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Working with Medicare

Medicare & Medicaid Nursing Facility Benefits: The Basics and Options for Improved Coordination and Quality

July 13, 2021

2:00-3:00 pm Eastern Time

The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services' Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica and the Center for Health Care Strategies.

The "Working with Medicare" Webinar Series

- Designed for all states interested in improving coordination of Medicare and Medicaid benefits for dually eligible individuals
- Webinars are repeated annually:
  - Medicare 101 and 201
  - Coordination of Medicare and Medicaid Behavioral Health Benefits
  - Medicare and Medicaid Nursing Facility Benefits
  - State Contracting with Dual Eligible Special Needs Plans (D-SNPs)
- Supplemented by:
  - ICRC updates/e-alerts on important new Medicare information
  - ICRC technical assistance briefs and other written tools on Medicare issues of importance to states
- Sign up and view past e-alerts: https://www.integratedcareresourcecenter.com/about-us/e-alerts

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Agenda

- Welcome and Introductions
- Medicare and Medicaid Spending on Dually Eligible Individuals
- Nursing Facility Benefits under Medicare and Medicaid
- Characteristics of Nursing Facilities and Residents
- Fee-for-Service (FFS) Payment Basics for Medicare Skilled Nursing Facilities (SNFs) and Medicaid Nursing Facilities (NFs)
- State Options to Improve Care Coordination and Quality in SNFs and NFs
- Expanding Home- and Community-Based Alternatives to Care in SNFs and NFs
- Questions and Discussion

Presenters

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Dually Eligible Individuals: The Basics

Dually eligible individuals qualify for both Medicare and Medicaid

Medicare Eligibility Criteria
Federal health insurance program

Age 65 or older

OR

Under age 65 with a disability, such as:

- Intellectual/Developmental disabilities
- Cognitive disabilities
- Physical disabilities
- Behavioral health needs
- Chronic medical conditions

OR

Any age with End Stage Renal Disease

Medicaid Eligibility Criteria
State health insurance program

Meet income and asset requirements (varies by eligibility group and state)

AND

Member of eligible group (varies by state)

- Adults with disabilities
- Older adults
- Children and families
- People who are pregnant
- Other

COVID-19 in Nursing Facilities as of June 2021

- Deaths in long-term care facilities accounted for almost a third (31%) of all COVID-19 deaths in the United States
- COVID-19 confirmed cases in nursing facilities
  - Residents: 656,336
  - Staff: 585,666
- COVID-19 deaths in nursing facilities
  - Residents: 132,882
  - Staff: 1,938

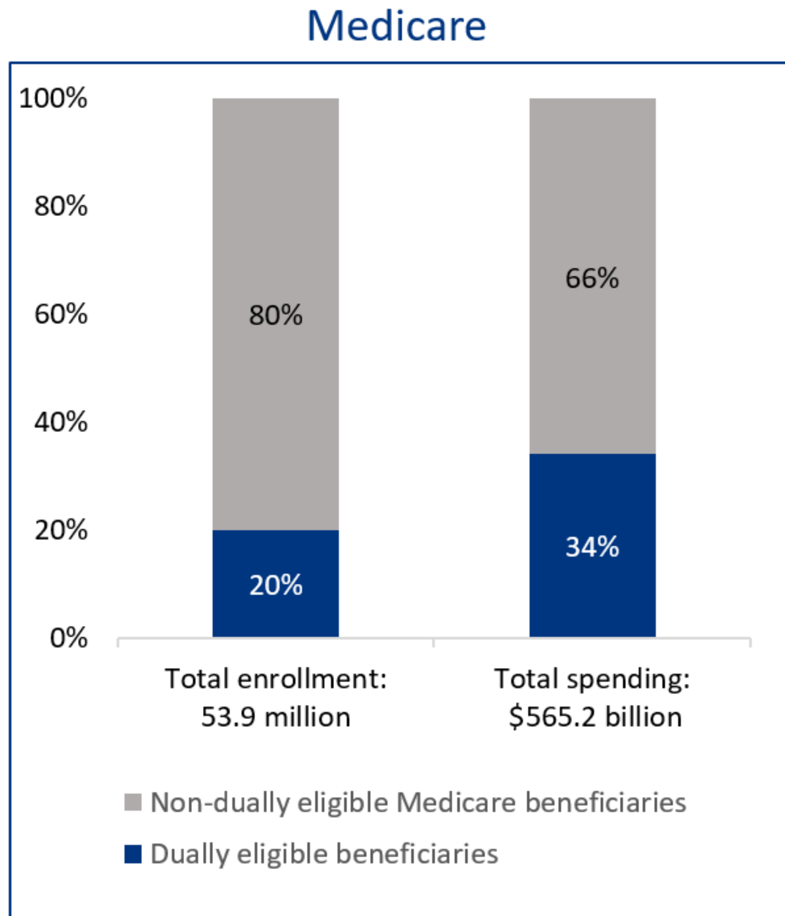
NOTE: Data is for the week ending 6/13/2021.
SOURCE: CMS. "COVID-19 Nursing Facility Data." Week Ending 6/13/2021. Available at: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/

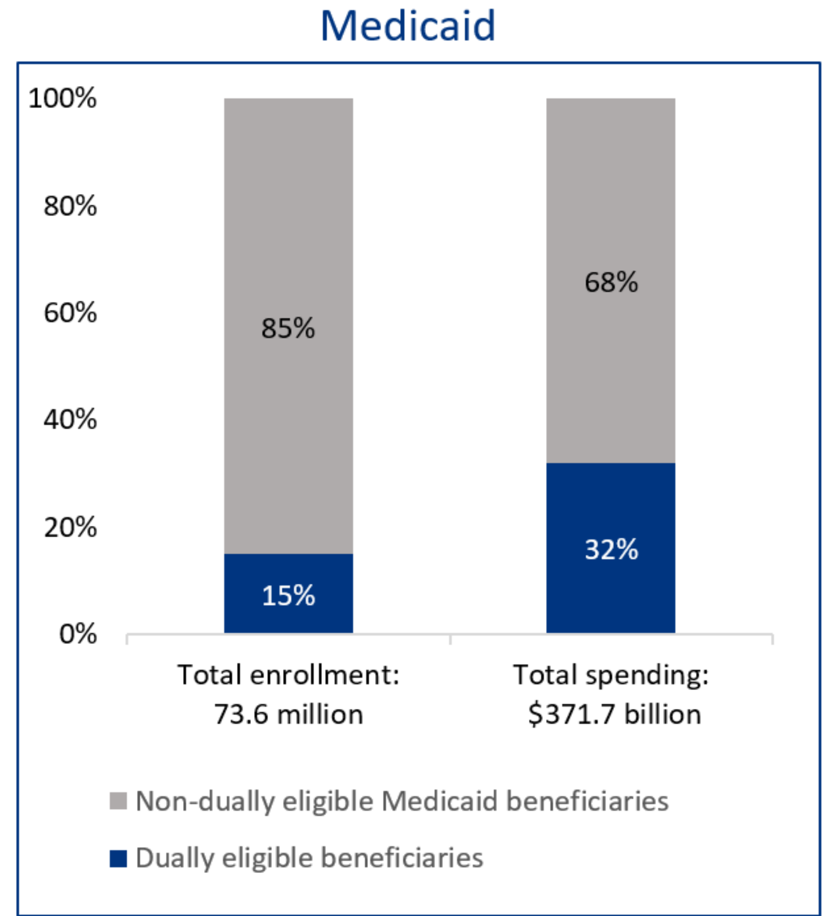
COVID-19 Related Resources

- Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes (Updated February 25, 2021)
- Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19 (Updated July 9, 2020)
- National Nursing Home COVID-19 Action Network
- National Training Program to Strengthen Nursing Home Infection Control Practices
- CDC COVID-19 Nursing Homes & Long-term Care Facilities Resources
- Interim Final Rule – COVID-19 Vaccine Immunization Requirements for Residents and Staff
- A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities: Final Report
- COVID-19 Intensifies Nursing Home Workforce Challenges

Medicare and Medicaid Spending on Dually Eligible Individuals

Dually Eligible Individuals as a Share of Medicare and Medicaid Enrollment and Spending, CY 2013





NOTE: Enrollment counts include number of beneficiaries ever-enrolled in CY 2013. Spending and enrollment totals include full and partial benefit dually eligible beneficiaries. Spending excludes program administration. Medicaid spending excludes payments by state Medicaid programs for Medicare premiums.
SOURCE: MedPAC–MACPAC. "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." Exhibit 4. January 2018.

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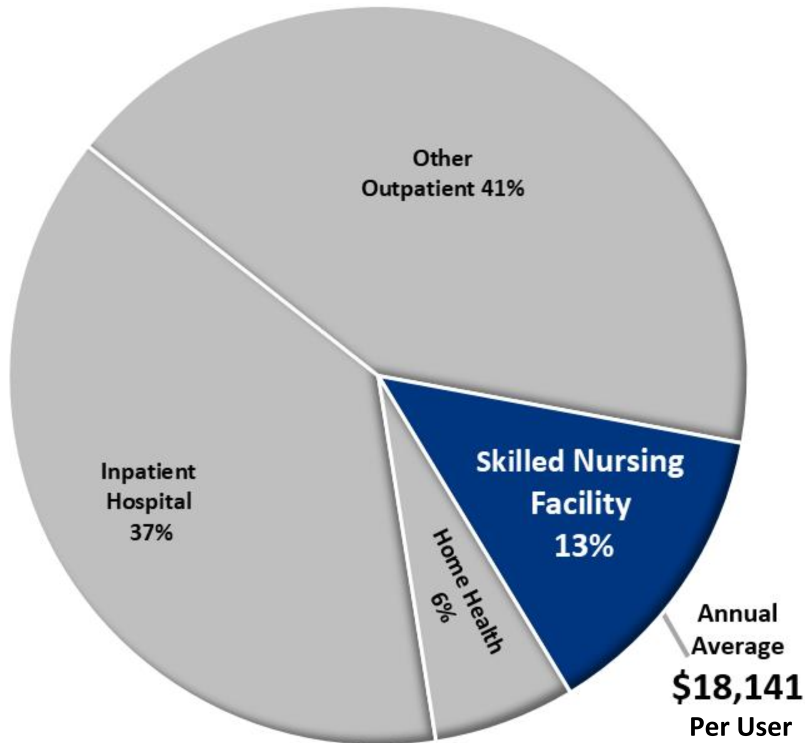
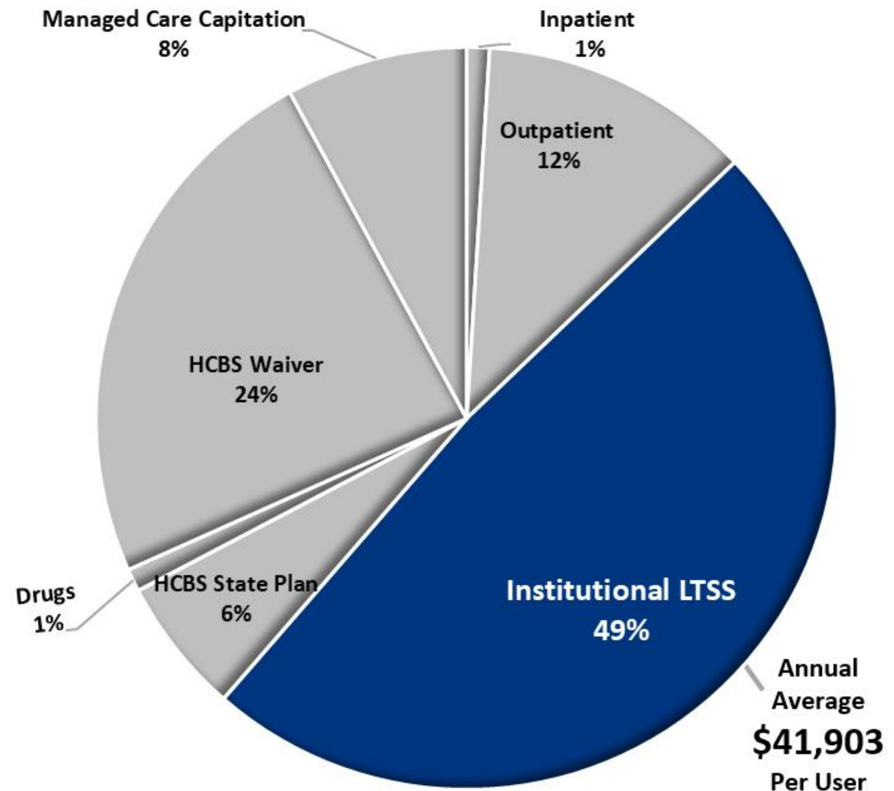
Fee-for-service (FFS) Medicare and Medicaid Spending on Full Benefit Dually Eligible Individuals (FBDEs) by Type of Service, 2013

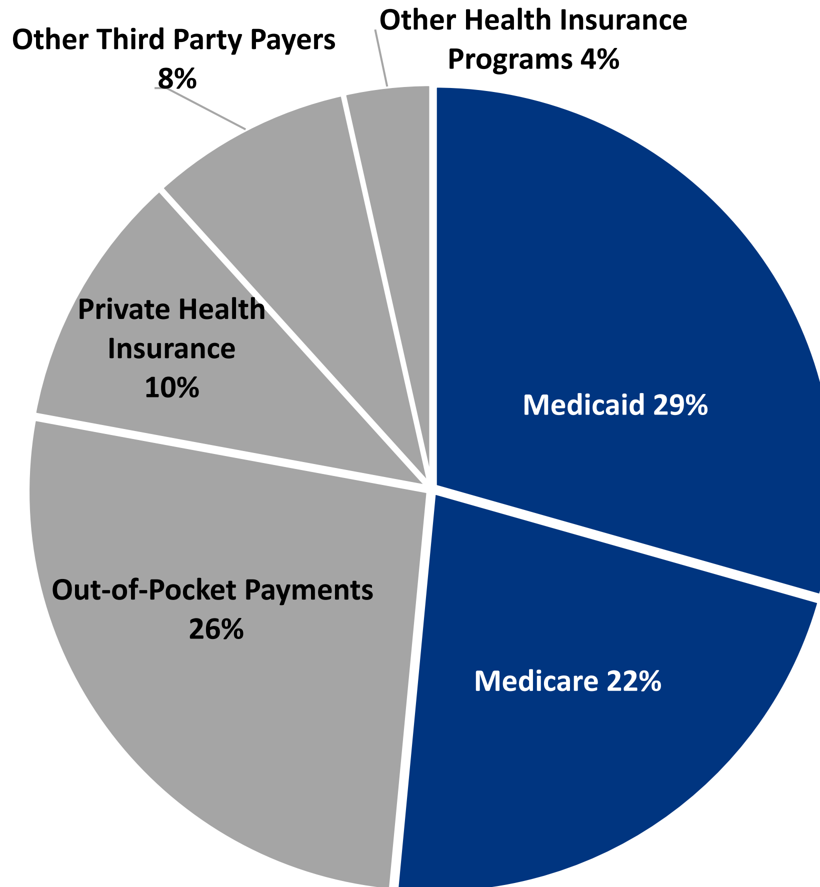




NOTE: Medicare spending percentages include only Part A and Part B services and do not sum to 100 because spending is shown only for selected services. Medicare Part D spending is not included. Medicaid managed care capitation includes payments to limited-benefit managed care plans for behavioral health, transportation, and/or dental services.
SOURCE: MedPAC–MACPAC. “Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid.” Exhibits 3, 14, and 15. January 2018.

Medicaid and Medicare Share of Total Payments to Nursing Facilities, 2019

SOURCES OF PAYMENT
$172.7 billion



Medicare and Medicaid account for **51%** of all payments to nursing facilities

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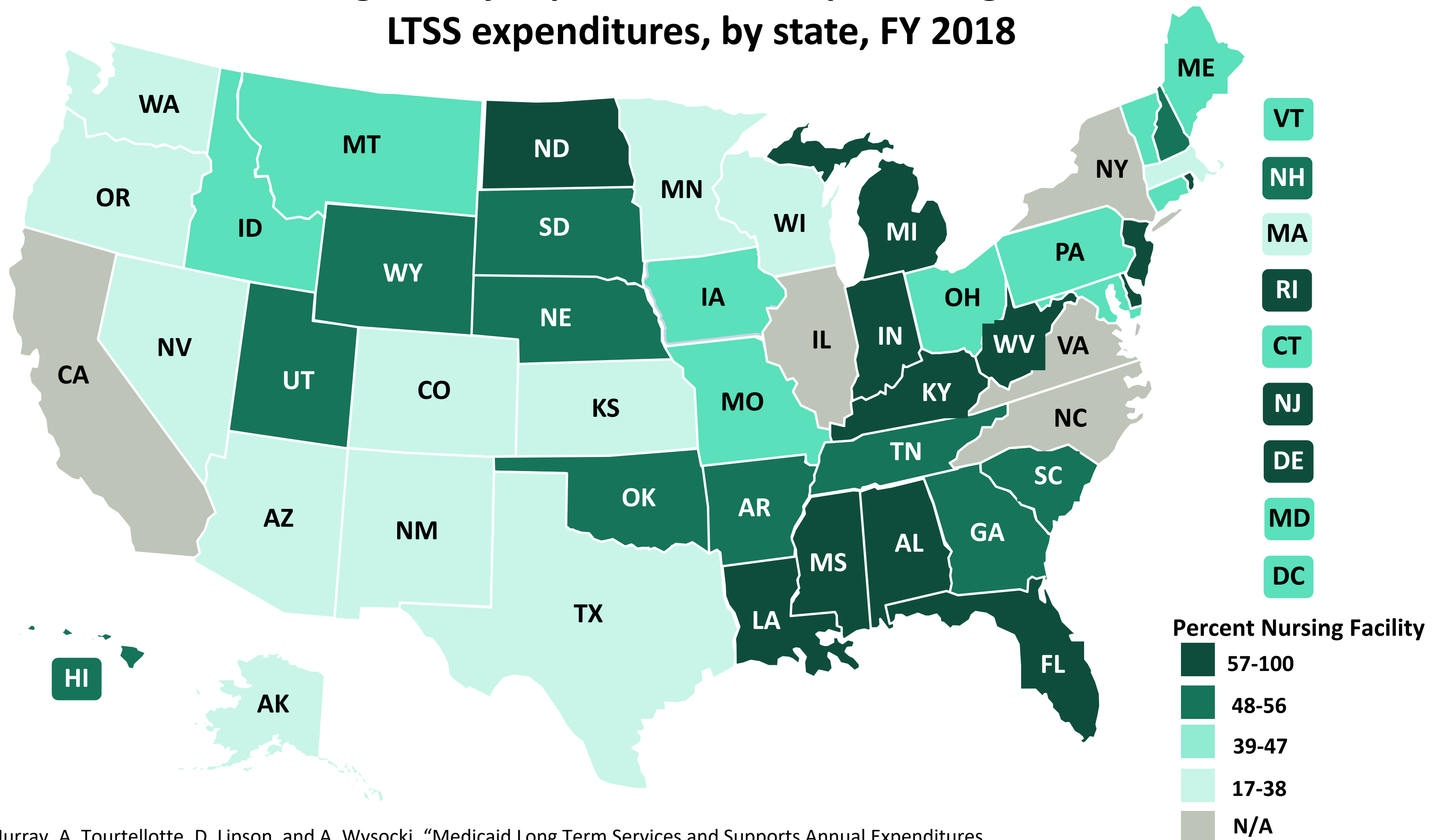
NOTE: Total payments include both nursing facilities and continuing care retirement communities.
SOURCE: National Health Expenditures Projections, 2019. https://www.cms.gov/files/zip/nhe-tables.zip

Nursing Facilities Remain an Important Source of Long-Term Care

Medicaid nursing facility expenditures as a percentage of total Medicaid LTSS expenditures, by state, FY 2018



SOURCE: C. Murray, A. Tourtellotte, D. Lipson, and A. Wysocki. "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018." Mathematica, January 2021. Available at: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf

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Key Takeaways

- Dually eligible individuals account for a disproportionate share of Medicare and Medicaid spending.
  - 20% of Medicare beneficiaries are dually eligible but account for 34% of total Medicare spending.
  - 15% of Medicaid beneficiaries are dually eligible but account for 32% of total Medicaid spending.
- Medicare and Medicaid account for 51% of all payments to nursing facilities.
- Medicaid is the predominant payer of nursing facility services and nationally covers 60 percent of nursing facility residents.
- Nursing facilities remain an important source of long-term care for Medicaid beneficiaries even amid rebalancing efforts toward home- and community-based services.

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Nursing Facility Benefits under Medicare and Medicaid

Medicare Coverage of Skilled Nursing Facility (SNF) Care

- Short-term skilled nursing care and rehabilitation services
- Requirements to qualify for coverage:
  - Must need skilled nursing and/or physical, occupational, or speech therapy
  - Requires a preceding 3-day inpatient hospital stay
- Up to 100 days of SNF care per spell of illness
- Ordered by a physician
- Includes skilled nursing, rehabilitation, medical social services, drugs/biologicals, durable medical equipment, and bed and board
- The Patient-Driven Payment Model (PDPM), implemented Oct. 2019, is based on an individual's medical conditions and functional status rather than therapy needs.

Medicaid Coverage of Nursing Facility (NF) Care

- Long-term custodial care
- Level of care criteria include:
  - Functional limitations in activities of daily living/instrumental activities of daily living
  - Cognitive capacity
  - Need for supervision
- Safety net for people who cannot afford the cost of NF care
- Mandatory service for ages 21+/optional for under age 21
- Includes room and board, skilled nursing care and related services, rehabilitation, and health-related care
- Optional state coverage of therapies, such as physical therapy, occupational therapy, and speech pathology and audiology services

Beneficiary Responsibility for Nursing Facility Costs

FFS Medicare Cost-Sharing for SNF	Medicaid Beneficiary Responsibility for NF
• Days 1-20: $0 • Days 21-100: $185.50 per day (2021)	• All income (minus personal needs allowance) applied to the cost of care • Special rules apply to community spouses

Who Pays These Costs for Dually Eligible Individuals?
• Medicaid pays Medicare cost-sharing for most dually eligible individuals • Other payers might include retiree insurance, or other supplemental coverage

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Key Takeaways

- Medicare covers short-term SNF stays up to 100 days when an individual needs skilled nursing and/or rehabilitation services.
- Medicaid coverage of NFs includes long-term custodial care and serves as a safety net for people who cannot afford the cost of nursing facility care.
- The program and eligibility criteria for nursing facility coverage differ for Medicare and Medicaid.
- A beneficiary's financial cost-sharing responsibilities differ by Medicare and Medicaid. Medicare beneficiaries are responsible for $185.50/day for days 21-100 of a SNF stay.
  - Medicaid pays the Medicare cost-sharing for most dually eligible individuals.

Characteristics of Nursing Facilities and Residents

Medicare Certified Nursing Facility Statistics, 2019

- Over 90% of SNFs are also certified as NFs
- 14,923 Medicare skilled nursing facilities
- Median bed size = 100; 10% > 173 beds; 10% ≤ 50 beds*
- Profit Status
  - For profit: 71%
  - Non-profit: 23%
  - Government: 6%
- Structure
  - 96% - Free-standing facilities
    - Provide both SNF and NF services
    - Only a limited number of SNF patients on a given day, but higher per diem reimbursement than NF patients. Higher turnover of SNF patients; NF patients stay longer.
  - 4% - Hospital-based facilities
    - Dedicated SNF beds
    - Swing beds in some rural hospitals

* **Describes all nursing facilities, not just dually Medicare and Medicaid certified.**

SOURCE: Medicare Payment Advisory Commission (MedPAC) and Medicaid and CHIP Payment and Access Commission (MACPAC). "Report to Congress. Medicare Payment Policy." Table 7-1. March 2021. Available at: http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf.

Medicaid-Certified Nursing Facilities

- Number of Medicaid-certified nursing facilities declined about 0.7% to 14,784 between 2019 and 2020
  - Lower payment rates by Medicare Advantage plans and their lower use of these facilities
  - Despite overall decline, some states with no certificate of need laws have overexpansion of supply
- Decline in count of Medicaid certified nursing facilities may also reflect expansion of home and community-based services (HCBS), an ongoing federal priority
  - In 2020, CMS announced $165 million in funding to help states with Money Follows the Person (MFP) demonstration programs transition individuals from nursing facilities to HCBS
  - American Rescue Plan Act of 2021 gives states the opportunity to significantly increase federal HCBS share of new Medicaid HCBS spending

SOURCE: Medicare Payment Advisory Commission (MedPAC). "Report to the Congress: Medicare Payment Policy." Chapter 7: Skilled Nursing Facility Services. March 2021, pp. 219-220. Available at: http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf.

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Characteristics of All Residents in Medicare- and/or Medicaid-Certified Nursing Facilities, 2014

Demographics

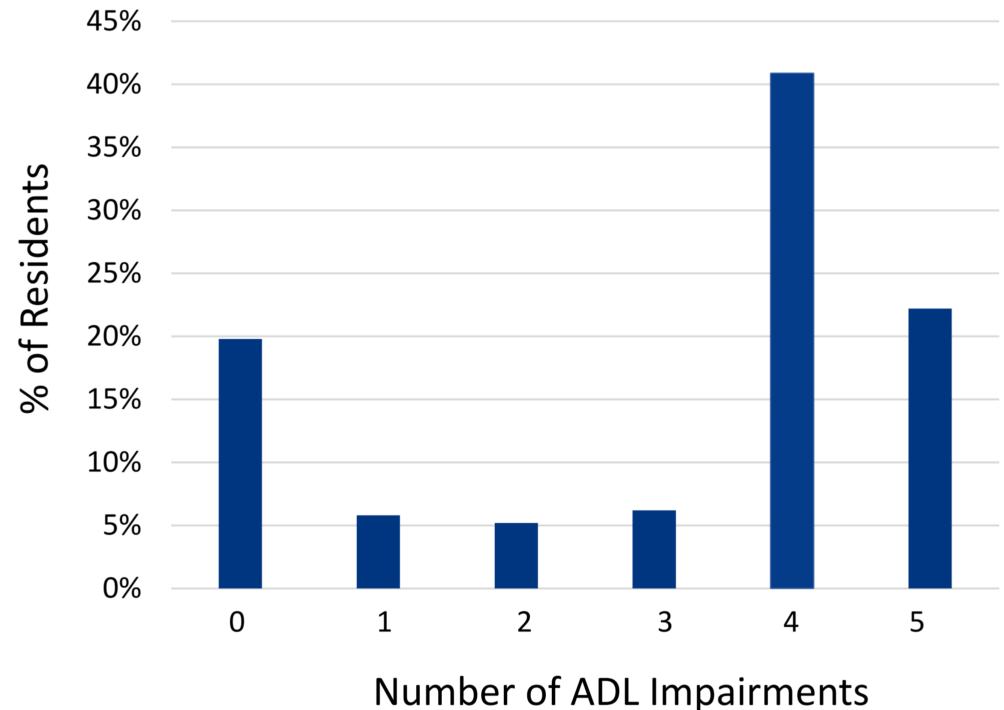
- 42% ≥ age 85, 16% < age 65
- 66% are women
- 78% are white

Impairments

- 20% - no limitation in ADLs
- 63% - 4-5 ADLs

Cognitive impairment

- 37% severe
- 25% moderate
- 39% mild



Note: Data describe all residents, regardless of payer or program participation.

SOURCE: CMS. "Nursing Home Compendium." 2015. Available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf

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Common Scenarios for Entry into Medicare SNF and Medicaid NF

Doorways into Medicare SNF Stay	Doorways into Medicaid NF Stay
• Experience an acute episode that results in an ED visit, followed by a hospital stay of ≥ 3 days. • Experience ≥ 3 day hospital stay, transferred to community or other post-acute setting, transferred to SNF within 30 days.	• Prior to NF stay, individual may be receiving home- and community-based services at home or in assisted living. Becomes increasingly frail and in need of higher level of care. Admitted to NF. • Transferred from Medicare SNF stay to extended stay as private pay. Deplete income and assets on care until qualify for Medicaid. • Already dually enrolled and residing in NF. NF sends resident to hospital. Return for skilled care as Medicare SNF. Then back to NF. • Recent CMS initiative aimed to reduce unnecessary hospitalizations (revolving door)

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Key Takeaways

- Most nursing facilities participate in both Medicare and Medicaid, are free-standing, and are for profit
- Nursing facility demographics: 66% are women, 78% are white, 42% are aged 85 and older
- States continue to expand HCBS
- Doorway to Medicare SNF stay begins with an acute episode resulting in a ≥ 3 day hospital stay
- Doorway to Medicaid NF begins with individual meeting state's standard of need for nursing home care and state's income and asset guidelines
  - Individuals are commonly transferred into Medicaid NF from receiving HCBS or from Medicare SNF stays

Medicare and Medicaid SNF/NF Payment Basics in FFS

FFS SNF and NF Payment Systems Used as Starting Points in Managed Care

- Most Medicare and Medicaid managed care organizations use existing SNF and NF FFS payment systems as the starting point for payment to network providers
  - Payment amounts may be higher or lower than FFS, but rate structure is generally the same
- Important for states to be aware of SNF and NF FFS payment basics
  - Helps to assess managed care network adequacy and managed care plan relationships with SNF and NF providers

Medicare SNF Prospective Payment System

Per Diem Base Rate*

Urban vs. Rural

6 Components

(see next slide)

Updated Annually

Geographic Adjustment

Adjustment based on labor costs

(Labor-related portion of daily rate multiplied by hospital wage index in SNF location)

NEW: Case-Mix Adjustment

Patient-Driven Payment Model (PDPM) implemented in October 2019

-Shifted payments from volume of **therapy** provided to need of medically complex patients

-Each resident assigned a case-mix classification that drives daily reimbursement for the individual

***Medicare covers certain high-cost, low-probability services separately from the per diem rate.**

SOURCE: MedPAC. "Skilled Nursing Facility Services Payment System." October 2020. Available at: http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_snf_final_sec.pdf?sfvrsn=0.

Patient-Driven Payment Model: 6 Components of Care

SOURCE: MedPAC. "Skilled Nursing Facility Services Payment System." October 2020. Available at: http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_snf_final_sec.pdf?sfvrsn=0.

FFS Medicaid Traditional NF Payment Approach

- States establish reimbursement methodologies and rates within broad federal guidelines
  - §1902(a)(30)(A) of the Social Security Act requires that Medicaid nursing facility payments be *"consistent with efficiency, economy, and quality of care and…sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area"*
- Under FFS, NFs are paid directly by states
  - Retrospective (interim rates + cost settlement) or prospective (rate determined prior to services, final reimbursement when services billed)
  - Cost-based or price-based methodology (or a combination of both)
    - Adjustments based on acuity (case-mix), peer group (groups of facilities of same size and in the same geographic area), or for high need patients
  - Supplemental payments, incentive payments
  - Facility-specific, statewide, peer group
- Rate setting methodology varies significantly among states

SOURCES: §1902(a)(30)(A) of the Social Security Act. Available at: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm; Medicaid and CHIP Payment and Access Commission (MACPAC). "Nursing Facility Fee-for-Service Payment Policy." December 2019. Available at: https://www.macpac.gov/wp-content/uploads/2019/12/Nursing-Facility-Fee-for-Service-Payment-Policy.pdf; Navigant. "Nursing Facility Payment Method Options." August 9, 2016. Available at: https://11042-presscdn-0-63-pagely.netdna-ssl.com/wp-content/uploads/indres/080916flahcanhpps.pdf

Features of FFS Medicaid NF Payment Policies, 2019

Basic Payment Policy		Duration of Bed Holds During Hospitalizations		Acuity-Based Payment System		Quality/ Pay-for-Performance Incentives	
Type	**# of States**	**Type**	**# of States**	**Type**	**# of States**	**Type**	**# of States**
Cost-Based	32	<10 days	11	RUGs-Based	34	Yes	25
Price-Based	15	10 – 19 days	15	State specific	8	No/None Found	26
Both	4	20 – 30 days	1	No/None Found	9		
		75% of Per Diem	1				
		No/None Found	23				

NOTES: Cost-based payments are based primarily on reported past facility costs, while price-based payments are based on estimates of future costs. Bed-hold days are days for which Medicaid pays NFs all or part of the regular per diem rate to keep a bed open for a resident's return. In this table, states include the District of Columbia.

SOURCE: MACPAC. "States' Medicaid Fee-for-Service Nursing Facility Policies" October 2019. Available at: https://www.macpac.gov/publication/nursing-facility-payment-policies/.

Medicaid NF Payments: Recent Trends

- Medicaid nursing facility rate-setting trends for **2020** before the public health emergency:
  - 40 states plus District of Columbia increased rates
  - 8 states restricted (froze or reduced) rates paid to nursing facilities in 2020
  - 2 states did not report data

- Medicaid nursing facility rate-setting in **2019**:
  - 40 states plus the District of Columbia increased rates
  - 10 states restricted rates to nursing facilities

SOURCE: Medicare Payment Advisory Commission (MedPAC). "Report to the Congress: Medicare Payment Policy." Chapter 7: Skilled Nursing Facility Services. March 2021, pp. 219-220. Available at: http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf

Key Takeaways

- Medicaid MCOs and D-SNPs typically use NF and SNF FFS rates as starting points in determining payments to network providers
- NEW PDPM
  - Shifted payments from **volume of therapy** provided to **need** of medically complex patients
  - Similar to acuity-based case mix Medicaid NF payment systems
- 25 states had NF performance-based payment incentives in 2019
- 40 states increased NF payment rates in 2020

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State Options to Improve Care Coordination and Quality in SNFs/NFs

Medicaid Managed Long-Term Services and Supports Programs

- State Medicaid programs increasingly use managed care as a strategy to improve care coordination and quality for populations with LTSS needs
  - As of November 2020, 25 states operated managed LTSS (MLTSS) programs
- States can consider a variety of strategies when designing nursing facility quality improvement efforts within MLTSS programs
  - Use existing data sources to reduce provider reporting burden
  - Enlist the help of internal or external quality measurement experts
  - Develop accountability for health plan quality (e.g., days in community post-NF discharge)
  - Seek stakeholder engagement, support, and collaboration
  - Understand how the initiative may influence beneficiary protections and access to care

SOURCES: MACPAC. "Managed Long-Term Services and Supports." November 2020. Available at: https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/ ; A.M. Philip * S. Gibbs. "Design Considerations for Nursing Facility Quality Improvement Initiatives in Medicaid Managed Long-Term Services and Supports Programs." Center for Health Care Strategies, August 2017. Available at: https://www.chcs.org/media/Nursing-Facility-Quality-Improvement-MLTSS-Brief_082417.pdf.

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Medicaid Value-Based Payment with Nursing Facilities

- States and managed care plans increasingly link financial rewards to demonstrated value through value-based payment (VBP) programs with NFs
- Benefits of integrated NF VBP Initiatives
  - Reduction in competing priorities can help to achieve desired outcomes
  - Alignment of VBP measures can reduce nursing facility reporting burden
  - More integrated approach to care for beneficiaries
- Lessons for states designing VBP for NFs
  - Over time, continue to increase the size of payments available
  - Align measures in VBP programs with those reported in Nursing Home Compare Star Ratings or used in the Medicare SNF VBP program
  - Carefully select stakeholders to be involved in program design
  - Provide technical assistance to participating facilities

SOURCE: J. Libersky, J. Stone, L. Smith, J. Verdier, and D. Lipson. "Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans." Integrated Care Resource Center, November 2017. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_VBP_in_Nursing_Facilities_November_2017.pdf.

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Examples of State NF VBP Programs Reviewed by ICRC in 2017

State, Program Name (Delivery System)	Approach
Arizona: Value-Based Purchasing Initiative (managed care)	Managed care plans must have a portion of total provider payment for LTSS governed by VBP strategies (15% for Medicaid-only contracts and 15% for MA D-SNP contracts in 2016).
Indiana: VBP Initiative (fee-for-service)	One-time increase in per diem rate. In the first year, the state distributed the maximum payment to the top 20% of providers, nothing to the bottom 20%, and an amount proportional to score for the remaining 60%.
Minnesota: Quality Incentive Payment Program (QIPP) (fee-for-service)	One-time add on to the per diem rate for the following year. Facilities select one measure to improve, and after 1 year, the state calculates the payment proportional to the amount of improvement over baseline.
Ohio: Nursing Home Quality Incentive System (fee-for-service and managed care)	The state withholds a portion of funding at the beginning of the year (~$1.79 per member per day), and facilities can earn it back proportionally based on their score on 5 quality measures.
Tennessee: Quality Improvement in Long Term Services and Supports (QuILTSS) (managed care)	Prospective, per diem rate adjustments. Facilities must meet threshold measures including accurate data and timely payment of the nursing home assessment.

SOURCE: J. Libersky, J. Stone, L. Smith, J. Verdier, and D. Lipson. "Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans." Integrated Care Resource Center, November 2017. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_VBP_in_Nursing_Facilities_November_2017.pdf.

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Medicare SNF Value-Based Purchasing Program

- The SNF VBP Program rewards SNFs with incentive payments based on the performance measure of hospital readmissions
- The Consolidated Appropriations Act of 2021 allows CMS to apply up to 9 additional measures to the SNF VBP Program for payments for services furnished on or after October 1, 2023
- Measures under consideration -- including measures of functional status, patient safety, care coordination, or patient experience -- are also applicable to the Medicaid NF experience. Examples include:
  - Percent of Residents Experiencing One or More Falls with Major Injury
  - Percent of High-Risk Residents with Pressure Ulcers
  - Percentage of Long-Stay Residents who got an Antipsychotic Medication
  - Discharge to Community Measure

SOURCE: CMS. "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2022." Available at: https://www.govinfo.gov/content/pkg/FR-2021-04-15/pdf/2021-07556.pdf.

CMS Nursing Home Compare Five-Star Quality Rating System

- Five-Star measures of quality for >15,000 nursing facilities
- 1-5 Star Rating based on performance in three domains
  - Health inspections (annual state inspections)
  - Staffing (RN and total staff hours, case mix adjusted)
  - Quality measures (24 measures)
- Part of Nursing Home Compare website: https://www.medicare.gov/care-compare/?providerType=NursingHome&redirect=true
- States can compare CMS star ratings to state Medicaid quality measures for same facilities, if available
  - Almost all nursing facilities provide both Medicare SNF services and Medicaid NF services

SOURCE: CMS. "Five-Star Quality Rating System." Available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS

Using Results from the CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

- From 2012 to 2020, CMS partnered with enhanced care & coordination providers to implement interventions and offer financial incentives to reduce avoidable hospitalizations among long-stay residents
- States and health plans can use similar VBP approaches to provide incentives to reduce avoidable hospitalizations
  - Use External Quality Review Organization (EQRO) activities to target reducing avoidable hospitalizations
  - Include provisions in the SMACs to require D-SNPs to directly address avoidable hospitalizations, including performance measures
- Integrated care plan examples of VBP initiatives that target avoidable hospitalizations
  - Arizona: Mercy Care target UTIs
  - Minnesota: HealthPartners target reducing pressure ulcers

For more information, see: CMS (2021) "Findings at a Glance - Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents - Payment Reform (NFI 2) Evaluation of Initiative Year 3 (FY 2019)" Available at: https://innovation.cms.gov/data-and-reports/2021/pah2-nfi2-ar4-aag-report. ICRC (2018) "Using Value Based Purchasing (VBP) Arrangement to Improve Coordination and Quality of Medicare and Medicaid Nursing Facility Benefits" Available at: https://www.integratedcareresourcecenter.com/webinar/using-value-based-purchasing-vbp-arrangements-improve-coordination-and-quality-medicare-and.

Integrated Care Programs: Opportunities to Improve Care Coordination and Quality for Dually Eligible NF Residents

- States can include provisions in SMACs to require plans to improve coordination of care for NF residents
  - Via requirements related to D-SNP models of care and/or enrollee and provider communications
- Improved coordination can result in improved quality for NF residents
  - Operate SNF and NF benefits more seamlessly
  - Improve care transitions between SNFs/NFs, hospitals, and the community
  - Reduce avoidable hospitalizations and emergency room use for SNF/NF residents
  - Improve monitoring and utilization of Part D prescription drugs in NFs
- Plans can partner with state LTC Ombudsman programs for quality oversight

Involuntary Discharges

- Facility-initiated discharges are one of the most frequent complaints made to State Long Term Care Ombudsman Programs
- States and integrated care plans may address some of these concerns
  - States can include provisions in SMACs requiring D-SNPs to address involuntary discharges in model of care requirements
  - Coordinated D-SNP and affiliated Medicaid plan benefits can reduce real or anticipated payor confusion
  - Plans provide additional oversight to state surveillance
  - Health plan staff can work on coordinated response to involuntary discharges

SOURCE: CMS. "An Initiative to Address Facility Initiated Discharges that Violate Federal Regulations." Memo December 22, 2017.
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-08.pdf

Key Takeaways

- States can consider a variety of strategies when designing nursing facility quality improvement efforts within MLTSS programs
- States and managed care plans increasingly use VBP programs with NFs
- States can include provisions in contracts with integrated care plans to address coordination and quality of care for NF residents

Expanding Home- and Community-Based Alternatives to Care in SNFs and NFs

Renewed Emphasis on Home- and Community-Based Care

- States have made considerable progress toward rebalancing LTSS, with 56% of Medicaid LTSS funds spent on HCBS in 2018
- COVID-19 accelerated state interest and efforts in promoting the use of HCBS over institutional services
  - Congregate housing settings as incubators for the virus created an impetus for states and beneficiaries to avoid institutional care settings and opt for home-based care
- Increased federal attention and efforts
  - Opportunities for enhanced FMAP (SMD Letter 21-003)
  - Extension of the Money Follows the Person program (Consolidated Appropriations Act, 2021)
  - LTSS rebalancing resources (Long-Term Services and Supports Rebalancing Toolkit)

State Strategies to Increase HCBS

- Develop LTSS system infrastructure to promote greater access to HCBS, such as
  - Increasing access points (e.g., No Wrong Door/Single Entry Point)
  - Enhancing direct care workforce
  - Supporting informal caregivers
- Invest in programs and services that help NF residents return to and remain in their communities, such as
  - Transition services
  - Tenancy-sustaining services
  - Affordable housing options
- Expand access to HCBS for “pre-Medicaid” individuals to prevent or delay NF use

For more information, see: CHCS and Manatt. “Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment: A Toolkit for States. March 2019. Available at: https://www.chcs.org/media/Strengthening-LTSS-Toolkit_032019.pdf

Integrated Care Program Opportunities to Increase Use of HCBS as Alternatives to SNF/NF Services

- Integrated plans have financial incentives to reduce use of costly SNF or NF care and can take advantage of Medicaid HCBS options to do so*
- States can:
  - Structure Medicaid capitated payments to D-SNPs or affiliated Medicaid plans to encourage Medicaid HCBS
    - Provide plans with payment incentives (for example, Wisconsin provides Money Follows the Person Relocation Incentive Payments to Family Care and Partnership health plans)
  - Include provisions in SMACs to require plans to facilitate HCBS using model of care requirements
    - Require D-SNPs to coordinate discharge and transition planning

*Note that Institutional SNPs (I-SNPs) described in the Appendix are non-integrated, Medicare-only plans that are generally not able to take advantage of Medicaid HCBS options.

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Integrated Care Program Opportunities to Increase Use of HCBS as Alternatives to SNF/NF Services, *continued*

- States can:
  - Require plans to report quality measures that focus on availability and use of HCBS
    - Align measures with HCBS waiver specific terms and condition requirements and other MLTSS program measures
    - Innovation Accelerator Program supported several states' efforts to develop VBPs for HCBS
      - For example, New Jersey used bonus performance payments to health plans to incentivize successful transitions of Medicaid beneficiaries from institutions appropriate community-based settings
  - Encourage plan efforts to expand enrollee awareness of Medicaid HCBS options
  - Encourage plans to work with providers
    - Build comfort with integrated care
    - Train HCBS providers in managed care billing patterns
    - Promote rapid HCBS provider contracting and credentialing

SOURCE: CMS. "Community Integration through Long-Term Services and Supports" Medicaid Innovation Accelerator Program. February 2019. Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/vbp-hcbs-strategy-implementation-092016.pdf

Key Takeaways

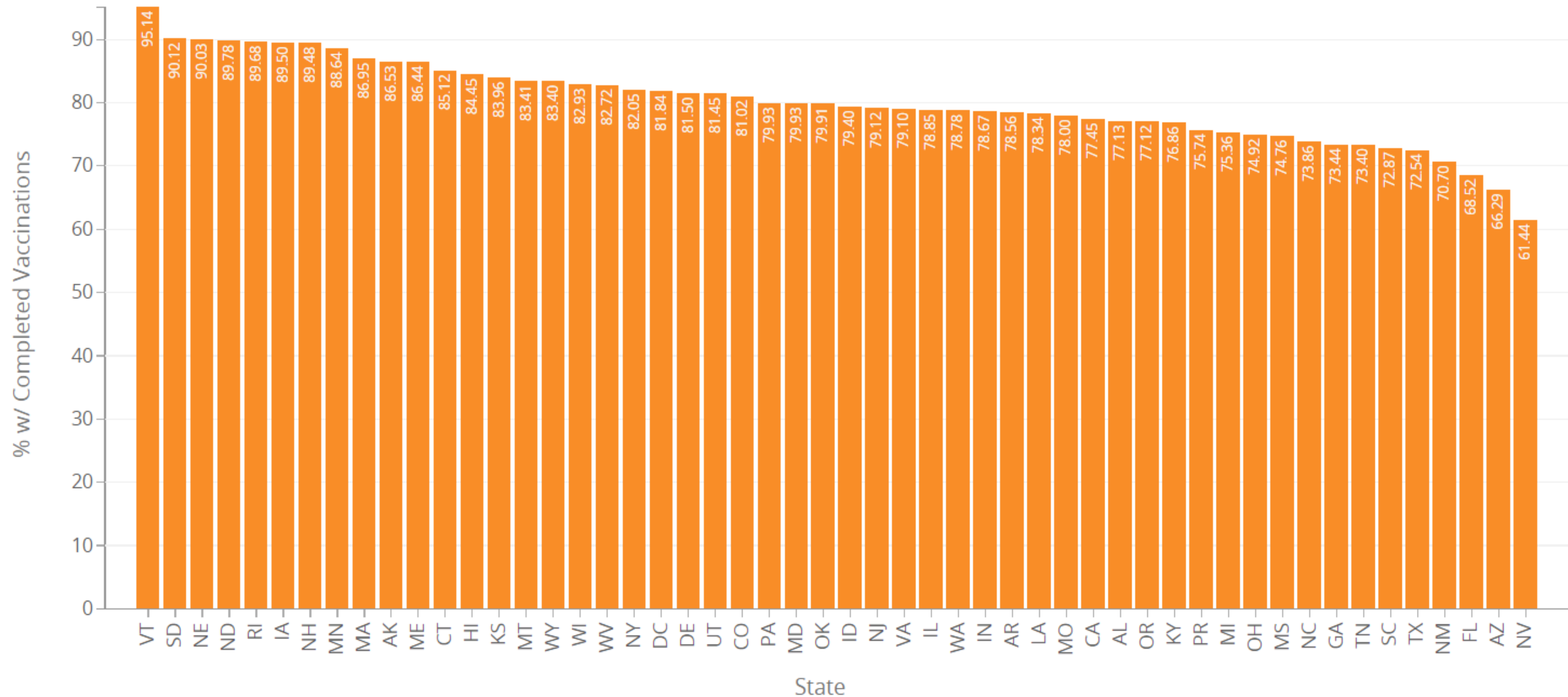
- States have made considerable progress toward rebalancing LTSS, and COVID-19 accelerated state interest and efforts in promoting the use of HCBS over institutional services
- States can work with integrated care plans to expand availability of HCBS options for dually eligible beneficiaries enrolled in such plans
  - D-SNPs have financial incentives to reduce costly SNF and NF care, and can take advantage of Medicaid HCBS options to do so

About ICRC

- Established by CMS to advance integrated care models for dually eligible individuals
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica and the Center for Health Care Strategies
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send other ICRC questions to: integratedcareresourcecenter@chcs.org

Appendix

COVID Vaccination Rates Among Nursing Facility Residents by State



SOURCE: CMS. "COVID-19 Nursing Facility Data." Week Ending 6/13/2021. Available at: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/

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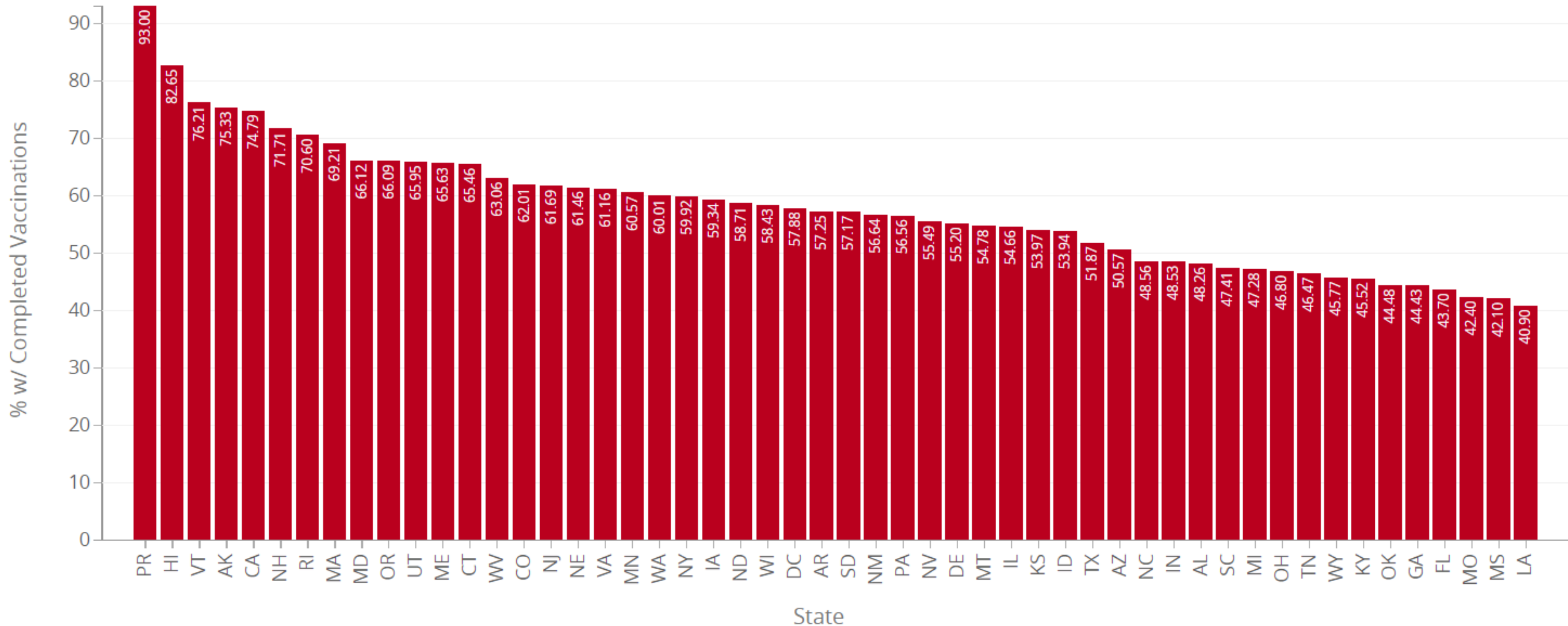
COVID Vaccination Rates Among Nursing Facility Staff by State



SOURCE: CMS. "COVID-19 Nursing Facility Data." Week Ending 6/13/2021. Available at: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/

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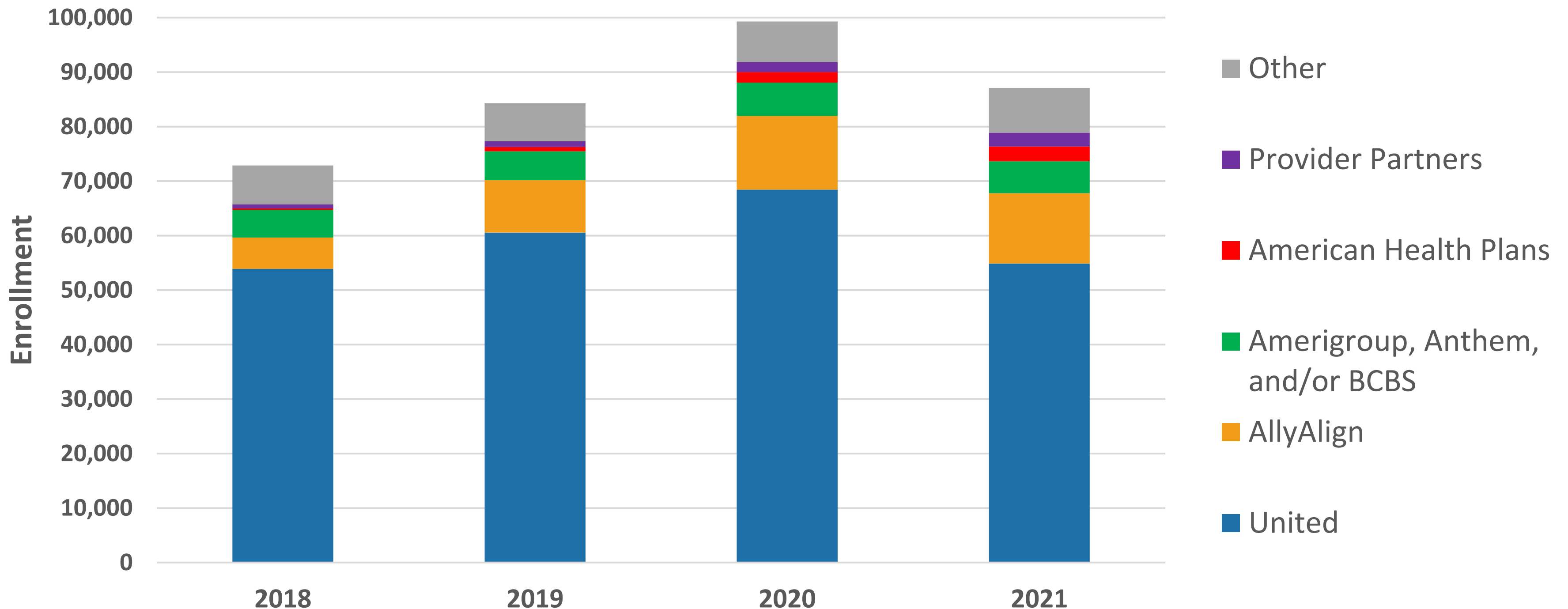
Institutional SNPs

- Institutional Special Needs Plans (I-SNP) are SNPs that focus on Medicare SNF and other Medicare benefits, and enroll both Medicare-only and dually eligible beneficiaries
- States and I-SNPs are free to contract with each other for I-SNPs to cover or coordinate Medicaid LTSS or other Medicaid benefits, but are not under any obligation to do so
- To the extent they operate in a state, they may compete with D-SNPs for enrollees and SNF network providers
- For national and state-by-state information on I-SNP enrollment, see the appendix and the monthly CMS SNP Comprehensive Report at this link: Special Needs Plan (SNP) Data | CMS

Enrollment Growth in all I-SNPs by Affiliation/Parent Organization, 2018-2021



NOTE: AllyAlign, American Health Plans, and Provider Partners are provider-sponsored plans.

SOURCE: CMS SNP Comprehensive Report, Feb 2018, 2019, 2020, and 2021. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

I-SNP Enrollment by State, February 2021

State	Number of I-SNP Plans	Total I-SNP Enrollment
New York	15	14,989
Florida	20	5,320
Georgia	6	4,501
Ohio	9	3,988
North Carolina	8	3,971
Pennsylvania	5	3,869
New Jersey	5	3,569
Delaware	3	3,317
Alabama	3	3,181
California	8	3,004
Connecticut	3	2,943
Arizona	5	2,865
Texas	7	2,864
Colorado	6	2,772
Illinois	7	2,476
Indiana	2	2,473
Maryland	9	2,253
Missouri	5	2,103
Oregon	6	2,093
Wisconsin	6	1,985
Virginia	8	1,980
Rhode Island	4	1,488
Washington	3	1,391
Tennessee	3	1,220

SOURCE: CMS SNP Comprehensive Report, Feb 2021. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

I-SNP Enrollment by State, February 2021 (*continued*)

State	Number of I-SNP Plans	Total I-SNP Enrollment
Idaho	1	1,026
Nevada	1	710
South Carolina	4	687
Oklahoma	3	601
West Virginia	1	584
Mississippi	2	581
Nebraska	2	493
Kentucky	2	335
Kansas	3	332
New Hampshire	2	283
Maine	1	283
South Dakota	2	240
Utah	2	191
North Dakota	2	190
Minnesota	6	189
Michigan	3	143
Iowa	1	112
Louisiana	1	92
DC	1	35
Massachusetts	1	14
Arkansas	1	-
TOTAL[1]	**198**	**87,736**

[1] Thirteen plans spanned across multiple states. In this table, we divided the number of enrollees in those plans evenly across the states and added the plan to each state's total number of I-SNP Plans. The total includes 76 enrollees in plans with fewer than 11 enrollees.

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