January 27, 2022.

an estimated 4.6 million additional people with coverage. CMS, state, and consumers have all recognized that if health coverage is made more affordable and if people learn about affordable options, individuals and families will sign up and enroll.

Additional affordability improvements to the ACA include a proposed tweak by the Treasury Department to fix a "family glitch" that would mean lower premiums for some families, while others would be eligible for subsidized insurance plans. The Biden Administration also has called on Congress to make subsidies (originally part of pandemic relief) permanent that are scheduled to expire in December.

The Medicare program is pursuing strategies to make Medicare services more affordable by targeting the price of health care services, including prescription drug prices, increasing price transparency, and reducing waste and low-value care that drive up patient costs.[6] CMS is also working with states to increase enrollment in Medicare Savings Programs for lower income beneficiaries. It is also increasing payment rates for Covid-19 vaccines and operationalizing lessons learned during the pandemic, such as continuing telehealth opportunities.

A significant affordability issue currently is whether and when to end the Covid-19 public health emergency (PHE) declaration, as this could result in as many as 15 million people losing their Medicaid coverage in 2022, according to the Urban Institute. An enhanced federal Medicaid funding match was available to states during the PHE period to help enable and maintain continuous Medicaid coverage. This contributed to Medicaid enrollment growing by 13.6 million (19.1%) between the start of the Covid-19 pandemic and September 2021. The current Covid-19 PHE declaration ends in mid-July and another extension is likely. Yet, the sheer volume of Medicaid enrollment growth due to temporary Covid-19 policies, the complexity of eligibility renewals and the risk that large number of eligible individuals could lose coverage requires a focused and coordinated effort among all stakeholder organizations.[7]

Expanding the availability of Medicaid home and community-based services (HCBS) is also an affordable coverage concern for millions of seniors and persons with disabilities. The American Rescue Plan Act of 2021 included a provision to increase the federal Medicaid match (FMAP) to states for their spending on HCBS. The enhanced funding must be used to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen" Medicaid HCBS. The funding is temporary, so states must work quickly to build their HCBS capacity, streamline eligibility, and expand services.

CMS recently announced it will offer more than $110 million to expand HCBS through Medicaid's Money Follows the Person (MFP) program; the initiative will focus on states and territories not currently participating in MFP.[8] **As we consider the challenge of affordable care, it is important to remember that long-term services and supports, primarily funded by families out-of-pocket and by Medicaid, must remain an important part of society's focus in addressing the overall cost of health care.**

[6] Meena Seshamani, Elizabeth Fowler, and Chiquita Brooks LaSure. "Building on the CMS Strategic Vision: Working Together for a Stronger Medicare." CMS blog, January 11, 2022.

[7] Longo and Maresca. "How stakeholders can prepare now for unwinding of Medicaid public health emergency continuous eligibility." Health Management Associates' blog, March 16, 2022.

Partnership Engagement

Partnerships are essential to achieving our nation's vision of a healthier population and reduced illness burden across urban and rural communities in the U.S. To effectively design, implement, and sustain meaningful improvements in the forces that influence health and well-being, more collaboration among health care delivery organizations, plans, government agencies, community stakeholders, and consumers (patients, their families, and caretakers) is essential.[9] Sustained attention and additional resources must be allocated to build the capacity of health care organizations, human services agencies, and their workforces to reduce disparities in measurable ways and address populations' priority needs. Multi-sector collaboration among stakeholders and partners, if well-orchestrated, has the potential to substantially improve the health of communities they serve.

CMS leadership has been meeting with scores of health care associations, institutions, states, and consumer stakeholders to hear their perspectives, listen to their concerns, and learn their ideas about areas where they and CMS can work together to make progress towards achieving improvements in health care access and delivery and health outcomes. CMS is also often engaging them as partners, not as vendors, collaborating with them and integrating the perspectives of communities they serve. This appears to be a shift in the way CMS has dealt with stakeholders in the past. A different approach is necessary because of a growing realization within CMS, other governmental agencies, and external stakeholders that the traditional medical model is insufficient for maximizing Americans' health given the documented social determinants of health that influence health and well-being. Finally, across the U.S.' decentralized and fragmented health care system, improving communication, building trust, and generating sustained collaborative action is the best way to effectively make progress towards accomplishing critical health, care delivery, and equity goals.

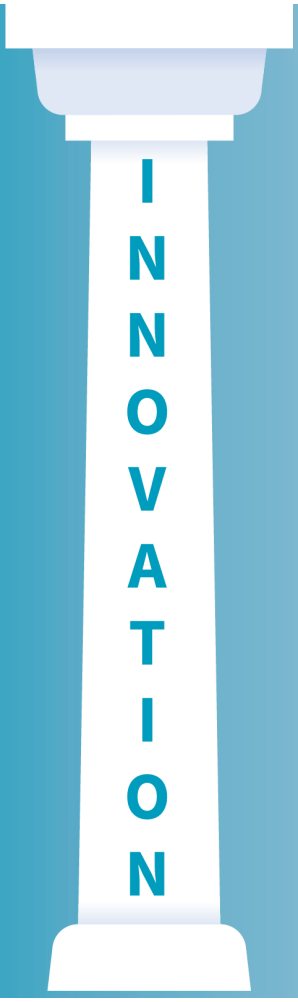
[8] CMS Press Release, "CMS Announces Funding to Strengthen Safety Net for Seniors and People with Disabilities," March 31, 2022.

[9] See Robert Wood Johnson's "Building a Culture of Health" initiative as a policy and operational roadmap to building effective partnerships. www.rwjf.org

An example of a CMS-initiated public-private partnership is the Partnership for Patients launched more than a decade ago to improve quality, safety, and affordability of health care. Physicians, clinicians, hospitals, employers, patients and their advocates have joined together to achieve significant reductions in hospital acquired conditions (e.g. adverse drug events, infections, etc.) and hospital re-admissions and, thus, achieve billions of dollars in cost savings. Over the years, the broader caregiver community has shared emerging best practices and implemented evidence-based practices to reduce patient harm and improve quality of care.

Another CMS partnership example is the Integrated Care for Kids (InCK) Model, a consortium of state Medicaid agencies, local providers, local human service organizations, community partners, and Partnership Councils. InCK is designed to improve early identification and treatment of children who have multiple physical, behavioral, and other health-related needs and risk factors; and overcome limited information sharing and differing eligibility processes among agencies that create barriers to effective care. Project goals include: improve child health, reduce avoidable inpatient stays and out-of-home placement, increase behavioral health access, and create sustainable Alternative Payment Models (APMs). The Model was launched in 2020 with $126 million in funding awarded across eight states; a five-year implementation period follows.

The CMS Innovation Center has launched numerous partnerships over the past few years to improve quality, increase access to effective care, and reduce wasteful spending. In honoring the role of partnerships, CMS has pledged to put people and patients at the center of everything the agency tackles and ensure that everyone, regardless of race, gender, or zip code, can age with dignity and achieve their full health potential.



Drive Innovation to Promote Value-Based and Person-Centered Care

Of the CMS Six Pillars, Innovation may be under-recognized as an important key to achieving other pillars; innovation is where the "rubber meets the road." Designing and implementing new – and innovative – care delivery and payment methods is the responsibility of CMS' Innovation Center (CMMI). Established under the ACA, the Center reviewed over 50 models of reform it has sponsored and is charting a path forward for the next ten years. This is a strategy refresh, driving the health delivery system towards genuine transformation, including focusing on equity, paying for health care based on value to the patient instead of volume, and delivering person-centered care.[10] For those living or working among persons with disabilities, the notion that U.S. medical care will become more "person-centered" is long-overdue.

The Innovation Center will continue to use its authority to test new and innovative payment and service delivery models. Chief among them are **accountable care organizations (ACOs).** The focus on "accountable care" will depend upon increasing the number of Medicare beneficiaries in a care relationship, such as advanced primary care providers, with accountability for quality and total cost of care.[11] Rewarding health care providers for delivering high quality and cost-effective care is easier said than done.[12] CMS wants to give providers the incentives and tools to deliver high-quality, coordinated, and team-based care; reduce low-value services; and include patient values and perspectives in innovative model designs.

Medicare is the single largest purchaser of health care in the U.S., accounting for one-fifth of all health expenditures. As such, its influence across the health sector is enormous; other payors often mirror Medicare's lead in their own payment policies. During the past 10 years, Medicare has accelerated participation in value-based care initiatives, such as its Shared Savings Program. This program has saved Medicare $1.9 billion in 2020, the fourth consecutive year of savings. There is much to learn from this program. Of note, many accountable care organizations invested in care managers and community health workers who provided critical support to communities struggling with health.

[10] http://innovation.cms.gov/strategic-direction

[11] Beneficiaries in traditional Medicare vs. Medicare Advantage.

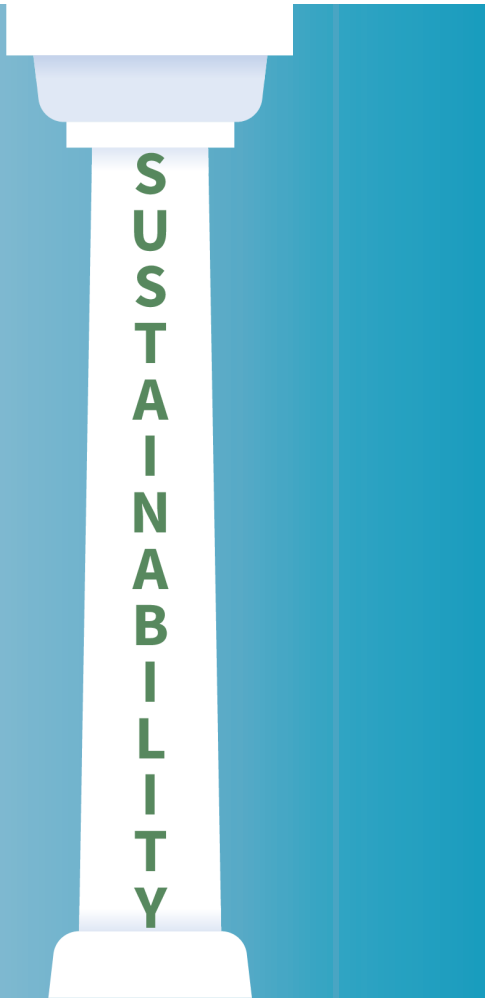
[12] Approaches might focus on specific diseases, type of provider, community (urban, rural), Medicare Advantage, etc.

The Fully Integrated Duals Advantage plan for adults with intellectual and developmental disabilities (FIDA-IDD) is an example of an ongoing innovation. Initiated in 2015 by CMS Innovation Center in partnership with NYS and Partners Health Plan (PHP), FIDA-IDD is a joint Medicare and Medicaid initiative designed to test a new integrated model for providing "dual"[13] enrollees with a more coordinated, person-centered care experience in downstate NY. The FIDA-IDD demonstration includes a robust benefit package tailored to support individuals with intellectual and developmental disabilities so they can live as independently as possible.[14] Enrollment in the FIDA-IDD plan offered by PHP is voluntary, thus, "take up" has been slow.

The CMS Innovation Center works closely with the CMS Center for Clinical Standards and Quality which is responsible for improving quality measurement and clinical approaches to care. The collaboration supports clinicians as they drive towards higher quality value-based care, promote performance measurement and improvement, and build shared learning across care teams.

Protect Programs' Sustainability for Future Generations

The level of health care spending in the U.S. and the continuing rise of these expenditures has been an ongoing concern for decades. U.S. health care spending reached $4.1 trillion in 2020, or $12,530 per person, rising 9.7% from the previous year.[15] National health spending is projected to slow in 2021, growing to $4.3 trillion, a 4.2% increase. Acceleration of health spending in 2020 was due primarily to a 36% increase in federal expenditures for health care that occurred in response to the Covid-19 pandemic. Public and private spending for health care now accounts for 19.7% of America's gross domestic product (GDP).

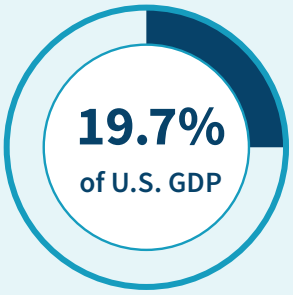


[13] Individuals who have dual coverage, both Medicare and Medicaid, are often the most vulnerable; they suffer from multiple chronic conditions, are low-income, and are forced to navigate across multiple uncoordinated systems for care.

[14] FIDA-IDD covers medical primary care, hospitalizations, plus long-term services and supports, behavioral health care, pharmacy benefits, and Office for People With Developmental Disabilities services.

[15] National Health Expenditure Accounts 2020. www.cms.gov.

U.S. HEALTH CARE SPENDING



2020
$4.1 trillion
(9.7% increase from previous year)

2021
$4.3 trillion
(4.2% increase from previous year)

CMS has a fundamental responsibility to be an effective and trusted steward of taxpayers' money that support health programs within its jurisdiction, primarily Medicare and Medicaid. This financial stewardship includes spending resources wisely, maximizing value in programming, and protecting the resources of the agency. It is beefing up partnerships with law enforcement agencies across the USA to identify and address fraud and abuse schemes and program vulnerabilities. **Earlier language of "cost control" has been replaced by "sustainability;" and management concepts expanded from clumsy and poorly targeted reimbursement approaches to strategies such as value-based reimbursement, clinical and community care process improvements, market competition, internal control redesign, performance-based spending, transparency, and so forth.**

CMS is committed to assuring Medicare's sustainability for future generations. It is reviewing and removing barriers so providers and health plans can compete to deliver better care at a lower cost. It is seeking to increase transparency in Medicare Advantage to assure the health care market is providing value to people and that extra health benefits from the plans' capitated premiums are meeting the needs of Medicare enrollees. CMS is also improving Medicare claims processing and payment accuracy, and reducing fraud, waste and abuse.

Finally, it is implementing increased price transparency. The hospital transparency rule requires health systems to publicly post the costs of (and standard charges for) their items and services online. **Beginning July 2022, most group health plans and issuers of group or individual health insurance will be required to post price information for covered items and services.** Efforts to increase price transparency are broader than the Medicare program; they respond to long-standing pleas from consumers and patients who have found it near impossible to make sense of health care bills they receive.

Foster Inclusion & Excellence in Workforce

This final pillar is carried out by CMS both directly in the agency's recruitment and management of its full-time and on-board personnel and procured contractors, as well as indirectly through its workforce development policies and funding for training the nation's health care workforce—from physicians to direct care professionals.

The pillar's aim is to foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS' operations. CMS' Administrator has stated that she's assembled an experienced and diverse workforce committed to promoting excellence among 6,300 CMS employees.

"At CMS, we believe the core of our organization are the employees that carry out the agency's vision: advancing health equity, expanding coverage, and improving health outcomes."[16]

CMS' Office of Equal Opportunity and Civil Rights provides leadership on issues of diversity, civil rights, and promotion of a supportive work environment for employees. In addition, several voluntary employee-led groups known as Employee Resource Groups (ERG) serve as a resource for CMS employees by fostering an inclusive workplace aligned with organizational mission and business practices.

CMS has a significant impact on ensuring the number and quality of health services professionals is adequate to meet the nation's growing and changing health care needs. **The U.S. health care sector is one of the largest and fastest growing sectors in the nation, employing 22 million individuals (14% of workforce) in 2019.**[17]

[16] Cms.gov, "Diversity, Equity, and Inclusion," March 2, 2022.

[17] www.census.gov "Who Are Our Health Care Workers?", April 5, 2021.

Examples of how CMS fosters both adequacy and excellence in the health care workforce include:

To address access and equity concerns, CMS announced (December 2021) it is funding through Medicare **1,000 new physician residency slots for hospitals; will total about $1.8 billion over 10 years.**[18] Slots will be largely targeted to rural hospitals and underserved areas.

CMS has devoted substantial resources over several years to **developing, strengthening, and expanding the HCBS workforce.** With stakeholders, it established core competencies for workers' knowledge and performance. It has published toolkits to help manage change in the workforce. The Medicaid program has sponsored numerous learning collaboratives to better address the needs of both paid and informal caregivers.

Part of workforce excellence is personnel security. During the Covid-19 pandemic, **CMS required its workforce and 17 million employees of health care facilities that serve Medicare and Medicaid patients to be vaccinated.**

Critical shortages of many health professionals and widespread rising clinician burnout are daunting and increasing challenges that are expected to continue in the years ahead. America will face a shortage of up to 124,000 physicians by 2033. Job vacancies for various types of nursing personnel increased 30% between 2019-2020. **One estimate suggested an expected shortage of up to 3.2 million health care workers by 2026.**[19]

The workforce shortages have serious consequences. America's behavioral health needs are reaching a crisis point amid gaps in the behavioral health workforce. Of great concern to people with disabilities is the dire shortage of direct support professionals (DSPs), given stagnant reimbursement rates and the inability of providers to offer competitive wages. **Many providers are turning away new referrals, discontinuing programs, and struggling to meet quality metrics because of the shortage of DSPs.**[20] It's important to remember that strengthening the health care workforce has been a challenge that predates the Covid-19 pandemic. Yet, it is uncertain how Congress and the Administration will be able to holistically tackle such serious and interconnected health care workforce concerns.

[18] www.cms.gov FY 2022 IPPS final rule.

[19] American Hospital Association, "Fact Sheet: Strengthening the Health Care Workforce," November 2021.

[20] ANCOR. "The State of America's Direct Support Workforce 2021."

Conclusion

The Center for Medicare and Medicaid Services (CMS) six-pillar framework organizes the current myriad of federal health policies, programs, and developments into a coherent framework for action. They offer a structure for engaging CMS' state and provider partners and a way to communicate to CMS' multiple stakeholders in a consistent and mutually reinforcing way.

As partners in national efforts to achieve access, equity, quality, and value in public spending, we must hold CMS (and each other) accountable as it seeks to accomplish its bold mission in the months and years ahead.

As the leading brand in holistic solutions that improve lives, drive efficiencies, and generate innovations for health and human service organizations that support our community, MediSked is committed to advancing CMS' six pillars.

MediSked is the leading brand in holistic solutions that improves lives, drives efficiencies, and generates innovations for health and human service organizations that support our community. MediSked solutions combine to provide innovative, person-centered technology that improves outcomes and quality, while reducing costs for individuals receiving home and community-based services and long-term services and supports through government & oversight, care coordination/payer and provider agencies. MediSked has supported clients across the United States since 2003.

Want to learn more? Check out medisked.com!