

Department of Health & Human Services

Centers for Medicare & Medicaid Services

Medicare-Medicaid

Coordination Office

Fiscal Year 2012 Report to Congress

Introduction

Section 2602 of the Patient Protection and Affordable Care Act (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), 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 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 programs¹ (Medicare-Medicaid enrollees, sometimes referred to as “dual eligibles”²). The Affordable Care Act sets forth the specific goals³ and responsibilities⁴ of the Medicare-Medicaid Coordination Office, including the annual submission of a Report to Congress.⁵

The Medicare-Medicaid Coordination Office continues to make progress on its statutory mandate, with a focus on initiatives to better integrate care and ensure access to care for beneficiaries. To that end, the Medicare-Medicaid Coordination Office works in three main areas: Program Alignment; Data and Analytics; and Demonstrations and Models.

This annual report describes the Medicare-Medicaid Coordination 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 our State and Federal partners, beneficiaries, advocates, and providers, it will continue to

¹ Section 2602(b) of the Affordable Care Act states the purpose of the Federal Coordinated Health Care Office.

² 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.

³ Affordable Care Act section 2602(c) establishes the specific goals of the Medicare-Medicaid Coordination Office: (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.

⁴ Section 2602(d) of the Affordable Care Act sets forth the specific responsibilities of the Federal Coordinated Health Care Office.

⁵ Section 2602(e) of the Affordable Care Act.

identify areas where regulatory or legislative changes are needed to improve care coordination and benefits. This report contains two such legislative recommendations.

Legislative Recommendations to Improve Care Coordination

The Affordable Care Act requires the Secretary to submit an annual report to Congress that may include recommendations for legislation that would improve care coordination and benefits for Medicare-Medicaid enrollees.⁶

In furtherance of its work to increase access to integrated care systems for Medicare-Medicaid enrollees, this year the Medicare-Medicaid Coordination Office recommends two legislative proposals, both of which are included in the President's 2014 Budget transmittal:

- Providing the Secretary of the Department of Health & Human Services (Secretary) with the authority to integrate the Medicare and Medicaid appeals processes; and
- Ensuring 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.

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 limits, amounts in controversy, and levels of appeals.⁷ 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.⁸ These requirements result in confusion, inefficiencies, and administrative burdens for beneficiaries, providers and States.⁹ For plans that integrate Medicare and Medicaid services and benefits, such requirements may be barriers

⁶ 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."

⁷ See Social Security Act §§ 1852(g), 1860D-4, 1869, 1902(a)(3).

⁸ *Id.*

⁹ 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>.

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). Although these Demonstrations will test aspects of an integrated appeals system, legislative authority is needed to implement an integrated appeals system for the broader Medicare-Medicaid enrollee population. In order to increase access to seamless integrated programs for Medicare-Medicaid enrollees through a simpler, more user-friendly appeals process, the Medicare-Medicaid Coordination Office 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 initiative¹⁰, include public comments from CMS' May 2011 Federal Register notice, and maintain or improve current beneficiary appeals rights.

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.¹¹

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 these beneficiaries into the LI NET Demonstration plan for any retroactive periods and for up to two prospective

¹⁰ <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/AlignmentInitiative.html>

¹¹ 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, low-income subsidy (LIS) beneficiaries, including partial-benefit dual eligible and other Part D LIS beneficiaries.

months. If these beneficiaries do not elect a Medicare Part D plan on their own within those two months, CMS then enrolls them into a Medicare Part D plan (PDP) that has a premium at or below the low-income premium benchmark.

The LI NET Demonstration was established to better align this system and eliminate gaps in coverage by having Medicare pay a specialized PDP using an alternative payment mechanism to provide retroactive coverage and limited prospective coverage for Medicare-Medicaid 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 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 also reduces costs by reimbursing the LI NET plan using narrower risk corridors such that payments are closer to the actual costs incurred by beneficiaries during the retroactive period.

The LI NET Demonstration will expire at the end of calendar year 2014. The Medicare-Medicaid Coordination Office recommends to 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.

Medicare and Medicaid: Program Alignment

The Medicare and Medicaid programs were designed with distinct purposes, which has resulted in numerous differences between the programs in overall administration, eligibility, payment, and covered benefits. These variations can result in a lack of coordination between Medicare and Medicaid, creating a fragmented system of care for beneficiaries, with increased potential for duplicative services, access barriers, and cost shifting among payers.

The goals of the Medicare-Medicaid Coordination Office include eliminating regulatory conflicts and cost-shifting between Medicare and Medicaid and among related providers. To foster progress in these goals and better coordinate benefits and services, the Medicare-Medicaid Coordination Office works within CMS as a catalyst to align laws, rules, requirements and policies among the programs.

Progress on Alignment

In May 2011, CMS compiled and categorized a list of opportunities for statutory, regulatory, and policy alignments between Medicare and Medicaid.¹² The Medicare-Medicaid Coordination Office is continually making progress in addressing these program alignment areas. FY 2012 highlights of the Medicare-Medicaid Coordination Office's progress in better alignment of the programs follow.

Quality Improvement

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

¹² CMS launched the "Alignment Initiative" to facilitate development of a better, more cost-effective system of care that strengthens Medicare and Medicaid for beneficiaries, their caregivers, providers, States and the Federal Government. The Alignment Initiative categorized 29 areas of alignment between Medicare and Medicaid as a notice for public comment in the Federal Register in May of 2011. Federal Register, Vol. 76, No. 94 page 28196. Available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FederalRegisterNoticeforComment052011.pdf>. Public comments received as part of the Alignment Initiative are available here: <http://www.regulations.gov/#!docketDetail;dct=FR%252BPR%252BN%252BO%252BSR%252BPS;rpp=25;po=0;D=CMS-2011-0080>.

CMS has worked with the National Quality Forum (NQF), as part of the Measure Applications Partnership,¹³ on developing a recommended core set of quality measures, and additional measures that are responsive to the unique needs of Medicare-Medicaid enrollees.¹⁴ The Medicare-Medicaid Coordination Office is incorporating the recommended starter set of measures in each of the Medicare-Medicaid Financial Alignment Demonstrations including, for example, all-cause readmissions, follow-up after hospitalization for mental illness, and the initiation and engagement of alcohol/other drug treatment.¹⁵ 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.

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.¹⁶ This written notice must include a description of the applicable appeals processes.¹⁷ There are separate requirements for Medicaid managed care plans¹⁸ 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.

¹³ The Department is required by law to have a contract with a consensus-based entity (currently the NQF) to perform specific quality-related tasks listed in the statute. Section 3014 of Affordable Care Act added additional tasks to the consensus-based entity's contract, including the requirement to convene multi-stakeholder groups to provide input to the Secretary on the selection of certain categories of quality and efficiency measures. The NQF convened the multi-stakeholder groups as the Measure Applications Partnership (MAP). The MAP has focused on a number of measure categories, including those of particular value to the Medicare-Medicaid enrollee population.

¹⁴ The National Quality Forum, Dual Eligible Beneficiaries Workgroup, Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS, June 01, 2012. Available at: http://www.qualityforum.org/Setting_Priorities/Partnership/Duals_Workgroup/Dual_Eligible_Beneficiaries_Workgroup.aspx. In December 2012, NQF released a follow-up report making further recommendations on quality measurement for Medicare-Medicaid enrollees. These measures are currently open for public comment and are still being finalized.

¹⁵ *Id.* at pages 14-15. These measures will be used in both the capitated and managed fee-for-service model.

¹⁶ Social Security Act § 1852(g)(1)(B).

¹⁷ 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.

¹⁸ 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>

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.¹⁹ 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. The notice is available for immediate use through the Medicare-Medicaid Financial Alignment Demonstration and is expected to be finalized in late 2013 for Medicare Advantage plans which integrate Medicare and Medicaid benefits.

Cost-Sharing

One area that requires better alignment between Medicare and Medicaid is cost-sharing. Today, 64 percent of the 10.2 million Medicare-Medicaid²⁰ enrollees are “Qualified Medicare Beneficiaries,”²¹ whose cost-sharing is covered by Medicaid.²² However, CMS continues to receive an increased number of questions and complaints from beneficiaries, caregivers, and providers²³ regarding the reimbursement process and inappropriate assessment of cost sharing for Qualified Medicare Beneficiaries.

Raising awareness of the current law prohibiting providers from collecting Medicare cost-sharing from Qualified Medicare Beneficiaries is one step that will help to improve the beneficiary experience with Medicare and Medicaid. A related step involves reducing provider difficulties with securing payment for services and better coordinating claims processing between State and Federal Governments.

¹⁹ 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>

²⁰ CMS Data Analysis Brief, Medicare-Medicaid Dual Enrollment from 2006 through 2011, (February 2013) http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf.

²¹ QMBs are persons who are entitled to Medicare Part A and are eligible for Medicare Part B; have incomes below 100 percent of the Federal Poverty Level; and have been determined to be eligible for QMB status by their State Medicaid Agency.

²² Inappropriate collection of cost-sharing occurs when providers bill beneficiaries the unpaid co-pay or cost-share from services received. Section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance-billing QMBs for Medicare cost-sharing.

²³ Social Security Act § 1902(n)(3) prohibits a provider from charging a QMB for Medicare Parts A and/or B services. Providers who bill QMBs for these charges are subject to sanctions. Under 42 CFR § 447.15, Medicaid providers must accept Medicaid payment as payment in full. Cost Sharing Standards are specified in Social Security Act § 1905(p)(3).

During FY 2012, CMS took steps to address the lack of awareness of the prohibition of collecting Medicare cost-sharing from Qualified Medicare Beneficiaries, issuing guidance reminding providers and State partners about this important protection,²⁴ and providing best practices such as ways to improve the claims process to further address this issue.²⁵ Resolving cost-sharing problems is a priority for CMS to strengthen the Medicare and Medicaid programs and better serve beneficiaries by partnering with both States and providers to ensure access to high quality care. CMS will continue to monitor beneficiary access to services and provider compliance and expects to continue working in this priority area in the coming year.

Medicaid Primary Care Physician Payment Rule

On November 6, 2012, CMS released the Final Rule outlining how State Medicaid programs will make these enhanced payments.²⁶ CMS also worked to raise awareness for States and providers of the increase in Medicaid payments for calendar years 2013 and 2014 for certain primary care services furnished by physicians with primary specialty designations of family medicine, general internal medicine or pediatric medicine. This includes primary care services furnished to Medicare-Medicaid enrollees who are Qualified Medicare Beneficiaries. The Affordable Care Act increases Medicaid payment rates to 100 percent of Medicare rates for such primary care services furnished by eligible physicians for those years and also provides that States receive full Federal funding of the required increase in Medicaid payment. The payment increase will also apply in States where the Medicaid coverage for cost-sharing has been limited to the Medicaid rate, promoting access to primary care services for Medicare-Medicaid enrollees.

²⁴ CMS, MLN Matters, <https://www.cms.gov/MLNMattersArticles/downloads/SE1128.pdf>; CMS, Informational Bulletin, Center for Medicare & Medicaid Services, Informational Bulletin, <http://www.medicaid.gov/Federal-policy-guidance/downloads/CIB-01-06-12.pdf>

²⁵ The Information Bulletin issued on January 06, 2012, discusses the following best practices for States: (1) Offering separate enrollment forms for QMB-only providers, or allowing providers to identify as “QMB-only” on provider enrollment forms; (2) Including guidance in all communications with QMB providers to emphasize that balance billing of QMBs is a violation of the providers’ Medicare agreement; and (3) Providing clear guidelines for QMB providers on Medicaid provider enrollment and billing processes. In addition, it discusses the following best practices for providers: (1) Recognize that you must complete the State’s provider enrollment process to be entered into the State payment system; and (2) Contact the State Medicaid Agency directly to determine the process to begin submitting claims and receiving payment. See generally for more information, <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf>.

²⁶ Federal Register Volume 77, Number 215 (Tuesday, November 6, 2012): <http://www.gpo.gov/fdsys/pkg/FR-2012-11-06/html/2012-26507.htm>.

The Program of All Inclusive Care for the Elderly (PACE)

The Medicare-Medicaid Coordination Office 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. Additional flexibilities may help the model improve its effectiveness, reduce costs, and expand its capacity to serve a greater number of Medicare-Medicaid enrollees. CMS has convened a cross-agency workgroup to explore whether additional flexibilities to the program could further improve care while reducing costs and expanding its capacity to serve a greater number of Medicare-Medicaid enrollees. HHS continues to work with Congress, States, and the National PACE Association to identify opportunities to improve the model.

Additional Flexibilities for Dual Eligible Integrated Special Needs Plans

In 2012, CMS amended regulations to enhance the ability of integrated Medicare Advantage Dual Eligible Special Needs Plans to serve Medicare-Medicaid enrollees.²⁷ The regulation²⁸ provides CMS with the ability to permit these plans to provide additional supplemental benefits to support individuals with long term support and service needs.

²⁷ 42 C.F.R. 422.102

²⁸ *Id.*

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 such data access and challenges integrating the data have been long-standing barriers to care coordination.

Enhancements to Available Medicare and Medicaid Data

The 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.²⁹ Traditionally, researchers and both the Federal Government and State governments 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 efficient delivery of services.

CMS developed new diagnostic conditions flags (coding used to identify characteristics/demographics)³⁰ for the CCW to more fully represent conditions prevalent among Medicare-Medicaid enrollees. The first set of condition flags released in the fall of 2012 provides tools to help State and Federal policymakers and external researchers better understand individuals with mental health conditions. In early 2013 CMS released a second set 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. These diagnostic condition flags facilitate and streamline research on beneficiary conditions and allow for a more targeted use of resources.

²⁹ The Chronic Condition Warehouse, *available at*: <http://www.ccwdata.org/index.htm>

³⁰ These new condition flags are: (1) Attention deficit, hyperactivity, and conduct disorders, (2) Anxiety disorders, (3) Bipolar disorder, (4) Type 1 major depression and Type 2 depressive disorders, (5) Personality disorders, (6) Post-traumatic stress disorders, (7) Schizophrenia (8) Schizophrenia and other psychotic disorders, and (9) Tobacco use disorders. <http://www.ccwdata.org/chronic-conditions/index.htm#NewAlgos>

Integrated Medicare-Medicaid Data

In addition, CMS made available a new Medicare-Medicaid integrated data set within the CCW that is now available to researchers, States and policymakers.³¹ 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 interventions to improve the quality, cost, and utilization of care for Medicare-Medicaid enrollees. Data sets for 2006-2008 were released in 2012; the 2009 data set will be 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.³² Twenty-eight states continue to work with CMS to receive and use these data,³³ and, with the new integrated data set tool, are better equipped to coordinate benefits and services in a seamless, cost-effective manner.

Medicare-Medicaid Enrollee State Profiles

In April of 2012, CMS released Medicare-Medicaid Enrollee State Profiles (State Profiles).³⁴ The State Profiles provide state-specific aggregate level data to help Congress and other policymakers to foster program development and improvement. The information released includes a national summary and overview of the data methodology underlying the analysis. The State-level profiles contain detailed demographic characteristics, utilization, and spending patterns of the Medicare-Medicaid enrollees in the State Medicaid programs. The national

³¹ The Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS): <http://www.ccwdata.org/data-dictionaries/index.htm#linkedfiles>.

³² 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>

³³ As of December 20, 2012, 28 States (AR, CA, CO, CT, IN, IL, IA, KS, 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. 24 States (AZ, CA, CT, CO, IL, IA, MA, ME, MI, MO, MN, NC, NY, OH, OK, OR, PA, RI, TN, TX, VA, VT, WA and WI) have been approved or are actively seeking for Medicare Part D data. Other States continue to request access and are working with CMS to receive data use agreements.

³⁴ CMS State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>

summary provides a composite sketch of the Medicare-Medicaid enrollee population including demographics, selected chronic conditions, service utilizations, expenditures and availability of integrated delivery programs. CMS will update the State Profiles annually.

State Data Resource Center

Supplementing efforts to increase access to Medicare and Medicaid data to support care coordination, CMS made available the State Data Resource Center (SDRC) to provide more tools and support for States using the data referenced in the above sections. The SDRC provides States with assistance with their data request, 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. This Center complements work from the Integrated Care Resource Center (ICRC), and expands resources and efforts to guide States in their use of the Medicare data. The SDRC is open to all States and will further support States in their development of coordinated care initiatives.

Demonstrations and Models

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 has several initiatives underway utilizing this authority and advancing a well-coordinated, person-centered, more efficient care delivery system.

Medicare-Medicaid Financial Alignment Demonstrations

In 2011, CMS launched the Medicare-Medicaid Financial Alignment Demonstration³⁵ 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 work, CMS is partnering with States to test two models—a capitated model and a managed fee-for-service model— to align the service delivery and financing between the Medicare and Medicaid programs while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees.³⁶

These Demonstrations afford an unprecedented opportunity to test better coordination of services in a multitude of localities and delivery systems across the country. In the past year,

³⁵ 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. The majority of these States are pursuing one of the two models in the Financial Alignment Demonstration.

³⁶ As reported in the FY 2011 Report to Congress: The first is a capitated model in which a State, CMS, and health plan or other qualified entity will 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. The second is a managed fee-for-service model under which a State and CMS will 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 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.

CMS has entered into memoranda of understanding (MOU) with Massachusetts,³⁷ Washington,³⁸ Ohio³⁹, Illinois⁴⁰, and California⁴¹ to test these new models to improve health care for Medicare-Medicaid enrollees. Key objectives of the Demonstration are to improve the beneficiary experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost shifting between Medicare and Medicaid, and reduce costs for the State and Federal Government through improvements in care and coordination.⁴² Although the approaches differ, in each Demonstration beneficiaries will receive all the current services and benefits they receive today from Medicare and Medicaid with added care coordination, protections and access to enhanced services.⁴³ CMS has entered into a Memorandum of Understanding with each of these five States that, in conjunction with issued Demonstration guidance,⁴⁴ delineates the standards for each approved Demonstration.

³⁷ CMS, MOU between CMS and the Commonwealth of Massachusetts, August 23, 2012. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf>

³⁸ CMS, MOU between CMS and the State of Washington, October 25, 2012. Available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf>

³⁹ CMS, MOU between CMS and the State of Ohio, December 12, 2012. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OHMOU.pdf>.

⁴⁰ CMS, MOU between CMS and the State of Illinois, February 22, 2013. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ILMOU.pdf>.

⁴¹ CMS, MOU between CMS and the State of California, March 27, 2013. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf>.

⁴² Massachusetts MOU, *supra* note 37, at page 3; Washington MOU, *supra* note 38, at page 4; Ohio MOU, *supra* note 39, at page 1.

⁴³ 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.

⁴⁴ Capitated Financial Alignment Guidance (January 09, 2013) available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2014_PlanGuidance01092013.pdf; Capitated Financial Alignment Guidance (March 29, 2012) available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MarchGuidanceDocumentforFinancialAlignmentDemo.pdf>; Capitated Financial Alignment Model Plan Guidance (January 25, 2012) available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf>; and Joint Rate-Setting Process Under the Capitated Financial Alignment Initiative, available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf>.

CMS continues to work with the remaining States⁴⁵ that have submitted proposals and expects to announce further Demonstration partnerships in 2013.

The Demonstrations also give CMS an opportunity to test an integrated set of critical protections and safeguards that foster high-quality care and improve the beneficiary experience. As the Government Accountability Office reported in December 2012, Medicare and Medicaid consumer protection requirements vary across programs, payment systems and States.⁴⁶ This same report noted differences in requirements for continuity and coordination of care, provider networks and marketing materials. Through these Demonstrations, CMS is working to integrate, improve, and enhance the current protection standards and requirements to create a more accessible, seamless system of care for Medicare-Medicaid enrollees.

The Demonstrations are intended to leverage the Medicare and Medicaid programs in a manner that incorporates the strongest aspects from the Federal Government and State governments to best meet the needs of beneficiaries, their caregivers and providers. For example, the Demonstrations will apply the more rigorous applicable network adequacy standard between Medicare and Medicaid, including: time, distance, and/or minimum number of providers or facilities. CMS is adopting the standards that are the most generous for beneficiaries, adding new supports to help improve the beneficiary care experience, and testing new ways of integrating benefits to make them more understandable and navigable. The demonstrations adhere to the Medicare Part D requirements regarding beneficiary protections, including protected classes and network adequacy.

To increase Medicare-Medicaid enrollees' understanding of and satisfaction with coverage under the Medicare and Medicaid programs, CMS is working to ensure consumer protections,

⁴⁵ At the time this Report was submitted, CMS has entered into MOUs with Massachusetts, Washington, Ohio, Illinois, and California.. CMS continues to work with the states listed on the Financial Alignment Demonstration website: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html.

⁴⁶ 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>.

incorporate beneficiary and family perspectives, and support informed decision-making. As part of this work, CMS partnered with the Administration for Community Living to provide support through Aging and Disability Resource Centers and State Health Insurance Assistance Programs for direct person-centered counseling and State information-sharing in Demonstration States.⁴⁷

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.⁴⁸ 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 fail to adequately incentivize nursing facilities to intervene to 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 increase Medicare spending.⁴⁹ Partnerships to facilitate coordination of services between States and the Federal Government will work to eliminate these incentives and find real solutions that improve the experience and quality of care for beneficiaries while reducing costs.

To address this misalignment, in early 2012 CMS launched the *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents*⁵⁰ where it is partnering with seven organizations⁵¹ to test strategies to reduce avoidable hospitalizations for Medicare and

⁴⁷ CMS Fact Sheet-SHIP and ADRC State Funding,

<http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4437&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date>

⁴⁸ 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

⁴⁹ Medicare Payment and Advisory Commission June 2010 Report at page 141: http://www.medpac.gov/documents/jun10_entirereport.pdf

⁵⁰ Press Release, <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4304>

⁵¹ The selected participants are in the following States: Alabama, Nebraska, Indiana, Missouri, New York, Pennsylvania, and Nevada. For a full list of these participants, please go to: <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4455&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date>.

Medicaid enrollees who are long-stay residents of nursing facilities.⁵²

Selected organizations are partnering with nursing facilities to test evidence-based interventions to accomplish these goals and will implement and operate proposed interventions over a 4-year period. The Demonstration began serving Medicare and Medicaid enrollees in February of 2013.

Evaluation of the Demonstrations

CMS is funding and managing the evaluation of all Demonstrations. CMS has contracted with an external independent evaluator 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 experience of care, care coordination, care transitions, and the caregiver experience, among many others.

In the Medicare-Medicaid Financial Alignment Demonstrations, the evaluator will design unique, State-specific evaluation plans for each individual State participating in the Demonstration, as well as an aggregate analysis that will look at the Demonstration overall including Demonstration interventions and impact on key subpopulations within each State. The evaluation contractor will compare pre- and post-demonstration changes in outcomes of interest for the demonstration group with pre- and post-demonstration changes in a comparison group. The approach to comparison group identification will be State-specific; all comparison groups will be comprised of Medicare-Medicaid enrollees not participating in the Demonstration.

⁵² 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.

Conclusion

The Medicare-Medicaid Coordination Office is committed to improving the beneficiary experience with the Medicare and Medicaid programs across the entire continuum of care. With the creation of the Medicare-Medicaid Coordination Office, the Affordable Care Act has provided CMS with an unprecedented opportunity to better serve Medicare-Medicaid enrollees. Through the Medicare-Medicaid Coordination Office's work in Program Alignment, Data and Analytics, and Demonstrations and Models, CMS has built a strong foundation for better, more comprehensive care by improving coordination between the programs, working to eliminate programmatic and systematic misalignments, and developing innovative models for integrated care.

The legislative recommendations in this report are based on our ongoing work in these areas and our continuous collaboration with our State and Federal partners, and with beneficiaries, their advocates, providers and other stakeholders. The Office looks forward to continuing to work with Congress and is committed to keeping Congress apprised of its work to ensure quality, coordinated care for all Medicare-Medicaid enrollees.