RADAR on

# Medicare Advantage

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## PACE Is Poised for Expansion as COVID Highlights Home Needs

As Congressional lawmakers consider additional funding for home and community-based services (HCBS) in Medicaid and the pandemic underscores the importance of enhanced support for community-dwelling seniors, a small but growing segment of the Medicare market is experiencing a resurgence. Programs of All-Inclusive Care for the Elderly (PACE) are designed to support frail, elderly Americans who require a nursing home level of care by providing comprehensive medical care and social supports to help them remain at home, and sources tell AIS Health that PACE competition is heating up as more venture capital firms look to invest in PACE organizations and as multiple states expand their programs.

The PACE market has seen steady growth in recent years and currently serves about 51,000 participants in 30 states, up from 34,000 participants in 2015 (see infographic, p. 6), according to AIS's Directory of Health Plans. Serving roughly 6,300 lives, private equity-funded InnovAge is by far the largest PACE organization, while other organizations on average serve about 380 participants. The PACE market has grown from about 30 to 140 organizations over the last two decades, according to the National PACE Association (NPA), and will see 14 new plan IDs in 2022, according to Clear View Solutions, LLC.

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## Rewards and Incentives Rule Has Compliance, Stars Implications

Although it may have gone largely unnoticed by Medicare Advantage plans this year, a clarification regarding rewards and incentives (R&I) programs embedded in an 894-page final rule issued in January 2021 could have significant implications for plans' star ratings strategy in addition to posing compliance risks and added costs in 2022. Industry experts say now is the time for plans to get compliant with the provision, which goes into effect on Jan. 1, 2022, and to begin rethinking their R&I programs to incentivize healthy behavior across the broader MA population and not just those members who are falling behind in their star measures.

An R&I program is offered by an MA plan to qualifying individuals to voluntarily participate in specified "health-related" activities in exchange for reward items. Such items can include points or tokens used to acquire tangible items or a gift card for a specific retailer but may not be offered in the form of cash, cash equivalents (e.g., VISA gift card), other monetary rebates (e.g., reduced cost sharing, premium rebates), or — as the 2022 MA and Part D final rule clarified — an Amazon gift card. That rule also for the first time formally defined "qualifying individual" to include: (1) "any plan enrollee who would qualify for coverage of the benefit" if related to a "plan-covered health benefit," and (2) "any plan enrollee" if related to a "non-plan-covered health benefit."

Prior communication from CMS has stated that rewards must be offered uniformly and without discrimination to all enrollees who qualify for the incentivized

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service, but plans' approach to R&I programs has historically been "pretty HEDIS-centric," explains Melissa Newton Smith, executive vice president, consulting and professional services with Healthmine. In other words, plans typically relied on HEDIS denominator and/or numerator status to target R&I participants and improve related star measures, but that practice would now be considered discriminatory.

This is CMS's way of clarifying and creating "a more level playing field for the consumers," weighs in Cary Badger, principal with HealthScape Advisors LLC. "The original intent [of R&I programs] was to reach the members who otherwise don't engage in these activities, so they were trying to do more targeted outreach. And from a population health basis, that's typically how it's done. It's just that there's an equality rule that CMS needs to be observant of when they apply these rules that they really didn't stress in the early days" of R&I programs.

Providing an example of a plan-covered benefit, CMS explained that rewards tied to breast cancer screening must be available to all members for whom a mammogram is covered as a plan benefit, such as men for whom mammograms are medically necessary and female members with advanced illness for whom the screening is covered.

Additionally, the rule clarified that disputes regarding R&I in MA are grievances, which must be handled in compliance with Section 30 of the Medicare Managed Care Manual, and it formalized that noncompliance with CMS R&I program requirements may result in sanctions.

"Until the current time, CMS has never issued notices of noncompliance, sanctions, [etc.] based on any plan's operation of R&I programs, so plans have indeed been very creative in their administration of these programs because they never felt like it was in the CMS regulatory cross hairs until this rule came out," remarks Smith. And plans have historically focused their R&I programs on a narrow group of activities related to stars because (a) they have competing priorities and (b) "it's a lot easier to justify transactions that drive immediate star needs and to get those programs approved internally than it is to justify programs where the rewards and incentives have long-term payback on medical spend over a multi-year period."

HealthScape expects that plans will ultimately take a more global approach to their R&I programs and refocus on activities such as the initial wellness visit, where multiple screenings that could impact star measures could be conducted, suggests Badger. "We think clients still will want to do incentives because it's important for the beneficiaries and another way of engaging the member," he says.

### Plans Are Likely to Rethink R&I Programs

"Members have become used to the incentives, so whenever you remove things, members don't like to perceive that things are being taken away," adds Alexis Seeder Levy, managing director with HealthScape. "So I don't think you're going to see incentives go away; I think they're just going to be deployed differently in the future to have incentives that are going to cover multiple things as opposed to an incentive around a specific activity related to a measure."

Those changes are likely to take effect for the 2023 plan year, given that bids are due in June and it will take plans some time to work with vendors to redesign their R&I programs. In the meantime, plans will have to be compliant and extend the rewards to anyone who can receive the related benefit, which could create some added cost in 2022, suggests Badger.

Based on her conversations with colleagues and Healthmine's star ratings stakeholder groups, Smith has learned that many plans aren't even aware of the changes taking effect on Jan. 1 and

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that most plans are still trying to figure out how to operationalize the program changes necessary to be compliant. "Not all of the vendors in this space offer easy turnkey solutions that automatically comply with these new regs, so a lot of plans are wondering if they have to change vendors to achieve compliance, or do they have to build different, internal analytics or add a new analytics function to their programs operations?" she tells AIS Health.

For those plans that are just getting wind of the change, Smith makes the following recommendations:

✦ ***Immediately alert your compliance and/or legal department*** to look at the language in the rule, determine how it impacts your practices and develop a compliant approach;

✦ ***Consider all "edge conditions" to avoid discriminatory behavior*** *(e.g.,* conditions of age, health status, gender or continuous enrollment), and determine what kind of reworked R&I program you can afford that meets the expanded eligibility criteria; and

✦ ***Think outside the box.*** Plans might consider incentivizing more behaviors in that category of non-covered benefits, she suggests. These could include "lifestyle activities" such as exercising, volunteering, eating healthy or attending a community service event. "Those are the things we want members to do to be healthy, but most plans have not offered it because it was too indirectly linked to stars," observes Smith.

"The star measures have changed so much that there aren't many directly measured stars activities that can be rewarded and incentivized using HEDIS measures criteria," she adds. "So my recommendation is to really get creative and incentivize good, healthy behavior that reflects your plan's passion and unleashes health and wellness activity to truly drive holistic health and wellness. Think bigger, not smaller, about how to take on this regulatory change."

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## Ahead of 2023 Rate Setting, BMA Issues End-of-Year Wish List

As CMS gets ready to set Medicare Advantage rates for the 2023 calendar year, the Better Medicare Alliance in a Dec. 6 letter urged Administrator Chiquita Brooks-LaSure to take several actions to address social determinants of health (SDOH) and close the gap on longstanding racial disparities. The research and advocacy group supports more than 170 ally organizations that include several major MA insurers. Among its recommendations, BMA asked that CMS:

✦ ***Ensure MA organizations can continue offering robust supplemental benefits*** by, for example, making changes to the Medicare Plan Finder (MPF). Specifically, the organization recommended that CMS: (1) standardize the format and language used on the Medicare Plan Finder so that supplemental benefits are characterized in a similar manner and it is easier for beneficiaries to compare supplemental benefit offerings, and (2) require the disclosure of additional information about supplemental benefits on the MPF, highlighting the "variety of benefits" offered in MA.

A BMA-commissioned report released this summer with NORC at the University of Chicago included a similar request. "The challenge that we generally hear, if you click through and see the supplemental benefits, is there's not a lot of consistency in how they're characterized, so the common ones get described sort of in a predictable way, but anything novel can be named differently," Caroline Pearson, senior vice president of health care strategy at NORC, explains to AIS Health. "Then there's the question of not just what is the benefit or naming the benefit you're getting, but what is the amount of benefit? Even if it's something simple like how many trips do you get for transportation, and do they roll over from one year to the next? It is a whole new set of benefits without a defined and standardized way of describing them to people, so it makes it hard to compare and shop in a meaningful way."

✦ ***Strengthen and expand the Value-Based Insurance Design model —*** the only MA-focused demonstration currently being tested by the Center for Medicare & Medicaid Innovation — by allowing additional MA plans (e.g., Employer Group Waiver Plans) to participate, and ultimately making those VBID flexibilities permanent.

✦ ***Modify the star quality ratings program to account for social risk factors (SRFs) that impact health outcomes, such as low income and being a racial-and-ethnic minority.*** For example, CMS could add measures that reflect beneficiaries' experience with how their social needs were addressed or adopt the Health Equity Summary Score (HESS), which some CMS officials and quality researchers in 2019 proposed as a strategy for identifying and incentivizing delivery of high-quality care to racial-and-ethnic minorities and dually eligible MA enrollees. While CAHPS scores are adjusted for dual eligibility through case-mix adjustment and star ratings for HEDIS measures are adjusted for dual status through the Categorical Adjustment Index, neither CAHPS nor HEDIS is adjusted for race and ethnicity, the HESS proof-of-concept designers explained in a November 2019

article published in the Journal of General Internal Medicine. They constructed the score as a composite of quality performance for two SRF groups across multiple quality measures and suggested it could be used to assign performance stars separate from HEDIS, CAHPS and other measures, "with incentives attached to each, according to policy goals."

✦ ***Strengthen the guidance and establish standards and processes for the collection of race, ethnicity, gender and additional SDOH information in partnership with stakeholders.*** "More robust, standardized data collection is key to identifying beneficiaries with social risk factors which, in turn, can help plans tailor interventions to address social and medical needs thereby improving health equity for Medicare Advantage's most at-risk seniors," asserts BMA President and CEO Mary Beth Donahue in a statement emailed to AIS Health.

"Some health plans currently collect this information in partnership with community benefit organizations, but creating minimum standards for data collection can help raise the bar on im-

## Stakeholders Consider Impact of BBBA Drug Pricing Reforms on Formularies, Innovation

The Build Back Better Act (BBBA), which passed the House on Nov. 19 but at press time was looking less and less likely to meet Democrats' self-imposed Christmas deadline, contains multiple drug pricing reforms that could lead to more than $300 billion in savings over the next decade, according to estimates from the Congressional Budget Office (CBO). These provisions include an overhaul of the Medicare D benefit, which a recent Avalere Health analysis suggests could lead to greater increases in mandatory manufacturer discounts on brand drugs within the benefit's six "protected classes" compared with brand Part D drugs overall.

The BBBA seeks to redesign the Part D benefit by establishing a $2,000 out-of-pocket (OOP) spending limit for beneficiaries, lowering enrollees' share of total drug costs below the spending cap and increasing manufacturer/plan liability in the catastrophic phase. The OOP cap would begin in 2024 and would rise each year based on the rate of increase in per capita Part D costs. Meanwhile, manufacturers would be required to pay a 10% discount on brand-name drugs in the initial coverage phase and a 20% discount in the catastrophic phase for individuals, regardless of their Low-Income Subsidy (LIS) status. Currently, drugmakers pay discounts on brand-drug costs for non-LIS beneficiaries in the coverage gap.

According to Avalere's latest assessment of various drug pricing proposals that have been considered in Congress, the firm estimated that manufacturers would pay $5.8 billion more (a 661% increase) in discounts under the BBBA (as passed by the House) for the six protected classes that include anticonvulsants, antidepressants and antipsychotics. This is compared with a 301% increase in the Lower Costs, More Cures Act (H.R.19/S.3129) and a 409% increase in the Prescription Drug Pricing Reduction Act for the six classes, and a $14.6 billion increase in discounts on Part D branded drugs overall, according to Avalere.

"As Congress explores ways to cap OOP spending in Part D and slow the growth in reinsurance costs, a redistribution of manufacturer discounts across the program remains central to each proposal," wrote Avalere. "Going forward, policymakers should evaluate how potential changes to the Part D program could impact formularies and beneficiary access to new and existing treatments, particularly for vulnerable populations and beneficiaries who require treatments that fall into the 6PCs [six protected classes]."

To some industry observers, the bill's most controversial attempts to rein in drug prices include allowing Medicare to negotiate the price of drugs with manufacturers and penalizing drugmakers if their list prices rise faster than inflation. "The consequences of this ill-considered plan to give HHS enormous, unchecked power to unilaterally reduce Medicare drug costs will have far-reaching and devastating ramifications: reduced investments in life-saving drug R&D, slower economic growth and reduced health care quality for U.S. patients, to name just a few," Numerof & Associates President Rita Numerof, Ph.D., writes in a statement emailed to AIS Health.

The CBO estimated that the drug pricing reforms in the BBBA will result in 10 fewer drugs entering the market over the next 30 years, out of an expected 1,300 new drugs.

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*Portions of this story appeared in the AIS Health sister publication RADAR on Drug Benefits.*

proving quality of care across vulnerable populations."

BMA is asking CMS to develop guidance and standards "in partnership with stakeholders" as an appeal for all parties to work together "rather than CMS working in a silo and releasing guidance that may not ultimately achieve needed goals," adds Donahue. "Stakeholder input here is critical."

✦ ***Promote the use of Z codes to identify beneficiary social needs.*** According to an analysis of the most recently available Z code data, NORC at the University of Chicago found that just 1.3% of all Medicare beneficiaries had their social needs tracked with a Z code in 2018. "Incentivizing providers to use Z codes with trainings, guidance on follow-up referrals, and possible financial incentives will help in identifying beneficiaries that could benefit from additional non-health related services," suggested BMA. This concept was also discussed in the BMA/NORC August report.

✦ ***Ensure that high-quality health risk assessments are being conducted in members'*** homes by codifying the best practices proposed in the 2016 rate notice and final call letter for in-home HRAs, establishing guidelines for follow-up care after an in-home HRA and developing enhanced screening for social risk factors as part of the assessment.

CMS at press time had yet to publish the United States per capita cost and the fee-for-service USPCC rate — a key component for upcoming MA rates that usually comes out in December — and is expected to issue the preliminary rate notice in early February.

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## PACE Market Is Poised for Growth

*continued from p. 1*

The PACE concept dates back to the early 1970s, when a public health dentist and a social worker founded On Lok (which means "peaceful, happy" abode in Cantonese) as a community-based model of culturally appropriate health care and supportive services for seniors in San Francisco. On Lok helped expand the model across the country, and it became a permanent part of Medicare in 1997. Individuals who meet eligibility criteria — age 55 or older, qualify for nursing home care, living in a PACE service area and able to safely live in the community — enroll and disenroll on a voluntary basis and never have to pay deductibles, coinsurance or any other type of Medicare or Medicaid cost sharing. It is a Medicare program that is separate from Medicare Advantage, and states can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit. The program then becomes the sole source of Medicaid and Medicare benefits for PACE participants, most of whom are dual eligibles.

> *What became unmistakably clear... during COVID, is just how well the model does work.*

"It's a model that works and delivers quality care — and what became unmistakably clear — during COVID, is just how well the model does work," says Jade Gong, who consults nationally with PACE organizations. She points to strong evidence recently published in 2021 by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), which compared utilization and outcomes across integrated care models for duals and highlighted PACE as a "consistently high performer." In the September report, ASPE observed that full-benefit dual-eligible beneficiaries in PACE "are significantly less likely to be hospitalized, to visit the ED [emergency department], or be institutionalized, while their mortality risk is not significantly higher, compared to regular MA enrollees." That analysis did not include dual-eligible beneficiaries in Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative demonstrations, which are being evaluated separately, ASPE noted.

Additionally, PACE participants fared better than their institutionalized counterparts during the COVID-19 pandemic, with comparison data consistently showing that PACE participants are at approximately one-third the risk of nursing home residents for contracting or dying from COVID-19, according to the NPA. As of June 2021, nearly one-third of all U.S. coronavirus deaths had been linked to nursing homes.

### Setting Up PACE Is Resource-Intensive

So with nearly 3.7 million MA enrollees in a Dual Eligible Special Needs Plan and an estimated 2.2 million PACE-eligible individuals in the U.S., why is PACE such a small market? For starters, it is "capital-intensive," explains Stephen Wood, co-founder and partner at Clear View. It takes several years and millions of dollars to set up a PACE program, which primarily involves the delivery of services through a physical site. That adult day center is where the participant meets with primary care physicians and other members of an interdisciplinary team that assesses the enrollee's needs and develops a care plan. The organization must provide transportation to and from the center, which also allows opportunities for socialization through classes, games and other activities, and any other wraparound services to carry out the care plan.

PACE organizations receive capitated payments from Medicaid and

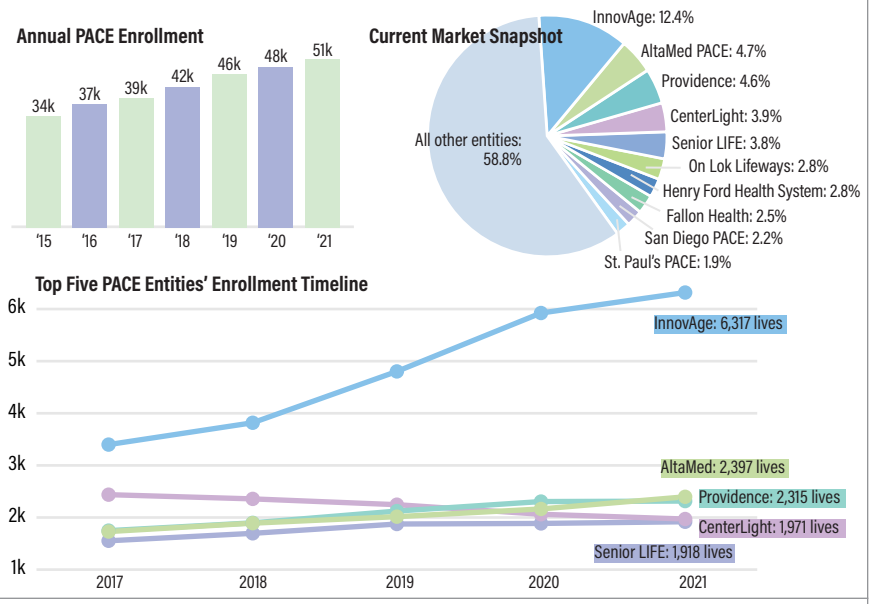
Medicare that are used to cover all medically necessary care (including prescription drugs), and they assume all the financial risk. And if the participant were to experience an event that required hospitalization and long-term care in an inpatient facility, the organization would have to pay for that, too. As a result, the PACE organization is incentivized to provide all the supports necessary to manage participants' care, "so by funneling all of your care activities through the center, you can manage the patient better and get better outcomes," explains Clear View Co-Founder and Partner Kirk Twiss.

Compared with the MA application process, the lead time to open a PACE program is much longer and more complex, as it involves securing state approval to set up a PACE program — possibly through a competitive request-for-proposal process — approvals from the federal government, securing and building out the physical center, hiring of staff in advance of the center opening, and operating or contracting with a full range of Medicare- and Medicaid-funded services such as acute care, specialty physician services and transportation, sources tell AIS Health.

## PACE Market Sees Steady Growth, Diverse Pool of Providers

*by Carina Belles*

Enrollment in Programs of All-Inclusive Care for the Elderly (PACE) topped 51,000 people in 2021, according to AIS's Directory of Health Plans, representing a small but impactful segment of the Medicare market that's seen consistent annual growth. Notably, no large national entities have a significant PACE presence, leaving regional actors to control the market. The largest PACE organization, InnovAge, enrolls just 12% of all lives, and the average PACE organization enrolls about 430 participants, per AIS data. There will be 14 new PACE plan IDs on the market in 2022, according to research from Clear View Solutions, LLC, up from 12 in 2021. And just two IDs have exited the market for 2022, Clear View found. See an overview of the current PACE market below.




SOURCES: DHP, AIS's Directory of Health Plans; Clear View Solutions, LLC.

When managed appropriately, the business can be very profitable — with combined Medicare/Medicare capitation rates ranging from $6,000 to $8,000 on average — but scale has historically been the biggest challenge, asserts Wood. "Contrast that with the MMPs, which really didn't take off... PACE seems to be getting its second or third wind, and now there's a lot of activity in that space," adds Twiss.

### Programs Can Address Overutilization

And PACE has all the "right ingredients" for managed care investors: "good revenue flow, lots of unnecessary health care utilization that could be reduced, and unaddressed market need," says Gong. But because of the heightened interest, states are going through "very deliberate processes, gathering information from interested organizations, in some cases doing a request for information before a request for proposal, then making selections through a formal RFP process," she explains. States also have different approaches to establishing new PACE programs. The District of Columbia, for example, just awarded a contract to one entity to serve one defined service area, while other states, like Illinois and Maryland, are looking for multiple organizations to serve more than one service area. Other states that are in various stages of expanding their PACE programs include Massachusetts, Ohio and New Jersey, according to Gong.

"It is just an unprecedented, competitive environment for establishing new PACE organizations," she says. "We are at a point where policymakers and consumers can clearly see that PACE had the unique flexibility to deliver quality care during COVID — so the case for expansion is so much more compelling, and we've never had this many states at the same time interested

in expanding. It's an incredible, exciting opportunity."

Historically, the competition would have been among not-for-profit, provider-led entities but since 2016, CMS has let for-profit entities participate. One company that's grown exponentially in recent years is Denver-based InnovAge, which as of 2016 had received the most private equity funding for a PACE organization, including from Welsh, Carson, Anderson & Stowe, the New York Times reported. (Hg Capital Partners and Welsh, Carson, Anderson & Stowe share control of MMIT, the parent of AIS Health.) The company went public in March and plans to expand its footprint of 16 centers in five states.

When asked why traditional managed care organizations, like a D-SNP carrier, haven't started a PACE program, Gong says there is "definitely interest" among the MCOs. "Even a large health plan like UnitedHealthcare or another plan must go through the process of securing state and federal approval to operate a new PACE program. You don't just get to operate a PACE program without specific approvals even if you already operate other plans."

The NPA, which is based in Alexandria, Va., seeks to advance the efforts of PACE programs nationwide. Robert Greenwood, senior vice president, communications and member engagement, tells AIS Health that the association's mission is to "have a PACE model of care available to as many people as could benefit from it," and it is working with states and PACE organizations to expand access to the program. The ongoing PACE 2.0 initiative is "looking at the model and public policy and trying to figure out how we could grow PACE exponentially," he explains, and has a goal of enrolling 200,000 participants by 2028. The NPA also continues to assess and advocate for PACE risk adjustment improvements to better reflect the acuity of PACE participants.

He adds that the NPA is supportive of increasing private equity interest. "Having as many sources of investment as possible is very helpful and we do think that will contribute to faster growth in the future," says Greenwood. "We've seen waves of growth and we're experiencing one now; the pandemic has really focused a lot of attention on the need to provide more services in the community for older people."

The Build Back Better Act, which passed the House on Nov. 19 and is currently being debated in the Senate, includes a $150 billion investment in HCBS so that states could make long-term, systemic changes to improve access to HCBS, such as by addressing workforce challenges, streamlining HCBS eligibility and enrollment and providing supports to family caregivers, according to a summary from the Center on Budget and Policy Priorities.

Greenwood says the additional funding could further the NPA's mission. "It's really been very encouraging to see caregiving and community support for seniors talked about in a public policy way as part of the basic infrastructure, so I think as far as the future workforce and being able to attract and train the type of workers that we'll need as we grow, I think those monies could be helpful," remarks Greenwood. "And I think as states look for ways to provide care and services for a population that is growing, I think these are monies that they could use to expand and support PACE development. And so, we've worked to make sure that legislation recognizes PACE as a type of home and community service so that states will have the option to use those funds to support PACE."

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## News Briefs

✦ ***New statistics showing a rise in telehealth usage among Medicare beneficiaries during the pandemic make a strong case for permanently expanding telehealth coverage for Medicare patients.*** A new report from the HHS Assistant Secretary for Planning and Evaluation (ASPE) found that the number of FFS beneficiary telehealth visits rose from approximately 840,000 in 2019 to nearly 52.7 million in 2020, with the largest increase seen in behavioral health specialist visits. Black and rural beneficiaries demonstrated lower use of telehealth compared with white and urban beneficiaries, respectively. The report did not include results for Medicare Advantage members, since plans had discretion to offer telehealth prior to the pandemic, noted ASPE. Meanwhile, a new Medicare Telemedicine Data Snapshot from CMS showed that the number of Medicare beneficiaries (including MA enrollees) using telemedicine services between March 1, 2020, and Feb. 28, 2021, increased over 30 times the number of users from the prior year (March 2019 to February 2020). Dual eligibles had higher use of telehealth than those with just Medicare. "These latest numbers prove that when given

the resources and opportunity to use telemedicine, many of these patients will opt to use the technology," wrote Connected Nation, which seeks to fill broadband and digital technology gaps through partnerships across all sectors. "We would argue that among the critical needs is to expand not only access to broadband but also working to ensure it is affordable and that others understand both how to access the technology and how it can benefit them."

✦ ***More than two-thirds of Medicare beneficiaries did not review their coverage options during the recent Annual Election Period (AEP) and 88% didn't change their plan, according to new survey results from MedicareGuide.com.*** Of those who did review their options, 15% said they were seeking dental, vision and hearing coverage, while 13% said they wanted better drug coverage, but 67% who didn't make a change in coverage reported that they could not find a better plan. That's according to a "snapshot" survey conducted three weeks before the AEP ended on Dec. 7. MedicareGuide.com polled 2,283 Americans ages 65 and older.

✦ ***As states prepare to resume Medicaid eligibility determinations once the COVID-19 public health emergency (PHE) ends, CMS late last month released two tools to support states, including one to help them consider and adopt strategies to maintain continuity of coverage for eligible individuals.*** The Biden administration in October extended the PHE through Jan. 16, 2022, marking the seventh renewal since the initial PHE was declared in March 2020. States receiving the temporary 6.2 percentage-point increase in the Federal Medical Assistance Percentage (FMAP) had to maintain enrollment of nearly all individuals enrolled in Medicaid during the PHE. The end of continuous enrollment for states receiving the increased FMAP marks the "single largest health coverage transition event since the first Marketplace Open Enrollment following enactment of the Affordable Care Act," noted CMS in the document. "To prevent inappropriate coverage loss among eligible individuals, states should implement actionable strategies to strengthen their renewal processes." To that end, the agency provided a detailed "punch list" to states containing suggestions such as expanding the number and types of data sources used for renewal, leveraging data from other means-tested programs (e.g., Supplemental Nutrition Assistance Program) and creating a data source hierarchy to guide verification.

✦ ***Minneapolis-based not-for-profit Medicare and Medicaid insurer UCare has partnered with LeadingAge MN Foundation (LAMF), the philanthropic arm of LeadingAge Minnesota, to create a new model of integrated care for aging adults living in rural communities in west central Minnesota.*** LAMF has awarded Connected Communities for Healthy Aging pilot grants of $800,000 each to two LeadingAge Minnesota members — Knute Nelson in Alexandria and Perham Health in Perham. The UCare Foundation contributed an additional $100,000 to each organization to support program design and implementation through year-end 2022, according to a Dec. 8 press release from UCare. The pilots will "coordinate and deliver an inter-connected continuum of community-based supports (socialization, meals, transportation); preventive and primary care; acute, post-acute and long-term care; and other services to support and enhance older adults' quality of life," explained UCare.

✦ ***A greater proportion of dual-eligible beneficiaries choose to enroll in Medicare Advantage over fee-for-service (FFS) Medicare, according to new research commissioned by Better Medicare Alliance (BMA). The industry-allied research and advocacy organization estimates that dual eligibles account for 23% of the overall MA population, compared with 17% in FFS Medicare. Moreover, 44% of all dual-eligible individuals elect MA, compared with 35% of non-dually eligible Medicare beneficiaries,*** reported ATI Advisory on behalf of BMA. The study also found that duals, who tend to have more chronic conditions, were more likely to receive key preventive services such as mammograms (42% in MA vs. 34% in FFS), flu shots (68% in MA vs. 62% in FFS) and blood cholesterol screenings (92% in MA vs. 84% in FFS).

✦ ***SCAN Health Plan, through a partnership with MedArrive, this month began deploying paramedic and EMT teams across Los Angeles and Orange counties to administer flu vaccines and COVID-19 boosters to homebound Medicare Advantage members.*** The vaccinations are available to members and caregivers at no cost, according to a Dec. 2 press release. The new initiative was modeled after SCAN's in-home COVID vaccination program, which provided two-dose vaccines to homebound members, their caregivers and family members earlier this year, reducing vaccination inequities among SCAN's Latinx, Black and low-income member population.