AMERICA'S PHYSICIAN GROUPS

State Programs Committee Meeting

Tuesday, June 29, 2021

10:30 – 12:00 (Pacific)

Registration link: Please **Register** today!

Agenda:

10:30: Welcome and introductions by Sean Atha, Chair, River City Medical Group

10:40: Summary of CalAIM implementation issues, and conversations with MC health plans – Bill Barcellona, APG

11:30: Presentation on pending Medi-Cal administrative simplification projects/issues – Mike Meyers, ICE

11:45: New Business from the Membership

12:00: Adjourn

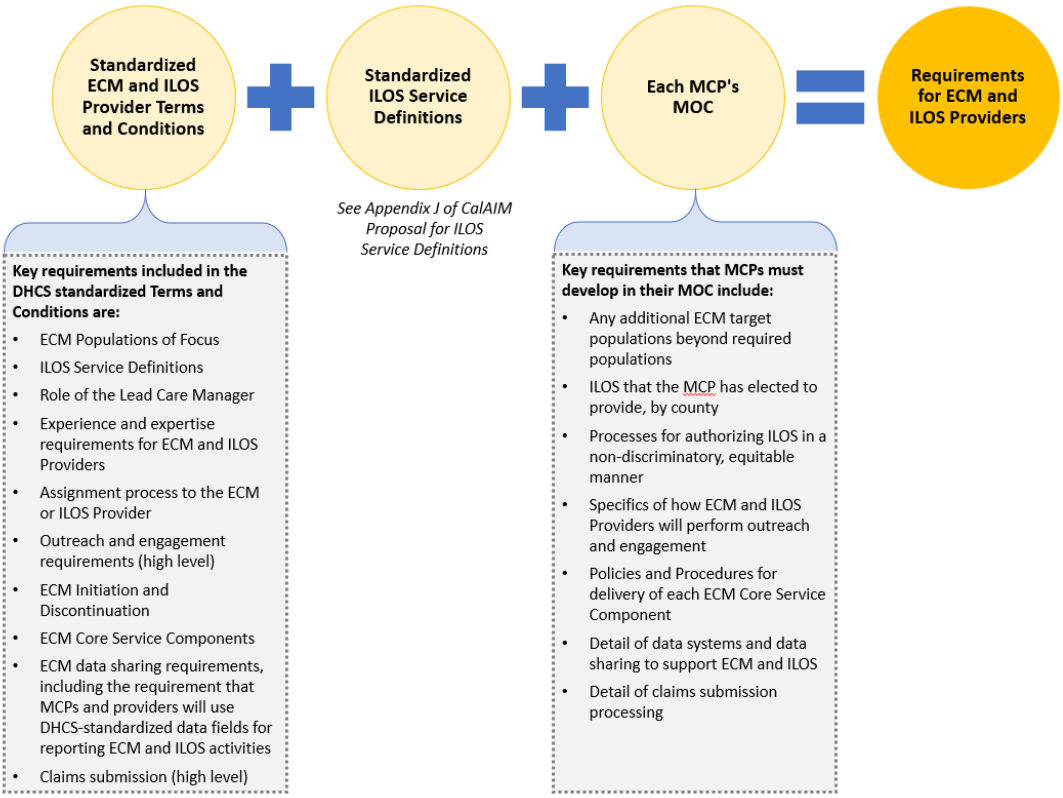
See attached Member Meeting Packet

Overview

The Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Model of Care (MOC) is each managed care plan's (MCP) framework for providing ECM and ILOS. Each MCP's MOC will include its overall approach to ECM and ILOS; its detailed Policies and Procedures with regard to ECM and ILOS Provider (including non-traditional Providers) contracting and oversight; its ECM and ILOS Provider network capacity; and the contract language that will define key aspects of its arrangements with its ECM and ILOS Providers. The MOC also includes specific "Transition and Coordination" content for MCPs operating in Whole Person Care (WPC) and/or Health Home Program (HHP) counties. MCPs in these counties must describe how they will ensure smooth transitions for their Members from WPC and HHP into ECM and ILOS.

In order to balance statewide consistency with the ability of MCPs to innovate in their design of ECM and of ILOS they elect to offer, DHCS is standardizing certain design aspects of ECM and ILOS, while allowing MCPs the flexibility to develop Policies and Procedures that will best meet the needs of their Members and communities. The standardized requirements for ECM and ILOS are found in the MCP Contract section on ECM and ILOS and in the Standard Provider Terms and Conditions. The structure of the MOC Template mirrors the MCP Contract section on ECM and ILOS, and MCPs should refer to the Contract as they develop their MOCs. The combination of the elements contained in the MOC will make up the ECM and ILOS model that will be reflected in each MCP's contracts with ECM and ILOS Providers (see Figure 1).

Figure 1: Elements of ECM and ILOS Provider Requirements



DHCS will use each MCP's MOC submission to determine its readiness to meet ECM and ILOS requirements. MCPs must lay out their MOCs using the DHCS-developed standard template (MOC Template) and submit them to DHCS for review and approval prior to initial ECM and ILOS implementation in 2022. MCPs must make updates to their MOCs (1) ahead of new ECM Populations of Focus being implemented in January and July 2023 and (2) to reflect any ILOS changes.

The ECM and ILOS Implementation timeline is provided in Figure 2 below. MOC submission requirements are provided in Figures 3 and 4 below. MCPs should refer to these detailed timelines to understand how MOC submission timelines relate to the statewide rollout of ECM and ILOS.

DHCS will continue to provide Technical Assistance to MCPs as they prepare for ECM and ILOS implementation, including webinars, FAQs and close engagement with the MCP associations. DHCS publishes all programmatic updates and guidance related to

ECM and ILOS on the ECM and ILOS website. MCPs may submit questions to DHCS at CalAIMECMILOS@dhcs.ca.gov with Contract Managers cc'd at any time.

DHCS reserves the right to make updates to these instructions and timelines. Any changes will be published on the ECM and ILOS website.

ECM and ILOS Implementation Timelines

ECM will go live on a phased timeline as described below. ILOS are optional for all MCPs to implement beginning 1/1/2022 (see Figure 2).

Figure 2. ECM and ILOS Implementation Timeline

Date	Health Home Program (HHP) Counties	Whole Person Care (WPC) Pilot Counties	Counties with Neither
January 1, 2022	• Transition and automatically authorize ECM for all Members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in HHP • ECM goes live for all of the following ECM Populations of Focus: ○ *Individuals & Families Experiencing; Homelessness;* ○ *High Utilizer Adults;* ○ *Adults with SMI/SUD.* *To ensure no interruption in service, children and youth currently served by HHP or WPC will be transitioned into ECM and reassessed.*	• Transition and automatically authorize all Members enrolled in a WPC Pilot who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus • ECM goes live for all of the following ECM Populations of Focus: ○ *Individuals & Families Experiencing; Homelessness;* ○ *High Utilizer Adults;* ○ *Adults with SMI/SUD;* ○ *Adults & Children/Youth Transitioning from Incarceration.*[1] *To ensure no interruption in service, children and youth currently served by HHP or WPC will be transitioned into ECM and reassessed.*	
	MCPs in all counties are able to offer ILOS		

[1] In WPC Pilot counties only: where the services provided in the Pilot are consistent with those described in the ECM Contract.

Figure 2 Continued. ECM and ILOS Implementation Timeline

Date	Health Home Program (HHP) Counties	Whole Person Care (WPC) Pilot Counties	Counties with Neither
July 1, 2022			• ECM goes live for the following ECM Populations of Focus: ○ *Individuals & Families; Experiencing Homelessness;* ○ *High Utilizer Adults;* ○ *Adults with SMI/SUD.*
	MCPs in all counties may elect to offer additional ILOS		
January 1, 2023	• ECM goes live for the following ECM Populations of Focus: ○ *Individuals Transitioning from Incarceration (adults and children/youth);* ○ *Members Eligible for LTC and at risk of Institutionalization;* ○ *Nursing Home Residents transitioning to community.*		
	• **MCPs in all counties may elect to offer additional ILOS**		
July 1, 2023	• ECM goes live for *all other Children and Youth*.		
	• **MCPs in all counties may elect to offer additional ILOS**		

Timelines for MOC Submission

MCPs must submit the MOC to DHCS for review and approval according to the MOC submission schedules provided below in Figure 3 (for WPC and HHP counties and Figure 4 (for All Other counties). Submission Due Dates for the 2023 Go-Live dates are subject to change.

Figure 3. MOC Submission Schedule for MCPs in WPC/HHP Counties

ECM and ILOS Content	MOC Submission Due Dates	

• ECM Populations of Focus:
  ○ Homeless;
  ○ High Utilizer adults;
  ○ Adults with SMI/SUD;
  ○ Adults Transitioning from Incarceration[1]
• ILOS
	MOC Part 1	**July 1, 2021**

	MOC Part 2	**September 1, 2021**
	MOC Part 3	**October 1, 2021**
• Any updates to ECM or ILOS submissions (as needed only)	**MOC Parts 1 and 2**	**January 1, 2022**
	MOC Part 3	**March 1, 2022**

• ECM Populations of Focus:
  ○ Individuals Transitioning from Incarceration;
  ○ Members Eligible for LTC and at risk of institutionalization;
  ○ Nursing Home Residents transitioning to community.
• Any changes to ILOS
	MOC Parts 1 and 2	**July 1, 2022**

	MOC Part 3	**September 1, 2022**
• All other Children/Youth ECM Populations of Focus • Any changes to ILOS	**MOC Parts 1 and 2**	**January 1, 2023**
	MOC Part 3	**March 1, 2022**

[1] In WPC Pilot counties only: where the services provided in the Pilot are consistent with those described in the ECM Contract.

Figure 4. MOC Submission Schedule <u>for All Other Counties</u>

ECM and ILOS Content	MOC Submission Due Dates	
• ILOS Only	**MOC Part 1**	**July 1, 2021**
	MOC Part 2	**October 1, 2021**

• ECM Populations of Focus:
  ○ Homeless;
  ○ High Utilizer adults;
  ○ Adults with SMI/SUD.
• Any changes to ILOS
	MOC Parts 1 and 2	**January 1, 2022**

	MOC Part 3	**March 1, 2022**

• ECM Populations of Focus:
  ○ Individuals Transitioning from Incarceration;
  ○ Members Eligible for LTC and at risk of institutionalization;
  ○ Nursing Home Residents transitioning to community.
• Any changes to ILOS
	MOC Parts 1 and 2	**July 1, 2022**

	MOC Part 3	**September 1, 2022**
• All other Children/Youth ECM Populations of Focus • Any changes to ILOS	**MOC Parts 1 and 2**	**January 1, 2023**
	MOC Part 3	**March 1, 2022**

DHCS MOC Approval Process

MCPs should expect review of the MOC to be an iterative process with DHCS during each review period, and DHCS may require resubmission of certain questions or additional material to ensure alignment with DHCS requirements. DHCS will review and provide feedback on the MOC submissions using DHCS' deliverable review process. If the MOC is approved, DHCS will issue final approval no later than 30 days prior to each go-live date. DHCS may meet with each MCP to gauge the development of the MCP's ECM and ILOS Provider capacity.

For MCPs in WPC and HHP counties, DHCS will pay special attention to appropriate transition of Members into ECM and will closely monitor any MCP decisions not to transition existing WPC/HHP services into the corresponding pre-approved ILOS. DHCS will also closely monitor for any concerns about contracting with existing WPC Lead Entities and Community-Based Care Management Entities (CB-CMEs), as is required in the Contract unless exceptional circumstances apply.

After statewide implementation of ECM and ILOS for all Populations of Focus, DHCS will no longer require updates to the MOC Template and will monitor MCPs' implementation using encounter data and supplementary data reporting. Any revisions to the MCP's approved s Procedures must be submitted to DHCS, using the standard deliverables submission process, for review and approval at least 60 days prior to implementation.

Additional MOC Submission Guidance

Transition and Coordination Planning for WPC and HHP Counties. Consistent with the CalAIM Proposal, MCPs operating in WPC and HHP counties must submit a "Transition and Coordination Plan" to DHCS that demonstrates how the MCP will transition existing programs into ECM and ILOS.[2] The Transition and Coordination Plan is incorporated in the MOC Template, and relevant questions are labeled "Transition and Coordination Questions for MCPs operating in WPC and HHP counties." MCPs that are not currently operating in WPC and HHP counties should not answer these questions.

- The Excel spreadsheets due in **Part 1** are intended to show which current WPC LE and HHP CB-CME Providers that could transition to serve as contracted ECM or ILOS Providers. The submission of this template is intended to provide DHCS with a status update on MCP ECM and ILOS Provider Network/capacity development in July 2021. For all WPC LE and HHP CB-CME Providers identified as not transitioning to ECM or ILOS Provider status, ('No' status),

[2] Revised CalAIM Proposal. Available at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-1-8-21.pdf.

MCPs will be required to submit an exception request in alignment with Section 6 of the Contract.

- A refresh of the information will be required to be submitted to DHCS as a component of **Part 2** submission to show updates to Provider contracting status that was initially reported as a '*To Be Determined*'. For all Providers identified as not transitioning ('No' status), MCPs will be required to submit an exception request in alignment with Section 6 of the Contract.
- The Final ECM and ILOS Provider Network/ capacity will be submitted as **Part 3** of the transition process.
- **How MCPs Should Group Information by County.** MCPs that operate in more than one county should submit a single MOC Template covering ECM and ILOS across all counties in their service area. Some questions specifically prompt the MCP to provide responses by county. Even if not prompted, other variations by county should be noted within the MOC. If details vary substantially between counties, MCPs may submit multiple responses to questions or sections of the MOC Template, clearly labeled by county. In Part 2, all Provider capacity information for ECM and ILOS should be provided by county as indicated in the instructions.
- **Subcontractors and Delegated Arrangements.** The MOC Template takes into account delegated arrangements between MCPs and other entities (including partner MCPs, independent physicians associations (IPAs) and management services organizations (MSOs)). MCPs may subcontract with other entities to administer ECM and ILOS, within the guidelines described in the ECM and ILOS Contract; see DHCS-MCP ECM and ILOS Contract Template: 16. Delegation of ECM to Subcontractor(s). All MCPs directly contracted with DHCS are responsible for ECM and ILOS implementation in accordance with DHCS' requirements, including for the compliance of subcontracted entities to which the MCP has delegated responsibility for ECM and ILOS. Each MCP directly contracted with DHCS is responsible for completing and submitting the MOC Template. Within their MOC Template responses, MCPs should include details of subcontracted and delegated arrangements, including in their Policies and Procedures, as they relate to the implementation of ECM and ILOS, and clearly describe how roles and responsibilities will be divided between and among the MCP and subcontractors or delegates.

Instructions for MOC Submission

To complete the ECM and ILOS MOC Template, copy and paste all questions into a separate Word document and complete with your responses. MCPs may use separate attachments, clearly labeled, as necessary. When complete, MCPs should email their

completed MOC, along with attachments (clearly labeled), to CalAIMECMILOS@dhcs.ca.gov. MCPs should submit any questions on the MOC process to DHCS using the same email address.

Approved 6/18/21

ICE Executive Summary of Team Activities
April 2021 / May 2021

ICE Team Leadership Co-chairs Report:

Leadership/Team Changes/Announcements

- New Leadership
  - ICE Pharmacy Regulations Team / CA
    - Dang Huynh, Santa Clara Family Health Plan (SCFHP)
  - ICE Contracting & Compliance Team IT Systems Integrity Workgroup
    - Munaf Razzak, Hoag Memorial Hospital Presbyterian
- Leadership Resignation
  - ICE RADAR Team / ICE Team Leadership Co-Chair
    - Connie Snyder, Brand New Day
  - ICE C&C Team IT Systems Integrity Workgroup
    - Octavio Campos, Identity MSO

ICE Teams/Workgroups are currently active in the following areas (*available reports from these teams can be viewed below – view leadership at: https://www.iceforhealth.org/iceleadership.asp*)

- ICE Appeals & Grievances Improvement Team
- ICE Claims Standardization Team - Main
- ICE Contracting and Compliance Team
- ICE Contracting and Compliance Team Coded DOFR Workgroup
- ICE Contracting and Compliance Team Delegated Entity Audit Tool Workgroup
- ICE Contracting and Compliance Team IT System Integrity Workgroup
- ICE Credentialing Shared Audit Policy Team – Main / California
- ICE Credentialing Shared Audit Policy Team – Main / Mid-Atlantic
- ICE Credentialing Shared Audit Policy Team – Main / Northwest
- ICE Credentialing Shared Audit Policy Team – Main / Texas
- ICE Cultural & Linguistic (C&L) Services Team
- ICE DMHC Access Regulations Team/Workgroup
- ICE Encounters Standardization Team
- ICE Pharmacy Regulations Team – CA
- ICE Quality Improvement/Utilization Management (QI/UM) Team – Main
- ICE Risk Adjustment Data Acquisition & Reporting (RADAR) Team - Main
- ICE Service Determination Standardization Team
- ICE UM Required Reports Team

ICE Membership Report- April 2021

- Total ICE membership: 6,676
- New members added: 83
  - New members breakdown
    - States represented – AZ (1), CA (70), CO (1), IL (2), MI (1), MN (1), NC (1), NY (1), OR (1), TX (3), WA (1)
    - Organization types - health plans (21), providers/MSOs/hospitals (35), other (27)

ICE WEBSITE REPORT - APRIL 2021

- Total site visits: 39,698
- Total page views: 117,857
- Library documents added: 84
- Calendar updates: 1
- Broadcast messages sent: 28

ICE MEMBERSHIP REPORT – MAY 2021

- Total ICE membership: 6,772
- New members added: 96
  - New members breakdown
    - States represented – AZ (1), CA (87), GA (1), MN (1), NJ (1), TX (2)
    - Organization types - health plans (16), providers/MSOs/hospitals (55), other (25)

ICE WEBSITE REPORT – MAY 2021

- Total site visits: 34,487
- Total page views: 102,053
- Library documents added: 63
- Calendar updates: 1
- Broadcast messages sent: 22

ICE BOARD OF DIRECTORS REPORT

- The following was reported at the ICE Board of Directors meetings in April and May:
  - Website Enhancements – the 2021 enhancements are proceeding on schedule.
  - 2021 ICE Annual Conference – November 18 & 19 – input was reviewed from potential presenters and exhibitors around in-person vs. virtual participation and discussions are underway around the best format for the 2021 conference, including in-person only, virtual only or a hybrid model that would include both of those options.
  - Organizational Strategic Direction Discussion – as part of the strategic direction work that has been ongoing for the last year and a half, the ICE Board has decided to move forward with transitioning to more of a stand-alone organization that will begin to add some additional staff to help support ICE activities going forward. This will include an associated rebranding and new logo, which is expected to be rolled out soon.

ICE AGENCY & ASSOCIATION RELATIONS REPORT

- Mike Myers, the ICE Director of Agency Relations, had the following to report in in April and May:
  - Association Alignment – monthly meetings are ongoing between ICE and the California Association of Health Plans (CAHP), as well as America's Physician Groups (APG). These discussions have been very beneficial on all sides and provide an opportunity to better align on collaborative work efforts for the industry, such as CalAIM and SB 855 related to the mental health training requirements.
  - Agency Partners – a meeting was held with Mary Watanabe and Amanda Levy at the Department of Managed Healthcare to discuss the letter that APG and CAHP co-authored to the DMHC to jointly suggest that the Department consider establishing periodic meetings/briefings with ICE to review the important work being done to help health plans and providers improve the health care system. The DMHC was very happy to hear that there will be better alignment between ICE and the associations, which will help streamline her communications and enable the DMHC to be more effective in direction. ICE was notified that Ann Duarte from CMS Region IX, a long-time supporter of ICE activities, has taken an early retirement. In the interim, the CMS Region X Administrator, Brenda Suiter, will be stepping in until a replacement is found.

- Health Net/Centene Medi-Cal Encounter Data Project – meetings continue with IHA to finalize the role of ICE in working with them as a sub-delegate related to the data standardization piece of this important industry initiative.

The Following ICE Teams Had Updates/Activities to Report:

ICE Appeals & Grievances (A&G) Improvement Team

- The ICE Appeals & Grievances Improvement Team Co-Leads had the following updates/activities to report:
  - Based on requested topics from the team, the co-leads discussed the topic of member grievances with allegations of discrimination and best practices in handling grievances with allegations of discrimination.
  - The co-leads discussed discrimination allegation related to sensitive services by providing guidance found in the Regulatory Sources APL 15-020 Health and Safety Code 1367.69.
  - There is still an open position for a third ICE A&G Improvement Team co-lead. The team co-leads encourage individuals interested in the position to reach out with questions to discuss the role responsibilities.

ICE Claims Standardization Team

- The ICE Claims Standardization Team Co-Leads had the following updates/activities to report from the April 2 and May 7, 2021 team meetings:
  - Merit-Based Incentive Payment System (MIPS) continues to be a topic of great discussion during each monthly meeting. Plans and delegates are looking for tools and training to assist in the process and details of handling MIPS adjustments. In April, Blue Shield shared sample calculations of different MIPS scenarios which were posted on the ICE website, and in May, Blue Shield presented a draft training tool developed by their organization. It was shared with the Claims Team first to determine if there was interest in bringing the document to ICE Leadership for approval of a formal training document for use by the industry. It was a very well-received training presentation and all agreed that this should be made available. Blue Shield is currently finalizing the document for presentation to ICE Leadership.
  - Each meeting includes discussions around proposed/new regulations or updates to existing regulations. AB 1162, which has not yet been approved, was presented to the team members. This proposed regulation would reduce timely turn-around times (TAT) to 20 days during federal emergencies such as the COVID pandemic. Applying interest is also proposed to change from 45 days to 20 days. Teams were advised to review and discuss this bill with their association and government affairs counterparts.
  - Team members continue to review ICE Claims Team documents that are set to archive to determine if they should be archived or reviewed and updated.
  - Workgroup Updates:
    - Misdirected Claims Workgroup – as reported at the last ICE Leadership meeting, the activities of this workgroup have been suspended as of April 2021.
    - Health Plan Workgroup – currently, this group is discussing the following topics: timely filing question regarding DMRs; updating the ICE health plan reporting address document; reviewing the CMS memo that defines a PDR different from an appeal in certain situations that seem new to the industry, i.e., down-coded claims or line items.
    - Audit Tool Workgroup – updates are being made to incorporate all audit tools into one complete Audit Tool Template. This included adding CMS PDR and Commercial PDR audit tools to the new template. There is discussion of also adding a DMR audit tool to the template, as well as possibly adding sequestration and MIPS to the tools. The Medi-Cal workgroup will assist with the Medi-Cal portion of the template. The workgroup is also making changes to certain audit criteria that are deemed as no longer necessary fields, i.e., the “Billed Date” field. A Revisions tab will be included in the document so all changes can be tracked.

- Medi-Cal Workgroup – workgroup members continue to review and update APLs and share them with the larger Claims Standardization team, and they are also assisting the Audit Tool workgroup in updating the Medi-Cal sections.
- Reopenings Workgroup – the workgroup continues to address defining for the grid what is truly considered a reopening in preparation for developing a training document once all of the materials have been put together. The workgroup continues to encourage more participation and is developing a tool to assist with understanding Reopenings that will include examples as well.

➢ Clarification Request Log 228: ICE Leadership has been discussing this issue with APG, who will be assisting ICE with escalating it with new leadership at DHCS. A meeting has been scheduled with APG, CAHP and ICE on June 22, 2021, to further discuss this issue.

ICE CONTRACTING & COMPLIANCE (C&C) TEAM

- The ICE Contracting & Compliance Team Co-Leads had the following updates/activities to report:

➢ FTE Attestation 2021:

- Currently discussing when the process should start – team members want to start sooner, such as September or October, versus November.

➢ ICE Universe Audit Tool Workgroup:

- This volunteer effort will coordinate and automate the ODAG Universe Tool that will allow participating FTEs and sponsors/health plans to populate CMS universes for Program Audits.
- CMS released the new protocols last week, so this group will start to discuss next steps soon.

➢ ICE Contracting & Compliance (C&C) Team IT System Integrity Workgroup:

- Octavio Campos from Identity MSO has resigned as co-lead. The workgroup is seeking a new delegate co-lead.
- 50-plus audits have been scheduled as of May 31, 2021.
- Updated policy/business rules posted.
- Enhancements that are live include the following and are ready to test:
  - Auditor and Scheduling Team can upload material
  - Check-off box of no PHI loaded by uploader prior to submission of audit evidence
  - Scheduling Team has a comments box
  - Affiliated plan contacts display
  - Submission confirmation check-off box as attestation
  - Administrative enhancements
  - Ability to add third health plan auditor
  - Link to blank audit form for reference
- Working towards single CAP process and quarterly monitoring

➢ ICE Contracting & Compliance (C&C) Team Delegated Entity Audit Workgroup (Compliance Program):

- The Policy Team submitted enhancements to transition the FTE Attestation (random) Audit to a Compliance Program Effectiveness Shared Annual Audit (all LOBs)
  - Enhancements included revised audit questions/tool
  - Enhancements included functional updates – such as a single CAP, etc. similar to IT audit tool enhancements
- Policy Team is working on evidence grid, policies/business rules and other material.
- Policy Team will be starting end-to-end testing.
- Policy Team sent an email blast to request affiliations between Plans and Delegates.
- Due to revisions and work being done on enhancements, the restart of the workgroup has been delayed until July.
- The workgroup is seeking a delegate co-lead.

- Coded DOFR Workgroup:
  - The workgroup continues to meet weekly to make suggested placements for new CPT codes with the goal of releasing an updated ICE Coded DOFR in July of 2021.

ICE CREDENTIALING SHARED AUDIT POLICY TEAM – MAIN / CALIFORNIA

- The ICE Credentialing Shared Audit Policy Team – Main / California (CA) Co-Leads had the following updates/activities to report:
  - April/May 2021 Audit Usage Statistics
    - Posted Audits: 48
    - Used Audits: 207
  - Approximate Total Cost Savings:
    - Group: $ 168,912
    - Health Plan: $ 517,500
  - Average TAT: 13 days (Goal 15)

- Policy Team Updates/Activities (meeting time the 3rd Thursday of each month)
  - Distributed ICE Newsletter for POs and Health Plans
  - Continued to address NCQA clarifications around standards and COVID-19
  - Continued discussions regarding COVID-19 Contingency Plans for site visits
  - Continue to educate and reply to multiple FAQs that are submitted

- Workgroup Updates/Activities (meeting time the 1st Tuesday of each month/combined meeting with Scheduling and Clarification Work Groups)
  - Scheduling Workgroup:
    - Scheduled Audits through December 2021
    - Discussed Audits that were pushed out due to COVID-19
    - Conducted and review IRR audits
    - Discussed appropriate documentation and notification of changes in audits due to COVID-19
    - Continue to maintain average TAT of less than 15 days.
    - Continue to update PO information sheet monthly.
    - Continue to discuss all MSO changes and focus groups as applicable.
    - Discuss group issues, MSO changes, group name changes, etc. as needed.
    - Continue to communicate with new accredited/unaccredited health plans who wish to participate with the ICE team for audit usage.
    - Continue to train new members on how to utilize the iCAN system for entering audit dates, LOBs, Uploading Audit results and Pre-Posting Letters, etc. as needed.
    - Continue to conduct inter-rater reviews to ensure health plan's compliance with ICE.
  - Clarification Team Workgroup:
    - Discussed COVID-19 auditing issues and appropriate documentation
    - Updated roster with new participants to Team
    - Continue to discuss issues and changes to auditing process

ICE CREDENTIALING SHARED AUDIT POLICY TEAM – MAIN / MID-ATLANTIC

- The ICE Credentialing Shared Audit Policy Team – Main / Mid Atlantic (MA) Co-Leads had the following updates/activities to report:
  - April/May 2021 Audit Usage Statistics
    - Posted Audits: 8
    - Used Audits: 25
  - Approximate Total Cost Savings:
    - Group: $ 20,400
    - Health Plan: $ 62,500
  - Average TAT: 9 (Goal 15)
  - Policy Team updates/activities:
    - Updated team on HICE name change
    - Discussed CAQH Proview
    - Reminder on how to submit PPL

- Clarification-Scheduling updates/activities
  - Discussed additional provider groups
  - Audits scheduled for remainder of the year

ICE CREDENTIALING SHARED AUDIT POLICY TEAM – MAIN / NORTHWEST

- The ICE Credentialing Shared Audit Policy Team – Main / Northwest (NW) Co-Leads had the following updates/activities to report:
  - April/May 2021 Audit Usage Statistics
    - Posted Audits: 5
    - Used Audits: 26
  - Approximate Total Cost Savings:
    - Group: $ 21,216
    - Health Plan: $ 65,000
  - Average TAT: 4 (Goal 15)

  - Policy Team updates/activities (meeting time the 3rd Wednesday of every other month):
    - Released 2021 ICE Credentialing Training and Audit Tools
    - Continued to address NCQA clarifications around standards and COVID-19
    - Continue to educate and reply to multiple FAQs that are submitted

  - Clarification-Scheduling updates/activities (meeting time the 4th Thursday of each month/combined meeting with Scheduling and Clarification workgroups):

    - Scheduling Workgroup:
      - Scheduled Audits through December 2021
      - Discussed appropriate documentation and notification of changes in audits due to COVID-19
      - Continue to maintain average TAT of less than 15 days.
      - Continue to update PO information sheet monthly.
      - Discuss group issues, MSO changes, group name changes, etc. as needed.
      - Continue to communicate with new accredited/unaccredited health plans who wish to participate with the ICE team for audit usage.
      - Continue to train new members on how to utilize the iCAN system for entering audit dates, LOBs, Uploading Audit results and Pre-Posting Letters, etc. as needed.

    - Clarification Team Workgroup:
      - Discussed COVID-19 auditing issues and appropriate documentation
      - Updated roster with new participants to Team
      - Continue to discuss issues and changes to auditing process

ICE CREDENTIALING SHARED AUDIT POLICY TEAM – MAIN / TEXAS

- The ICE Credentialing Shared Audit Policy Team – Main / Texas (TX) Co-Leads had the following updates/activities to report:
  - April/May 2021 Audit Usage Statistics
    - Posted Audits: 8
    - Used Audits: 16
  - Approximate Total Cost Savings:
    - Group: $ 13,056
    - Health Plan: $ 40,000
  - Average TAT: 10 (Goal 15)

  - Policy Team updates/activities:
    - Updated team on HICE name change
    - Continued discussion on additional HP participation
    - Discussed CAQH Proview
    - Reminder on how to submit PPL

  - Clarification-Scheduling updates/activities
    - Interrater scheduled
    - Audits scheduled for remainder of the year

ICE Encounters Standardization Team

- The ICE Encounters Standardization Team Co-Leads had the following updates/activities to report:
    - This team is working on the claim adjustment reason denial codes and determining which denial reasons should be sent to the health plan as an encounter.

ICE Pharmacy Regulations Team – CA

- The Pharmacy Regulations Team – CA Team Co-Leads had the following updates/activities to report:
    - This team now meets quarterly and the February and May meetings were cancelled. The next meeting is scheduled for August 18, 2021.
    - Dang Huynh from Santa Clara Family Health Plan has joined Amit Khurana from Aetna as the new co-lead for this team.

ICE Quality Improvement/Utilization Management (QI/UM) Team – Main

- The QI/UM Team - Main Lead had the following updates/activities to report:
    - A workgroup has been formed to collaboratively discuss developing a centralized location on the ICE website for the listing of SB 855 training programs developed by non-profit clinical specialty associations that fulfill the requirements of CA SB 855, the Health Coverage Mental Health or Substance Use Disorders Law. A meeting was held with the regulators to determine if this approach is acceptable, with a response pending.

Risk Adjustment Data Acquisition & Reporting (RADAR) Team – Main

- The ICE RADAR Team Lead had the following updates/activities to report:
    - Discussion about RADV audits. Group reports they are still seeing RADV audits come in; no new information to report.
    - Discussion of best practices for chart chases for chart audits, including how provider organizations and health plans are working together to improve the burden this puts on practices. Will continue discussion.
    - Discussion about best practices for deleting unsupported HCC diagnosis codes and how to ensure deleting a diagnosis for one date of service does not remove the HCC from the patient's CMS risk profile if it was billed on other dates of service and supported. Will continue discussion.

ICE Service Determination Standardization Team

- The ICE Service Determination Standardization Team Co-Leads had the following updates/activities to report:
    - The team co-leads are currently working on developing a training module to assist delegates with appropriately completing the Commercial Service Denial Notice (CSDN).

ICE UM Required Reports Team

- The ICE UM Required Reports Team typically meets from July to November.

HEALTH AFFAIRS BLOG

RELATED TOPICS:
COVID-19 | MEDICARE SAVINGS PROGRAMS | MEDICAID | PAYMENT | ORGANIZATION OF CARE | MEDICARE ELIGIBILITY | DUAL ELIGIBILITY | SOCIAL DETERMINANTS OF HEALTH

COVID-19 Shows Now Is The Time To Integrate Care For Dual-Eligible Beneficiaries

Michael O. Leavitt

FEBRUARY 17, 2021 10.1377/hblog20210211.45136

As the number of COVID-19 cases surge, Congress must

Related

CONTENT

COVID-19

TOPICS

COVID-19

Medicare Savings Programs

Medicaid

Payment

Organization Of Care

Medicare Eligibility

Dual Eligibility

Social Determinants Of Health

Cite As

"COVID-19 Shows Now Is

examine how federal policies need recalibrating to respond to lessons from the pandemic. COVID-19's disproportionate impact on the more than 12 million Americans who are enrolled in both Medicare and Medicaid is one such issue.

Dually eligible individuals, often referred to as "duals," have been severely affected by the virus. Duals, who are usually both elderly and low income, are three times more likely than Medicare-only beneficiaries to report poor health, and many of the health conditions duals have put them at higher risk for COVID-19. According to data released by the Centers for Medicare and Medicaid Services (CMS), duals were more than three times as likely to be hospitalized due to COVID-19 than Medicare-only beneficiaries.

Especially concerning are the inequities and disparities facing duals' care. CMS data show that Black duals were more than twice as likely to be hospitalized due to COVID-19 as White duals (note 1). And as the pandemic rages, duals also face inequities in the social determinants of health, as one analysis of a cohort of duals found.

Many governors and policy makers in Congress have expressed to me in recent years their interest in improving duals' health outcomes. Yet, a core problem is that Medicare and Medicaid were simply not designed to work together to serve duals. The payment and the incentives for care are not aligned to incentivize a single organization to keep quality high, costs low, and outcomes strong.

As a result, the delivery of care is fragmented as duals are left navigating multiple sets of program rules and can face worse outcomes.

Toward Integration

The Time To Integrate Care For Dual-Eligible Beneficiaries, " Health Affairs Blog, February 17, 2021.
DOI: 10.1377/hblog20210211.45136

Over the past decade, through duals demonstrations and legislative requirements for greater plan integration, Congress and CMS have taken some steps to better integrate care for duals. This progress is welcome, but compared to the need, much remains to be done.

Last year, just one in ten full-benefit duals was enrolled in an integrated program. Even then, such approaches are simply work-arounds for the conflicting program structures of Medicare and Medicaid. What is needed now is not another step toward integration but a quantum leap to fully integrate care at the program and payment level. Fortunately, federal policy makers are increasingly recognizing both the need and opportunity for fully integrating care for duals.

In recent months, leaders of the Medicaid and CHIP Payment and Access Commission discussed potential approaches to reimagine current structures in a way that fully integrates care for duals. Among the approaches discussed was a proposal developed by the Dual Eligible Coalition, composed of beneficiary advocates, health care providers, and health plan representatives, and informed by state advisers.

A Single Integrated Financing Stream And Shared Savings Model

The alliance has worked over the past several years to listen to state leaders, consult with actuaries, and engage with dozens of national experts. The result is a comprehensive new proposal that allows states the option of fully integrating Medicaid and Medicare financing and services to deliver a comprehensive benefit package that meets duals' medical, long-term care, behavioral, and social needs.

Operating under strong CMS oversight, states would contract with at-risk providers or health plans to deliver

fully integrated benefits to duals. States opting into this program would leverage relationships with providers, plans, and community-based organizations to drive accountability at the local level and ensure the totality of a dual's medical and non-medical needs are met.

A single integrated financing stream and shared savings model encourages efficiencies through care management, aligned incentives, and value-based payment arrangements, but also requires states to reinvest a portion of savings into ongoing efforts to support duals. Such efforts could include interventions targeting challenges that disproportionately impact duals —such as the social determinants of health, mental illness, and chronic disease.

To be accountable to duals and stakeholders, our proposal includes requirements for strong consumer protections, robust reporting, continual oversight, and ongoing quality improvement. In many ways, the proposal leverages the best of state delivery system experience and federal oversight. Having served as both a governor and a Department of Health and Human Services secretary, I recognize the importance of both dynamics.

The Coalition is now in talks with Congress about the details of the proposal. As policy makers continue to work on legislation addressing the fallout of the COVID-19 pandemic, enacting changes to further integrate duals care remains a needed area of focus. For duals served by Medicare and Medicaid, fully integrating care is an opportunity to better serve more than 12 million of our fellow Americans. The time to seize that opportunity is now.

Author's Note

The author founded Leavitt Partners, which manages the Dual Eligible Coalition on behalf of its members. Governor Leavitt is not involved in the day-to-day

operation of the Coalition.

Note 1

Per slide 10 in the CMS data snapshot, 2,037 Black duals were hospitalized per 100,000 beneficiaries, compared to 1,022 for White dual beneficiaries. (Slide 9 has data by ethnicity, but it's not clear if it's for Medicare-only status so it was not used.)

7500 Old Georgetown Road,
Suite 600
Bethesda, Maryland 20814
T 301 656 7401
F 301 654 2845
customerservice@healthaffairs.org

TOPICS
Access & Use
Costs & Spending
COVID-19
Health Equity
Health Reform
Leading To Health
More Topics

CONTENT
Journal
Blog
Briefs
Events
Podcasts
Collected Works

INFORMATION FOR
Authors
Request For Abstracts
Reviewers
Subscribers
Advertisers
Media News Room
Funders
Event Attendees

SERVICES & RESOURCES
Submit Content
Subscribe/Renew
Manage My Account
Purchase Content Permissions
Alerts
Newsletter Sign Up
Advertising Kit

HEALTH AFFAIRS
About
Terms & Conditions
Privacy Policy
Jobs At Health Affairs
Contact Us

Terms and conditions | Privacy | Project HOPE

Health Affairs is pleased to offer Free Access for low-income countries. Health Affairs gratefully acknowledges the support of many funders.

Project HOPE is a global health and humanitarian relief organization that places power in the hands of local health care workers to save lives across the globe. Project HOPE has published Health Affairs since 1981.

LEAVITT PARTNERS

The Dual Eligible Coalition *(2021)*

The Opportunity to Improve Care

There are more than 12 million dual eligible beneficiaries enrolled in both Medicare and Medicaid. This is a diverse population that includes people with multiple chronic conditions, physical disabilities, mental illness, cognitive impairments such as dementia, and intellectual and developmental disabilities.

Both MedPAC and MACPAC have noted that concerns have been raised as to how the existence of separate funding streams creates barriers to coordination of care and the extent to which lack of coordination increases costs and leads to poor health outcomes. Numerous researchers, health policy experts, states, and stakeholders have expressed interest in seeing more aligned incentives and integrated care to improve health outcomes and quality of care for dual eligible beneficiaries.

About the Dual Eligible Coalition

The Dual Eligible Coalition is a group of multi-sector stakeholders including beneficiary advocates, managed care plans, provider systems, state advisors, and behavioral health and social support service organizations. The Coalition was founded to develop actionable, long-term policy and programmatic solutions to improve the delivery of care and outcomes for the dual eligible population. Public sector advisors include state advisors from Massachusetts, Tennessee, and Washington state.

The Coalition's Work

The Coalition has been at work since 2017 to assess the challenges and opportunities facing the dual eligible population and the stakeholders who work with and serve them. The Coalition has developed a framework for fully integrating Medicare and Medicaid into a single program addressing medical, long-term care, behavioral, and social needs. In conducting its work, the Coalition seeks to promote a set of principles around integration and whole-person care, including the following:

- Supporting Beneficiaries to Live as Fully as Possible
- Ensuring Comprehensive Integration
- Promoting State-Federal Partnership
- Ensuring Robust Reporting, Accountability, and Continuous Quality Improvement
- Aligning Incentives for Value-Based Care
- Promoting Consumer Engagement

The Coalition's framework was developed through Coalition member input and expertise, as well as a structured stakeholder outreach process in which Leavitt Partners facilitated more than 40 individual conversations with a wide array of diverse stakeholders across the health care community, including with policy experts, providers, advocates, associations, and foundations.

Current Policy Efforts to Integrate Care

In developing its policy framework, the Coalition was informed by current efforts underway to integrate care for the dual eligible population. Integrated care models are designed to align the delivery, payment, and administration of Medicare and Medicaid services to improve care for dual eligible beneficiaries and reduce spending. There are currently three primary models for integrating Medicare and Medicaid services, with some states using more than one:

- Medicare Advantage (MA) dual eligible special needs plans (D-SNPs) or fully integrated dual eligible special needs plans (FIDE-SNPs) that are aligned with Medicaid managed long-term services and supports (MLTSS) programs;
- the Financial Alignment Initiative (FAI)[1]; and,
- the Program of All-Inclusive Care for the Elderly (PACE).

The Coalition's framework builds on the learnings of current efforts and advances the goal of truly integrating care for dual eligible beneficiaries by creating a new program which states could adopt that eliminates the need to navigate both Titles 18 and 19 of the Social Security Act (SSA). The Coalition proposes the new program be created under new title of the SSA, effectuated as "Title 22" – an approach which highlights the true integration of the best of elements of both Titles 18 and 19.

The Need for Further Integration

The Bipartisan Budget Act of 2018 (BBA18) permanently extended operating authority for MA SNPs and added new integration requirements for Medicaid and SNPs. While many of the BBA18 policies will result in better integrated care for dual eligible beneficiaries, there still remains a level of fragmentation.

Building on the steps BBA18 to improve integrated care for the dual eligible population, Congress could further work to align incentives, integrate care, and improve efficiencies. For example, even with the requirements in BBA18, the following areas of fragmentation still exist:

Fragmented Beneficiary Experience

- Current Fragmentation: Today, the majority of dual eligible beneficiaries find themselves in fee-for-service or in managed care plans that are not integrated. As a result, they have multiple ID cards; separate provider networks and directories; uncoordinated notices from the state, the Centers for Medicare and Medicaid Services (CMS), and perhaps a health plan; as well as confusing coverage policies in areas of overlap (e.g., home health, durable medical equipment, supplemental benefits, etc.).
- Further Integration Under Title 22: Under Title 22, beneficiaries would be receiving services from a fully integrated program that no longer has to navigate two separate programs with conflicting and/or confusing policies and requirements. This new program would give many beneficiaries greater peace of mind and confidence in accessing care.

[1] The Financial Alignment Initiative is designed to provide individuals dually enrolled for Medicare and Medicaid with a better care experience and to better align the financial incentives of the Medicare and Medicaid programs. Through the Initiative, CMS partners with states to test two new models for their effectiveness in accomplishing these goals. This initiative is possible through the collaboration of the CMS Innovation Center and the CMS Medicare-Medicaid Coordination Office. https://innovation.cms.gov/initiatives/Financial-Alignment/.

Limited State Incentives

- Current Fragmentation: States have limited incentives to develop more highly integrated D–SNPs because they do not benefit financially from any Medicare savings that those plans might generate.
- Further Integration Under Title 22: Under Title 22, states would have an opportunity to share in savings generated through the operation of a fully integrated program by virtue of the blended state and federal financing.

Two Contracts

- Current Fragmentation: A D-SNP has one contract with CMS and one with the state (and the state contract with the state may or may not include long term services and supports (LTSS) or behavioral health).
- Further Integration Under Title 22: Under Title 22, there would be one contract between the new program administering entities and the state to cover both Medicaid and Medicare. The state and CMS would have a separate agreement outlining the federal requirements that dictate state participation and federal oversight.

Siloed Funding

- Current Fragmentation: The Medicare D-SNP bid and the Medicaid managed care rate are still developed in isolation of each other, which can result in cost-shifting between the two, duplication of services and benefits, and few or no value-based incentives around quality, total cost of care, and beneficiary experience.
- Further Integration Under Title 22: Under Title 22, there would be one rate taking into account all services, eliminating duplication of services, aligning incentives for rebalancing, and recognizing efficiencies from integrated care delivery.

Separate Marketing Materials

- Current Fragmentation: Dual eligible beneficiaries will still get all of the D-SNP notices along with whatever notices the state uses for Medicaid. While there is an effort for more coordination on Plan Annual Notice of Change and Explanation of Coverage documents, they are still "Medicare" and "Medicaid" notices and these practices create confusion for beneficiaries, providers, and plans.
- Further Integration Under Title 22: Under Title 22, there would be one set of notices for all practices related to the program (e.g., enrollment, marketing, grievances and appeals, etc.).

Separate Enrollment

- Current Fragmentation: BBA18 did not tackle aligning the *actual* enrollment processes and making it easier for beneficiaries to get the services which they are entitled to receive. While CMS can do some of this administratively, it is only happening in certain limited instances.
- Further Integration Under Title 22: Under Title 22, beneficiaries would be enrolled into one program, eliminating the need to coordinate and align enrollment processes that prove challenging today.

The Coalition's Vision for Integrated Care

The Coalition's goal is federal legislation which would create a new integrated program for full benefit dual eligible beneficiaries – overseen by CMS and administered by states – that folds together current Medicare and Medicaid authorities and funding, into a new "Title 22" of the Social Security Act.

PROGRAM ADMINISTRATION

- The Secretary, acting through the Federal Coordinated Health Care Office established under Section 2602 of Public Law 111-148, shall oversee the Title 22 program.
- States shall be given the option to select to participate in Title 22, and states that choose to do so shall undergo and pass a rigorous federal readiness review as a condition of launch. (This program is not federally mandated, so some states may choose not to participate.)
- Title 22 will be operated under a minimum set of federal standards, including access to care, quality of care, beneficiary protections, marketing and enrollment, grievances and appeals, and procurement, among others. There will be strong federal oversight of Title 22 in partnership with the state. The oversight structure will build on the institutional learnings from the FAI contract management teams.
- Enhanced funding will be available to states for a period of time to assist with the staff, IT, planning and evaluation, and launch of this option.
- Title 22 will be delivered at the state level through capitated managed care plans or at-risk/value-based alternative fully-integrated delivery systems, as requested by a state and approved by the Secretary. PACE will continue to be an option within the state, at the discretion of the state.

ELIGIBILITY

- The eligible population is "full benefit" duals (i.e., anyone with a full Medicaid benefit) aged 21 and over. Individuals would not be required to have both Medicare Parts A and B.
- States will not be permitted to carve eligible populations out of Title 22. The Secretary will have discretion to allow states to phase in new populations over a defined time frame (e.g., IDD population).
- There will be a standard floor for income and asset levels. A state would have the option to go above the floor in income, assets or disregards, including allowing buy-in and/or spenddown.
- There will be a maintenance of effort for existing eligibility levels (e.g., income and asset) for dual eligible beneficiaries.

BENEFITS

- Title 22 funding shall be available to cover a core benefit package that addresses medical, behavioral, long-term care, and social needs. The core package will include:
    - (a) all Medicare A, B and D services;
    - (b) all Medicaid mandatory services; and
    - (c) additional behavioral health, social and supportive services provided "in lieu of" that enable flexibility to achieve person-centered outcomes in the most cost-effective settings.
- There will be a maintenance of effort for participating states to maintain existing benefit levels for dual eligible beneficiaries.

- There shall be no benefit or services carve-outs in Title 22, unless determined essential by the Secretary for a state to take such option. In such a case, the Secretary may make an exception for limited period of time.

ENROLLMENT AND BENEFICIARY PROTECTIONS

- Each Title 22 state will be required to contract with an independent enrollment broker to assist beneficiaries in understanding Title 22 and making enrollment choices.
- States will be permitted to utilize existing enrollment flexibilities that exist today (e.g., default enrollment).
- Each participating state will establish a dedicated Title 22 Ombudsman Program that will coordinate with current state and federal beneficiary protection services and provide three core services:
    - 1) individual assistance;
    - 2) systemic monitoring and reporting; and
    - 3) consumer education and empowerment.
- Each Title 22 administering entity will be required to have a Beneficiary Advisory Council.
- Each administering state and each administering entity in each administering state will establish a Consumer Advisory Board that will provide regular feedback to the administering state and the administering entity's governing board, respectively, on issues of beneficiary care.
- Continuity of care provisions shall apply for the first 6 months of an individual's enrollment in Title 22.

PROGRAM FINANCING

- This new Title 22 program will combine the Medicare expenditures (Parts A, B, and D), the federal share of Medicaid expenditures, and state share of Medicaid expenditures (including for Part D) into a single, integrated funding stream that would be sufficient to cover the cost of care for all individuals enrolled in the program. The funds will no longer be identified as Medicare or Medicaid; they will be Title 22 federal/state contributions.
- The Coalition evaluated several different financing models and has selected an expenditures-based model. This model acknowledges the need for up front investments in financing the program, as well as ongoing contributions from federal and state governments.
- The current statutory and regulatory authorities that govern appropriate source and use of federal and state dollars will generally continue to be applied to this program and there will be federal CMS oversight regarding the use of funds, which may include federal audits.

PROCUREMENT STANDARDS

- The Medicare-Medicaid Coordination Office (MMCO) will consult with states to develop a set of minimum procurement standards for administering states' selection of an entity within such state to administer the program within one year of the date of passage.
- Consistent with other requirements, the state must implement the program with a capitated managed care plan or other entities with two-sided risk.
- Selection criteria for the administering entity must take into account prior experience in serving the dual eligible population, and can include other criteria such as:
    - Quality measure performance and performance on key health outcomes;
    - Member satisfaction scores;

- Models of care (including models for social supports);
- Experience with supplemental benefits;
- Provider network adequacy and access to essential providers; and
- Experience with LTSS and behavioral health, including experience integrating medical, LTSS, and behavioral health.

OVERSIGHT RESPONSIBILITIES

- Administering states will be responsible for day-to-day oversight of the administering entity.
  - Oversight will include comprehensive readiness reviews, compliance monitoring, and review and approval of areas such as network adequacy, outreach materials, complaints and appeals procedures, utilization management functions, eligibility processes, and assessment tools.
  - Administering states will also be responsible for performance reviews, periodic audits, receiving and responding to complaints, enrollee surveys, and sanctions if appropriate.
- CMS will be responsible for oversight of the administering state.
  - Oversight includes monitoring selection of organizations to participate in the 22 program, conducting a readiness review of the state, ensuring the state maintains a dedicated Ombudsman program, and ensuring state oversight of administering entity compliance.
  - CMS will also coordinate review of eligibility and enrollment processes and procedures, monitor state data systems, ensure actuarial soundness of rates, conduct state audits, and apply any warranted disciplinary action.
- The administering state and CMS will also share a joint partnership role in oversight through Joint Contract Management Teams (CMTs) utilized in the FAI.
  - The CMT will be composed of one contract officer from CMS and at least one contract officer from the state.
  - CMT will serve as a liaison among the administering entity and CMS to facilitate communications and smooth operations.

Moving Forward

With more than 12 million dual eligible beneficiaries enrolled in both Medicare and Medicaid, the Coalition is committed to working collaboratively to legislatively advance its framework for fully integrating Medicare and Medicaid into a single program addressing medical, long-term care, behavioral, and social needs.

About Leavitt Partners

Leavitt Partners is a health care intelligence business. We help clients successfully navigate the evolving role of value in health care by informing, advising, and convening industry leaders on value market analytics, alternative payment models, federal strategies, insurance market insights, and alliances. Through our family of businesses, we provide investment support, data and analytics, member-based alliances, and direct services to clients to support decision-making strategies in the value economy.

LEAVITT PARTNERS

April 2021

Dual Eligible Coalition Financing

Overview

The overall goal of Title 22 is to consolidate care for full dual eligible beneficiaries within a new program expressly designed to address their situation and needs. Such beneficiaries have a much higher average cost for health care, have more chronic conditions and functional limitations and currently experience considerable fragmentation since they are receiving care from two separate programs.

In Title 22, financing care for individuals dually eligible for Medicare and Medicaid requires a combination of federal and state contributions. This new program will combine the Medicare expenditures (Parts A, B, and D), the federal share of Medicaid expenditures, and state share of Medicaid expenditures (including for Part D) into a single, integrated funding stream to cover the cost of care for all full dual eligible beneficiaries enrolled in the Program. The funds will no longer be identified as Title 18 (Medicare) or Title 19 (Medicaid); they will be Title 22 dual eligible funding.

In evaluating financing options, the Coalition considered six distinct approaches to financing before selecting this model. This paper outlines our financing model. The model envisions ongoing contributions from federal and state governments based on their respective percentage contribution in the base year, adjusted annually as described below. The model also proposes reinvesting program savings above a certain threshold back into the program.[1] The Coalition envisions this model will also include robust federal oversight to ensure, at a minimum, that all funds are spent in accordance with Title 22 requirements.

Baseline and Data Sources

The baseline is established on the federal fiscal year two years prior to the implementation of the program. The baseline will be adjusted for any material changes in the Program from one year to the next, as determined by the Secretary, and, if appropriate, an adjustment for year over year growth for the 2 years prior to the implementation of the program.

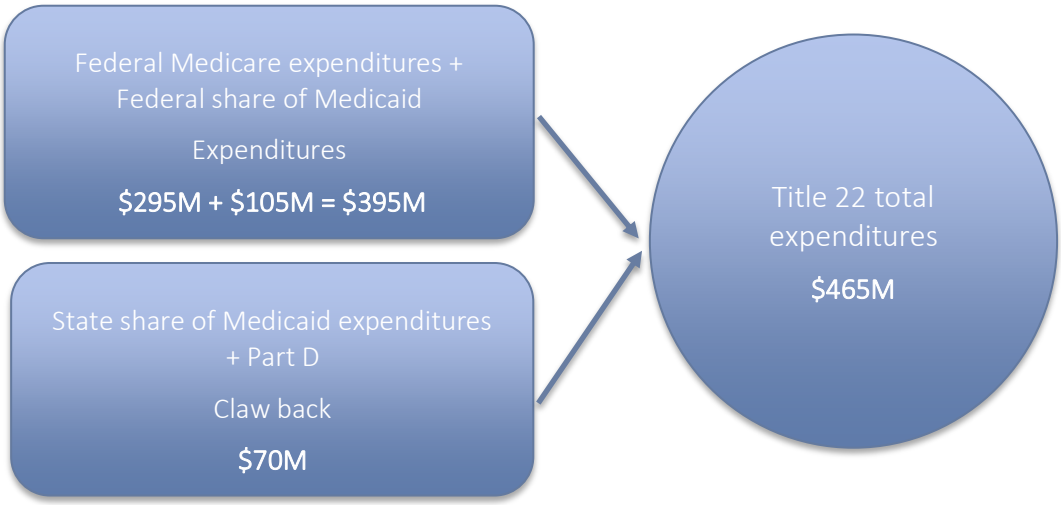
Data will be collected from the Medicare program for original Medicare, Medicare managed care (Part C and D-SNP plans) and Part D. For Medicaid, expenditures will be collected from fee for service (including case management and waiver services), managed care, and the Part D claw back.

Federal and State Contribution

Financing is a blend of a baseline of Medicare and Medicaid expenditures for dual eligible beneficiaries derived from a prior federal fiscal year period, weighted by each program's percentage of the baseline's

[1] The Coalition envisions a financing approach that enables "permanent" financing for the program, akin to how Medicare (vs. Medicaid) is currently financed. While most mandatory spending programs bypass the annual appropriations process and automatically receive funding each year according to either permanent or multi-year appropriations in the substantive law, Medicaid is funded in the annual appropriations acts. For this reason, Medicaid is referred to as an appropriated entitlement. Conversely, Medicare is never appropriated, and is considered an entitlement. (Medicaid is a federal entitlement to states, and in federal-budget parlance entitlement spending is categorized as mandatory spending, which is also referred to as direct spending.)

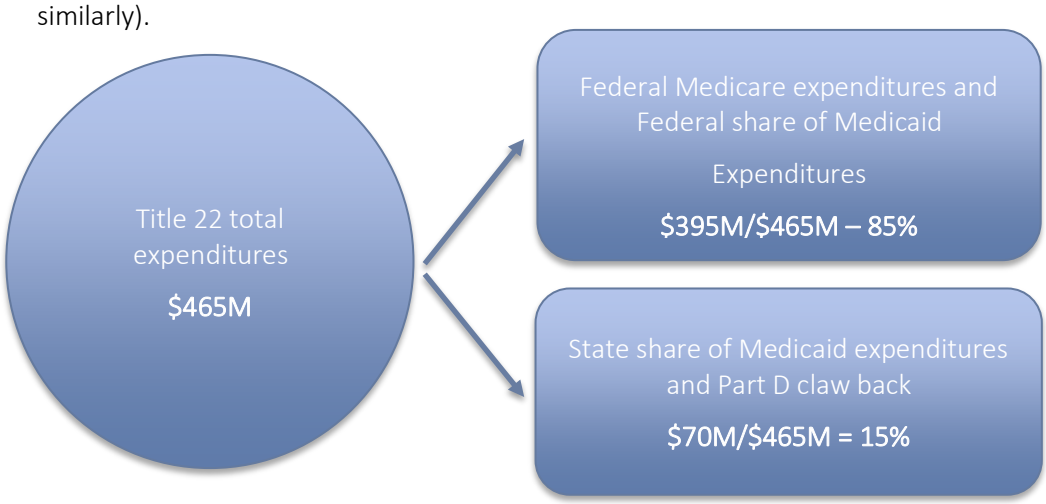
total expenditures. The federal and state contributions to dual eligible beneficiaries' expenditures are combined into one Title 22 total allocation, which would be directed to a participating state that assumes full risk for managing the program. The following example assumes a 60% FMAP.



The federal and state share of the expenditures would be determined as follows: in Year 1 and later, all costs for Title 22 are paid without limit as they are incurred by a combination of federal and state dollars and these costs would be allocated to the federal and state government based on their weighted contribution percentage.

The percentages for Year 1 would be set equal to base year percentages:

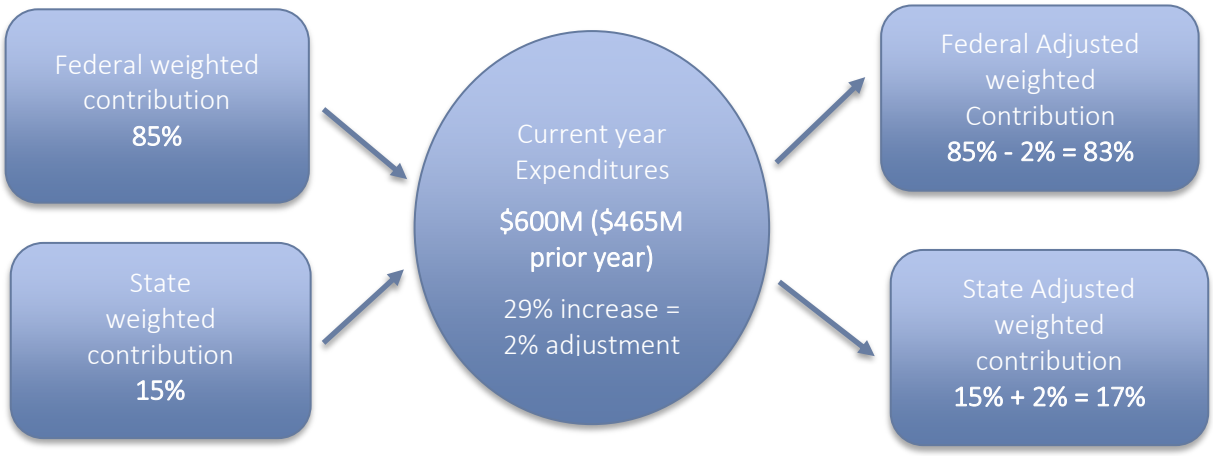
- The federal dollar amount includes all Medicare costs for full dual beneficiaries, plus the federal Medicaid matching payments for full dual beneficiaries;
- The state dollar amount includes all state Medicaid costs for dual beneficiaries (including long term care) and including the claw back payments to Part D; and
- The federal percentage would simply equal the federal dollar in the base year divided by the total federal and state dollar amounts in the base year (with the state percentage share determined similarly).



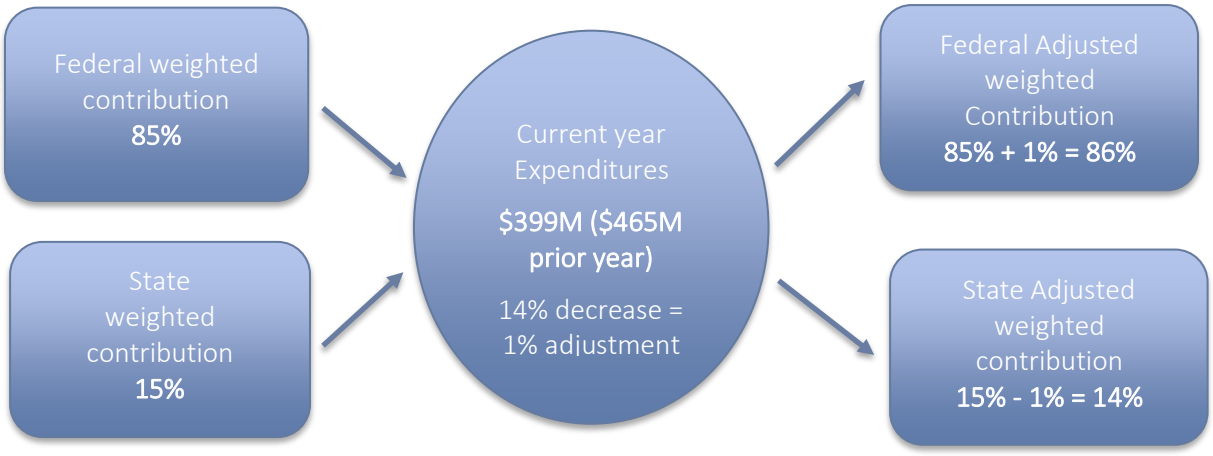
The weighted contribution percentage for each subsequent year would be calculated on the prior year expenditures. At the end of each year, the weighted contribution percentages are applied to the prior year expenditures to establish the weighted contribution for the following year.

An important part of designing a financing model is to ensure there are appropriate financing incentives to meet the goals of the program. With no further financing adjustments, other than those described above, there is no incentive for states to appropriately limit increases or decreases in expenditures. To provide the right incentives, increases or decreases in expenditures will be controlled by adjusting the federal/state weighted contribution percentages. If total expenditures increase above 10%, the federal contribution decreases 1% for every 10% increase, and the state contribution increases 1% for every 10% increase. If the total expenditures decrease below 10%, the federal contribution increases, and the state contribution decreases, in the same way.

Expenditure Increase above 10%



Expenditure Decrease above 10%



Updates and Adjustments

We propose three updates/adjustments to the financial calculation.

First, the Title 22 program funds are updated annually based on total expenditures; they are not specifically adjusted for clinical or demographic or geographic factors. As described above, adjustments will be made within spending thresholds to ensure increases and decreases in expenditures are appropriate.

Second, this model deems total expenditures below a predetermined threshold, to be considered "savings." To ensure some of the savings are used to improve the Program, there will be a requirement to reinvest some of those savings back into the Program if the expenditures decrease above 15%.

Third, there will be an exception process to account for expenditure increases and decreases above or below threshold that would not be subject to the adjustment in the weighted contribution percentages. Some examples of an exception would be:

- A significant increase in enrollment; or
- The declaration of a national emergency that impacts Title 22.

Savings Calculation and Distribution

A decrease in expenditures represents savings to the federal and state government and the benefit is realized by the federal and state government. However, annual expenditure decreases in excess of 15%, will be required to be reinvested into the Title 22 program.

We are also proposing guidelines for reinvesting savings. For example, the state will have the authority to use savings to promote the following core principles:

- Consumer Power and Choice – to provide consumers more information and control over their health care and community support options.
- Prevention and Wellness – striving to better enable consumers to receive individualized health care that is outcomes-oriented and focused on prevention, wellness, recovery and maintaining independence.
- Pay for Performance – to employ purchasing and payment methods that encourage and reward service quality and cost-effectiveness by linking reimbursements to common, evidence-based quality performance measures, including patient satisfaction.
- Innovative and Technological Advancements – making improvements that facilitate remaining in the community.
- Addressing Social Needs – increase integration with social needs that impact health outcomes.
- Hiring for State Personnel
- Capacity Building – such as community-based care; and caregiver assistance.

State Reporting and Payment

In lieu of creating a new reporting system, we propose to build on the current process used in the Medicaid Budget and Expenditures System (MBES). The state projects its quarterly expenditures, which determines the amount of federal money available for use by the state in that quarter. The state then draws down the money as it incurs expenditures during the quarter. The estimated expenditures and the incurred expenditures are reconciled at the end of each quarter. There is no annual reconciliation.

The state's estimated matchable expenditures (total computable and federal share) are reported by quarter for each federal fiscal year on the CMS-XX (Title 22 replacement for CMS-37). CMS must make federal funds available based upon the state's estimate, as approved by CMS.

Within thirty (30) days after the end of each quarter, the state would submit the Form CMS-XX (Title 22 replacement for the CMS-64) quarterly expenditure report, showing expenditures made in the quarter just ended. CMS must reconcile expenditures reported on the Form CMS-XX (64 replacement) with federal funding previously made available to the state, (Title 22 replacement for CMS-37) and include the reconciling adjustment in the finalization of the grant award to the state.

Federal Oversight

First, the current Medicaid statutory and regulatory authorities that govern appropriate sources of non-federal share ("state share") funding will apply to this program (i.e., pertaining to health care-related taxes, provider-related donations, intergovernmental transfers, and certified public expenditures).

Second, the quarterly budget and expenditure process described in the immediately preceding section includes a detailed federal review of the state's quarterly expenditures.

Third, the current Medicaid deferral and disallowance processes will also apply to this program and can be utilized during the federal review of the quarterly expenditures and beyond.

Fourth, there will be federal oversight regarding the use of funds, which may include federal audits by CMS or other federal agencies such as the Office of Inspector General and the Government Accountability Office.