ICRC | Integrated Care Resource Center

Helping states develop integrated programs for individuals who are dually eligible for Medicare and Medicaid

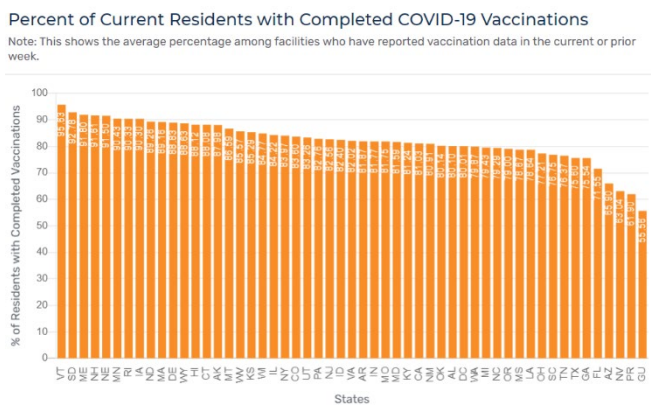
July 29, 2021

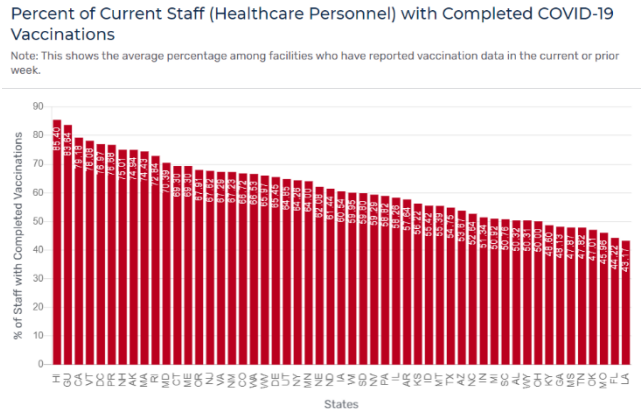
Integrated Care Updates

Working with Medicare | Medicare and Medicaid Nursing Facility Benefits: The Basics and Options for Improved Coordination and Quality

On July 13, ICRC hosted a Working with Medicare webinar on Medicare and Medicaid Nursing Facility Benefits: The Basics and Options for Improved Coordination and Quality. The webinar provided an overview of Medicare and Medicaid nursing facility benefits and payment methods, as well as options to improve coordination and quality of nursing facility benefits for dually eligible individuals in both fee-for-service and managed care systems.

These strategies can be key to improving care for dually eligible individuals who often have significant long-term care needs and make up a high proportion of nursing facility residents. The COVID-19 pandemic has had a significant impact in nursing facilities. In the United States, almost one-third of all deaths from COVID-19 have been among institutional residents. Although the Centers for Medicare & Medicaid Services (CMS) and other federal agencies have developed resources for both states and providers to control the spread of COVID-19 infection in nursing facilities and boost vaccination rates, vaccination rates remain low for nursing facility staff in many states (click on the charts below to view data or visit CMS' website).





MedPAC Publishes Data Book on Medicare Spending

On July 17, the Medicare Payment Advisory Commission (MedPAC) released its 2021 Data Book: Health Care Spending and the Medicare Program, which provides data on Medicare spending, demographics of the Medicare population,

beneficiaries' access to care, and Medicare program quality, among other information. Section 4 covers dually eligible individuals and includes information on the percentage of Medicare spending for this population, demographic data, health status, and service use. Within this section, **Chart 4-4: Dually eligible beneficiary demographic characteristics, 2018,** includes survey-based data on ADL limitations, living arrangements, and education level that are not available from other sources. Section 9 covers Medicare Advantage (MA) and includes information on enrollment trends in Dual Eligible Special Needs Plans (D-SNPs) and enrollment of dually eligible individuals in MA plans by age and full or partial dual eligibility status. **Chart 9-3: Average monthly rebate dollars, by plan type, 2016–2021** includes data on the recent growth in average monthly rebate dollars, which plans can use to provide supplemental benefits. In addition, **Chart 9-5: Percent of Medicare enrollees in MA plans by state in 2021,** shows MA penetration rates by state.

New Tools for Medicaid and CHIP Managed Care Monitoring and Oversight Tools

On June 28, CMS' Center for Medicaid and CHIP Services issued an Informational Bulletin describing Medicaid and CHIP Managed Care Monitoring and Oversight Tools, including:

- Web-Based Reporting Portal for the Collection of Required Managed Care Reports (e.g., Annual Program Oversight Report, the Medical Loss Ratio Summary Report, and the Access Standards Report).
- Annual Managed Care Program Report
- Appeals and Grievances Data Collection Pilot
- Technical Assistance Toolkits to Improve State Compliance and Oversight
- Tools to Assist States in Managed Care Monitoring and Oversight
    - Behavioral Health Access Toolkit
    - Quality Strategy Toolkit

While these tools are focused on monitoring and oversight of Medicaid managed care, they may be helpful to states seeking insight into service use and quality of care for their dually eligible populations.

CMS Proposes Home Health Rule

Also on June 28, CMS issued a proposed rule, published in the July 7, 2021 *Federal Register*, that seeks to improve home health care for older adults and people with disabilities.

This rule would accelerate the use of value-based payment approaches for Medicare home health services by expanding the Home Health Value-Based Purchasing (HHVBP) Model. The rule also includes proposals and routine updates to the Medicare Home Health Prospective Payment System and the home infusion therapy services payment rates for Calendar Year (CY) 2022. In addition, it proposes to make permanent changes to the home health Conditions of Participation that were implemented during the COVID-19 Public Health Emergency.

Dually eligible individuals make up a high percentage of Medicare home health care recipients. States may want to incorporate features of the Medicare HHVBP model into their Medicaid health home programs to align quality measures and provider incentives across the Medicare and Medicaid programs. More details of the proposed rule can be found in CMS' Fact Sheet.

New Reports from Financial Alignment Initiative Demonstrations

CMS has posted additional evaluation and actuarial cost reports for demonstrations under the Medicare-Medicaid Financial Alignment Initiative as well as an aggregate report on social determinants of health:

- **Colorado:** Evaluation Report for the Colorado managed fee-for-service model demonstration under the Medicare-Medicaid Financial Alignment Initiative and Concluding Demonstration Year 2 and Demonstration Year 3 Medicare Cost Savings Report for the Colorado managed fee-for-service model demonstration under the Medicare-Medicaid Financial Alignment Initiative.
- **Minnesota:** Third Evaluation Report for the Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience. This report highlights important features of the Minnesota demonstration, including the state's role in Medicare network adequacy and D-SNP model of care reviews, the state-CMS demonstration management team, integrated beneficiary materials, and an integrated enrollment process.
- **New York:** Combined Second and Third Evaluation Report for the New York Fully Integrated Duals Advantage (FIDA) capitated model demonstration under the Medicare-Medicaid Financial Alignment Initiative.
- **Virginia:** Evaluation Report for the Commonwealth Coordinated Care capitated model demonstration under the Medicare-Medicaid Financial Alignment Initiative.
- **Washington:** Fourth Evaluation Report for the Washington managed fee-for-service model demonstration under the Medicare-Medicaid Financial Alignment Initiative and Demonstration Year 4 Final and Demonstration Year 5 Preliminary Medicare Cost Savings Report for the Washington managed fee-for-service model demonstration under the Medicare-Medicaid Financial Alignment Initiative. Of note, the Washington demonstration achieved statistically significant gross Medicare Parts A & B savings of nearly $280 million from 2013-2018. Actuarial cost findings showed similar Medicare savings. Also, consistent with results in prior years, most respondents to the Washington 2018 *Consumer Assessment of Healthcare Providers and Systems* (*CAHPS*) survey reported satisfaction with the care coordination services that they received, and an ability to access needed services in a timely manner.
- **Aggregate Report:** Addressing Social Determinants of Health in Demonstrations Under the Financial Alignment Initiative. This brief draws upon findings from stakeholder interviews and beneficiary focus groups to summarize approaches that Financial Alignment Initiative demonstration states, health plans, and care coordination entities have taken to address enrollees' social determinant of health (SDOH) needs. Promising SDOH practices in the demonstrations involve: 1) providing person-centered care; 2) providing SDOH-related connections/services; 3) including SDOH-related requirements in plan, provider, and partner contracts; 4) educating enrollees about the availability of these supports; and 5) collecting and integrating SDOH data in health information technology systems.

July 2021 Enrollment in Medicare-Medicaid Plans

Between June and July 2021, total Medicare-Medicaid Plans (MMP) enrollment in the nine states (CA, IL, MA, MI, NY, OH, RI, SC, and TX) currently implementing capitated model demonstrations under the Financial Alignment Initiative increased from 403,263 to 406,798 as shown in ICRC's table Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, June 2020 to June 2021.

July 2021 Enrollment in PACE Organizations

PACE organizations provide comprehensive medical and social services to frail, community-dwelling individuals age 55 and older, most of whom are dually eligible. As shown in ICRC's table, Program of All Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization, PACE organizations were operating in 31 states in July 2021. Between June and July 2021, the total number of Medicare beneficiaries enrolled in PACE increased from 50,649 to 51,096.

New Resources on the ICRC Website

- Key 2021 Medicare Advantage Dates: This calendar of key Medicare Advantage (MA) dates was developed to assist states and health plans in the implementation of integrated care programs for people dually eligible for Medicare and Medicaid. (ICRC/July 2021)

- Medicare and Medicaid Nursing Facility Benefits: The Basics and Options for Improved Coordination and Quality: This webinar provides an overview of Medicare and Medicaid nursing facility benefits and payment methods, as well as options to improve coordination and quality of nursing facility benefits for dually eligible individuals in both fee-for-service and managed care systems. (ICRC/July 2021)

Key Upcoming Dates

- **September 30 –** Deadline for all Medicare Advantage (MA), Medicare Advantage-Prescription Drug (MA-PD), Medicare-Medicaid Plan (MMP), Prescription Drug Plan (PDP), and cost-based plans (including those not offering Part D and those that do offer Part D) to send the standardized Annual Notice of Change (ANOC) and Low-Income Subsidy (LIS) rider to current enrollees.
- **October 1 –** MA and Medicare Part D plan marketing begins for CY 2022.
- **October 1 –** Deadline by which enrollees of non-renewing PDPs, MA plans, MA-PD plans, MMPs, and cost-based plans must receive final personalized beneficiary non-renewal notification letters.