

**DEPARTMENT
of HEALTH
and HUMAN
SERVICES**

**Centers for
Medicare & Medicaid
Services**

**Medicare-Medicaid
Coordination Office
FY 2011 Report to Congress**

Table of Contents

Executive Summary.....	2
Introduction.....	3
Background.....	4
The Medicare-Medicaid Coordination Office	8
Program Alignment	10
<i>Alignment Initiative</i>	10
Medicare Data for Care Coordination	13
State Demonstrations and Models.....	15
<i>Integrated Care Design Contracts</i>	15
<i>Financial Alignment Initiative</i>	16
<i>Integrated Care Resource Center</i>	19
<i>Initiative to Reduce Preventable Hospitalization</i>	20
<i>Among Nursing Facility Residents</i>	20
Improving Coordination and Benefits for Medicare-Medicaid Enrollees	22
Conclusion	24
APPENDIX A:.....	25

Executive Summary

In its inaugural year, the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) developed and implemented a number of initiatives to improve coordination and alignment across the Medicare and Medicaid programs for the more than 9 million Medicare-Medicaid enrollees (also known as dual eligibles).¹ The Medicare-Medicaid Coordination Office has worked to engage stakeholders, including providers, advocacy groups, States, federal partners, and beneficiaries, and to incorporate their valuable input into its efforts to improve care coordination, quality, and costs for Medicare-Medicaid enrollees.

The Department of Health and Human Services presents this report pursuant to the requirements of 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).

The Report provides an update on the Medicare-Medicaid Coordination Office's action and highlights key initiatives in three primary areas: Program Alignment, Data and Analytics, and State Demonstrations and Models. These initiatives are:

- The Alignment Initiative
- Medicare Data Initiative
- State Integrated Care Design Contracts
- Financial Alignment Demonstrations
- Initiative to Reduce Preventable Hospitalization Among Nursing Facility Residents

Furthermore, the report also highlights areas for future exploration to improve care coordination and benefits for Medicare-Medicaid enrollees.

¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (§ 2602(f), codified at 42 U.S.C. § 1315b(f)) [hereinafter The Affordable Care Act] 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. Throughout this Report, dual eligible individual, dual eligible beneficiary and Medicare-Medicaid enrollee are used interchangeably.

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 Affordable Care Act set forth the goals and responsibilities of the Medicare-Medicaid Coordination Office, including the annual submission of a Report to Congress² to improve care coordination and benefits for Medicare-Medicaid enrollees.

This report describes the Medicare-Medicaid Coordination Office’s approach over the past year to developing policies, programs, and demonstrations that promote coordinated, seamless, high-quality, cost-effective care for all Medicare-Medicaid enrollees. The Medicare-Medicaid Coordination Office initiatives advance person-centered care based on the goals identified by the individual. These initiatives provide a foundation for future efforts to improve care coordination, quality, and reduce costs for Medicare-Medicaid enrollees.

Throughout this report the terms integrated care and coordinated care are used interchangeably to describe care that is seamless across the full spectrum of an individual’s needs, including primary, acute, behavioral health, and long-term services and supports. For a Medicare-Medicaid enrollee this means the ability to use one identification card to access comprehensive benefits, an individualized care plan, a single coordinated care team, and non-traditional benefits such as transportation and home-delivered meals that permit low-income seniors and people with disabilities to remain at home, living independently. Such systems have shown great potential to improve quality, access, well-being, and the beneficiary (and caregiver) care experience as well as reduce costs.³

² The Affordable Care Act, *supra* note 1, at Section 2602(e). 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.

³ See generally, The Medicare Payment Advisory Payment Advisory Commission, Report to Congress: Aligning Incentives in Medicare, Chapter 5, June 2010 available at http://medpac.gov/documents/Jun10_EntireReport.pdf [hereinafter MedPAC Report 2010]; The Medicare Payment Advisory Payment Advisory Commission, Report to Congress: Medicare

Background

The Medicare and Medicaid programs were originally established in 1965 as distinct programs with different purposes. Medicare provides health insurance for elderly individuals over the age 65 and individuals with disabilities, while Medicaid provides coverage for low-income families including children, pregnant women, parents, seniors and individuals with disabilities. Medicare and Medicaid are separate programs despite a growing number of people who depend on both for their care and the increasing need for the programs to work together to improve outcomes for these beneficiaries.

Medicare-Medicaid enrollees receive benefits and services from both programs: Medicare provides primary coverage for health care services and prescription drugs, and Medicaid covers additional benefits, such as long-term services and supports. Medicaid also provides help to pay Medicare premiums and cost sharing. Currently, many Medicare-Medicaid enrollees must navigate three sets of rules and coverage requirements (Medicare Parts A/B, Medicaid, and Medicare Part D) and manage multiple identification cards, benefits, and plans. As a result of this lack of coordination, care often is fragmented or episodic, resulting in poor health outcomes for a population with complex needs. It also leads to misaligned incentives for both payers and providers, resulting in cost-shifting and unnecessary spending.

Today, more than 9 million Americans⁴ are enrolled in both the Medicare and Medicaid programs; nearly two-thirds are low-income elderly and one-third are people who are under age 65 with disabilities.⁵ Nearly eighty percent of Medicare-Medicaid enrollees

and the Health Care Delivery System, Chapter 5, June 2011 *available at* http://www.medpac.gov/documents/Jun11_EntireReport.pdf; Integrated Care Resource Center, Integrated Care Resources, <http://www.integratedcareresourcecenter.com/icmprogramdesign.aspx>; Webinar, The National Senior Citizens Law Center, Dual Eligibles: Consumer Protection, Integration & Advocates, July 2011 *available at* <http://www.nslc.org/index.php/health/dual-eligibles/>; AARP Public Policy Institute, Experienced Voices: What Do Dual Eligibles Want From Their Care? Insights from Focus Groups with Older Adults Enrolled in Both Medicare and Medicaid (December 2011) *available at* http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2011/dual-eligibles-12-2011.pdf.

⁴ Based on the Centers for Medicare & Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office for Research, Development and Information, July 2010.

⁵ Kaiser Family Foundation, Medicaid's Role for Low-Income Medicare Beneficiaries 1, May 2011 Report *available at* <http://www.kff.org/medicaid/upload/4091-08.pdf> [hereinafter Kaiser, Medicaid's Role 2011]; Kaiser Family Foundation,

receive full Medicaid benefits and assistance with Medicare premiums and cost-sharing while the remaining receive assistance only with Medicare premiums and cost-sharing, (commonly referred to as partial benefit Medicare-Medicaid enrollees).⁶

Pathways to becoming dually enrolled vary. Some Medicare-Medicaid enrollees become eligible for Medicare first, when they turn 65 or qualify based on disability, and then later become eligible for Medicaid as a result of functional or financial decline. Others become eligible for Medicaid initially, and later qualify for Medicare based on age or disability. Medicare-Medicaid enrollees are among the most chronically ill and complex enrollees in both programs. Compared to non-dually eligible Medicare beneficiaries, Medicare-Medicaid enrollees:

- Include higher proportions of women and minorities;⁷
- Are more likely to have low-incomes: more than half have incomes below the poverty line, compared with eight percent of non-dually eligible Medicare beneficiaries;⁸ and
- Are three times more likely to have a disability, and have higher rates of diabetes, pulmonary disease, stroke, Alzheimer's disease, and mental illness.⁹

As a result of the complexity and volume of their health care needs, Medicare-Medicaid enrollees represent the highest cost individuals within the Medicare and Medicaid programs. Costs for individuals within this population are nearly five times greater than individuals enrolled only in Medicare.¹⁰ Total annual spending for their care exceeds \$300

Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007 10, December 2010 *available at* <http://www.kff.org/medicaid/upload/7846-02.pdf>; MedPAC Report 2010, *supra* note 3, at 131.

⁶ Kaiser, Medicaid's Role May 2011 Report, *supra* note 5, at 2; MedPAC Report 2010, *supra* note 3, at 131.

⁷ Kaiser Family Foundation Program on Medicare Policy, The Role of Medicare for the People Dually Eligible for Medicare and Medicaid 3, January 2011 *available at* <http://www.kff.org/medicaid/upload/8081.pdf> [hereinafter Kaiser, Role of Medicare for People Dually Eligible, January 2011 Report].

⁸ MedPAC Report 2010, *supra* note 3, at 132.

⁹ Kaiser Family Foundation, Chronic Disease and Co-Morbidity among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Commission on Medicaid and the Uninsured 1, July 2010 [hereinafter Kaiser Report, Chronic Disease and Co-Morbidity among Dual Eligibles] *available at* <http://www.kff.org/medicaid/upload/8081.pdf>; Kaiser, Role of Medicare for People Dually Eligible, January 2011 Report, *supra* note 7, at 1.

¹⁰ Kaiser Family Foundation, Medicare Spending and Financing: A Primer 2011 3, February 2011 *available at* <http://www.kff.org/medicare/upload/7731-03.pdf>; Kaiser Family Foundation, Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries 3, April 2009 *available at* <http://www.kff.org/medicaid/7895.cfm>; Kaiser Report, Chronic Disease and Co-Morbidity among Dual Eligibles, *supra* note 9 at 1.

billion across both programs.¹¹ In the Medicaid program, Medicare-Medicaid enrollees represent 15 percent of enrollees but 39 percent of all Medicaid expenditures.¹² In Medicare, they represent 16 percent of enrollees and 27 percent of program expenditures.¹³

There are tremendous opportunities to improve care coordination, quality, and costs for Medicare-Medicaid enrollees by addressing inefficiencies and fragmented care for this population. There is also a growing awareness of the potential benefits that greater alignment across Medicare and Medicaid will provide not only to beneficiaries but also to providers, States, and the federal government in areas of improved quality of service, costs and program simplification.¹⁴ This is consistent with the Medicare Payment Advisory Commission's June 2010 Report to Congress which states, "Integrated care has the potential to offer enrollees enhanced, patient-centered, and coordinated services that target the unique needs of the dual eligible enrollees."¹⁵

The Medicare-Medicaid Coordination Office has also heard directly from a variety of stakeholders about the importance of such integration.¹⁶ For example, the National Governors Association letter to President Obama underscored the importance of efforts by the Medicare-Medicaid Coordination Office to coordinate care for this population, stating,

¹¹ Based on the Centers for Medicare & Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office for Research, Development and Information, July 2010. This number reflects both full benefit and partial benefit Medicare-Medicaid enrollees.

¹² Kaiser, Role of Medicare for People Dually Eligible, January 2011 Report, *supra* note 7, at 1.

¹³ MedPAC Report 2010, *supra* note 3, at 131.

¹⁴ The Initiative to Align the Medicare and Medicaid Programs, 76 Fed. Reg. 28196 (May 16, 2011), Notice for Public Comment [hereinafter The Alignment Initiative] Comments on Care Coordination, State of Tennessee Department of Finance and Administration, Bureau of TennCare *available at* <http://www.regulations.gov/#!documentDetail:D=CMS-2011-0080-0083> (commenting, "Tennessee believes that coordination of care for dual eligibles across the full continuum is the ultimate objective."); Beneficiary Advocacy Groups (Alzheimer's Association, Center for Medicare Advocacy, Families USA, Medicare Rights Center, National Health Law Program, and National Senior Citizens Law Center) *available at* <http://www.regulations.gov/#!documentDetail:D=CMS-2011-0080-0088> (commenting, "As CMS pursues its agenda of aligning Medicare and Medicaid in such a way as to align benefits and incentives and improve access for beneficiaries under both programs, we encourage CMS to... Streamline access to programs so more people can establish dual eligibility and obtain access to benefits quickly...[and] Fix problems with existing program and delivery models so that dual eligibles get more seamless care..."); Disability Practice Institute *available at* <http://www.regulations.gov/#!documentDetail:D=CMS-2011-0080-0082> (commenting, "One of the most significant – and poignant – aspects of the matter of the misalignment of Medicare and Medicaid services is the resulting confusion (often leading to despair and a sense of futility) experienced by the beneficiaries.").

¹⁵ MedPAC Report 2010, *supra* note 3, at 142.

¹⁶ The Alignment Initiative, *supra* note 14.

“We believe a system where care can be coordinated and savings can be shared is the necessary next step....”¹⁷ In addition, the Bazelon Center for Mental Health Law noted the importance of individual care needs in care coordination, urging that “[C]are coordination for dual eligibles be premised on patient-centered care, patient engagement, performance measurement, and meaningful patient and stakeholder involvement, we see significant value in these efforts”.¹⁸ UPMC Health Plan also highlighted the importance of alignment between the two programs, saying, “UPMC fully supports CMS in its ongoing efforts to identify and ameliorate the existing barriers that have historically made coordinating and managing the care of dually eligible Medicare and Medicaid beneficiaries challenging.”¹⁹ This sentiment was echoed by the State of Texas, which noted, “Fully integrated care, in which one entity manages Medicare covered services as well as Medicaid services, cost sharing, and long-term supports and services, offers a significant opportunity for providing a seamless set of benefits for dual eligibles, therefore improving care and controlling costs for both programs.”²⁰ This input reflects the growing and continued support to better align the Medicare and Medicaid programs to improve both quality and cost.

¹⁷ The National Governors Association, Letter to President Barack Obama, July 2011.

¹⁸ Comment to The Alignment Initiative, *supra* note 14, submitted July 11, 2011 by the Bazelon Center for Mental Health Law available at <http://www.regulations.gov/#!documentDetail:D=CMS-2011-0080-0101>.

¹⁹ Comment to The Alignment Initiative, *supra* note 14, submitted July 11, 2011 by UPMC available at <http://www.regulations.gov/#!documentDetail:D=CMS-2011-0080-0059>.

²⁰ Comment to The Alignment Initiative, *supra* note 14, submitted May 16, 2011 by Texas Health and Human Services Commission available at <http://www.regulations.gov/#!documentDetail:D=CMS-2011-0080-0065>.

The Medicare-Medicaid Coordination Office

Congress established the Medicare-Medicaid Coordination Office within the Centers for Medicare & Medicaid Services (CMS) to better coordinate the two programs to ensure they work together more effectively for Medicare-Medicaid enrollees. To achieve this, the Medicare-Medicaid Coordination Office is charged with the following goals:

- 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.²¹

These goals have served as the framework for the Medicare-Medicaid Coordination Office's work and have provided the basic foundation for each initiative undertaken in its first year. The Medicare-Medicaid Coordination Office has made considerable progress in achieving these goals as highlighted in Appendix A. Over the last year, the Medicare-Medicaid Coordination Office launched key initiatives to fulfill its Congressional mandate in three main areas: Program Alignment; Medicare Data; and State Demonstrations and Models.

²¹ The Affordable Care Act, *supra* note 1, Section 2602 (c) (1-8).

Furthermore, the Medicare-Medicaid Coordination Office has developed specific considerations and recommendations for future coordination opportunities across the two public programs.

Program Alignment

The Medicare and Medicaid programs were established at the same time, but designed with distinct purposes, which can create barriers to beneficiaries receiving coordinated quality care. For example, the two programs differ in benefit coverage and provider qualifications for behavioral health services. Medicare covers reasonable and necessary “partial hospitalizations” and traditional outpatient and inpatient visits to behavioral professionals and providers, while Medicaid can cover a broader range of behavioral health services including supports and services to keep beneficiaries in the community. For individuals with severe and persistent mental illness, the fragmented care delivery system can lead to poor follow-up, especially for those individuals transitioning from inpatient care to a community setting. Lack of sufficient care coordination may increase the incidence of duplicative services, contraindicated therapies and drugs, inefficiencies in care, and cost shifting. To the extent current systems create waste, confusion or poor care, the Medicare-Medicaid Coordination Office’s mission is to reduce or eliminate their underlying sources, creating a more streamlined system that delivers appropriate, quality, cost-effective care.

Alignment Initiative

The Alignment Initiative is an ongoing effort of the Medicare-Medicaid Coordination Office to identify and address these conflicting requirements between the programs that may create barriers to quality and cost-effective care for Medicare-Medicaid enrollees. It aims to advance solutions that will improve Medicare-Medicaid enrollees’ (and their caregivers’) understanding of, interaction with, and access to seamless high quality, cost-effective care. The Alignment Initiative also focuses on providers and payers, aligning incentives so that quality of care and improved outcomes drive all care decisions. Through the Alignment Initiative, the Medicare-Medicaid Coordination Office has started a national dialogue on

improving care and more effectively aligning benefits for Medicare-Medicaid enrollees.²²

The Alignment Initiative will:

1. Identify areas for program alignment;
2. Prioritize and develop an action plan to address these areas; and
3. Implement the plan to strengthen the programs for beneficiaries, providers, States and the federal government.

The initial phase of the Alignment Initiative identified potentially conflicting Medicare and Medicaid requirements. The Medicare-Medicaid Coordination Office compiled a wide-ranging list of opportunities for statutory, regulatory, and policy alignment in areas identified through numerous discussions with internal and external partners. There were 29 specific areas identified for improved coordination across both programs, in the following categories: care coordination, fee-for-service benefits, prescription drugs, cost sharing, enrollment, and appeals. CMS published this list in the Federal Register on May 16, 2011, and requested the public to comment on and help inform policy and program development.²³

Feedback on the Alignment Initiative ranged from large-scale and broad reforms, such as the suggested creation of an entirely new program for Medicare-Medicaid enrollees, to more issue-specific proposals, such as altered time frames for Medicare/Medicaid appeals and an aligned Medicare and Medicaid mental health provider credentialing process. Public comments also provided ideas for additional areas of consideration, such as payment flexibilities for treatment of End Stage Renal Disease and for services furnished in Federally Qualified Health Centers. Comments also pointed out basic, common sense solutions. For example, Graceful Senescence Adult Day Center noted the potential for great improvement if the programs would “just talk to each other.”²⁴ This comment highlights

²² The Alignment Initiative, *supra* note 14; *See*, The Alignment Initiative webpage, http://www.cms.gov/medicare-medicare-coordination/07_AlignmentInitiative.asp#TopOfPage (site last visited January 31, 2012).

²³ The Alignment Initiative, *supra* note 14; The Alignment Initiative, Federal Register Notice, <http://www.cms.gov/medicare-medicare-coordination/Downloads/FederalRegisterNoticeforComment052011.pdf> (site last visited January 31, 2012).

²⁴ Comment to the Alignment Initiative, *supra* note 14, submitted July 11, 2011 by Graceful Senescence Adult Day Health Care available at <http://www.regulations.gov/#!documentDetail:D=CMS-2011-0080-0102>.

how much progress can be made through enhanced communication across Medicaid and Medicare, as well as with States and federal government, to assure that beneficiaries have a seamless care experience across the two programs.

The Alignment Initiative will serve as the primary guide for the Medicare-Medicaid Coordination Office's future policy and regulatory agenda to reduce program inefficiencies, waste and confusion. Over the next phases of the Alignment Initiative, the Medicare-Medicaid Coordination Office will continue to focus on priority areas for alignment, using existing authority, as well as identifying opportunities to make recommendations to Congress. Many of the conflicts could be addressed through modification of current regulations, policies and practices, and may not require statutory changes. Ultimately, aligning these areas will create a more streamlined system that appropriately delivers quality, cost-effective care.

Regulatory Alignment Efforts

The Administration has also released regulations in the past year to better align the Medicare and Medicaid programs. Section 2702 of the Affordable Care Act²⁵ required the Secretary to issue regulations prohibiting federal payments to States for certain health care-acquired conditions (HCACs) while ensuring that these Medicaid HCAC regulations do not impact beneficiary access to care. In June 2011, the Department of Health & Human Services published a final rule that prohibits federal Medicaid payments for Medicare's current list of hospital acquired conditions, and allows States flexibility to identify additional conditions for non-payment. This rule brings Medicaid payment policies more closely in line with Medicare hospital payment policies that prevent hospitals from receiving additional reimbursement when a patient is diagnosed with selected hospital-acquired conditions. States must comply with the provisions of the final rule by July 1, 2012.

²⁵ The Affordable Care Act, *supra* note 11, at Section 2702.

Medicare Data for Care Coordination

Limited access to Medicare data has been a long-standing barrier to States seeking to coordinate care for Medicare-Medicaid enrollees. Lack of Medicare data on hospital, physician, and prescription drug use prevents States from having a complete picture of the care being provided to this population. For example, without access to service utilization data, a State cannot prevent duplicative services that could be harmful to the individual and costly to both Medicare and Medicaid. For years, States have asked CMS to expand access to timely Medicare data to help them better analyze, understand, and coordinate a beneficiary's care.

The Medicare-Medicaid Coordination Office was able to use existing regulatory and statutory authority to address this challenge directly. Specifically, CMS established a new process for States²⁶ to access Medicare data to support care coordination, while also protecting individual privacy and confidentiality by assuring compliance with the Privacy Act and Health Insurance Portability and Accountability Act. CMS works with States throughout the entire process of requesting and receiving the data. The process begins with a Data Use Agreement (DUA) that identifies and approves users to ensure data are used for care coordination purposes, and upholds required privacy considerations. Medicare data will enable States to provide better, safer care based on the specific care needs of each Medicare-Medicaid enrollee.

The State of Washington provides an example of the value of these data for Medicare-Medicaid enrollees. Washington is preparing to use these new data to expand its care coordination program to include Medicare-Medicaid enrollees. By incorporating Medicare data into its secure, web-based care management system, Washington will allow care coordinators to better identify Medicare-Medicaid enrollees' care needs and utilization of

²⁶ See, Medicare Data for States to Support Care Coordination, http://www.cms.gov/medicare-medicaid-coordination/06_MedicareDataforStates.asp#TopOfPage (site last visited December 30, 2011). As of January 31, 2012, 17 States (Arkansas, California, Colorado, Connecticut, Iowa, Massachusetts, Michigan, North Carolina, New York, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin) have been approved for Medicare A/B data. Seven States (Connecticut, Massachusetts, New York, Oklahoma, Vermont, Washington and Wisconsin) have been approved for Medicare Part D data.

Medicare-covered hospital, physician, and prescription drug use. Now that Medicare data will be combined with Medicaid data, care coordinators in the State will be able to better identify high risk and high cost individuals, determine their primary health risks, and provide tailored care interventions. Washington's experiences with data demonstrate the potential and future opportunities for a more cost-effective, safer, coordinated system.

Medicare data for Medicare-Medicaid enrollees will allow States to make more informed policy and program decisions. Nationally, States have varying levels of capacity to receive and analyze Medicare data. Therefore, CMS is creating opportunities for States to engage with and learn from innovator States, like Washington, as they prepare to move forward on their own data initiatives to improve coordination between Medicare and Medicaid. In addition, CMS is providing ongoing technical assistance to States seeking or newly using these data to coordinate care for Medicare-Medicaid enrollees. States' efforts in this area directly support CMS' goals to improve care and reduce costs – including federal costs –for this population.

State Demonstrations and Models

In 2011, the Medicare-Medicaid Coordination Office, in partnership with the Center for Medicare & Medicaid Innovation (Innovation Center), created opportunities to develop, test, and rapidly deploy innovative and effective care models for Medicare-Medicaid enrollees. The two Offices have announced several new opportunities and resources: Integrated Care Design Contracts, the Financial Alignment Initiative, the Integrated Care Resource Center, and a demonstration to reduce preventable hospitalizations among nursing facility residents. Consistent with the Medicare-Medicaid Coordination Office's mission and Congressional goals, a critical component of these initiatives is to ensure strong beneficiary protections. Additionally, these initiatives are designed to address inefficiencies in care delivery in order to achieve State and federal health care savings.

Integrated Care Design Contracts

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.²⁷ 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.

As a condition of participation in this initiative, each of these 15 States is working to:

- Develop integrated care models and interventions that would fully coordinate the delivery of primary, acute, behavioral health, and long-term supports and services;
- Engage with stakeholders in the design process; and

²⁷ See, State Demonstrations to Integrate Care for Dual Eligible Individuals, http://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage (site last visited January 31, 2012).

- Target implementation in calendar year 2012.

Participating States are expected to submit demonstration proposals in the Spring of 2012.²⁸ CMS and other federal partners will review each State-submitted proposal to determine which might be approved for implementation. As part of the review and approval process, CMS will pay close attention to a State's stakeholder engagement process as well as the extent to which the State incorporates important beneficiary protections such as meaningful notice, robust provider network, and access to a grievances and appeals system. CMS will also take into consideration Medicare Payment Advisory Commission recommendations for improving care management for Medicare-Medicaid enrollees, including testing capitated payment models, collecting consistent quality and cost data across demonstrations, assessing ways to increase enrollment, preserving beneficiary protections, and preserving Medicare's role in managing federal resources.²⁹ Additionally, all proposals must demonstrate the likelihood of achieving savings for the State and the federal government before they will be approved.

These demonstrations will be continuously evaluated and improved throughout their development and implementation. Lessons learned from these efforts will inform future integration models in these 15 States and others.

Financial Alignment Initiative

A key component of a fully integrated system is the inclusion of new payment and financing models to promote better care and align the incentives for improving quality and lowering costs between the programs. Because Medicare benefits focus primarily upon the acute medical care needs of enrollees, there is little incentive for State Medicaid programs to invest in care coordination for services for which Medicare is the primary payer. Financial savings gained through State-led care improvement efforts, resulting in decreases in hospitalization, emergency department uses, and skilled nursing care, are believed to

²⁸ Award of a CMS design contract does not confer authority to implement, or endorsement of, the particular model.

²⁹ MedPAC Report 2010, *supra* note 3, at 153.

primarily accrue to the Medicare program. Similarly, Medicare has little incentive to invest in programs that primarily benefit beneficiaries through Medicaid-only services. A major barrier to better serving Medicare-Medicaid enrollees has been this fundamental financial misalignment between the two programs.

In FY 2011, the Medicare-Medicaid Coordination Office, in partnership with the Innovation Center, established a demonstration opportunity for States to align incentives between Medicare and Medicaid through the *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees* (Financial Alignment Initiative). Through this Initiative, CMS created two approaches for States to test models to align financing between the Medicare and Medicaid programs while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees.³⁰

One approach is a capitated model. In this model, 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 approach is a managed fee-for-service model. Under this model, a State and CMS will enter into an agreement by which the State would be eligible to benefit from savings resulting from managed fee-for-service initiatives that improve quality and reduce costs for both Medicare and Medicaid. Both models are designed to achieve both State and federal health care savings by improving health care delivery and encouraging high-quality, efficient care. CMS will evaluate the care improvement resulting from these models while also monitoring the models' impact on quality and costs.

The Financial Alignment Initiative was open to all States, with a target of up to 2 million beneficiaries. In order to be considered, States were required to submit a letter of intent expressing interest in one or both of the models. Thirty-eight States and the District of Columbia expressed interest in participating in these new models. State approaches to

³⁰See, Financial Models to Support States Efforts in Care Coordination, http://www.cms.gov/medicare-medicaid-coordination/08_FinancialModelstoSupportStatesEffortsinCareCoordination.asp#TopOfPage (site last visited January 31, 2012).

these models will vary by scope, population, and model of care coordination, among other key factors. States may build upon existing programs, such as Medicaid health homes,³¹ to coordinate services for which Medicare is the primary payer (e.g., inpatient hospital stays and home health services). States may also utilize the demonstration to expand existing care management programs to Medicare-Medicaid enrollees. However, all States must establish a fully integrated care model that is capable of improving care as well as lowering costs prior to approval to begin implementation.

To date, CMS has actively engaged with all 38 States and the District of Columbia and will continue to work with those States interested in further developing their financial alignment demonstration proposals. CMS anticipates that not all of these States will participate in the demonstration and are committed to providing technical assistance to improve services for Medicare-Medicaid enrollees outside of this initiative. As with the design contracts described above, States interested in pursuing financial alignment demonstrations must actively engage with partners and stakeholders while developing their proposals and incorporate robust beneficiary protections into their demonstration programs.³² For example one State has held six public meetings to date to inform and develop the State demonstration proposal. In addition, ten States have held Medicare-Medicaid enrollee focus groups to better inform efforts.

³¹ Affordable Care Act, *supra* note 1, at Section 2703. Created a Medicaid State Plan option for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. CMS expects States' health home providers to operate under a "whole-person" philosophy. Health home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

³² Centers for Medicare & Medicaid Services, State Medicaid Director Letter, Attachment 13 Section E, http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf (noting that beneficiary protections for the capitated model must include: meaningful processes for beneficiary participation, ensure proper and accessible enrollee communications, have participating plans require customer service representatives, ensure privacy, and provide appropriate care that is person-centered and encourages consumer-direction).

Integrated Care Resource Center

In July 2011, CMS established the Integrated Care Resource Center (ICRC).³³ Through the resource center, the Medicare-Medicaid Coordination Office is supporting States in developing integrated care programs and promoting best practices for serving Medicare-Medicaid enrollees and other beneficiaries with chronic conditions. This center augments the resources of the Medicare-Medicaid Coordination Office in providing technical assistance to all States, including those that are implementing or improving programs for Medicare-Medicaid enrollees using existing statutory vehicles in Medicaid and Medicare, as well as those planning new demonstration programs under new authority. States are able to contact the center with questions and support needs; the center will then work with the State to answer questions, provide technical assistance, or work with CMS to meet the State's needs. For example, for one State the ICRC developed key information on Medicare-Medicaid enrollees for stakeholder meetings and helped facilitate beneficiary focus groups, while in another State the ICRC reviewed and provided comments on a State's health home proposal to refine the approach before submission to CMS. To date, the ICRC has worked with nearly two-thirds of the States to implement best practices for Medicare-Medicaid enrollees, navigate use of new Medicare data, and support development of Medicaid health homes.³⁴

³³ Integrated Care Resource Center, <http://www.integratedcareresourcecenter.com/> (site last visited January 31, 2012).

³⁴ Affordable Care Act, *supra* note 1, at Section 2703.

Initiative to Reduce Preventable Hospitalization Among Nursing Facility Residents

Nursing facility residents are subject to frequent preventable inpatient hospitalizations. These hospitalizations are expensive, disruptive, disorienting, and often dangerous for frail elders and people with disabilities.³⁵ Preventable hospitalizations among nursing facility residents stem from multiple system failures, including inadequate primary care, poor quality of care, poor communications, family preferences, lack of advance care planning, and other issues.³⁶ Compounding these problems, nursing homes have little incentive to reduce preventable hospital utilization, improve quality of care, and better coordinate transitions of care between hospitals, nursing facilities and in-home services.³⁷

CMS research found that 27 percent of Medicare-Medicaid enrollees were hospitalized at least once during the year, totaling 2.7 million hospitalizations. More than a quarter of these hospital admissions could have been avoided, either because the condition itself could have been prevented (e.g., a urinary tract infection), or the condition could have been treated in a less costly and more appropriate setting (e.g., chronic obstructive pulmonary disease). The study also found that skilled nursing facilities were by far the most frequent setting from which preventable hospitalizations occur.³⁸ Furthermore, in 2011 alone, it was projected that the total costs for all potentially avoidable hospitalizations for Medicare-Medicaid enrollees were \$7-8 billion, demonstrating opportunities for improvements in quality and costs.

³⁵ 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.

³⁶ See generally, Grabowski, D., Stewart, K., Broderick, S., & Coots, L. (2008). Predictors of Nursing Home Hospitalization: A Review of the Literature. *Medical Care Research and Review*, 65 (1), 3-39.

³⁷ MedPAC Report, *supra* note 3, at 141; Intrator, O., Grabowski, D. C., Zinn, J., Schleintiz, M., Feng, Z., Miller, S., & Mor, V. (2007). Hospitalization of Nursing Home Residents: The Effects of States' Medicaid Payment and Bed-Hold Policies. *Health Services Research*, 42(4), 1651-71.

³⁸ Centers for Medicare & Medicaid Services, Center for Strategic Planning, Policy and Data Analysis Group Policy Insight Report: Dual Eligible and Potentially Avoidable Hospitalizations, 2011 available at <https://www.cms.gov/Insight-Briefs/downloads/PAHInsightBrief.pdf>.

To address these problems, the Medicare-Medicaid Coordination Office, in collaboration with the Innovation Center, announced a new initiative in FY2011 to improve the quality of care for residents of nursing facilities by reducing preventable inpatient hospitalizations.³⁹

Through this new initiative, CMS will competitively select and partner with independent organizations that will provide enhanced clinical services to people in approximately 150 nursing facilities. Interventions will be targeted to nursing facilities with high hospitalization rates and a high concentration of residents who are Medicare-Medicaid enrollees. The demonstration is expected to begin in 2012.

³⁹ See, Reducing Preventable Hospitalizations Among Nursing Facility Residents, https://www.cms.gov/medicare-medicaid-coordination/09_ReducingPreventableHospitalizationsAmongNursingFacilityResidents.asp#TopOfPage. This initiative also supports the Administration's Partnership for Patients goal of reducing hospital readmission rates by 20% by the end of 2013. See, <http://www.healthcare.gov/compare/partnership-for-patients/index.html> (site last visited January 31, 2012).

Improving Coordination and Benefits for Medicare-Medicaid Enrollees

Improving the care for Medicare-Medicaid enrollees requires changes in the delivery and financing of care for this population. In its first year, the Medicare-Medicaid Coordination Office has been building the foundation for more integrated care systems to benefit all Medicare-Medicaid enrollees.

Through each Medicare-Medicaid Coordination Office initiative, CMS has come to appreciate the importance of certain elements that should be considered in future efforts, whether legislative or regulatory in nature. These elements are consistent with and support the Congressional goals established in Section 2602 (c) of the Affordable Care Act (also referenced in Appendix A of this Report) and include:

- Guarantee certain protections for beneficiaries;
- Be person-centered instead of payer-centric;
- Be informed by input from beneficiaries, their caregivers, their advocates and other key stakeholders and partners;
- Address financial misalignments;
- Simplify navigation of the care system for beneficiaries;
- Aim to reduce administrative burden for beneficiaries, caregivers, providers and States;
- Recognize the diversity among subpopulations of Medicare-Medicaid enrollees;
- Focus beyond medical issues to incorporate long-term services and supports and support community integration and independence to the maximum degree possible; and
- Improve quality while reducing costs.

Potential Areas of Exploration

There are also areas that we could explore through our current efforts regarding the alignment of Medicare and Medicaid appeals processes for Medicare-Medicaid enrollees and the Program of All-Inclusive Care for the Elderly (PACE).

Streamlining Medicare and Medicaid Appeals for Medicare-Medicaid enrollees

The Medicare-Medicaid Coordination Office has identified a potential alignment opportunity through the streamlining of Medicare and Medicaid appeals processes for Medicare-Medicaid enrollees. Because of conflicting statutory rules governing Medicare and Medicaid appeals, States are unable to provide a simplified, streamlined appeals process. This results in confusing and complicated experiences for Medicare-Medicaid enrollees, as these enrollees as well as providers must navigate two separate systems, each with their own forms, timeframes, and rules. We are utilizing demonstration authority under the Financial Alignment Initiative to test the alignment of the appeals process between the two programs. Aligning these two processes could help maintain core beneficiary protections and create a more beneficiary-friendly and less confusing appeal process for Medicare-Medicaid enrollees, their families, and providers.

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

In addition to initiatives underway to test new models of integrated care, we are also exploring the viability of existing models. The model authorized under current law that achieves the greatest degree of integration to date is the PACE, which serves individuals age 55 and older who meet a nursing home level of care. PACE has proven successful in keeping frail, older Medicare-Medicaid enrollees in the community. However, it may be worth testing whether additional flexibilities to the program could further improve its effectiveness at improving care while reducing costs and expanding its capacity to serve a greater number of Medicare-Medicaid enrollees. Potential areas to explore could include issues of eligibility, additional operational partners, alternative settings, and tailored multi-disciplinary teams within the PACE program.

Conclusion

The Medicare-Medicaid Coordination Office is working to ensure better health, better care, and lower costs for individuals enrolled in both Medicare and Medicaid. A lack of coordination for this population has led to fragmented and episodic care, which leads to poor health outcomes and inevitably higher costs for both Medicare and Medicaid. With the creation of the Medicare-Medicaid Coordination Office, Congress has provided CMS with a tremendous opportunity to better serve this population. Through the Medicare-Medicaid Coordination Office's work in Program Alignment, Data and Analytics, and State Demonstrations and Models, CMS has built a strong foundation for better care for Medicare-Medicaid enrollees by improving coordination between the programs, working to eliminate misalignments, and developing innovative models for integrated care.

Integrated care programs offer Medicare-Medicaid enrollees enhanced, person-centered, and coordinated services that target their diverse needs.⁴⁰ CMS is committed to strengthening and preserving the Medicare and Medicaid programs, while enhancing the programs' capacity to better serve Medicare-Medicaid enrollees. Expanded access to seamless, integrated care programs will not only have the ability to improve the lives of Medicare-Medicaid enrollees, but will also have the result of creating a more effective and efficient health care system for all low-income seniors and people with disabilities.

⁴⁰ MedPAC Report 2010, *supra* note 3, at 142.

APPENDIX A:

Goal- Pursuant to Section 2602 (c) of the Affordable Care Act	Alignment Initiative	Data Initiative	State Demonstration Initiatives	Nursing Facility Initiative	Other Initiatives ⁴¹
(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.	✓	✓	✓	✓	✓ <i>The Integrated Care Resource Center works with States (32 States to date) to implement new innovative approaches to caring for Medicare-Medicaid enrollees such as medical homes.</i>
(2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.	✓		✓	✓	✓ <i>Qualified Medicare Beneficiary (QMB) Initiative-Aims to improve outreach and awareness on the prohibition of balance billing on QMBs. As part of this initiative, CMS released a MedLearn article to providers and an Informational Bulletin to State Medicaid agencies on this issue.⁴²</i>

⁴¹ Other initiatives by the Medicare-Medicaid Coordination Office include: Collaborations across CMS; National Quality Forum, Provider Technical Assistance Initiative; Data efforts to analyze and understand pathways to becoming Medicare-Medicaid enrollees; State Profiles; Qualified Medicare Beneficiary (QMB) Initiative; and Partnerships with the CMS Innovation Center, Centers for Medicaid and CHIP Services, and the Center for Medicare.

⁴² CMS, MLN Matters, <https://www.cms.gov/MLN MattersArticles/downloads/SE1128.pdf>; CMS, Informational Bulletin, Center for Medicare & Medicaid Services, Informational Bulletin, http://www.cms.gov/medicare-medicaid-coordination/11_MedicareMedicaidGeneralInformation.asp#TopOfPage.

Goal- Pursuant to Section 2602 (c) of the Affordable Care Act	Alignment Initiative	Data Initiative	State Demonstration Initiatives	Nursing Facility Initiative	Other Initiatives ⁴³
(3) Improving the quality of health care and long-term services for dual eligible individuals.	✓	✓	✓	✓	✓ <i>Development of Framework for National Quality Strategy.⁴⁴</i>
(4) Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.	✓		✓		✓ <i>Focus Groups to increase understanding of Medicare-Medicaid enrollees' experiences and to inform program and communication strategies.</i>

⁴³ Other initiatives by the Medicare-Medicaid Coordination Office include: Collaborations across CMS, National Quality Forum, Provider Technical Assistance Initiative, Data efforts to analyze and understand pathways to becoming Medicare-Medicaid enrollees, State Profiles, Qualified Medicare Beneficiary (QMB) Initiative, Partnerships with the CMS Innovation Center, Centers for Medicaid and CHIP Services, and the Center for Medicare.

⁴⁴ The Medicare-Medicaid Coordination Office worked with The Measure Applications Partnership (MAP) by participating in the development of measures. MAP is a public-private partnership convened by the National Quality Forum (NQF). MAP was created for the explicit purpose of providing input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. NQF was selected by HHS to fulfill a provision in the Affordable Care Act requiring a consensus-based entity to convene multi-stakeholder groups to:

- Identify the best available health care performance measures for use in specific applications.
- Provide input to HHS on measures for use in public reporting, performance-based payment, and other programs.
- Encourage alignment of public and private sector efforts.

As part of this initiative, the MAP is assisting CMS by developing recommendations for a quality framework outlining multi-stakeholder input on performance measures to assess and improve the quality of care delivered to Medicare-Medicaid enrollees. National Quality Forum, Measure Applications Partnership, http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx.

Goal- Pursuant to Section 2602 (c) of the Affordable Care Act	Alignment Initiative	Data Initiative	State Demonstration Initiatives	Nursing Facility Initiative	Other Initiatives ⁴⁵
(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.	✓		✓		<p style="text-align: center;">✓</p> <p style="text-align: center;"><i>Convene agency and department-wide committees to coordinate on strategies and guidance to eliminate current and future regulatory conflicts.</i></p>
(6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.	✓	✓	✓	✓	<p style="text-align: center;">✓</p> <p style="text-align: center;"><i>Work with CMS partners on Affordable Care Act initiatives that focus on this goal for Medicare-Medicaid enrollees such as: Community-Based Care Transitions Program, Community First Choice Option, Health Homes and Partnership for Patients.</i></p>
(7) Eliminating cost shifting between the Medicare and Medicaid program and among related health care providers.	✓	✓	✓	✓	<p style="text-align: center;">✓</p> <p style="text-align: center;"><i>Continued work with States, providers and beneficiaries to eliminate cost-shifting between programs and to reduce cost-shifting in the home health benefit.</i></p>

⁴⁵ Other initiatives by the Medicare-Medicaid Coordination Office include: Collaborations across CM; National Quality Forum; Provider Technical Assistance Initiative; Data efforts to analyze and understand pathways to becoming Medicare-Medicaid enrollees; State Profile; Qualified Medicare Beneficiary (QMB) Initiative; and Partnerships with the CMS Innovation Center, Centers for Medicaid and CHIP Services, and the Center for Medicare.

Goal- Pursuant to Section 2602 (c) of the Affordable Care Act	Alignment Initiative	Data Initiative	State Demonstration Initiatives	Nursing Facility Initiative	Other Initiatives ⁴⁶
(8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.	✓	✓	✓	✓	✓ <i>Provider Technical Assistance and Support to promote best practices in caring for Medicare-Medicaid enrollees.</i>

⁴⁶ Other initiatives by the Medicare-Medicaid Coordination Office include: Collaborations across CMS, National Quality Forum, Provider Technical Assistance Initiative, Data efforts to analyze and understand pathways to becoming Medicare-Medicaid enrollees, State Profiles, Qualified Medicare Beneficiary (QMB) Initiative, Partnerships with the CMS Innovation Center, Centers for Medicaid and CHIP Services, and the Center for Medicare.