UPDATE

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

IN THIS ISSUE

ABOUT THE INTEGRATED CARE RESOURCE CENTER

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

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

Integrated Care Updates

June 2015 Enrollment in Medicare-Medicaid Plans

Total Medicare-Medicaid Plan (MMP) enrollment in the nine states (CA, IL, MA, MI, NY, OH, SC, TX, and VA) currently implementing capitated model financial alignment demonstrations rose from 341,851 in May 2015 to 354,904 in June 2015, an increase of 3.8 percent. ICRC's *Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, June 2014 to June 2015* shows that most of this increase can be attributed to Texas, which began passive enrollment on April 1, and to Michigan, which started passive enrollment on May 1.

MACPAC Report: Medicaid Behavioral Health Services for Medicare-Medicaid Enrollees

The Medicaid and CHIP Payment and Access Commission (MACPAC) June 2015 Report to Congress includes a chapter titled *Behavioral Health in the Medicaid Program – People, Use, and Expenditures.* A three-page section (pp. 112-115) at the end of the chapter focuses on Medicaid behavioral health services for enrollees dually eligible for Medicare and Medicaid, using 2010 fee-for-service data. MACPAC notes that: (1) the prevalence of depressive disorders in the under-65 dually eligible population is much higher (27 percent) when both Medicare and Medicaid claims are examined than when only Medicaid claims are analyzed (11 percent); (2) dually eligible enrollees age 65 and older have a much higher prevalence of behavioral health conditions (especially Alzheimer's, depressive disorders and schizophrenia) than non-dually eligible Medicare beneficiaries in that age group; and (3) dually eligible beneficiaries under age 65 have a higher prevalence of schizophrenia (15 percent) and depressive disorders (27 percent) than Medicaid-only beneficiaries with disabilities in that age group (9 percent and 10 percent, respectively).

MedPAC Report: Risk Sharing in Medicare Part D

The Medicare Payment Advisory Commission (MedPAC) June 2015 Report to the Congress suggests that the multiple levels of risk sharing in the Medicare Part D prescription drug benefit (risk-adjusted direct subsidies, individual reinsurance, and risk corridors) may warrant reconsideration now that the program is more firmly established (Chapter 6, pp. 139-169). In discussing options for change that could increase Part D plan incentives to contain costs more effectively, MedPAC notes that beneficiaries receiving the Part D low-income subsidy (LIS) account for a large share of high-cost enrollees (about 80 percent of those reaching the "catastrophic" threshold for individual reinsurance, for example), and are also highly concentrated in plans that specialize in serving them, like Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs) and MMPs. MedPAC says that the "special role" of the LIS in assuring access to coverage for these high-cost enrollees needs to be taken into account when considering modifications to Part D risk sharing.

June 1 Notices to CMS of D-SNP Intentions for Departures and Service Area Reductions in CY 2016

All MA plans, including D-SNPs, were required to notify CMS by June 1 of their intentions not to renew contracts for calendar year (CY) 2016, or to reduce service areas. MA plan bids for CY 2016 were also due to CMS by June 1. States that are contracting with D-SNPs, or planning to do so, should request that D-SNPs doing business in their state submit that information to the state as well, in order to assist with state planning for these changes.

Related ICRC Resources:

- Medicare Advantage Enrollment Processes: D-SNP New Entries, Service Area Changes, Terminations, Non-Renewals, and Seamless Conversions (Integrated Care Resource Center/March 2014) This document summarizes a telephone discussion among states, CMS, the National Association of Medicaid Directors, and ICRC regarding D-SNPs non-renewals, service area changes, terminations, new entries, seamless conversions, and passive enrollment.
- Medicare Advantage D-SNP Non-Renewals, Service Area Changes, Terminations, and New Entries: CMS Requirements and State Options (Integrated Care Resource Center/February 2014) This tool outlines CMS requirements and state contracting options under a variety of situations affecting D-SNPs.

Kaiser Family Foundation Reports on Early Insights from MA, OH, and VA Financial Alignment Demonstrations

The Kaiser Family Foundation recently released reports on the initial experiences of Massachusetts, Ohio, and Virginia in implementing their financial alignment demonstrations. The reports are based primarily on interviews with state officials, service providers, health plans, advocates, and other stakeholders.

New Resources on the ICRC Website

- Reducing Avoidable Hospitalizations Among Nursing Facility Residents: Three Perspectives (Integrated Care Resource Center/June 2015) This webinar featured perspectives and lessons learned from two Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) and one of seven organizations participating in the CMS Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents. Recording
- State Use of Medicare Advantage Encounter Data (Integrated Care Resource Center/May 2015) This webinar provided a brief overview of how states are obtaining and using MA encounter data, followed by a facilitated discussion of how Arizona and Tennessee are using both Medicaid and Medicare encounter data in their D-SNP programs. Recording

News and Key Upcoming Dates

Recent Integrated Care News	
June 1	Deadline for plans to submit bids; plans deciding not to renew their MA contracts should have notified CMS in writing. Also organizations interested in offering a MA, prescription drug plan (PDP), or MMP product should have submitted a plan benefit package that accurately describes the coverage details and cost-sharing for all covered benefits.

Mid-June	MedPAC and MACPAC reports to Congress released.
July 1	D-SNP applicants were required to submit State Medicaid Agency Contract (SMAC or "MIPPA contract") to CMS; D-SNPs requesting review as FIDE SNPs should have submitted their FIDE SNP Matrix to HPMS.
Key Upcoming Dates	
Late July/ Early August	Part D national average monthly bid amount (NAMBA) released.
Mid-September	CMS executes Medicare Advantage and PDP contracts with plans.
October 1	Medicare Advantage and Medicare Part D marketing begins for the following CY.