Integrated Care Resource Center

UPDATE

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

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ABOUT THE INTEGRATED CARE RESOURCE CENTER

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

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

Integrated Care Update

MedPAC Reviews Progress of Financial Alignment Demonstrations and Analyzes Options for Medicare Savings Programs

In Chapter 9 of its June 2016 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) provides a status report on the financial alignment demonstrations, based in part on site visits to California, Illinois, and Massachusetts and phone interviews with stakeholders in Washington State. MedPAC also analyzes options for expanding access to Medicare Savings Programs (MSPs) that assist Medicare-Medicaid enrollees with Medicare beneficiary cost sharing. The chapter discusses three areas that may be especially interesting to states:

- State experiences with passive enrollment, including the different ways that demonstration states have used passive enrollment, what some of the results have been, and some options for future refinements. (pp. 279-284)
- Care coordination, including the key elements of the care coordination model that Medicare-Medicaid Plans (MMPs) have been using and some of the challenges of implementation, especially for enrollees with substantial behavioral health needs. (pp. 284-287)
- Options for expanding MSP access, including discussion of some current problems with MSP access: (1) low beneficiary participation rates (an estimated 51 percent of those eligible); and (2) limited payments to providers, due to policies in almost all states that base payment on the "lesser of" Medicaid or Medicare payment levels for some or all providers, resulting in state payment of only about of 35 percent of beneficiary cost-sharing liability on average across all states. MedPAC discusses three scenarios for expanding access to MSPs, the third of which would federalize the program by shifting responsibility for the cost sharing payments to Medicare, with states making maintenance-of-efforts payments to Medicare based on their historical MSP spending, similar to the state "clawback" payments in the Medicare Part D program. (pp.291-297)

MACPAC Report to Congress Documents the Wide Variation of Functional Assessment Tools Used across State Medicaid Programs and Reviews Considerations for Their Selection

In Chapter 4 of its June 2016 Report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) examines states' use of functional assessment tools to determine eligibility and develop care plans for individuals who require long-term services and supports (LTSS). The federal government does not require states to use a particular assessment tool for either purpose, and MACPAC found that each state uses one or more tools. In addition, managed care plans that participate in managed LTSS (MLTSS) programs often use different functional assessment tools to develop care plans. The chapter discusses three areas that may be especially interesting to states:

- Documentation of wide variation in the functional assessment tools used across states. MACPAC found that there are at least 124 tools currently in use across states. Most states use different tools for different population groups. The actual

number of tools used in states with MLTSS programs is likely greater because managed care plans have their tools as well. Although most functional assessment tools address similar domains and criteria, how they define limitations with activities of daily living or instrumental activities of daily living and the amount of detail collected across these domains can differ significantly.

- Considerations for selecting tools. States weigh several factors when deciding to develop their own functional assessment tool (i.e., "homegrown tool") versus using a nationally available, standardized tool. Factors include the degree to which states and stakeholders prefer customizable tools, state resources available to develop their own tools, and importance of using a tool that is already tested for validity and reliability that may be easier to implement. Several states noted that federal support to states to develop their own tools, such as from the Balancing Incentive Program, can help them to develop streamlined, homegrown tools across different population groups.
- Discussion on use of a single national tool. A national tool would facilitate analyses of LTSS use across states that would inform many program operations, including developing benchmarks and quality metrics, setting payment rates, and analyzing strategies that advance more effective use of state and federal resources. It could also reduce burden on states. However, MACPAC does not recommend moving toward a national tool at this time due to burden on states that recently developed their own tools, variation across LTSS programs, and lack of clear evidence that one tool is better than others.

CMS Guidance to Medicare Advantage Organizations on Submitting State Medicaid Agency Contracts with D-SNPs May Permit Subcontracting Arrangements

In a June 8, 2016 memo, the Centers for Medicare & Medicaid Services (CMS) reminded Medicare Advantage Organizations seeking to offer a Dual Eligible Special Needs Plan (D-SNP) in contract year 2017 and D-SNPs wishing to be reviewed for qualification as a fully integrated dual eligible (FIDE) SNP that they must submit required documentation to CMS by July 1, 2016.

The memo also stated that while D-SNPs are expected to contract directly with State Medicaid Agencies, CMS recognizes that some states may only be able to contract with a limited number of D-SNPs due to state statutory requirements, budgetary concerns, or limited staff resources. Therefore, in limited circumstances, and with state approval, CMS may consider a D-SNP's subcontracting arrangements with a State Medicaid Managed Care Organization (MCO) to be equivalent to a direct state contract as long as the subcontract contains all of the MIPPA required elements. For example, if a state wanted Medicaid MCOs that provide long-term supports and services to Medicare-Medicaid enrollees to partner with a D-SNP to provide Medicare benefits to these enrollees, the Medicaid MCO could enter into a subcontract with a D-SNP rather than requiring the D-SNP to have a separate contract with the state.

June 2016 Enrollment in Medicare-Medicaid Plans

Between May and June, total MMP enrollment in the ten states (CA, IL, MA, MI, NY, OH, RI, SC, TX, and VA) currently implementing capitated model financial alignment demonstrations increased from 364,863 to 370,372 as shown in ICRC's table Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, June 2015 to June 2016. Much of this increase can be attributed to MI where enrollment increased 27 percent from the previous month. Also of note, RI started opt-in demonstration enrollment on May 1, but has reported only a small number of enrollees so far. Passive enrollment in RI began on July 1.

Enrollment in PACE Organizations

PACE organizations provide comprehensive medical and social services to frail, community-dwelling individuals age 55 and older, most of whom are Medicare-Medicaid enrollees. As shown in ICRC's table Program of All Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization, there were a total of 35,631 individuals enrolled in 120 PACE organizations in June 2016, operating in 32 states.

Mathematica Report on Medicaid MLTSS Programs in AZ, FL, IL, NY, and WI

In a March 2016 working paper, Mathematica researchers report on major themes from site visits they conducted in the summer of 2014 with staff from MACPAC to learn more about Medicaid MLTSS programs in AZ, FL, IL, NY, and WI. States that are using Medicaid MLTSS programs as a building block for integrating Medicare and Medicaid services in the financial alignment demonstrations and through partnerships with D-SNPs can find guidance and insights from the experiences of these five states. The Mathematica report stresses the importance of taking into account the history, context, institutions, and stakeholders unique to each state in developing program design, protections for beneficiaries and providers in the transition to MLTSS, ongoing operations and oversight, and program evaluation and improvement.

New Resources on the ICRC Website

- Alternatives to Inpatient Psychiatric Services for Medicare-Medicaid Enrollees: A Case Study of Commonwealth Care Alliance (Integrated Care Resource Center/May 2016) This brief describes Commonwealth Care Alliance's development of enhanced residential crisis stabilization units that fill a gap in the behavioral health continuum of care available to enrollees in Massachusetts' Medicare-Medicaid financial alignment demonstration.

News and Key Upcoming Dates

Recent Integrated Care News	
July 1	D-SNP applicants required to submit State Medicaid Agency Contract (SMAC or "MIPPA contract") to CMS.
July 1	Deadline for D-SNPs requesting to be reviewed as FIDE SNPs to submit 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 MA and PDP contracts with plans.
Late September	D-SNPs that requested review for FIDE SNP determination notified as to whether they meet required qualifications.