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

Upcoming Webinar on Part D PDE Data and the Opioid Epidemic

On **August 30, 2017 from 3:30-4:30 pm ET**, the State Data Resource Center (SDRC) and its data experts will explore how State Medicaid Agencies can utilize Part D Prescription Drug Event (PDE) data to combat the opioid epidemic. From the early 1990s to the early 2010s, the number of opioid prescriptions in the United States has more than doubled, while the number of opioid-related overdose deaths has more than tripled during the 2000s and 2010s. SDRC will illustrate which Part D PDE elements can maximize State Medicaid Agencies' efforts to implement opioid-related care coordination and program integrity initiatives. A brief Q & A session will follow the presentation. Register for the webinar.

Highlights from the 2016 CAHPS Survey of Beneficiaries Enrolled in Financial Alignment Initiative Demonstrations

In July, the Centers for Medicare & Medicaid Services (CMS) released a report summarizing results from the 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for capitated and managed fee-for-service (MFFS) model demonstrations under the Medicare-Medicaid Financial Alignment Initiative.

To obtain feedback on consumer experiences, the Medicare-Medicaid Plans (MMPs) in the capitated model demonstration use the Medicare Advantage Prescription Drug CAHPS survey with additional supplemental questions that take a closer look at areas of greater focus under the demonstrations including care coordination, behavioral health, and home and community-based services, while the MFFS demonstrations use a modified version of the CAHPS 5.0 Adult Medicaid Health Plan Survey. For the 2016 reporting cycle, 40 MMPs participating in eight capitated model demonstrations (CA, IL, MA, MI, NY, OH, TX, and VA) were able to report CAHPS data. Data was also reported for the MFFS demonstrations in CO and WA.

Overall, respondents had positive views of the quality of their care and of their accountable care organization (CO), health home (WA), or MMP (CA, IL, MA, MI, NY, OH, TX, and VA). MMP enrollees reported high levels of access to needed care and prescription drugs, but were less positive about getting appointments and care quickly. For demonstrations with two years of measurement, overall views of health plans and quality of health care improved considerably. Enrollees in MMFS demonstration reported that they were satisfied with their ability to access the care they need in a timely manner. Enrollees in both the capitated and MFFS demonstration reported satisfaction with their care coordination.

Washington State Managed Fee-For-Service Demonstration Continues to Show Savings

A new report shows that Washington State's MFFS demonstration continued to generate savings in its second demonstration period (January-December 2015), building on savings estimated for the first demonstration period (July 2013-December 2014).

Background on Washington's demonstration. CMS and Washington State launched the Washington Health Home MFFS Model Demonstration in 2013. The demonstration uses

Medicaid health homes to integrate care for high-cost, high-risk, full-benefit Medicare-Medicaid beneficiaries.

Details on the savings estimates. In January 2016, CMS released a preliminary estimate of Medicare Parts A and B savings for the Washington Health Home demonstration for the first demonstration period as part of an issue brief on early findings in Washington. That report found *preliminary* gross Medicare savings of $21.3 million. The results presented in the report released today update those results, providing a *final* estimate of Medicare savings for the first demonstration period of $34.9 million. The new report estimates *preliminary* Medicare savings for second demonstration period of $32.1 million. Combined gross Medicare savings across both time periods is $67.0 million. Medicaid savings or costs have not yet been estimated.

The increase in Medicare savings for the first demonstration period between the preliminary and final reports was largely driven by updates to the savings calculation methodology intended to improve accuracy of results, including a more accurate data source for determining beneficiary eligibility for the demonstration and comparison groups.

CMS performance payments to the state. On the basis of these Medicare savings and meeting quality requirements, CMS has made interim performance payments to Washington State for both demonstration periods. The final payment amounts will be determined once Medicaid savings have been calculated. Depending on that analysis, Washington can ultimately share in up to half of the gross Medicare savings.

CMS Finalizes Medicare Hospice Wage Index and Payment Rates for FY 2018

State Medicaid programs are required (see Social Security Act section 1902(a)(13)(B)) to pay hospice providers amounts that are no lower than Medicare payments and that are calculated in the same way.

Each year, states need to update their payment calculations based on the Medicare payment rates and wage index for hospices serving Medicaid beneficiaries. On August 4, 2017, CMS issued a final rule (CMS-1675-F) that updates fiscal year (FY) 2018 Medicare payment rates and the wage index, and also updates the hospice quality reporting requirements. In FY 2018, Medicare hospice payment rates, which are tied to the market basket percentage, will increase by 1 percent, resulting in an estimated aggregate increase in Medicare payments of $180 million. The Medicare hospice rule includes several quality reporting requirements that may impact payment.

A 2015 CMS presentation described a series of structural hospice payment changes that went into effect on January 1, 2016, and that should be reflected in state Medicaid payment systems. CMS typically issues a memo for Medicaid programs that describes specifically how these payment changes affect Medicaid. Last year's version of this annual memo may also be a useful reference for states. ICRC will provide states with a link to this year's version when it becomes available. Additional information on hospice payments and quality reporting requirements can be found in the Hospice Center on CMS' website.

ICRC Presentation on State Approaches to Medicare and Medicaid Integration

On July 20, 2017, ICRC staff gave a presentation on national trends and state approaches to integrating Medicare and Medicaid benefits for dually eligible beneficiaries for a New York stakeholders meeting on the future of integrated care in New York State. CMS and New York have agreed to extend the state's Fully Integrated Duals Advantage (FIDA) financial alignment demonstration for two years, through December 31, 2019. The state, health plans, providers, beneficiary advocates, and other stakeholders are now considering what form integration efforts should take in 2020 and later years. Other states considering new integrated care programs and refinements to existing ones may find this discussion of current state approaches to be of interest.

New Resources on the ICRC Website

- Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working With Managed Care Delivery Systems (Integrated Care Resource Center/August 2017) This brief explores the experience of six states that have achieved varying levels of behavioral health and physical health integration or collaboration for dually eligible beneficiaries within a managed care environment. It describes: (1) opportunities for explicit state action and requirements to push development of integration components; and (2) opportunities for states to signal the importance of integration elements while providing flexibility to allow plans to innovate.
- Medicaid Agency Partnerships with State Health Insurance Programs: Opportunities to Improve Care for Medicare-Medicaid Enrollees (Integrated Care Resource Center/July 2017) This brief describes opportunities for Medicaid agencies to partner with State Health Insurance Assistance Programs (SHIPs) in educating Medicare-Medicaid enrollees and their families on new integrated care program options.
- Preventing Improper Billing of Medicare-Medicaid Enrollees in Managed Care: Strategies for States and Dual Eligible Special Needs Plans (Integrated Care Resource Center/July 2017) This brief describes the ongoing problem of improper billing of protected dually eligible beneficiaries for Medicare cost-sharing and describes steps states and health plans can take to address it.

News and Key Upcoming Dates

Recent Integrated Care News	
July 29	Deadline for CMS to inform currently contracted MA organizations of its decision not to renew a contract for 2018.
July 31	Part D national average monthly bid amount (NAMBA) released.
Key Upcoming Dates	
Mid-September	CMS executes Medicare Advantage and Prescription Drug Plan contracts.
Late September	Dual Eligible Special Needs Plans that requested review for a Fully Integrated Dual Eligible Special Needs Plan determination notified as to whether they meet required qualifications.
October 1	Medicare Advantage and Medicare Part D marketing begins for CY 2017.