

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MEDICARE-MEDICAID COORDINATION OFFICE

FISCAL YEAR 2015 REPORT TO CONGRESS



INTRODUCTION

Section 2602 of the Patient Protection and Affordable Care Act, hereinafter referred to as the Affordable Care Act, created the Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office” hereinafter “the Office” or “MMCO”). The purpose of 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 enhance access to quality services for individuals who are enrolled in both programs (Medicare-Medicaid enrollees, sometimes referred to as “dual eligibles”). The Affordable Care Act sets forth goals and responsibilities for the Office, including the annual submission of a Report to Congress.

The Medicare and Medicaid programs were originally created as distinct programs with different purposes. Not surprisingly, the programs have different rules for eligibility, covered benefits, and payment. Over the past 50 years, the Medicare and Medicaid programs have operated as separate and distinct systems despite a growing number of people who depend on both programs for their health care. There is an increasing need to align these programs to improve care delivery for enrollees.

Efforts by MMCO and numerous partners in the public and private sectors have changed the care delivery and payment environment significantly since the Office’s inception, both within CMS and more broadly. With more than 55 million individuals covered by Medicare and more than 50 million covered by Medicaid on the 50th anniversary of the programs in 2015, CMS is in a position to shift payment for services from volume to value at a rapid pace. That work has already begun; the Agency is focused on new payment models that align with the HHS framework, released in 2015, which categorizes health care payment according to provider accountability for quality and total cost of care and emphasizes population health management rather than payment for specific services. CMS has also increased its focus on integrated service delivery as a means toward improving quality, beneficiary-centered care, bending the health care cost curve, and using data to inform the design and continuous improvement of new initiatives.

As MMCO continues this work in collaboration with state and Federal partners, beneficiaries, advocates, and providers, we will continue to identify areas where regulatory or legislative changes are needed to improve care coordination and benefits. This report contains four such legislative recommendations, three of which were also presented in the previous year’s report. The legislative recommendations are included in the President’s Fiscal Year (FY) 2017 Budget.

In its fifth year, MMCO continues to make progress on its statutory mandate, with a sustained focus on initiatives to better integrate and strengthen access to care for beneficiaries dually eligible for Medicare and Medicaid. In this report, we discuss some of the ways in which CMS is:

- Rapidly implementing delivery system reform, including models that integrate Medicare and Medicaid service delivery and financing and eliminate cost-shifting between the two programs;
- Improving the quality of facility-based health care and long-term services, while encouraging care delivery in community-based settings wherever possible;
- Investing in new ways to support beneficiaries in accessing care and understanding their Medicare and Medicaid benefits;

- Providing more support to states to develop and implement new models, including models that address regulatory conflicts between Medicare and Medicaid;
- Providing more support to providers to engage in new models that promote access to care, continuity of care, and safe care transitions;
- Making data more accessible to improve care to beneficiaries; and
- Developing performance measures that reflect beneficiary experience and quality of services provided to high-need, high-cost individuals, including Medicare-Medicaid enrollees.

ABOUT MEDICARE-MEDICAID ENROLLEES

Individuals enrolled in both Medicare and Medicaid tend to have complex, chronic care needs. During 2013, more than 10.7 million Americans¹ were enrolled in both the Medicare and Medicaid programs, representing a 24 percent increase from 2006. Two-thirds of this population were low-income elderly individuals, and one-third were individuals who were under age 65 and had disabilities. About 43 percent of Medicare-Medicaid enrollees had a Medicare-qualifying disability, compared to 12 percent of Medicare-only beneficiaries. Overall, Medicare-Medicaid enrollees have had a higher prevalence of many conditions (including, but not limited to, diabetes, pulmonary disease, stroke, Alzheimer’s disease, and mental illness) than their Medicare-only and Medicaid-only peers. Medicare-Medicaid enrollees’ health costs were four times greater than those of all other people with Medicare.²

More than 10.7 million Americans are enrolled in both the Medicare and Medicaid programs

For Medicare-Medicaid enrollees, Medicare coverage includes primary, preventive, and acute health care services and prescription drugs. Medicaid covers a comprehensive range of services, but since it is always the payer of last resort, for Medicaid-Medicare enrollees, it covers supplemental benefits services such as durable medical equipment (DME) and home health for less acute needs, as well as services not covered by Medicare,

such as long-term care services and supports. Medicaid also provides help to qualifying individuals with low incomes to pay their Medicare premiums and cost-sharing. A lack of alignment and cohesiveness between the programs can lead to fragmented or episodic care for Medicare-Medicaid enrollees and misaligned incentives for both payers and providers, resulting in reduced quality and increased costs to both programs and to enrollees. Enrollees could benefit from more integrated systems of care that meet all of their needs – primary, acute, long-term, behavioral, and social – in a high quality, cost-effective manner. Better alignment of the administrative, regulatory, statutory, and financial aspects of these two programs holds promise for improving the quality and cost of care for this complex population.

LEGISLATIVE RECOMMENDATIONS TO IMPROVE CARE COORDINATION

The Affordable Care Act requires the Secretary of the Department of Health and Human Services (hereinafter “the 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.³

In the FY 2014 Report to Congress, as well as the President’s FY 2015 and FY 2016 Budgets, CMS recommended that the Congress create a pilot to expand Programs of All-Inclusive Care for the Elderly (PACE) eligibility to individuals between ages 21 and 55. Over time, we have worked with our partners in the HHS Administration for Community Living, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), and with external stakeholders to further develop the parameters for a PACE-like model for individuals between ages 21 and 55.

On November 5, 2015, President Obama signed into law the PACE Innovation Act. The PACE Innovation Act gives CMS new opportunities to test PACE-like models, including for younger adults with disabilities. We are assessing these opportunities currently. As a result, the President’s FY 2017 Budget does not include the PACE proposal from prior years.

This year, CMS continues to recommend three other legislative proposals that were included in the FY 2014 Report to Congress and the President’s FY 2016 Budget:

- Ensure Retroactive Part D Coverage of Newly-Eligible Low-Income Beneficiaries;
- Establish Integrated Appeals Process for Medicare-Medicaid Enrollees; and
- Allow for Federal/State Coordinated Review of Dual Eligible Special Needs Plan Marketing Materials.

CMS also recommends the following new legislative proposal, which also is in the President’s FY 2017 Budget:

- Improve Alignment of Medicare Savings Program and Part D Low-Income Subsidy (LIS) Income and Asset Definitions.

Each of these recommendations is discussed in greater detail below.

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

Consistent with last year’s report, CMS recommends that the Medicare Part D Demonstration for Retroactive and Point of Sale Coverage for Certain Low-Income Beneficiaries (LI NET Demonstration) be made a permanent program. Over the past several years this demonstration has been successful in helping to provide timely Medicare Part D coverage for newly eligible Medicare-Medicaid enrollees.

The LI NET Demonstration was established to fill gaps in prescription drug coverage by enabling Medicare to pay a specialized Part D plan to provide retroactive coverage and limited prospective coverage for low-income subsidy-eligible enrollees during these gaps. Prior to the demonstration, CMS faced challenges finding a Part D sponsor that could effectively cover all retroactive periods, in all states, and across multiple years. By contracting with one plan, CMS established a single point-of-contact for enrollees and pharmacies seeking reimbursement.

CMS works closely with both states and the Social Security Administration to identify all Medicare-Medicaid enrollees and other individuals deemed eligible for the LIS. To avoid gaps in prescription drug coverage, CMS first enrolls LIS-eligible individuals into the LI NET Demonstration plan for uncovered retroactive months and up to two prospective months. For beneficiaries who do not elect a Medicare Part D plan within those two months, CMS enrolls the individuals in a Medicare Part D plan that has a premium at or below the low-income premium benchmark to provide coverage after the LI NET coverage expires.

The LI NET Demonstration has been extended through the end of Calendar Year (CY) 2019. CMS recommends to the Congress that this Demonstration be made permanent so that Medicare-Medicaid enrollees continue to receive uninterrupted prescription drug coverage as they transition into the Medicare Part D program.

Establish Integrated Appeals Process for Medicare-Medicaid Enrollees

Consistent with last year's report, CMS again submits a legislative recommendation for an integrated appeals process for Medicare-Medicaid enrollees in managed care plans providing Medicare and Medicaid benefits.

Different provisions of the Social Security Act govern the Medicare and Medicaid appeals processes, and therefore each program has different requirements related to procedures, amounts in controversy, and levels of appeals. In addition to these different requirements, the Medicare appeals process varies depending upon whether the claim involves Medicare Parts A, B, C, or D. These requirements can result in confusion, inefficiencies, and administrative burdens for enrollees, providers, and states. For providers that serve Medicare and Medicaid enrollees, such requirements may be barriers to seamless delivery of benefits and services to Medicare-Medicaid enrollees. For enrollees, caregivers, and their families, the disparate requirements can be confusing to navigate and may delay access to care.

Establishing a streamlined appeals process for Medicare-Medicaid health plan 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 Initiative (discussed later in this report). In developing memoranda of understanding and contracts to set terms for the different demonstrations under that initiative, CMS 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 population enrolled in health plans that integrate Medicare and Medicaid benefits.

In order to increase access to more seamlessly integrated programs for Medicare-Medicaid health plan enrollees through a simpler, more user-friendly appeals process, CMS 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's Alignment Initiative, including public comments received in response to CMS's May 2011 Federal Register notice, Opportunities for Alignment under Medicaid and Medicare: Request for Information (FRN Doc. No. 2011-11848; in which we identified a range of policy alignment opportunities and solicited comments), as well as experience gained from the ongoing Financial Alignment Initiative, a series of demonstrations testing comprehensive, integrated care delivery models, to maintain or improve the current enrollee appeals experience.

Allow for Federal/State Coordinated Review of Dual Eligible Special Needs Plan Marketing Materials

Under existing law, all marketing materials provided to enrollees by Medicare Advantage (MA) plans—including Dual Eligible Special Needs Plans (D-SNPs)—must be reviewed by CMS for accuracy, content, and other requirements. Because integrated D-SNPs also market to Medicaid enrollees, many of the same marketing and enrollee communications materials must also go through a separate review by a State Medicaid Agency for compliance with a different set of rules and regulations governing Medicaid managed care organizations. Current statute explicitly directs CMS to review marketing materials. The absence of shared marketing review responsibility with states leads to duplicative and frequently non-concurrent reviews by states and CMS. It also leads to difficulty ensuring both the Medicare and Medicaid information provided by D-SNPs is accurate and understandable to Medicare-Medicaid enrollees.

CMS has explored this flexibility in a demonstration in Minnesota, through which CMS allows a more integrated marketing review that leverages the relative strengths of both state and Federal review, in order to establish a process and materials that improve the enrollee experience, while maintaining rigorous standards.

Consistent with last year's report, CMS again recommends introducing flexibility to rules around the review of marketing and enrollee communications materials provided by D-SNPs. Providing CMS with the ability to perform cooperative and concurrent reviews with states of these marketing and enrollee communications materials, for compatibility with a unified set of standards, will reduce the burden on CMS, the states, and plans, resulting in a more uniform message to enrollees and improved quality of materials.

Improve Alignment of Medicare Savings Program and Part D Low-Income Subsidy Income and Asset Definitions

Under existing law, income and asset definitions used to determine eligibility for Medicare Savings Programs (MSPs) that help beneficiaries pay Medicare premiums, deductibles, coinsurance, and copayments do not always align with the definitions of countable income and assets currently used to determine eligibility for the Medicare Part D LIS. This means that determination of eligibility for the Part D LIS by the Social Security Administration (SSA) does not necessarily provide enough information to allow a state to determine if a beneficiary is automatically eligible for MSP, even though many of those currently enrolled in LIS also meet their states' eligibility standards for MSP. This is true even though the statute requires an application for LIS to be considered to be an application for MSP as well (unless an applicant opts out) and the SSA provides states with complete records of LIS applications in order to permit the states to determine MSP eligibility.

As a result, beneficiaries in some states are found eligible for LIS but subsequently need to provide documentation to another office on the value of a burial fund or life insurance policy before being found eligible for MSP. These extra verification steps are a barrier to MSP enrollment, as they complicate outreach to potential beneficiaries and can deter potentially eligible MSP beneficiaries from completing applications. They also create extra administrative work for low-income individuals and for state eligibility workers.

Moreover, as an increasing number of low-income adults move into Medicare after having coverage through new categories of Medicaid eligibility or subsidized coverage in the Marketplace, streamlined eligibility standards are becoming more important.

The proposal would change MSP income and asset rules to be no more restrictive than LIS rules in the following categories: life insurance, in-kind support and maintenance, and treatment of burial funds.

AREAS OF INTEREST

In addition to making specific legislative recommendations, this report includes four policy areas CMS is examining that have the potential to improve the experience of Medicare-Medicaid enrollees.

- Coverage Standards for Overlapping Medicare and Medicaid Benefits
- Cost-Sharing Rules for Qualified Medicare Beneficiaries
- Quality Measures and Medicare-Medicaid Enrollees
- Payment Accuracy

We discuss each of these areas below. This report is meant to update the Congress on the ongoing activity CMS is undertaking to examine the impact of these areas, and is not meant to make any specific policy recommendations in these areas.

Coverage Standards for Overlapping Medicare/Medicaid Benefits

CMS continues to examine better aligning coverage standards for beneficiaries where Medicare and Medicaid benefits overlap. For services such as durable medical equipment and home health, the programs may apply different standards for covering the same item or service. CMS continues to assess whether these complexities adversely affect access to care, create inefficiencies, result in conflicting incentives, or lead to cost-shifting between programs that can harm beneficiaries and increase costs.

DME is an example of where differences in eligibility, coverage standards, and supplier requirements may lead to challenges in access to needed equipment for Medicare-Medicaid enrollees. Prompt access to needed DME – including repairs – is critical to maintaining health and preventing complications that harm the beneficiary and result in needless costs (e.g., ER visits or hospital admissions). Addressing this issue remains a point of focus for CMS.

Cost-sharing Rules for Qualified Medicare Beneficiaries

State Medicaid programs pay Medicare Parts A and B premiums and cost-sharing (coinsurance and deductibles) for Medicare-Medicaid enrollees in the Qualified Medicare Beneficiary (QMB) program. These expenditures are reimbursed by the Federal Government according to each state's Federal Medical Assistance Percentage. States have the option to limit their payment of Medicare deductibles and coinsurance to the lesser of the Medicare cost-sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service. A recent study by the Medicaid and CHIP Payment and Access Commission (MACPAC) showed that most states have now taken up the latter option.⁴

By law, Medicare providers may not bill QMBs for any balances that are not reimbursed by the state, commonly known as balance billing. Part A providers such as hospitals can collect bad debt payments for part of this difference in payment from Medicare; Part B providers and suppliers, however, including primary care physicians and specialists, are typically not eligible for bad debt payments.

In March 2015, MACPAC summarized its analysis showing that Medicare-Medicaid enrollees (including QMBs as well as other full-benefit dually eligible individuals for whom states opt to cover Medicare cost-sharing) have greater access to certain primary care and behavioral health in states that pay a higher percentage of Medicare cost-sharing. In July 2015, MMCO published a study quantifying the impact on QMBs' utilization of outpatient services in states that pay less than full Medicare cost sharing and, through interviews with beneficiaries, the financial and other impacts on beneficiaries when providers improperly balance bill and improperly refer beneficiaries to collection agencies.⁵ Issues of access to care and improper billing are an ongoing point of focus for CMS.

Quality Measures and Medicare-Medicaid Enrollees

Private plans and other stakeholders have raised concerns that plans with a high percentage of Medicare-Medicaid and/or Part D LIS enrollees are disadvantaged in the current Medicare Part C and D Star Rating Program. CMS, in coordination with ASPE, has gathered information and conducted research to determine if the star ratings are sensitive to the socio-economic and disability status of a Part C and D contract's enrollees. The research to date has provided empirical evidence that there exists a within-contract effect from enrollees' Medicare-Medicaid, LIS, and disability status for a subset of the star ratings measures.⁶

CMS is firmly committed to building the foundation for a long-term solution that appropriately addresses the issue and aligns with our policy goals. CMS has encouraged the measure stewards for the impacted subset of measures to examine our findings and undertake an independent evaluation of the measures' specifications to determine if measure re-specification is warranted. While the measure stewards are undertaking this review, CMS is exploring options for interim analytical adjustments to address the effect of enrollees' Medicare-Medicaid, LIS, and disability status on contracts' star ratings, including the proposed adjustment methods, discussed in more detail in the November 12, 2015, Request for Comments: Enhancements to the Star Ratings for 2017 and Beyond.⁶

CMS is also developing a star rating system for Medicare-Medicaid Plans (MMPs) operating under the capitated model of the Medicare-Medicaid Financial Alignment Initiative to capture the breadth

of plans' responsibility for delivering high quality care across the spectrum of Medicare and Medicaid benefits, and to serve as an aid for meaningful plan comparison used by potential enrollees, which is similar to other star rating systems developed by CMS. The MMP star rating system will also be robust enough to serve as a potential basis for quality-based payments for plans. While a new, fully mature star rating system will not be in place during the testing of the capitated model of the Financial Alignment Initiative, we intend to start work now to prepare for potential future expansion of the Model.

Payment Accuracy

In 2015, CMS evaluated the accuracy of the 2014 CMS-Hierarchical Condition Category (HCC) risk adjustment model in predicting costs of Medicare-Medicaid enrollees. The evaluation found that the model:

- predicts national costs well for Medicare-Medicaid enrollees who are long-term residents in facility settings, and
- with respect to Medicare-Medicaid enrollees residing in the community, under-predicts costs for full-benefit enrollees and over-predicts costs for partial-benefit enrollees.

In November 2015, CMS solicited public comment on the findings of this analysis and on plans for a potential revised risk adjustment model for MA plans for payment year 2017. For payment year 2016, payments to Medicare-Medicaid Plans participating in the demonstrations under the Financial Alignment Initiative will continue to be based on the prevailing risk adjustment model used for beneficiaries enrolled in MA. However, CMS will adjust Medicare Parts A and B payments to health plans participating in the demonstrations, which exclusively enroll full-benefit Medicare-Medicaid beneficiaries, to better align payments with fee-for-service costs. Ensuring payment accuracy will be a continuing point of focus in future years.

REVIEW OF 2015⁷

In its fifth year, MMCO continues to make progress on its statutory mandates, with a sustained focus on initiatives to better integrate and strengthen access to care for beneficiaries dually eligible for Medicare and Medicaid and to eliminate cost-shifting between the two programs.

Efforts by MMCO and numerous partners in the public and private sectors have changed the care delivery and payment environment significantly since the Office's inception. With more than 55 million individuals covered by Medicare and more than 50 million covered by Medicaid on the 50th anniversary of the programs in 2015, CMS is in a position to shift payment for services from volume to value at a rapid pace. That work has already begun; the Agency is focused on new payment models that align with the HHS framework, released in 2015, which categorizes health care payment according to provider accountability for quality and total cost of care, and emphasizes population health management rather than payment for specific services. In addition, CMS has further increased its focus on integrated service delivery as a means toward bending the health care cost curve and on using data to inform the design and continuous improvement of new initiatives. These have been an important part of the context for recent MMCO achievements, which we discuss below.

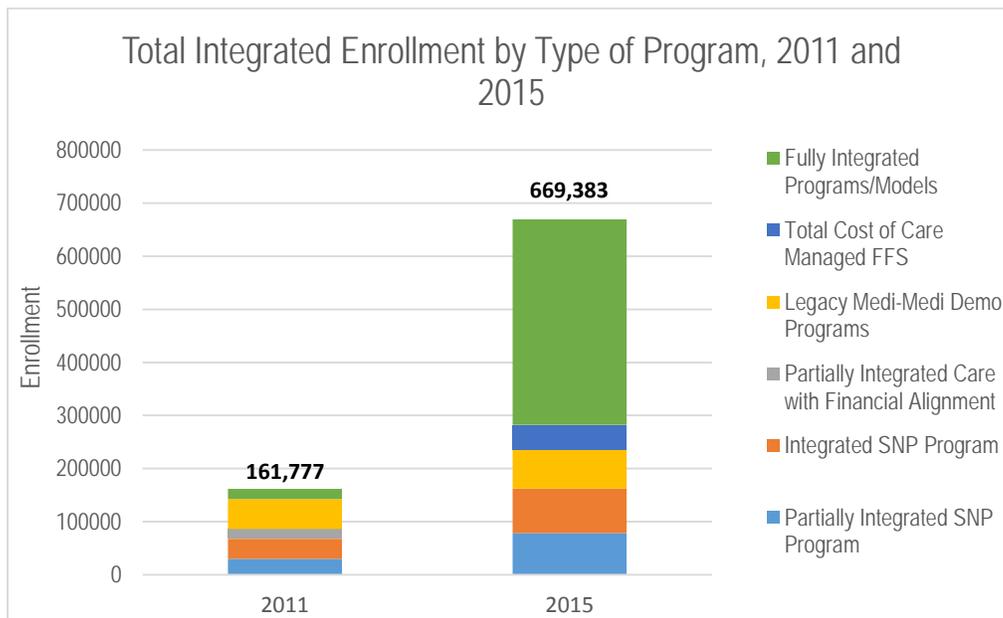
- **CMS is rapidly implementing delivery system reform, including models that integrate Medicare and Medicaid service delivery and financing.**

Between 2011 and 2015, the estimated number of Medicare-Medicaid enrollees served by integrated programs rose from approximately 162,000 to more than 650,000. Notably, enrollment in PACE for individuals age 55 and older with nursing facility level of care needs rose by almost two-thirds, from just under 20,000 in 2011 to more than 34,000 in 2015. Over the same period, enrollment in those MA Special Needs Plans (SNPs) that also offered most or all Medicaid services grew from fewer than 38,000 to approximately 220,000 enrollees.

“I WAS GOING TO THE EMERGENCY ROOM THREE OR FOUR TIMES A WEEK FOR LITTLE THINGS. SINCE I STARTED WORKING WITH [A CARE COORDINATOR] OVER THE LAST TWO YEARS, I’VE BEEN TO THE ER ONCE IN TWO YEARS.”

- Enrollee in the Washington Managed Fee-For-Service Model Demonstration

Figure 1. Total Integrated Care Enrollment by Program Type⁸



In 2015, the Administration also announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity, of care. The Administration set a goal of having 85 percent of Medicare fee-for-service payments in value-based purchasing arrangements by 2016 and 90 percent by 2018.

Medicare-Medicaid Financial Alignment Initiative. In 2011, CMS launched the Medicare-Medicaid Financial Alignment Initiative to address the financial misalignment between Medicare and Medicaid and to integrate primary, acute, behavioral health, and long-term services and supports for Medicare-Medicaid enrollees. 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.⁹ Although the approaches differ in each demonstration, beneficiaries in every version of the model 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.¹⁰

To date, CMS has entered into 14 memoranda of understanding with 13 states to test new models.¹¹ Eleven of these demonstrations, including two in New York state, use the capitated model.¹² Two demonstrations, in Colorado and Washington, use the managed fee-for-service model, serving approximately 52,000 beneficiaries as of October 1, 2015. CMS has partnered with Minnesota to implement an alternative model, building on its longstanding Minnesota Senior Health Options program.¹³

Health plans in nine states are serving 378,640 beneficiaries in capitated model demonstrations as of November 1, 2015.

Approved demonstrations are at different stages of implementation for the capitated model, with start dates ranging from October 1, 2013, for the Massachusetts demonstration to March 1, 2015, for the Michigan and Texas demonstrations. Plans in nine states were serving about 379,000 beneficiaries in demonstrations as of November 1, 2015.

Table 1. Medicare-Medicaid Financial Alignment Initiative Enrollment by State¹⁴

STATE	GEOGRAPHIC AREA (BY COUNTY)	ENROLLMENT (AS OF 11/1/2015)
CALIFORNIA	7 of 58 counties	119,299
COLORADO	Statewide	30,408
ILLINOIS	21 of 102 counties	54,411
MASSACHUSETTS	9 of 14 counties	12,653
MICHIGAN	25 of 83 counties	39,068
MINNESOTA	Statewide	36,641
NEW YORK	6 of 62 counties	8,275
OHIO	29 of 88 counties	62,287
SOUTH CAROLINA	42 of 46 counties	1,776
TEXAS	6 of 254 counties	53,326
VIRGINIA	66 of 95 counties	27,545
WASHINGTON	37 of 39 counties	21,467
TOTAL ENROLLMENT		467,156

A second capitated model demonstration in New York for Medicare-Medicaid enrollees with intellectual and developmental disabilities and a capitated model demonstration in Rhode Island are expected to start serving enrollees in 2016.

CMS and the states continue to invest in and collaborate on monitoring and oversight activities designed to protect beneficiary rights and maximize the benefits of integrated care. These activities include the following:

- Contract Management Teams – For each capitated demonstration, CMS and the state establish a joint contract management team, which represents Medicare and Medicaid staff in overseeing the three-way contract.
- Implementation Funding – Certain states were eligible for Federal funding for implementation activities, with priority given to activities that promote beneficiary engagement and the protection of beneficiary rights. CMS made implementation funding awards to eight states.¹⁵

CMS has contracted with an independent evaluator, RTI International, to measure and evaluate the overall impact of the demonstrations under the Medicare-Medicaid Financial Alignment Initiative. This effort includes looking at the beneficiary experience of care, impacts on quality and beneficiary-level outcomes, and Medicare and Medicaid expenditures and service utilization. State-specific and aggregate evaluation plans are available on the Financial Alignment Initiative website.¹⁶ The first annual evaluation reports for the demonstrations that began in CY 2013 are expected in FY 2016.

- **CMS is focused on improving the value of facility-based services, while encouraging care delivery in community-based settings wherever possible.**

CMS has launched several efforts to improve quality of services delivered in facility-based settings, and announced additional initiatives for the future. On July 30, 2015, CMS issued a final rule [CMS-1622-F] outlining FY 2016 Medicare payment rates for skilled nursing facilities (SNFs). New subsection 1888(h) of the Social Security Act authorizes the establishment of a SNF Value-Based Purchasing Program applicable to payments for services furnished beginning in FY 2019. Under the new program, value-based incentive payments will be made to SNFs based on their performance on a hospital readmission measure.

Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents.

Nearly 45 percent of hospitalizations among Medicare-Medicaid enrollees are avoidable.¹⁷ These avoidable hospitalizations can be disruptive and dangerous for beneficiaries – and costly for Medicare. Numerous researchers and policymakers have noted that payment structures in Medicare and Medicaid may not adequately incentivize nursing facilities and providers serving nursing facility residents to provide care that would reduce preventable hospital utilization. In particular, transferring Medicare-Medicaid enrollees receiving long-

term care in nursing facilities to hospitals may create inappropriate financial incentives that may cause disruptions to beneficiaries and increase Medicare spending.¹⁸

To address this misalignment, in early 2012 CMS launched the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.¹⁹ The primary objective of the Initiative is to reduce avoidable hospitalizations. In this initiative, CMS selected seven organizations, known as Enhanced Care and Coordination Providers (ECCPs),²⁰ to test strategies to reduce avoidable hospitalizations for Medicare and Medicaid enrollees who are long-stay residents of nursing facilities.²¹ These organizations are partnering with 144 nursing facilities to test evidence-based interventions over a four-year period. The model serves about 16,000 beneficiaries each month.

In August 2015, CMS announced a second phase of the Initiative to test whether three new payments for nursing facilities and practitioners will further reduce avoidable hospitalizations, lower combined Medicare and Medicaid spending, and improve the quality of care received by nursing facility residents.

Nursing Facility Initiative Evaluation Results in PA and MO

2014 evaluation data shows reductions in hospitalization and Medicare spending for nursing facility residents from 2012 to 2014. For example:

In Pennsylvania, the University of Pittsburgh Medical Center (UPMC) Community Provider Services reduced potentially avoidable hospitalizations and potentially avoidable emergency department (ED) visits by 27.8% and 40%, respectively, relative to a matched comparison group.

In Missouri, the Curators of the University of Missouri reduced potentially avoidable hospitalizations and potentially avoidable ED visits by 34.5% and 39.0%, respectively, relative to a matched comparison group.

The new payments, scheduled to begin in October 2016, aim to reduce avoidable hospitalizations by funding higher-intensity interventions in nursing facilities for residents who may otherwise be hospitalized upon an acute change in condition. Improving the capacity of nursing facilities to treat medical conditions as effectively as possible within the facility has the potential to improve the residents' care experience at a lower cost than a hospital admission. The model also includes payments to practitioners (i.e., physicians, nurse practitioners, and physician assistants) similar to the payments they would receive for treating beneficiaries in a hospital. Practitioners would also receive new payments for increased engagement in multidisciplinary care planning activities.

CMS has contracted with an external independent evaluator, RTI International, to measure and evaluate the overall impact of the current phase of the Initiative. This effort includes looking at the quantitative impacts on quality, utilization, and Medicare and Medicaid expenditures, as well as qualitative observations on demonstration implementation and performance. In FY 2015, RTI drafted the third annual evaluation report²² for the Initiative, which includes the estimated effect of each of the seven interventions in 2014.

While not all effects are statistically significant, initial utilization and cost results have improved relative to a comparison group:

- All-cause and potentially avoidable hospitalizations decreased among all seven ECCPs;
 - All-cause and potentially avoidable emergency room visits decreased among five of the seven ECCPs; and
 - Total Medicare spending decreased in all seven ECCPs.
- **CMS is investing in new ways to support beneficiaries in accessing care.**

Funding for Ombudsman Services. CMS requires states participating in the Medicare-Medicaid Financial Alignment Initiative to have dedicated ombudsman support, and CMS provides funding to these states for ombudsman services. These ombudsman programs, with technical support from the HHS Administration for Community Living, provide beneficiaries 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 October 2015, CMS had made awards to 10 states through this funding opportunity.²³

Funding for State Health Insurance Counseling and Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs). In states with demonstrations under the Medicare-Medicaid Financial Alignment Initiative, CMS provides additional funds to local SHIPs and ADRCs so they can conduct beneficiary outreach and one-on-one options counseling to those eligible for the demonstrations. As of October 2015, CMS had made awards to seven states.²⁴

Improving Communications with Beneficiaries. CMS started a second round of testing with beneficiaries of key model materials used by health plans and states to communicate with beneficiaries about integrated care. This testing builds on related beneficiary interviews about the experiences in the Medicare-Medicaid Financial Alignment Initiative. CMS is targeting release of updated model materials for use in 2017.

- **CMS is providing more support to states to develop and implement new models.**

CMS has made a number of new resources available to support states in recent years. Some of the resources are associated with providing technical assistance related to particular CMS initiatives, such as the Money Follows the Person rebalancing demonstration or the Health Homes Resource Center for states coordinating services for Medicaid beneficiaries with chronic conditions. We discuss several other places CMS is providing these resources below.

State Innovation Models. The CMS State Innovation Models (SIM) Initiative continues to provide financial and technical support to states to develop and test state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for all residents of participating states. SIM provides an opportunity for each participating state to work with CMS to implement a comprehensive, statewide strategy that reflects the individual state's circumstances and priorities. As of FY 2015, more than half of states, representing 61

percent of the U.S. population, will be working to support comprehensive state-based innovation in health system transformation.²⁵

Medicaid Innovation Accelerator Program. In late July 2014, CMS launched the Medicaid Innovation Accelerator Program (IAP), a new technical support program designed to improve health care for Medicaid beneficiaries and reduce costs by supporting states' ongoing payment and service delivery reforms. The IAP offers state Medicaid agencies targeted program support across four main program areas: 1. reducing substance use disorders; 2. improving care for Medicaid beneficiaries with complex needs and high costs; 3. promoting community integration for Medicaid beneficiaries using community-based long-term services and supports; and 4. integration of physical and mental health care, as well as targeted program support to states in the areas of quality measurement, data analytics, performance improvement, and payment modeling and financial simulations. In FY 2015, the IAP work included a three-part measure development contract led by IAP, MMCO, and the CMS Center for Medicaid and CHIP Services (CMCS).

The quality measures development contract is designed to coordinate measurement efforts in measurement gap areas, and represents an opportunity to address gaps in measures for Medicare-Medicaid enrollees that have been identified by the National Quality Forum.

Integrated Care Resource Center.

MMCO has continued to offer states a number of resources for technical assistance to promote integration of services and financing for Medicare-Medicaid enrollees. In 2011, MMCO established the Integrated Care Resource Center (ICRC) to serve as a technical resource center for states, supporting them in developing integrated care programs, and promoting best practices for better serving Medicare-Medicaid enrollees. The ICRC assists states with program design, stakeholder engagement, data analysis, and other functions. The ICRC also facilitates the sharing of best practices across states. This resource is available to all states. In FY 2015, ICRC worked directly with 17 states. ICRC also provided small group learning events and hosted webinars on topics of interest to multiple states.

State Data Resource Center. Access to Medicare data is an essential tool for states seeking to coordinate care, improve quality, and control costs for Medicare-Medicaid enrollees. Supplementing efforts to increase access to Medicare and Medicaid data to support care coordination, described below, 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

“IT’S A LOT SMOOTHER FOR ME. IT DOESN’T BRING ANXIETIES. BEFORE, YOU’D BE TALKING TO SOMEBODY, AND THEY’D SWITCH YOU TO SOMEBODY ELSE AND SWITCH YOU TO SOMEBODY ELSE...[NOW] I JUST TALK TO MY NAVIGATOR. THEY TAKE CARE OF EVERYTHING AROUND.”

- Enrollee in the Massachusetts One Care Demonstration

to set priorities and support care coordination. SDRC has also updated its processes to help states use Medicare data for program integrity purposes. The SDRC is open to all states and provided assistance to 42 states²⁶ in FY 2015.

Medicare Medicaid Data Integration. In September of 2014, CMS created the Medicare Medicaid Data Integration (MMDI) Team to provide technical assistance to states on the integration of Medicare and Medicaid data. In FY 2015, the MMDI Team has assisted Colorado, Minnesota, Ohio, and Virginia. In this same year, CMCS's IAP partnered with MMCO to make the MMDI Team's technical support available to an additional six State Medicaid Agencies to support the integration of Medicare and Medicaid data.

- **CMS is providing more support to providers to engage in new models.**

In 2015, CMS launched the Health Care Payment Learning and Action Network to provide a forum where payers, providers, employers, purchasers, state partners, consumer groups, individual consumers, and others can discuss adoption of alternative payment models that emphasize value of services over volume. Interest has been high; more than 4,100 individuals and organizations have already signed up to participate in the Network.

Resources for Integrated Care. To help providers better serve Medicare-Medicaid enrollees, MMCO established Resources for Integrated Care (RIC).²⁷ Since 2011, RIC has worked to build the capacity of various provider types, including clinicians, behavioral health providers, health plans, nursing facilities, and caregivers. RIC provides trainings and technical assistance on topics including disability competent care, geriatric competent care, meaningful member engagement, and integrating behavioral health with primary care, among others.

Additionally, RIC and MMCO are partnering with the Substance Abuse and Mental Health Services Administration (SAMHSA) on the development of a Care Transitions Toolkit for Individuals with serious and persistent mental illness. RIC also facilitates an intensive learning community on disability competent care, which includes assessing current disability competence and implementing pilot projects for improvement.

- **CMS is streamlining the process for sharing Medicare data with states and providers.**

CMS has created new pathways for states, providers, and other innovators to obtain data to support research on and effective implementation of models to improve care delivery. For example, as a part of its Medicare Shared Savings Program, CMS shares Medicare Parts A, B, and D utilization data with Accountable Care Organizations for their aligned individuals on a monthly basis (beneficiaries may choose to opt out of having their data shared). This allows providers to have access to information on the broad array of services an individual beneficiary may use across various providers. With additional data, providers are able to better coordinate care for beneficiaries for whom they might otherwise have limited information and understanding of their health care services and needs. CMS has also promoted better access to states on their Medicare populations, including recently proposed regulations to permit Qualified Entities (who are primarily state and local governments) to share analyses and data that will help providers, employers, and others make more informed decisions about care delivery, as well as previous efforts to create faster and less expensive state access to data for research purposes.

Medicare Data to States for Medicare-Medicaid Enrollees. As described in the FY 2011 Report to Congress, CMS established a process for states to access Medicare Parts A, B, and D data to support care coordination for Medicare-Medicaid enrollees, while also protecting beneficiary privacy and confidentiality.²⁸ In FY 2015, 39 states are receiving or working with CMS to receive these data.²⁹ With the new integrated data set tool, states are better equipped to coordinate benefits and services in a seamless, cost-effective manner. Newly in 2015, states can also access Medicare data for program integrity purposes.

- **CMS is developing performance measures that reflect beneficiary experience and quality of services provided to high-need, high-cost individuals, including Medicare-Medicaid enrollees.**

In FY 2015, CMS released the first CMS plan to address health equity in Medicare. The CMS Equity Plan for Improving Quality in Medicare³⁰ focuses on Medicare populations that experience disproportionately high burdens of disease, lower quality of care, and barriers accessing care. The Equity Plan identifies six priority areas, two of which include a focus on measurement: expanding the collection, reporting, and analysis of standardized data; and evaluating disparities impacts and integrating equity solutions across CMS programs.

Identification of performance measures that reflect Medicare-Medicaid enrollee needs and experiences. MMCO, together with other parts of CMS, is developing performance measures that reflect beneficiary experience and quality of services provided to high-need, high-cost individuals, including Medicare-Medicaid enrollees. Many stakeholders have helped to guide CMS in this endeavor, most notably the Measures Application Partnership (MAP) for Dual Eligible Beneficiaries led by the National Quality Forum (NQF). This public-private partnership of health care stakeholders, including advocacy groups, provider associations, professional associations, and health plans, is convened by NQF to identify quality measurement gaps, select potential quality measures, and provide expert guidance to CMS on health care system improvement for Medicare-Medicaid enrollees.

In FY 2015, MMCO supported the MAP's recommendations and related efforts to further develop and refine endorsed measures for Medicare-Medicaid enrollees:

- To address the noted gaps in the area of home and community-based services (HCBS), MMCO convened an HHS-wide HCBS measures workgroup where quality and policy experts meet to ensure the coordination and alignment of HCBS measure development across the Agency.
- MMCO is a Federal partner in the NQF-led HCBS project to develop a conceptual framework and perform an environmental scan to address performance measure gaps in home and community-based services to enhance the quality of community living.
- As noted above, CMS awarded a new contract with Mathematica Policy Research, effective September 30, 2015, to develop a small number of endorsed quality measures in key gap areas relevant to Medicaid adults and Medicare-Medicaid enrollees. One purpose of this collaborative contract between CMCS and MMCO is to develop a portfolio of endorsed quality measures specific to Medicare-Medicaid enrollees across programs and across the continuum of care. The purpose of this contract is to develop de novo, maintain, reevaluate,

and/or refine existing quality measures across program areas while being mindful that State Medicaid Agencies, health plans, providers, and beneficiaries will want to use measures that are more aligned, meaningful, outcomes-based, and not burdensome or duplicative of currently available measures.

CONCLUSION

In its fifth year, MMCO continued work to improve the beneficiary experience with the Medicare and Medicaid programs by integrating service delivery, strengthening access to care, and aligning financial incentives. The legislative recommendations, if implemented, will help further these goals. MMCO continues to examine other policy areas that have the potential to improve the experience of Medicare-Medicaid enrollees.

Through continuous collaboration with state and Federal partners, and with beneficiaries and their caregivers, advocates, providers, and other stakeholders, MMCO will continue to explore, implement, and improve approaches to integrate Medicare and Medicaid service delivery and financing. MMCO looks forward to continuing to work with the Congress and is committed to keeping the Congress and other stakeholders apprised of its work, and broader agency efforts, to promote quality, coordinated care for all Medicare-Medicaid enrollees.

NOTES

¹ <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DualEnrollment20062013.pdf>

² <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2008NationalSummary.pdf>

³ 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 the 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.

⁴ MACPAC 2013 Report to Congress, Ch. 4, available at: <https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid-Coverage-of-Premiums-and-Cost-Sharing-for-Low-Income-Medicare-Beneficiaries.pdf>.

⁵ Centers for Medicare & Medicaid Services, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf

⁶ Centers for Medicare & Medicaid Services, available at: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2017-Star-Ratings-Request-for-Comments.pdf>

⁷ The beneficiary quotes in this section of the report are from enrollees during a focus group conducted during the RTI evaluation of the Washington demonstration and Massachusetts One Care demonstration and do not constitute the full spectrum of comments from the focus groups.

⁸ Source: analysis performed by the Integrated Care Resource Center, under contract with CMS. “Fully Integrated Programs/Models” include MMP and PACE enrollment through June 2015. “Total Cost of Care Managed FFS” includes enrollment in the Colorado and Washington Managed Fee-For-Service demonstrations under the Medicare-Medicaid Financial Alignment Initiative. “Legacy Medi-Medi Demo Programs” includes enrollment in FIDE SNP programs in Massachusetts, Minnesota, and Wisconsin that began as demonstrations. “Partially Integrated Care with Financial Alignment” refers to the North Carolina Medicare Health Care Quality Demonstration; no 2015 information is included for 2015 because the initiative had ended. “Integrated SNP Program” and “Partially Integrated SNP Program” enrollment includes programs in which a Medicare-Medicaid enrollee receives both Medicare and Medicaid services from companion or aligned Medicare D-SNPs and Medicaid managed care plans.

⁹ 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 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. The 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 benefits.

¹⁰ For example, in Massachusetts beneficiaries receive new services such as diversionary behavioral health services and expanded dental benefits. Massachusetts MOU, *supra* note 31, at page 69-81.

¹¹ CA, CO, IL, MA, MI, MN, NY, OH, RI, SC, TX, VA, and WA.

¹² CA, IL, MA, MI, NY, OH, RI, SC, TX, and VA.

¹³ 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. The Minnesota demonstration is separate and distinct from the Financial Alignment Initiative. The Minnesota demonstration

involves a set of administrative improvements to simplify the process for beneficiaries to access the services for which they are eligible under Medicare and Medicaid, focusing 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>.

¹⁴ Data for Colorado and Washington are as of October 1, 2015. All others are as of November 1, 2015.

¹⁵ CA, CO, MA, MI, MN, NY, SC, and WA. These states were eligible based on their prior involvement with CMS in the Demonstration to Integrate Care for Dual Eligible Individuals. Additional information is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ImplementationSupportforStateDemonstrations.html>.

¹⁶ Available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.

¹⁷ 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.

¹⁸ Medicare Payment and Advisory Commission June 2010 Report at page 141, available at: http://www.medpac.gov/documents/reports/Jun10_EntireReport.pdf?sfvrsn=0.

¹⁹ <http://innovation.cms.gov/initiatives/rahnfr/>

²⁰ The selected participants are in AL, NE, IN, MO, NY, PA, and NV. For additional information, please go to: <http://innovation.cms.gov/initiatives/rahnfr/>.

²¹ 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.

²² The third annual report was under CMS review at the time of this report. The second annual report included estimated results of the Nursing Facility Initiative for the first year of operations in 2013, when the interventions were being implemented. The report noted that the generally positive results of the first annual report could not be definitively attributed to the Initiative because 2013 was a transitional period. A summary of the evaluation through December 2014, which includes results of the quantitative analysis of data from the first Initiative year, 2013, can be found here: <http://innovation.cms.gov/Files/reports/irahnfr-secondevalrpt.pdf>.

²³ CA, CO, IL, MA, OH, VA, and WA. Additional information is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html>

²⁴ CA, IL, MA, VA, and WA. Additional information is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOptionsCounselingforMedicare-MedicaidEnrollees-.html>

²⁵ CMS website, State Innovation Models Initiative: General Information, available at: <https://innovation.cms.gov/initiatives/State-Innovations/>

²⁶ AL, AZ, AR, CA, CO, CT, DE, FL, GA, ID, IA, IL, KS, KY, LA, MD, MA, MI, MN, MT, MO, MS, NE, ND, NH, NY, NC, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, and WI.

²⁷ Please see the Resources for Integrated Care website for additional information and to access the library of resources for providers and health plans: <https://www.resourcesforintegratedcare.com/>.

²⁸ 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>.

²⁹ As of October 1, 2015, thirty-one states (AZ, CA, CO, CT, FL, GA, IL, IA, IN, KS, KY, LA, MA, 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-nine states (AZ, CA, CO, CT, GA, IL, IA, KS, KY, LA, MA, 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 Part D data. Other states continue to request access and are working with CMS to receive data use agreements.

³⁰ CMS website, The CMS Equity Plan for Improving Quality in Medicare, available at: https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf