

**DEPARTMENT**

**of HEALTH**

**and HUMAN**

**SERVICES**

**Centers for**

**Medicare & Medicaid**

**Services**

**Medicare-Medicaid**

**Coordination Office**

**Fiscal Year 2013 Report to Congress**

## Introduction

Section 2602 of the Patient Protection and Affordable Care Act<sup>1</sup>, hereinafter referred to as the Affordable Care Act, created the Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office”). The purpose of the Medicare-Medicaid Coordination Office (“the Office” or “MMCO”) is to bring together Medicare and Medicaid in order to more effectively integrate benefits, and improve the coordination between the Federal Government and states to ensure access to quality services for individuals who are enrolled in both programs<sup>2</sup> (Medicare-Medicaid enrollees, sometimes referred to as “dual eligibles”<sup>3</sup>). The Affordable Care Act sets forth the specific goals<sup>4</sup> and responsibilities<sup>5</sup> for the Office, including the annual submission of a Report to Congress.<sup>6</sup>

In its third year, MMCO continues to make progress on its statutory mandate, with a sustained focus on initiatives to better integrate care and ensure access to care for beneficiaries. This annual report describes the Office’s efforts to develop policies, programs, and initiatives that promote coordinated, high-quality, cost-effective care for all Medicare-Medicaid enrollees.

As the Office approaches this work in collaboration with state and Federal partners, beneficiaries, advocates, and providers, it will continue to identify areas where regulatory or legislative changes are needed to improve care coordination and benefits. This report contains

---

<sup>1</sup> (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

<sup>2</sup> Section 2602(b) of the Affordable Care Act states the purpose of the Federal Coordinated Health Care Office.

<sup>3</sup> Section 2602(f) defines Dual Eligible. In this section, the term ‘dual eligible individual’ means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII of such Act, and is eligible for medical assistance under a state plan under title XIX of such Act or under a waiver of such plan.

<sup>4</sup> Affordable Care Act section 2602(c) establishes the specific goals for MMCO: (1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs; (2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs; (3) Improving the quality of health care and long-term services for dual eligible individuals; (4) Increasing dual eligible individuals’ understanding of and satisfaction with coverage under the Medicare and Medicaid programs; (5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs; (6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals; (7) Eliminating cost-shifting between the Medicare and Medicaid programs and among related health care providers; and (8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

<sup>5</sup> Section 2602(d) of the Affordable Care Act sets forth the specific responsibilities of the Federal Coordinated Health Care Office.

<sup>6</sup> Section 2602(e) of the Affordable Care Act.

three such legislative recommendations, including two that were also presented in the previous year's report. The three legislative recommendations are included in the President's Fiscal Year (FY) 2015 Budget submission to the Congress. In addition, this report includes other issues identified by the Office as areas of interest for future consideration.

## **Legislative Recommendations to Improve Care Coordination**

The Affordable Care Act requires the Secretary of the Department of Health and Human Services (“Secretary”) to submit an annual report to the Congress that may include recommendations for legislation that would improve care coordination and benefits for Medicare-Medicaid enrollees.<sup>7</sup>

This year MMCO continues to recommend two legislative proposals that were included in the Fiscal Year 2012 Report to the Congress, as well as the President’s FY 2014 Budget:

- Provide the Secretary the authority to integrate the Medicare and Medicaid appeals processes; and
- Ensure retroactive Medicare Part D coverage of newly-eligible low income beneficiaries, the majority of whom are Medicare-Medicaid enrollees, by making “The Medicare Part D Demonstration for Retroactive and Point of Sale Coverage for Certain Low-Income Beneficiaries” (LI NET Demonstration) a permanent program.

MMCO also recommends the following new legislative proposal:

- Pilot the Program for All-Inclusive Care for the Elderly (PACE) to individuals between ages 21 and 55.

### **Integrate Appeals Process for Medicare-Medicaid Enrollees**

Consistent with last year’s report, the Office again submits a legislative recommendation for an integrated appeals process for Medicare-Medicaid enrollees.

Different provisions of the Social Security Act govern the Medicare and Medicaid appeals processes and therefore each program has different requirements related to time frames and

---

<sup>7</sup> Section 2602(e) of the Affordable Care Act states that “[the] Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, United States Code, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.” To avoid a possible conflict with the Recommendations Clause, U.S. Const. art. II, § 3, the Secretary interprets the section 2602(e) reference to legislative recommendations as precatory rather than binding.

limits, amounts in controversy, and levels of appeals.<sup>8</sup> In addition to these different requirements, the Medicare appeals process varies depending upon whether the claim involves Medicare Parts A and B, Part C, or Part D.<sup>9</sup> These requirements result in confusion, inefficiencies, and administrative burdens for beneficiaries, providers and states.<sup>10</sup> For plans that integrate Medicare and Medicaid services and benefits, such requirements may be barriers to seamless delivery of benefits and services to Medicare-Medicaid enrollees. For beneficiaries and their families, the disparate requirements can be confusing to navigate.

Establishing a streamlined appeals process for health plans that provide integrated care to Medicare-Medicaid enrollees would permit a more efficient, aligned system of program rules and requirements. Efforts are underway to fully integrate the service delivery and financing of the Medicare and Medicaid programs through the Medicare-Medicaid Financial Alignment Demonstrations (discussed later in this report). In developing Memoranda of Understanding and contracts to set terms for the different state demonstrations under that initiative, MMCO has worked closely with states to identify opportunities to more effectively integrate appeals systems under current law. However, legislative authority is needed to implement an integrated appeals system for the broader Medicare-Medicaid enrollee population enrolled in health plans that integrate Medicare and Medicaid benefits.

In order to increase access to seamless integrated programs for Medicare-Medicaid enrollees through a simpler, more user-friendly appeals process, the MMCO recommends legislation providing the Secretary with the necessary authority to develop such a system for health plans that provide integrated care to Medicare-Medicaid enrollees. The appeals process would consider information and insights from CMS' Alignment Initiative<sup>11</sup>, include public comments from CMS' May 2011 Federal Register notice, and maintain or improve current beneficiary appeals rights.

---

<sup>8</sup> See Social Security Act §§ 1852(g), 1860D-4(h), 1869(b), 1902(a)(3).

<sup>9</sup> *Id.*

<sup>10</sup> U.S. Government Accountability Office, Report to Congressional Requesters, "Medicare and Medicaid Consumer Protection Requirements Affecting Dual-Eligible Beneficiaries Vary across Programs," Payment Systems and States 15 (December 2012). Available at: <http://www.gao.gov/assets/660/650558.pdf>

<sup>11</sup> <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/AlignmentInitiative.html>

## **Ensure Retroactive Part D Coverage of Newly-Eligible Low-Income Beneficiaries**

The LI NET Demonstration helps ensure timely Medicare Part D coverage for newly eligible Medicare-Medicaid enrollees.<sup>12</sup>

CMS works closely with both states and the Social Security Administration to identify all Medicare-Medicaid enrollees and other individuals deemed eligible for the low-income subsidy (LIS). To avoid gaps in prescription drug coverage, CMS first enrolls full benefit dual eligible and Supplemental Security Income (SSI)-only beneficiaries, as well as all LIS-eligible beneficiaries with no Medicare Part D coverage for up to two prospective months, into the LI NET Demonstration plan. For beneficiaries who do not on their own elect a Medicare Part D plan within those two months, their coverage becomes effective in the Medicare Part D plan into which CMS has auto-enrolled them or facilitated their enrollment, to ensure coverage after the LI NET coverage expires. CMS uses auto-enrollment or facilitated enrollment to enroll all applicable LIS-eligible beneficiaries into a Medicare Part D prescription drug plan (PDP-only) that has a premium at or below the low-income premium benchmark.

The LI NET Demonstration was established to eliminate gaps in prescription drug coverage by having Medicare pay a specialized PDP using an alternative payment mechanism to provide retroactive coverage and limited prospective coverage for LIS-eligible enrollees during these gaps. Prior to the demonstration, CMS faced challenges finding a Part D Sponsor that could effectively cover all retroactive periods, (*i.e.*, that offered benchmark PDPs in all states, and across multiple years). By contracting with one plan, CMS established a single point of contact for beneficiaries and pharmacies seeking reimbursement. Additionally, to facilitate meaningful coverage during the retroactive periods, CMS removed network, formulary, and timely filing restrictions that would otherwise apply, as well as improved financial incentives for the demonstration plan to process all appropriate claims. Finally, CMS made the payment more reflective of the cost to operate the specialized PDP by reimbursing the LI NET plan using narrower risk corridors such that payments are closer to the actual costs.

---

<sup>12</sup> Through the LINET Demonstration, CMS can pay a single entity via an alternative payment mechanism to: (1) auto-enroll certain low-income beneficiaries and to provide retroactive and point of sale Part D coverage to full-benefit dual eligible and Supplemental Security Income (SSI)-only beneficiaries, from the date of retroactive eligibility to enrollment in a Part D plan; and (2) provide point of sale coverage to all uncovered, LIS beneficiaries, including partial-benefit dual eligible and other Part D LIS beneficiaries.

The LI NET Demonstration is scheduled to expire at the end of Calendar Year (CY) 2014. MMCO recommends to the Congress that this Demonstration be made permanent to ensure that Medicare-Medicaid enrollees continue receiving uninterrupted prescription drug coverage as they transition into the Medicare Part D program.

**Pilot the Program for All-Inclusive Care for the Elderly (PACE) Eligibility to Individuals  
between Ages 21 and 55**

MMCO seeks to enhance existing person-centered, integrated care models. The current PACE program serves individuals ages 55 and older who meet a nursing home level of care. PACE has proven successful in keeping these Medicare-Medicaid enrollees in the community and providing interdisciplinary integrated care to a frail population.

CMS proposes that the Congress amend the Social Security Act to provide CMS with the authority to launch a new pilot under which eligibility for PACE would be extended to individuals over age 21 in qualifying states. Under this authority, CMS could pursue testing in a limited number of sites, and pursue a formal evaluation to assess whether or not the PACE model of care would be successful in promoting community services in line with the integration of Olmstead, supporting self-determination, and achieving better health outcomes without increasing costs for this younger population.

## **Areas of Interest**

In addition to making specific legislative recommendations, this report includes two additional areas the Office is examining that may have potential to improve the experience of Medicare-Medicaid enrollees.

- Coverage standards for Medicare-Medicaid enrollees; and
- Cost-sharing rules for Qualified Medicare Beneficiaries (QMBs).

Below is additional background on each of these areas, including a description of existing law and concerns. This report is meant to update the Congress on the ongoing activity MMCO is undertaking to examine the impact of these potential issues. This report is not meant to make any policy recommendations in these areas.

### **Coverage Standards for Medicare-Medicaid Enrollees**

Medicare coverage policies can vary regionally and Medicaid policies vary state-to-state within Federal rules and guidelines. Where Medicaid and Medicare overlap on coverage rules and benefits, the programs may apply different threshold standards for items and services, which may result in confusion for states, providers, and Medicare-Medicaid enrollees. Varying coverage rules may also result in conflicting incentives, which could result in cost-shifting between programs and additional administrative expenses.

For example, Medicare and Medicaid have different rules for home health care coverage. The more expansive Medicaid home health benefit may create incentives for providers to bill Medicaid when Medicare should be the primary payer. On the other hand, in states where Medicare payments are more generous in relation to Medicaid payments, home health agencies may first seek Medicare payment for certain services. CMS conducted a demonstration from 2000-2010 using a statistical sampling methodology intended to more efficiently review

state-initiated home health appeals, and the evaluation is pending.<sup>13</sup> MMCO plans to leverage the knowledge gained from this evaluation to continue exploring this issue in greater depth.

**Cost-Sharing Rules for Qualified Medicare Beneficiaries (QMBs).**

State Medicaid programs pay Medicare cost-sharing (coinsurance and deductibles) for Medicare-Medicaid beneficiaries in the QMB program. These expenditures are reimbursed by the Federal Government according to each state's Federal medical assistance percentage (FMAP). Providers are prohibited from billing QMBs for Medicare cost-sharing, but complexities of the existing financing often result in that cost-sharing not being reimbursed.

MMCO is interested in studying the extent to which this issue occurs and whether it impacts beneficiaries' access to services or payment to providers.

---

<sup>13</sup> CMS operated the Home Health Third Party Liability Demonstration from 2000 to 2010.

## Review of 2013

In 2013, MMCO continued its work toward improving the care experience of Medicare-Medicaid enrollees nationwide. This work included the continued development and implementation of demonstrations, improvements to the availability and quality of data on beneficiaries, and other initiatives designed to better align the Medicare and Medicaid programs.

### Demonstrations

The Affordable Care Act gives CMS the ability to test innovative payment and service delivery models that have the potential to improve the coordination and quality of care furnished to beneficiaries while also reducing program expenditures in Medicare and Medicaid. CMS continues to implement several initiatives utilizing this authority<sup>14</sup> and advancing a well-coordinated, person-centered, more efficient care delivery system.

#### *Medicare-Medicaid Financial Alignment Initiative and State Demonstrations*

In 2011, CMS launched the Medicare-Medicaid Financial Alignment Initiative<sup>15</sup> to more effectively integrate the Medicare and Medicaid programs to improve the overall beneficiary experience, as well as both quality and costs of care. Through this initiative and related work, CMS is partnering with states to test models intended to achieve those goals, including a capitated model and a managed fee-for-service model.<sup>16</sup> Although the approaches differ in each

---

<sup>14</sup> Demonstrations discussed in this Report are conducted under the authority of the Center for Medicare and Medicaid Innovation, as described in section 3021 of the Affordable Care Act.

<sup>15</sup> As a first step to this effort in 2011, CMS awarded contracts worth up to \$1 million each to 15 States to design person-centered approaches to coordinate care across primary, acute, behavioral health, and long-term supports and services for Medicare-Medicaid enrollees. This initiative seeks to identify delivery system and payment integration models that can be tested and, if successful, replicated in other States. CMS awarded contracts to the following States: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. Many of these States are pursuing one of the two models in the Financial Alignment Initiative, or are continuing to work with CMS on alternative models.

<sup>16</sup> As reported in previous Reports to Congress: under the capitated model, a State, CMS, and health plan or other qualified entity enter into a three-way contract through which the health plan or other qualified entity will receive a prospective blended payment to provide comprehensive, coordinated care. Under the managed fee-for-service model, a State and CMS enter into an agreement by which the State would invest in care coordination and be eligible to benefit from savings resulting from such initiatives that improve quality and costs. Both models are

state demonstration, all beneficiaries will receive all the current services and benefits they receive today from Medicare and Medicaid with added care coordination, beneficiary protections, and access to enhanced services.<sup>17</sup>

To date, CMS has entered into Memoranda of Understanding (MOUs) with ten states to test new models: California, Colorado, Illinois, Massachusetts, Minnesota, New York, Ohio, South Carolina, Virginia, and Washington. Seven of these states (California, Illinois, Massachusetts, New York, Ohio, South Carolina, and Virginia), are pursuing the capitated model. Colorado is pursuing the managed fee-for-service model. Washington is pursuing both the managed fee-for-service model and the capitated model. Minnesota is pursuing an alternative model, building on its longstanding Minnesota Senior Health Options (MSHO) program.<sup>18</sup>

Approved demonstrations are at different stages of implementation. The Washington fee-for-service demonstration began on July 1, 2013. Health plans in Massachusetts began serving beneficiaries on October 1, 2013, and plans participating in the Illinois demonstration are accepting beneficiary enrollment for a planned effective date of March 1, 2014. In other states with signed MOUs, beneficiaries will begin enrollment at various points in 2014.

---

designed to improve quality and achieve State and Federal health care savings by improving health care delivery, encouraging high-quality, efficient care, and better streamlining services. The authority for these models and Demonstrations was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act) coupled with the relevant Medicaid authority. Congress created the Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures ... while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or State Children’s Health Insurance Program (CHIP) benefits.

<sup>17</sup> For example, in Massachusetts beneficiaries will receive new services such as dental benefits and diversionary behavioral health services. Massachusetts MOU, supra note 31, at page 69-81.

<sup>18</sup> CMS is also continuing to work with some states to pursue demonstrations designed to improve care for Medicare-Medicaid enrollees outside the two models of the Financial Alignment Initiative. Minnesota’s demonstration is separate and distinct from the Financial Alignment Initiative. Minnesota’s demonstration involves a set of administrative improvements that will simplify the process for beneficiaries to access the services for which they are eligible under Medicare and Medicaid. Accordingly, Minnesota’s demonstration will not use the passive enrollment approach applied in other states testing capitated models. Instead, the demonstration focuses on ways to improve the beneficiary experience in health plans that maintain separate contracts with CMS as D-SNPs and with the state. More information on the Minnesota demonstration is available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Minnesota.html>.

CMS continues to work with other states on initiatives designed to improve care coordination for Medicare-Medicaid enrollees.<sup>19</sup> This work will continue to be an important part of MMCO's efforts in the coming year.

### *Monitoring, Oversight, and Infrastructure Investments*

As more demonstrations move toward implementation, CMS and the states have invested in new monitoring and oversight activities designed to protect beneficiary rights and maximize the benefits of integrated care. These activities include:

- *Readiness Reviews* – Plans participating in the capitated model and states participating in the managed fee-for-service model must complete readiness reviews prior to the start of the demonstration. These comprehensive reviews help ensure that each plan or state is ready to accept enrollments, provide the required continuity of care, ensure access to the full spectrum of providers, and fully meet the diverse needs of the Medicare-Medicaid population.
- *Implementation Funding* – The 15 states that previously received design contracts for a Demonstration to Integrate Care for Dual Eligible Individuals and also have a signed MOU for the demonstration are eligible for additional funding for implementation activities, especially those activities that promote beneficiary engagement and the protection of beneficiary rights. As of February 2014, CMS has made awards to California, Massachusetts, Minnesota, New York, and Washington.<sup>20</sup>
- *Contract Management Teams* – For each capitated demonstration, CMS and the state establish a joint Contract Management Team (CMT), which represents Medicare and Medicaid in all aspects of the three-way contract. The CMT is responsible for day-to-day monitoring of the demonstration and conducts contract management activities related to

---

<sup>19</sup> Additional states with whom CMS continues to work are listed on the Financial Alignment Demonstration website at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html).

<sup>20</sup> Additional information is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ImplementationSupportforStateDemonstrations.html>.

ensuring access, beneficiary protections, quality, program integrity, and financial solvency.

- *Funding for Ombudsman Services* – Through funding provided by CMS and technical support from the Administration for Community Living, the Demonstration Ombudsman Programs provide beneficiaries in states with approved Financial Alignment demonstrations with access to person-centered assistance in answering questions and resolving issues, monitor the beneficiary experience, and offer recommendations to CMS, the states, and participating plans. As of January 2014, CMS has made awards to California, Illinois, and Virginia through this funding opportunity.<sup>21</sup>
- *Funding for State Health Insurance Counseling and Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs)* – This funding supports local SHIPs and ADRCs in providing beneficiary outreach and one-on-one options counseling in states participating in demonstrations. As of January 2014, CMS has made awards to California, Illinois, Massachusetts, Virginia, and Washington.<sup>22</sup>

#### *Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents*

Research shows that nearly 45 percent of hospitalizations among Medicare-Medicaid enrollees are avoidable, costing the Federal Government billions each year.<sup>23</sup> These avoidable hospitalizations can be disruptive, dangerous and costly for Medicare-Medicaid enrollees residing in nursing facilities. Numerous researchers and policymakers have noted that payment structures in Medicare and Medicaid may not adequately incentivize nursing facilities to intervene to reduce preventable hospital utilization. In particular, transferring Medicare-

---

<sup>21</sup> Additional information is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html>

<sup>22</sup> Additional information is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOptionsCounselingforMedicare-MedicaidEnrollees-.html>

<sup>23</sup> Walsh, E., Freiman, M., Haber, S., Bragg, A., Ouslander, J., & Wiener, J. (2010). Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community Based Services Waiver Programs. Washington, DC: CMS. Also available at [http://innovation.cms.gov/Files/x/rahnfr\\_foa.pdf](http://innovation.cms.gov/Files/x/rahnfr_foa.pdf).

Medicaid enrollees receiving long-term care in nursing facilities to hospitals may create inappropriate financial incentives that increase Medicare spending.<sup>24</sup>

To address this misalignment, in early 2012 CMS launched the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents<sup>25</sup>. Under this demonstration, CMS is partnering with seven organizations<sup>26</sup> to test strategies to reduce avoidable hospitalizations for Medicare and Medicaid enrollees who are long-stay residents of nursing facilities.<sup>27</sup> Selected organizations are partnering with approximately 145 nursing facilities to test evidence-based interventions to accomplish these goals and will implement and operate proposed interventions over a four-year period. The demonstration began serving Medicare and Medicaid enrollees in February 2013.

CMS staff have worked closely with participating organizations to support implementation of the model. This support includes learning and diffusion activities designed to facilitate collaboration between model participants, as well as careful monitoring of the experience of beneficiaries in the model. CMS expects preliminary evaluation findings in late 2014.

### *Evaluation of the Demonstrations*

CMS is funding and managing the evaluation of all demonstrations, including demonstrations under the Financial Alignment initiative and the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents. CMS has contracted with an external independent evaluator, RTI International, to measure, monitor, and evaluate the overall impact of the demonstrations, including impacts on Medicare and Medicaid expenditures and service utilization and quality, as well as patient level outcomes and patient-centeredness measures related to each care model. Examples of the types of areas that will be measured in all demonstrations include beneficiary

---

<sup>24</sup> Medicare Payment and Advisory Commission June 2010 Report at page 141, available at: [http://www.medpac.gov/documents/jun10\\_entirereport.pdf](http://www.medpac.gov/documents/jun10_entirereport.pdf).

<sup>25</sup> Press Release, <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4304>

<sup>26</sup> The selected participants are in Alabama, Nebraska, Indiana, Missouri, New York, Pennsylvania, and Nevada. For a full list of these participants, please go to: <http://innovation.cms.gov/initiatives/rahnfr/>.

<sup>27</sup> The initiative directly supports CMS' ongoing work to reduce avoidable hospitalizations for Medicare-Medicaid enrollees. The goals of this initiative are to: (1) reduce the number of and frequency of avoidable hospital admissions and readmissions; (2) improve beneficiary health outcomes; (3) provide better transition of care for beneficiaries between inpatient hospitals and nursing facilities; and (4) promote better care at lower costs while preserving access to beneficiary care and providers.

experience of care, care coordination, care transitions, and the caregiver experience, among many others. State-specific and aggregate evaluation plans are available on the Financial Alignment initiative website.<sup>28</sup>

### **Integrated Denial Notice**

Medicare health plans are required to provide enrollees with a written notice in understandable language that explains the plan's reasons for denying a request for payment or coverage of a service the beneficiary has already received or has requested to receive.<sup>29</sup> This written notice must include a description of the applicable appeals processes.<sup>30</sup> There are separate requirements for Medicaid managed care plans<sup>31</sup> which means that plans contracting with both Medicare and Medicaid must use two separate forms to issue such a denial notice. This can be especially confusing for a beneficiary when a service is denied by one payer but covered by another.

In 2012, CMS formally launched the process to issue an integrated notice in which the existing Medicare Notice of Denial of Payment will be expanded to include optional language for use in cases where a Medicare health plan also contracts with Medicaid to provide Medicaid benefits.<sup>32</sup> This integrated denial notice is a first step in streamlining requirements. It leverages existing authority and procedures to better align appeals, and enhances existing Medicare and Medicaid beneficiary protections by providing individuals with a unified and understandable form.

In FY 2013, the notice was put into use through the Medicare-Medicaid Financial Alignment Demonstration. The notice was also finalized in late 2013 for Medicare Advantage plans that integrate Medicare and Medicaid benefits.

---

<sup>28</sup> Available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.

<sup>29</sup> Social Security Act § 1852(g)(1)(B).

<sup>30</sup> Regulatory authority for this notice is set forth in Subpart M of Part 422 at 42 CFR 422.568, 422.572, 417.600(b), and 417.840.

<sup>31</sup> The Medicaid managed care appeals regulations are set forth in Subpart F of Part 438 of Title 42 of the CFR. Rules on the content of the written denial notice can be found at 42 CFR 438.404. <http://www.gpo.gov/fdsys/pkg/FR-2012-09-07/pdf/2012-22087.pdf>

<sup>32</sup> Federal Register, Vol. 77, No. 174, Friday September 07, 2012, Notices. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2012-09-07/pdf/2012-22087.pdf>.

## **Quality Improvement**

A primary goal of the MMCO is to improve quality of care for Medicare-Medicaid enrollees.

CMS continued work in improving quality measures for Medicare-Medicaid enrollees in partnership with a multi-stakeholder group convened by the National Quality Forum (NQF). This work builds upon a recommended starter set of quality measures that have been incorporated into the Medicare-Medicaid Financial Alignment Demonstrations. The NQF workgroup is exploring quality measures responsive to the needs of subpopulations of Medicare-Medicaid enrollees (*e.g.*, behavioral health measures) as well as delving into high priority measurement gaps in areas such as quality of life and coordination across clinical care and long term services and supports. These efforts are all focused on assessing the most critically important aspects of care for Medicare-Medicaid enrollees. Based on recommendations from NQF, CMS has also begun work to develop and test expanded measure sets for long term services and supports.

CMS has also been collaborating with NCQA in working with advocates, health systems and providers to identify key elements for measures of high quality integrated, person-center care. This pioneering effort includes identification of critical aspects of integrated care that lead to improved health outcomes as well as a clear focus on the beneficiary's preferences and goals within a health system that coordinates successfully across clinical and community health care.

CMS will continue to work with NQF, the National Committee for Quality Assurance, as well as other partners on the development of programs and measures that support quality improvement for the entire Medicare-Medicaid enrollee population.

## **Data and Analytics: A Better Understanding of Medicare-Medicaid Enrollees**

CMS has undertaken numerous efforts to improve access to Medicare and Medicaid data to support better care for Medicare-Medicaid enrollees. A lack of access to data and challenges integrating Medicare and Medicaid data have been long-standing barriers to care coordination.

### *Enhancements to Available Medicare and Medicaid Data*

The CMS Chronic Condition Warehouse (CCW) is a research database designed to make Medicare and Medicaid claims data, nursing home and home health assessment data, and Part D Prescription Drug Event data more readily available to support policymakers and research designed to improve the quality of care, reduce costs and increase efficient utilization.<sup>33</sup>

Traditionally, researchers and both Federal and state government officials use the CCW to understand beneficiaries' utilization, demographics, and spending, as well as other key factors to identify and support policies and programs that ensure a more effective and efficient delivery of services.

In early 2013, CMS released a second set of new diagnostic condition flags (coding used to identify characteristics/demographics) for the CCW to more fully represent conditions prevalent among Medicare-Medicaid enrollees. These new flags focused on conditions more prevalent among individuals with intellectual and developmental disabilities. For example, bipolar disorder and schizophrenia are newly-added condition flags that support analysis to better understand beneficiaries and take into account the full beneficiary care experience. This release supplemented multiple updates to the CCW made in FY 2012.<sup>34</sup> Through these updates, MMCO strives to facilitate and streamline research on beneficiary conditions and allow for a more targeted use of resources.

### *Integrated Medicare-Medicaid Data*

To support enhanced care coordination, CMS made available a new Medicare-Medicaid integrated data set within the CCW that is now available to states, policymakers, and researchers.<sup>35</sup> This data set provides tools to identify new opportunities for care coordination, including information on eligibility, enrollment, beneficiary conditions, service use and expenditures for both the Medicare and Medicaid programs. The data set will assist researchers, as well as Federal and state policymakers, to better identify regions, populations or necessary

---

<sup>33</sup> The Chronic Condition Warehouse, available at: <http://www.ccwdata.org/index.htm>.

<sup>34</sup> For more information on previous updates, please reference the FY 2012 Report to Congress of the Medicare-Medicaid Coordination Office: [http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO\\_2012\\_RTC\\_v2.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_2012_RTC_v2.pdf).

<sup>35</sup> The Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS): <http://www.ccwdata.org/data-dictionaries/index.htm#linkedfiles>.

interventions to improve the quality, cost, and utilization of care for Medicare-Medicaid enrollees, including for individuals who need long term supports and services. Data sets for 2006-2008 were released in 2012, and the 2009 data set was released in early 2013.

As indicated in our FY 2011 Report, CMS established a process for states to access Medicare data to support care coordination for Medicare-Medicaid enrollees, while also protecting beneficiary privacy and confidentiality.<sup>36</sup> In FY 2013, CMS continued this work, expanding to 31 the total number of states receiving or working with CMS to receive these data.<sup>37</sup> With the new integrated data set tool, states are better equipped to coordinate benefits and services in a seamless, cost-effective manner.

### *State Data Resource Center*

Supplementing efforts to increase access to Medicare and Medicaid data to support care coordination, CMS developed and launched the State Data Resource Center (SDRC) to provide more tools and support for states using the data referenced in the above sections. The SDRC assists states with their data requests, guides states on how to best use the data, provides technical consultation and helps states maximize the use of data to set priorities and support care coordination. In FY 2013, this assistance included numerous webinars meant to share best practices and guide states through key steps in obtaining and utilizing this important data. The SDRC is open to all states and will further support states in their development of coordinated care initiatives.

---

<sup>36</sup> Assuring compliance with the Privacy Act, the Health Insurance Portability and Accountability Act, and the corresponding implementing rules. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/MedicareDataforStates.html>.

<sup>37</sup> As of January 6, 2014, 31 states (AR, AZ, CA, CO, CT, FL, IN, IL, IA, KS, LA, MA, MD, ME, MI, MN, MO, NC, NY, OH, OK, OR, PA, RI, SC, TN, TX, VA, VT, WA, and WI) have been approved for or are actively seeking Medicare A/B data. Twenty-five states (AZ, CA, CT, CO, IL, IA, LA, MA, ME, MI, MO, MN, NC, NY, OH, OK, OR, PA, RI, TN, TX, VA, VT, WA and WI) have been approved for or are actively seeking Medicare Part D data. Other states continue to request access and are working with CMS to receive data use agreements.

## **Conclusion**

In its third year, the Medicare-Medicaid Coordination Office continued making important strides toward its goals of improving the beneficiary experience with the Medicare and Medicaid programs across the entire continuum of care. Building on the important work that began in earlier years, the Office made progress in the areas of Program Alignment and Data Analytics. Demonstrations developed through the authority of the Center for Medicare and Medicaid Innovation continued to progress, with the first beneficiaries having the opportunity to enroll in plans that can offer a comprehensive set of Medicare and Medicaid benefits.

Through continuous collaboration with our state and Federal partners, and with beneficiaries, their advocates, providers and other stakeholders, CMS will continue to work to identify legislative recommendations such as those discussed in this report. The Office looks forward to continuing to work with the Congress and is committed to keeping the Congress and other stakeholders apprised of its work to ensure quality, coordinated care for all Medicare-Medicaid enrollees.