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

CMS Solicits Letters of Intent for the Second Round Medicare-Medicaid Accountable Care Organization Models

The Medicare-Medicaid ACO (MMACO) Model initiative is designed to improve the quality of care and lower costs for dually eligible beneficiaries. Through MMACO, the Centers for Medicare & Medicaid Services (CMS) is partnering with interested states to offer new and existing Medicare Shared Savings Program ACOs the opportunity to take on accountability for the Medicaid costs for their assigned Medicare-Medicaid enrollees. The MMACO model is open to all states and the District of Columbia that have a sufficient number of Medicare-Medicaid enrollees in fee-for-service. CMS will enter into Participation Agreements with up to six states, with preference given to states with low Medicare ACO saturation.

The deadline for states to submit letters of intent for the one-year performance period starting January 1, 2019 is **August 4, 2017**. The first round of models was announced in December 2016, and a third round of models will start January 1, 2020. ACOs in a state can apply to participate in the model after a state is selected by CMS. Interested states may want to focus first on the nine-page CMS Frequently Asked Questions document, and then review the 34-page Request for Letters of Intent for more details. Additional information is available on CMS' website.

CMS Releases Informational Bulletin on Strategies to Streamline Transitions for Adults in the Medicaid Expansion Group Who Newly Qualify for Medicare

On June 7th, 2017, CMS issued an informational bulletin to promote smooth transitions for adults in the Medicaid expansion group who become Medicare eligible. The bulletin discusses the required processes for completing redeterminations of eligibility when these beneficiaries turn 65 or have received Social Security Disability Income benefits for 24 months. The bulletin highlights opportunities for states to promote smooth transitions for these beneficiaries while reducing administrative burdens on them and states. The adult Medicaid expansion group is defined in 42 CFR 435.119.

California Medicare-Medicaid Plans Launch Pilots to Reduce Avoidable Hospitalizations for Nursing Facility Residents

A June 15 blog on CalDuals.org, the website of Cal MediConnect – the California Medicare-Medicaid Financial Alignment Demonstration – describes pilot projects recently launched by six Cal MediConnect plans in Los Angeles and Orange County. The pilots will test interventions to reduce avoidable hospitalizations and other adverse events for nursing facility residents. States and health plans are increasingly focusing on this issue, which ICRC addressed in a July 2015 brief Reducing Avoidable

Hospitalizations for Medicare-Medicaid Enrollees in Nursing Facilities: Issues and Options for States and will revisit in a brief "Value-Based Purchasing in Nursing Facilities: Options and Lessons for States and Managed Care Plans" to be released later this summer.

New Report Scores State Progress toward Building High Quality Long-Term Services and Supports Systems

The AARP Foundation, The Commonwealth Fund, and The SCAN Foundation have released the third edition of the Long-Term Services and Supports (LTSS) State Scorecard, which measures state performance in creating a high-quality system of care for older adults and people with physical disabilities, and their family caregivers. The report presents results across five dimensions: (1) affordability and access; (2) choice and setting of provider; (3) quality of life and quality of care; (4) support for family caregivers; and (5) effective transitions. Subtitled "Picking Up the Pace of Change," this edition of the report also compares changes in states' performance over time.

New Kaiser Family Foundation Analysis of Shows Trends in Medicare Advantage and D-SNP Enrollment

A June 2017 Kaiser Family Foundation issue brief reports that 33 percent of Medicare beneficiaries are now enrolled in Medicare Advantage managed care plans, up from 13 percent in 2005. Managed care penetration rates were 40 percent or higher in six states (CA, FL, HI, MN, OR, and PA), as shown in Table 1 in the brief. Table A4 shows penetration rates in large metropolitan counties.

Enrollment is heavily concentrated in a small number of private insurance companies both nationally and in individual states. UnitedHealthCare, Humana, and BCBS affiliates together account for 57 percent of Medicare Advantage enrollment nationally. In 17 states, one company has more than half of all Medicare Advantage enrollment (Table A6).

Appendix A on p. 14 shows the growth in Special Needs Plans between 2006 and 2017, and Table A7 shows the percentages of dually eligible beneficiaries in each state that are enrolled in Dual Eligible Special Needs Plans (D-SNPs). The percentages are highest in HI (53 percent), AZ (42 percent, FL (32 percent), TN (31 percent, MN (26 percent, NY (26 percent), and PA (25 percent). The national average is 15 percent.

June 2017 Enrollment in Medicare-Medicaid Plans

Between May and June 2017, total Medicare-Medicaid Plan (MMP) enrollment in the ten states (CA, IL, MA, MI, NY, OH, RI, SC, TX, and VA) currently implementing capitated model Financial Alignment Initiative demonstrations decreased slightly from 397,776 to 397,697 as shown in ICRC's table Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, June 2016 to June 2017.

June 2017 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 38,879 individuals enrolled in 122 PACE

organizations in June 2017, operating in 31 states. Between May and June 2017, total PACE enrollment increased from 38,535 to 38,879.

New Resources on the ICRC Website

- State and Health Plan Strategies to Grow Enrollment in Integrated Managed Care Plans for Dually Eligible Beneficiaries (Integrated Care Resource Center/June 2017) This brief outlines a variety of actions that states and health plans can take to support enrollment growth in integrated care programs.
- Medicare Basics: An Overview for States Seeking to Integrate Care for Medicare-Medicaid Enrollees (Integrated Care Resource Center/June 2017) This brief – updated from the 2013 version – is designed to help states better structure and coordinate the Medicaid benefits they offer to Medicare-Medicaid enrollees by providing them with basic information on the Medicare program, the services it covers, and the process used to set rates.
- Moving Toward Value-Based Payment for Medicaid Behavioral Health Services (Center for Health Care Strategies/June 2017) This brief describes how innovative states and Medicaid managed care organizations are building on models developed for physical health services and incorporating value-based purchasing arrangements into behavioral health programs.

News and Key Upcoming Dates

Recent Integrated Care News	
June 5	Deadline for plans to submit CY 2017 Medicare Advantage (MA), Medicare Advantage-Prescription Drug, MMP, and Prescription Drug Plan (PDP) bids; plans deciding not to renew their MA contracts must notify CMS in writing.
June 5	Organizations interested in offering a MA, PDP, or MMP product must submit a plan benefit package that accurately describes the coverage details and cost-sharing for all covered benefits.
Key Upcoming Dates	
July 1	D-SNP applicants required to submit State Medicaid Agency Contract (SMAC or “MIPPA contract”) to CMS. Deadline for D-SNPs requesting to be reviewed as Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) to submit their FIDE SNP matrix to HPMS.
July 29	Deadline for CMS to inform currently contracted MA organizations of its decision not to renew a contract for 2018.