ICRC | Integrated Care Resource Center

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

August 31, 2022

Integrated Care Updates

CMS Issues FY2023 Hospice Payment Final Rule

On July 27, 2022, the Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1773-F) that updates Medicare hospice payments and the aggregate cap amount for FY 2023 in accordance with existing statutory and regulatory requirements. This final rule establishes a permanent mitigation policy to smooth the impact of year-to-year changes in hospice payments related to changes in the hospice wage index. CMS is committed to addressing consistent and persistent inequities in health outcomes by improving data collection to measure and analyze disparities across programs and policies that apply to the Hospice Quality Reporting Program (HQRP). This final rule discusses the HQRP, including the Hospice Outcomes and Patient Evaluation (HOPE) tool; provides an update on Quality Measures (QMs) that will be in effect in FY 2023 as well as future QMs; and also provides updates on the Consumer Assessment of Healthcare Providers and Systems, Hospice Survey Mode Experiment. The provisions in the final rule are summarized in a CMS fact sheet: Hospice Payment Rule Fact Sheet.

Under the final rule, hospices will see a 3.8 percent increase for FY 2023 Medicare hospice services starting October 1, 2022, compared to the FY 2022 rates. Since Medicaid hospice payment rates are tied to the Medicare payment rates, this will require modifications to Medicaid hospice payment rates and methodologies. (State Medicaid payments for hospice care are required by federal law to be “in amounts no lower than the amounts, using the same methodology” as in Medicare (Section 1902(a)(13)(B) of the Social Security Act)). CMS annually provides an update to states with information regarding the specific impacts on Medicaid hospice rates in a separate memo.

CMS Announces Home and Community-Based Services Quality Measure Set

On July 21, CMS announced the first official version of the home and community-based services (HCBS) quality measure set. The HCBS Quality Measure Set is intended to promote more common and consistent use, within and across states, of nationally standardized quality measures in HCBS programs and to create opportunities for CMS and states to have comparative quality data on HCBS programs. It is comprised of measures that assess quality across a broad range of areas identified as measurement priorities for HCBS. States are encouraged to use the measure set to assess quality and outcomes in their HCBS programs, regardless of federal authority.

CMS expects to issue additional guidance in the future on how states can use the measure set to meet federal reporting requirements for HCBS programs.

August 2022 Enrollment in Medicare-Medicaid Plans

Between July and August 2022, total Medicare-Medicaid Plan (MMP) enrollment in the nine states (CA, IL, MA, MI, NY, OH, RI, SC, and TX) with current capitated model demonstrations under the Financial Alignment Initiative increased from 427,559 to 428,703 as shown in ICRC's table Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, August 2021 to August 2022.

August 2022 Enrollment in PACE Organizations

Program of All Inclusive Care for the Elderly (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, PACE Total Enrollment by State and by Organization, PACE organizations were operating in 30 states in August 2022. Between July and August 2022, the total number of Medicare beneficiaries enrolled in PACE increased from 54,043 to 54,338.

New Resources on the ICRC Website

- Integrated Appeal and Grievance Processes for Integrated D-SNPs with "Exclusively Aligned Enrollment" (April 2019) This fact sheet, updated in July 2022, is intended to help states with applicable integrated plans understand the new integrated appeal and grievance processes, the types of D-SNPs that are required to use them, and steps that states can take to help ensure effective implementation of the new processes.
- Appeals and Grievances: Comparisons of Existing and New Integrated Processes for Individuals Enrolled in Applicable Integrated Plans (July 2022) The flowcharts in this resource are designed to help states, health plans, and other stakeholders understand the differences between existing Medicare and Medicaid appeal and grievance processes and the new integrated appeal and grievance processes established at 42 CFR Part 422 Subpart M for fully and highly integrated D-SNPs with exclusively aligned enrollment.

Key Upcoming Dates

- **Mid-September 2022-** CMS fully executes CY2023 MA and PDP contracts with plans.
- **September 30, 2022-** Deadline for all MA, MA-PD, MMP, 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 LIS rider to current enrollees.