Integrated Care Resource Center

UPDATE

Highlights of federal and state integrated care initiatives, Medicare and Medicaid news, and new ICRC resources

December 27, 2018

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ABOUT THE INTEGRATED CARE RESOURCE CENTER

The Integrated Care Resource Center (ICRC) is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees.

The state technical assistance activities are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit the ICRC website.

Integrated Care Update

Implications for States of the New Medicare Payment System for Skilled Nursing Facilities

As detailed in an August 14, 2018 ICRC Spotlight, CMS is implementing a new payment system for Medicare skilled nursing facilities, starting on October 1, 2019, that will no longer rely on the Resource Utilization Group (RUG) system to adjust facility payments for resident care needs and costs. Since many states use the RUG system and its underlying Minimum Data Set (MDS) resident assessments to adjust payments to Medicaid nursing facilities for resident case mix, states will need to begin considering changes to these payment systems to reflect the fact that information from the Medicare RUG system and the MDS that states may previously have relied on will no longer be available.

A Centers for Medicaid & CHIP Services Informational Bulletin, issued on December 6, 2018, spells out the implications for states, including timelines for the phase-out of the RUG system and related MDS assessments, and support for states during the transition. In particular, the bulletin notes that, with removal of several MDS data elements that underlie RUG payment systems, states that continue to use the RUG system for case mix adjustment after a one-year transition ends on October 1, 2020 will need to implement a new process to gather the assessment data they need.

Social Security Administration Clarifies Guidelines That Allow QMB Applicants to Enroll Conditionally in Medicare Part A

New Social Security Administration (SSA) guidelines clarify how states can help Medicaid beneficiaries obtain state payment of Medicare premiums through the Qualified Medicare Beneficiary (QMB) program.

The Problem. Most Medicare beneficiaries qualify for premium-free Part A, but some lack the work history needed to be eligible for this benefit. They must pay a premium to receive Part A, which may be a significant financial burden for low-income Medicaid beneficiaries. States pay the Part A premium for individuals who are enrolled in the Qualified Medicare Beneficiary (QMB) program. However, to qualify for the QMB program an individual must be enrolled in Part A, creating an impossible predicament for low-income individuals who cannot afford to pay their Part A premium.

Conditional Enrollment in Part A. SSA has clarified its existing program policy to address this challenge by allowing individuals to “conditionally enroll” in Part A at SSA offices without paying the first month’s premium on the condition that the state

approves their QMB application and thus becomes liable for the Part A premium. With this conditional enrollment in Part A, individuals meet the eligibility criteria for the QMB program, enabling states to find them eligible for QMB and begin paying the Part A premiums. Conditional enrollment in Part A does not generate a bill, so if the state subsequently denies the QMB application, the individual will not be enrolled in Part A and no Part A payment will be due. When processing the conditional Part A enrollment, SSA will refer the individual to the appropriate state office to apply for the QMB program and may give the individual a screen shot of their application to bring as proof of conditional enrollment. The state can also query SSA's State Verification & Exchange System (SVES) to verify the conditional Part A enrollment.

Individuals who live in the 36 states and the District of Columbia that pay the Part A premium for QMBs under the terms of their Medicare buy-in agreements ("Part A buy-in states") can enroll conditionally in Part A at any time, while individuals who live in the remaining 14 states that do not have buy-in agreements ("Group Payer states") can only enroll during a prescribed Medicare enrollment period. (The states in each category are listed in the SSA program policy notice in the link above.)

Additional Streamlined Enrollment in Part A Buy-in States. In the 36 Part A buy-in states, if QMB applicants lack premium-free Part A, but are already enrolled in Part B (and otherwise eligible for QMB), the state buy-in agreement requires the state to enroll them in QMB (if they are otherwise eligible) without referring them to SSA for conditional enrollment. Only if the individual lacks both Parts A and B do they need to go through the conditional enrollment process.

CHCS Blogs Describe State Approaches to Integrating Medicare and Medicaid for Dually Eligible Beneficiaries

The Center for Health Care Strategies (CHCS) recently released two blogs posts that examine the different approaches taken by Idaho and Ohio to provide their dually eligible populations with more integrated, coordinated care:

- A New Approach to Integrating Care for Dually Eligible Beneficiaries: Idaho's Medicare Medicaid Coordinated Plan (MMCP) looks at this Dual Eligible Special Needs Plan (D-SNP)-based program's structure and highlights early successes and lessons for other states. Idaho's approach may be interesting to states that want to integrate care, but do not have Medicaid managed long-term services and supports (MLTSS) programs.
- Successfully Connecting Medicare and Medicaid for Dually Eligible Beneficiaries: MyCare Ohio, describes this capitated model demonstration under the Financial Alignment Initiative. This blog post highlights the efforts of Ohio and its federal and health plan partners to develop and implement MyCare Ohio, which has enrolled more than 80,000 people, making it the second-largest of the 10 capitated model demonstrations.

December 2018 Enrollment in Medicare-Medicaid Plans

Between November and December 2018, total Medicare-Medicaid Plan (MMP) enrollment in the nine states (CA, IL, MA, MI, NY, OH, RI, SC, and TX) currently implementing capitated model Financial Alignment Initiative demonstrations decreased from 383,840 to 379,451 as shown in ICRC's table Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, December 2017 to December 2018.

December 2018 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 Medicare-Medicaid enrollees. As shown in ICRC's table, Program of All Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization, 124 PACE organizations were operating in 31 states in December 2018. Between November and December 2018, total PACE enrollment increased from 43,932 to 44,240.

New Resources on the ICRC Website

- How States Can Better Understand their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources (ICRC/November 2018) This newly updated technical assistance tool shows states how to use data on Medicare-Medicaid dually eligible beneficiary demographics, service utilization, spending, and other characteristics to create tables, graphs, and figures and interpret their meaning for a wider audience of stakeholders. The update adds information from the 2016 CMS Medicaid Managed Care Enrollment Report.

- Building a Stronger Foundation for Medicare- Medicaid Integration: Opportunities in Modifying State Administrative Processes (ICRC/November 2018). This brief highlights administrative changes to build a stronger foundation for integrated care.

- Technical Guide for Medicare-Medicaid Plan Enrollment v 2.9 (ICRC/November 2018) This resource describes the interface to the Infocrossing applications for Medicare Eligibility verification and Enrollment submission to the CMS MARx systems and contains updates reflecting the CMS Fall 2018 Software changes, as documented in the final CMS HPMS notice dated October 4, 2018.

Key Upcoming Dates

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December 31	Comments due on proposed New Requirements for D-SNP Medicaid Integration and Unified Grievance and Appeals Procedures.