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Center for Medicaid, CHIP and Survey & Certification

CMCS Informational Bulletin

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SUBJECT: Recent Developments in Medicaid and CHIP Policy

As 2010 comes to a close, we wanted to share with you a series of announcements and updates regarding our work here at CMCS and to wish you all a productive and peaceful New Year. This Informational Bulletin provides information about a range of issues related to Medicaid policy, continued efforts to effectively implement CHIPRA and the Affordable Care Act, and some new developments in our cross cutting work with the Medicare program. We hope you will find this information helpful as you administer these critical health coverage programs.

Federal Coordinated Health Care Office

First, we are pleased to announce that the Centers for Medicare & Medicaid Services (CMS) has formally established the Federal Coordinated Health Care Office. This new office, created by Section 2602 of the Affordable Care Act, will bring together officers and employees at CMS in order to more effectively integrate benefits under the Medicare and Medicaid programs. The new office will be led by Melanie Bella.

The *Federal Register* notice announcing the Federal Coordinated Care Office is available at: http://www.gpo.gov/fdsys/pkg/FR-2010-12-30/pdf/2010-32957.pdf

The Federal Coordinated Health Care Office will focus on:

- Fostering overall improvements in the quality of health care and long-term services for individuals who are dually eligible for both Medicaid and Medicare;
- Simplifying processes for dual eligible individuals to access items and services available to them;
- Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs;
- Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs; and
- Improving coordination between the Federal government and the States.

As you know, dual eligibles account for 16 to 18 percent of enrollees in Medicare and Medicaid, but roughly 25 to 45 percent of spending in these programs respectively. With the vast majority of these nine million individuals receiving fragmented care at an estimated cost of over $300 billion in State and federal spending, improving care for this population is ripe for innovation.

As we announced in an Informational Bulletin on December 10, the Center for Medicare and Medicaid Innovation is partnering with the Federal Coordinated Health Care Office on a new initiative to promote innovative service delivery models for dual eligible individuals. Through the State Demonstrations to Integrate Care for Dual Eligible Individuals, CMS will provide funding for States to design new person-centered models that align the full range of acute, behavioral health, and long-term supports and services and improve the actual care experience and lives of dual eligible beneficiaries. The solicitation for this contracting opportunity is available on the Innovation Center website (http://innovations.cms.gov) and at the following link:
https://www.fbo.gov/index?s=opportunity&mode=form&tab=core&id=7ffe8a7ccbd80dffeccfbb55d7ae7d62&_cview=0

Adult Quality Measures
Section 2701 of the Affordable Care Act requires CMS to develop a recommended set of core quality measures that can be used for voluntary reporting by States to monitor and improve the quality of care obtained by adults enrolled in Medicaid. The recommended adult quality measures were required to be published for public comment by January 1, 2011. The *Federal Register* notice announcing the measures is available at: http://www.gpo.gov/fdsys/pkg/FR-2010-12-30/pdf/2010-32978.pdf

The Agency for Healthcare Research and Quality (AHRQ), on behalf of CMS, convened a meeting of a Subcommittee to its National Advisory Council on Healthcare Research and Quality (the Subcommittee) October 18-19, 2010 to provide guidance on adult quality measures. The Subcommittee consisted of State Medicaid representatives, health care quality experts from a range of clinical disciplines, and representatives of health professional organizations.

Overall, the Subcommittee reviewed a thousand measures for assessing the quality of care for adults from a list of previously established measures, such as those endorsed by the National Quality Forum or measures currently being used at the Federal or state levels. The Subcommittee identified 51 measures to recommend as the initial core set of adult quality measures. These measures are organized into the following categories: prevention and health promotion, management of chronic conditions, management of acute conditions, family experiences of care, and availability of services.

On October 28, 2010 CMCS held a listening session with States to obtain initial feedback on the core set. And we are seeking comment in the Federal Register notice on how to balance the need for quality measurement with minimizing the reporting burden on States. AHRQ will also be providing additional information about the process for identifying the core set of adult quality measures on their website at www.ahrq.gov.

Prohibition on Payments to Institutions or Entities Located Outside of the United States
On December 30, 2010, CMCS released a letter to State Medicaid Directors providing guidance on the implementation of a Medicaid payment provision of the Affordable Care Act of 2010 -- Section 6505 - *Prohibition on Payments to Institutions or Entities Located Outside of the United States.* Section 6505 amends section 1902(a) of the Social Security Act (the Act), and requires that a State shall not provide any payments for items or services provided under the Medicaid State plan or under a waiver to any financial institution or entity located outside of the United States (U.S.). This section of the Affordable Care Act is effective January 1, 2011, unless the Secretary determines that implementation requires State legislation, other than legislation appropriating funds, in order for the plan to comply with this provision. The letter is attached to this Bulletin.

Report to Congress on Preventive and Obesity-Related Services Available to Medicaid Enrollees. The Affordable Care Act requires the Department of Health and Human Services to provide guidance to States regarding preventive and obesity-related services available to individuals enrolled in Medicaid. States are to design public awareness campaigns to educate Medicaid enrollees on the availability and coverage of such services. HHS is required to issue a report to Congress no later than January 1, 2011, and every three years through 2017, addressing the status and effectiveness of these efforts. On December 23, 2010, the Secretary transmitted the first report to Congress, providing baseline information on the types of preventive and obesity-related services covered by Medicaid, as well as a summary of current and planned Federal and State activities. The report is attached to this Bulletin. Future reports will identify and assess the effectiveness of Federal and State efforts to increase awareness of coverage for obesity-related services.

CMS is preparing further guidance for States that will further clarify what obesity-related services Medicaid will cover and offer technical assistance to help States improve awareness of and access to obesity prevention and treatment services.

Report to Congress on Improving Children's Health Care Quality in Medicaid and CHIP
The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) includes a series of provisions designed improve the quality of care provided to children in the Medicaid and CHIP programs. The law requires the Secretary to submit to Congress, every three years, a report that details the status of a) efforts to improve the duration and stability of children's health insurance coverage in Medicaid and CHIP; b) voluntary quality reporting by States under Medicaid and CHIP, utilizing the initial core quality measurement set established under the statute; and c) recommendations for legislative changes needed to improve the quality of care provided to children in Medicaid and CHIP. As reflected in the report, improving continuity of coverage for children is a top priority for CMCS and for the Department more broadly. The Report was transmitted to Congress on December 30, 2010 and will soon be available on the CMS website.

Report to Congress on the High Risk Pool Grant Program for FY08 and FY09
The State High Risk Pool Extension Funding Act of 2006 requires an annual report to Congress on grants to States to support "high risk pools" for individuals who cannot afford or are unable to enroll in private health insurance programs due to complex or pre-existing health conditions.

This second annual report covers federal fiscal years (FY) 2008 and 2009. CMS awarded 30 high risk pool grants in FY08 and 31 high risk pool grants in FY09, resulting in comprehensive healthcare coverage for nearly 200,000 individuals who were otherwise unable to obtain health insurance due to their health history. (Note that these high risk pool programs are separate from the Pre-Existing Condition Insurance Plans or PCIPs established under the Affordable Care Act.)

Most State high risk pools have utilized the CMS grant funds to sustain existing programs by offsetting operational losses, but also to offer expanded consumer benefits, disease management services, and income-related premium subsidies. Overall, high risk pool benefit packages, which largely serve individuals with chronic and/or severe conditions, include a strong emphasis on case management, utilization review, and disease management programs. However, despite the low-income premium subsidies, the high risk pools are often still unaffordable to those in need of comprehensive health insurance coverage in the individual market. The report was transmitted to Congress on December 30, 2010 and will soon be available on the CMS website.

Medicaid Change as a Result of the Extenders Act

On December 15, 2010, the President signed into law the Medicare and Medicaid Extenders Act of 2010, which repealed new section 1902(a)(78) of the Social Security Act (the Act), as added by Section 6502 of the Affordable Care Act. Section 6502, *Medicaid Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliations*, required States to exclude individuals or entities from participating in Medicaid for a specified period of time if the individual or entity owns, controls, or manages an entity that: (1) has unpaid overpayments under Title 19; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation. The effective date of this provision was January 1, 2011.

Although section 1902(a)(78) will no longer go into effect in January, States may continue to review providers' affiliations when enrolling them in Medicaid as part of ongoing efforts to keep fraudulent providers out of the program. Questions regarding this information can be directed to Angela Brice-Smith of the CMS Center for Program Integrity at 410-786-4340 or via email at Angela.Brice-Smith@cms.hhs.gov.

Medicare's New End Stage Renal Disease Prospective Payment Systems Impact on Dual Eligible ESRD Beneficiaries. The Medicare Improvements for Patients and Providers Act (MIPPA) requires Medicare's implementation of the ESRD bundled payment system effective January 1, 2011. Under the End Stage Renal Disease Prospective Payment System (ESRD PPS), Medicare-certified ESRD facilities that provide outpatient maintenance dialysis services to Medicare beneficiaries will receive an all-inclusive bundled payment, replacing the current basic case-mix adjusted composite payment system used for the reimbursement of separately billable outpatient ESRD items and services.

On August 12, 2010, the CMS Center for Medicare (CM) published in the *Federal Register*, a final rule entitled, "End-Stage Renal Disease Prospective Payment System" (75 FR 49030), which is available at http://www.cms.gov/ESRDPayment/. In the final rule, CM stated its intent to educate State Medicaid agencies regarding their responsibilities to adjust their systems so that co-insurance amounts are properly determined and paid for dual eligible beneficiaries.

Under the new system, ESRD-related items and services furnished to Medicare beneficiaries on or after January 1, 2011, are considered renal dialysis services and are included in the payment amount paid to ESRD facilities. Because MIPPA redesignated these services as renal dialysis services, under the ESRD PPS, Medicare beneficiaries will incur a 20 percent co-insurance liability for the full bundle of services or the ESRD-related items and services (lab tests, supplies, drugs, and biologicals).

The statute requires a 4-year phase-in to the ESRD PPS and ESRD facilities are permitted to make a one-time election to be excluded from the transition. For ESRD facilities that do not elect to transition to the ESRD PPS in 2011, Medicare payment will be made as a blended payment of the current composite payment rate and the ESRD PPS. The beneficiary co-insurance liability will be 20 percent of the total ESRD PPS payment amount regardless if the ESRD facility will go through the transition or will be excluded from the transition.

Under the ESRD PPS, on or after January 1, 2011, ESRD facilities will continue to be required to report to Medicare on the ESRD claim items and services that they furnish. However, these line items and services will not be separately paid. For items and services that are not renal dialysis services, ESRD facilities will be required to place an AY modifier to indicate that an item or service is not ESRD-related, in order to receive separate payment. Items and services without an AY modifier are considered renal dialysis services and therefore, are included in the Medicare bundled payment. States should look to the total Medicare payment, excluding any items or service with an AY modifier and not the line items made to the ESRD facility for renal dialysis services, in determining the State obligation going forward. Questions regarding adjustments to Medicaid Management Information Systems (MMIS), may be directed to Robert Guenther of the Data and Systems Group at (410) 786-0618, or by email at Robert.Guenther@cms.hhs.gov. Questions regarding ESRD PPS policies may be directed to Terri Deutsch at (410) 786- 9462, or by email at Terri.Deutsch@cms.hhs.gov.

We hope you will find this information helpful. Thank you for your continued commitment to these critical health coverage programs.