Integrated Care Resource Center

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

Rhode Island to Launch Capitated Financial Alignment Demonstration

On July 30, the Centers for Medicare & Medicaid Services (CMS) announced that it had signed a Memorandum of Understanding with the state of Rhode Island to test a capitated financial alignment demonstration. The demonstration will build off of the state's Rhody Health Options (RHO) Medicaid managed care program under which Medicaid members – including Medicare-Medicaid enrollees – enroll in a health plan that coordinates their Medicaid services, including long-term services and supports. The demonstration will allow a contracted, qualifying RHO plan to also serve as a Medicare-Medicaid Plan (MMP) that will cover Medicare benefits in addition to the existing set of Medicaid benefits it currently offers, allowing for an integrated set of benefits for enrollees. Approximately 30,000 individuals will be eligible for the demonstration, which will begin opt-in enrollment sometime after December 1, 2015.

Annual Redetermination of Medicare Part D Low-Income Subsidy Deemed Status

Medicare beneficiaries with limited incomes and resources (including all full-benefit and most partial-benefit dually eligible individuals) automatically qualify to receive the Medicare Part D low-income subsidy (LIS), which helps to pay for Medicare prescription drug plan premiums, co-pays, and annual deductibles. CMS re-determines eligibility for this benefit every year using state Medicare Modernization Act (MMA) and Social Security Administration files. It is important for states to ensure the accuracy of the MMA files that they submit between July and December 2015, because this information will be used to determine the eligibility of dually eligible beneficiaries in their state for LIS. States should use the Loss of Deemed Status file, found in Appendix A of CMS' July 30, 2015 Informational Bulletin on LIS re-deeming, to screen beneficiaries for Medicaid or Medicare Shared Saving Program eligibility or to help them apply for LIS.

Revised Medicare Managed Care Marketing Guidelines for 2016 Include Provisions Affecting States and Dual Eligible Special Needs Plans (D-SNPs)

The CMS Medicare Marketing Guidelines for calendar year 2016 for Medicare managed care plans contain several provisions affecting states and D-SNPs, including:

- **No CMS review of state-created marketing materials.** The revised guidelines incorporate existing guidance stating that marketing materials created by state governments are not subject to CMS marketing review. (Section 20)
- **Additional state-required languages in multi-language insert advertising availability of free interpreter service.** D-SNPs can add additional languages beyond those required by Medicare to comply with state contract requirements. The D-SNPs must work with CMS to determine whether any additional state contract requirements can be incorporated in the CMS multi-language insert or may be met in another way. (Section 30.5.1)

- **Provider affiliations with SNPs.** Providers that contract with D-SNPs can feature their SNP affiliation in mailings, including information on special plan features, the population served, or specific benefits. (Section 70.11.3)

Proposed Revisions in Medicare Hospice Payments May Affect State Medicaid Hospice Payment Systems

In May 2015, CMS proposed a revision to the Medicare hospice payment system that could, if adopted as proposed, require changes to the structure of state Medicaid hospice payment systems.

Medicare's long-standing hospice payment system pays a flat daily rate for routine home care (RHC) for each day of a hospice stay, no matter how short or long the stay. CMS is proposing that the base daily rate for RHC be higher during the first 60 days of an episode, and lower for days 61 and beyond. It is also proposing to make additional "service intensity add-on" payments in the last seven days of life tied to visits by registered nurses or social workers. These changes are aimed at better reflecting the actual costs of providing hospice care, which are generally higher at the beginning and end of a hospice episode, and lower during the middle of an episode.

Medicaid is required by the Social Security Act ((Section 1902(a)(13)(B)) to pay for hospice care "in amounts no lower than the amounts, using the same methodology" that are paid in Medicare. CMS provides annual guidance to states on these amounts, most recently in a memo dated September 5, 2014. State Medicaid payment systems that are structured to pay a flat daily amount for routine home care may need to be modified to follow the proposed new Medicare pattern of higher daily payments for the first 60 days, lower payments thereafter, and hourly add-on payments in the last seven days of life. The proposed change, if adopted, would be effective October 1, 2015 through September 30, 2016. The comment period for the proposed rule ended on June 29, 2015. ICRC will alert states when the proposed rule is made final.

July 2015 Enrollment in Medicare-Medicaid Plans

Total 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 354,904 in June to 370,701 in July, an increase of 4.5 percent. ICRC's Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, July 2014 to July 2015 shows that most of this increase can be attributed to Michigan, which started passive enrollment on May 1, and to Texas, which began passive enrollment on April 1.

CMS Informational Bulletin on Housing-Related Activities and Services

On June 26, CMS released an Informational Bulletin on *Coverage of Housing-Related Activities and Services for Individuals with Disabilities*. The bulletin describes how states can use Medicaid authorities and demonstration programs to cover the costs of various housing-related services including: individual housing transition services; individual housing and tenancy sustaining services; and state-level housing related collaborative activities. These services can help Medicaid-only as well as dually eligible beneficiaries to locate and apply for housing, prepare the residence and provide basic furnishings, and support individuals to sustain them in the community. Stable housing and community support is a critical component of integrated care programs for high-need populations, including dually eligible beneficiaries. The information in this bulletin should assist states in creating benefit packages that provide holistic, person-centered care and services.

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 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

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 an 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.
July 29	Part D national average monthly bid amount (NAMBA) released.
Key Upcoming Dates	
Mid-September	CMS executes Medicare Advantage and PDP contracts with plans.
October 1	Medicare Advantage, Medicare Part D, and MMP marketing begins for the following CY.