

DEPARTMENT

of HEALTH

and HUMAN

SERVICES

Centers for

Medicare & Medicaid

Services

Medicare-Medicaid

Coordination Office

Fiscal Year 2014 Report to Congress

Executive Summary

Section 2602 of the Patient Protection and Affordable Care Act,¹ hereinafter referred to as the Affordable Care Act, created the Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office,” hereafter “the Office” or “MMCO”). The purpose of MMCO is to bring together Medicare and Medicaid in order to more effectively integrate benefits, and improve the coordination between the Federal Government and states to enhance access to quality services for individuals who are enrolled in both programs² (Medicare-Medicaid enrollees, sometimes referred to as “dual-eligibles”³). The Affordable Care Act sets forth the specific goals⁴ and responsibilities⁵ for the Office, including the annual submission of a Report to Congress.⁶

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

The Medicare and Medicaid programs were originally created as distinct programs with different purposes. Not surprisingly, the programs have different rules for eligibility, covered benefits, and payment. Over the past 50 years, the Medicare and Medicaid programs have remained

¹ (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).

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

³ 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.

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

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

⁶ Section 2602(e) of the Affordable Care Act.

separate systems despite a growing number of people who depend on both programs for their health care. Many of these Americans become eligible for Medicare first, and then qualify for Medicaid as a result of an income-changing event. Others qualify for Medicaid initially and then become eligible for Medicare. As the number of people who rely on both programs for their coverage grows, there is an increasing need to align these programs so as to improve care delivery for enrollees.

In 2014, MMCO better served the Medicare-Medicaid enrollee population through innovative initiatives, data analytics, and streamlining of Medicare and Medicaid. Simultaneously, MMCO is focusing on the following areas to continue to reduce misalignments, improve quality and lower costs:

Data Analytics: As of 2014, more than 10.7 million Americans⁷ are enrolled in both the Medicare and Medicaid programs; two-thirds of this population are low-income elderly individuals, and one-third are individuals who are under 65 and have disabilities. We are actively analyzing internal data and releasing reports to help CMS and external researchers better understand the heterogeneity and complexities of Medicare-Medicaid enrollees. This improved understanding will help us better direct and tailor interventions for individuals with Medicare and Medicaid.

Alignment Initiative: In 2011, MMCO compiled the Opportunities for Alignment List,⁸ which included a broad range of content areas in which the Medicare and Medicaid programs have conflicting requirements or incentives that prevent Medicare-Medicaid enrollees from receiving seamless, high-quality care. MMCO has used this list to help identify and implement solutions that advance better care, improve health, and lower costs.

Models: The Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility

Residents: MMCO is leading an initiative, in partnership with the Center for Medicare and Medicaid Innovation (Innovation Center), to reduce preventable inpatient hospitalizations among residents of nursing facilities. Research shows that nearly 45 percent of hospitalizations among

⁷ <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DualEnrollment20062013.pdf>

⁸ <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/AlignmentInitiative.html>

Medicare-Medicaid enrollees are avoidable, while costing the Federal Government billions of dollars each year;⁹ these hospitalizations are disruptive, and potential harmful to beneficiaries. Under this initiative, CMS is partnering with seven organizations¹⁰ and 146 nursing facilities to test strategies to reduce avoidable hospitalizations for Medicare-Medicaid enrollees who are long-stay residents of nursing facilities.¹¹ The initiative began serving enrollees in February 2013 and is projected to end by September 2016. Currently, the initiative serves about 16,000 enrollees in seven states.

Models: The Financial Alignment Initiative: MMCO, in partnership with the Innovation Center, leads the Financial Alignment Initiative, which seeks to improve care, improve coordination, and improve access for Medicare-Medicaid enrollees—all while enhancing quality and reducing costs. The Financial Alignment Initiative integrates the service delivery and financing of both Medicare and Medicaid through a Federal-state demonstration. Ten states have approved capitated financial alignment models,¹² two states have approved managed fee-for-service financial alignment models,¹³ and Minnesota has an alternative model to integrate care for Medicare-Medicaid enrollees building on the state’s current Dual Eligible Special Need Plans infrastructure. As of January 1, 2015, about 350,000 beneficiaries are being served by this initiative in eight states, and more states will begin implementation in 2015.

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

⁹ 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, D.C.: CMS.

¹⁰ The selected participants are in AL, NE, IN, MO, NY, PA, and NV. For a full list of these participants, please go to: <http://innovation.cms.gov/initiatives/rahnfr/>.

¹¹ 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.

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

¹³ CO and WA.

President's Fiscal Year (FY) 2016 Budget submission to the Congress. In addition, this report includes other issues CMS has identified as areas of interest for future consideration.

About Medicare-Medicaid Enrollees

Individuals enrolled in both Medicare and Medicaid tend to have complex, chronic care needs. Overall these individuals have higher prevalence of many conditions (including, but not limited to diabetes, pulmonary disease, stroke, Alzheimer’s disease, and mental illness) than their Medicare-only and Medicaid-only peers. Medicare-Medicaid enrollees’ health costs are four times greater than all other people with Medicare.¹⁴

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

¹⁴ <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2008NationalSummary.pdf>

Legislative Recommendations to Improve Care Coordination

The Affordable Care Act requires the Secretary of the Department of Health and Human Services (“Secretary”) to submit an annual report to the Congress that may include recommendations for legislation that would improve care coordination and benefits for Medicare-Medicaid enrollees.¹⁵

This year, CMS continues to recommend three legislative proposals that were included in the Fiscal Year 2013 Report to the Congress, as well as the President’s FY 2015 and FY 2016 Budgets:

- Create Pilot to Expand Programs of All-Inclusive Care for the Elderly (PACE) Eligibility to Individuals between Ages 21 and 55;
- Ensure Retroactive Part D Coverage of Newly-Eligible Low Income Beneficiaries; and
- Establish Integrated Appeals Process for Medicare-Medicaid Enrollees;

CMS also recommends the following new legislative proposal, which also is in the President’s FY 2016 Budget:

- Allow for Federal/State Coordinated Review of Duals Special Need Plan Marketing Materials.

Each of these four recommendations is discussed in greater detail below.

¹⁵ Section 2602(e) of the Affordable Care Act states that “[the] Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, United States Code, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.” To avoid a possible conflict with the Recommendations Clause, U.S. Const. art. II, § 3, the Secretary interprets the section 2602(e) reference to legislative recommendations as precatory rather than binding.

Create Pilot to Expand Programs of All-Inclusive Care for the Elderly (PACE) Eligibility to Individuals between Ages 21 and 55

CMS seeks to enhance existing person-centered, integrated care models. The current PACE program serves individuals ages 55 and older who meet their state's standards for nursing home level of care, among other requirements. Most PACE participants are dually eligible for Medicare and Medicaid; PACE aims to keep participants in the community and provides interdisciplinary, integrated care to an often frail population.

CMS proposes that the Congress amend the Social Security Act to provide CMS with the authority to launch a new pilot under which eligibility for PACE would be extended to individuals between the ages of 21 and 55. Under this authority, CMS would pursue testing in a limited number of PACE sites, and conduct a formal evaluation to assess whether PACE can effectively serve a younger population without increasing costs. This pilot would promote access to community services in line with the integration principles promoted by the landmark *Olmstead* Supreme Court decision¹⁶ which support increased self-determination on the path to achieving better health outcomes for people with disabilities.

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

Consistent with last year's report, CMS is recommending that the Medicare Part D Demonstration for Retroactive and Point of Sale Coverage for Certain Low-Income Beneficiaries (LI NET Demonstration) be made a permanent program. Over the past several years this demonstration has been successful in helping to provide timely Medicare Part D coverage for newly eligible Medicare-Medicaid enrollees.¹⁷

¹⁶The U.S. Supreme Court's 1999 landmark decision in *Olmstead v. L.C.* (*Olmstead*) found the unjustified segregation of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act (ADA). *Olmstead* requires states to administer programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

¹⁷ Through the LINET Demonstration, CMS pays a single entity via an alternative payment mechanism to: (1) auto-enroll certain low-income beneficiaries and to provide retroactive and point of sale Part D coverage to full-benefit dual eligible and Supplemental Security Income (SSI)-only beneficiaries, from the date of retroactive eligibility to enrollment in a Part D plan; and (2) provide point of sale coverage to all uncovered, LIS beneficiaries, including partial-benefit dual eligible and other Part D LIS beneficiaries.

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

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

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

Establish Integrated Appeals Process for Medicare-Medicaid Enrollees

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

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.¹⁸ In addition to these different requirements, the Medicare appeals process varies depending upon whether the claim involves Medicare Parts A, B, C or D.¹⁹ These requirements can result in confusion, inefficiencies, and administrative burdens for beneficiaries, providers and states. For providers that serve Medicare

¹⁸ See Social Security Act §§ 1852(g), 1860D-4(h), 1869(b), 1902(a)(3).

¹⁹ *Id.*

and Medicaid enrollees, such requirements may be barriers to seamless delivery of benefits and services to Medicare-Medicaid enrollees. For beneficiaries, caregivers, and their families, the disparate requirements can be confusing to navigate and may delay access to care.

Establishing a streamlined appeals process for those 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 Initiative (discussed later in this report). In developing Memoranda of Understanding and contracts to set terms for the different state demonstrations under that initiative, CMS has worked closely with states to identify opportunities to more effectively integrate appeals systems under current law. However, legislative authority is needed to implement an integrated appeals system for the broader Medicare-Medicaid enrollee population enrolled in health plans that integrate Medicare and Medicaid benefits.

In order to increase access to more seamlessly integrated programs for Medicare-Medicaid enrollees through a simpler, more user-friendly appeals process, CMS recommends legislation providing the Secretary with the necessary authority to develop such a system for health plans that provide integrated care to Medicare-Medicaid enrollees. The appeals process would consider information and insights from CMS' Alignment Initiative,²⁰ including public comments received in response to CMS' May 2011 Federal Register notice, *Opportunities for Alignment under Medicaid and Medicare: Request for Information* (FRN Doc. No. 2011-11848),²¹ as well as experience gained from the ongoing financial alignment demonstrations, to maintain or improve the current beneficiary appeals experience.

Allow for Federal/State Coordinated Review of Duals Special Need Plan Marketing Materials

²⁰ <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/AlignmentInitiative.html>

²¹ <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FederalRegisterNoticeforComment052011.pdf>

Under existing law, all marketing materials provided to beneficiaries by Medicare Advantage (MA) plans—including Dual Eligible Special Needs Plans (D-SNPs)²²—must be reviewed by CMS for accuracy, content, and other stated requirements. Because integrated D-SNPs also market to Medicaid beneficiaries, many of the same marketing materials must also go through a separate review by a state Medicaid agency for compliance with a different set of rules and regulations governing Medicaid managed care organizations.²³ Currently, statute does not provide the flexibility for CMS to share the marketing review responsibility with states.

CMS has explored this flexibility through a demonstration in Minnesota, an alternative model to the Financial Alignment Initiative administered jointly by MMCO and the Innovation Center, as well as through previous Medicare-Medicaid demonstrations. Through the Minnesota demonstration, CMS allows a more integrated marketing review, that leverages the relative strengths of both state and Federal review, in order to establish a process and materials that improve the beneficiary experience while maintaining rigorous standards.

CMS recommends introducing flexibility to rules around the review of marketing materials provided by D-SNPs to beneficiaries. Providing CMS with the ability to perform cooperative reviews of these marketing materials for compatibility with a unified set of standards will reduce the burden on CMS, the states, and plans, resulting in a more uniform message to beneficiaries.

²² <http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/DualEligibleSNP.html>

²³ See § 1932(d)(2) of the Act and 42 CFR 438.104.

Areas of Interest

In addition to making specific legislative recommendations, this report includes three policy areas CMS is examining that may have the potential to improve the experience of Medicare-Medicaid enrollees, many of which were identified in the Alignment Initiative.

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

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

Coverage Standards for Overlapping Medicare/Medicaid Benefits

CMS is examining coverage standards for beneficiaries where Medicare and Medicaid benefits overlap. Under existing law, coverage for Medicare-Medicaid enrollees is subject to distinct laws, regulations, and coverage policies for both Medicare and Medicaid. Where Medicare and Medicaid coverage overlaps, the programs may apply different standards for covering items and services.

CMS is assessing whether these complexities adversely affect access to care, and if varying coverage rules also result in conflicting incentives or lead to cost-shifting between programs that can harm beneficiaries and increase costs.

Durable Medical Equipment (DME) is an example of where Medicare and Medicaid have overlapping but distinct coverage standards. Differences in eligibility, coverage standards, and supplier requirements may lead to challenges in access to needed equipment for Medicare-Medicaid enrollees.

Prompt coverage of needed DME is critical to maintaining health and in preventing avoidable complications that harm the beneficiary and result in needless costs (e.g., emergency room visits or hospital admissions).

Medicare and Medicaid also have different rules for home health care coverage. Medicare covers skilled care for homebound beneficiaries, while Medicaid covers both skilled and chronic care, without requiring the beneficiary to be homebound. The more expansive Medicaid home health benefit may create incentives for providers to bill Medicaid when Medicare should be the primary payer. On the other hand, in states where Medicare payments are more generous in relation to Medicaid payments, home health agencies may first seek Medicare payment for certain services. CMS conducted a demonstration from 2000-2010 using a statistical sampling methodology intended to more efficiently review state-initiated home health appeals, and the evaluation is pending. MMCO plans to leverage the knowledge gained from this evaluation to continue exploring this issue in greater depth.

Cost-sharing Rules for Qualified Medicare Beneficiaries

State Medicaid programs pay Medicare cost-sharing (coinsurance and deductibles) for Medicare-Medicaid enrollees in the Qualified Medicare Beneficiary (QMB) program. These expenditures are reimbursed by the Federal Government according to each state's Federal Medical Assistance Percentage (FMAP). States have the option to limit their payment of Medicare deductibles and coinsurance to the lesser of the Medicare cost-sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service. A recent study by the Medicaid and CHIP Payment and Access Commission (MACPAC) showed that most states have now taken up the latter option.²⁴

²⁴ See MACPAC 2013 Report to Congress, Ch. 4, available at: https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid_Coverage_of_Premiums_and_Cost_Sharing_for_Low-Income_Medicare_Beneficiaries.pdf.

By law, Medicare providers may not bill Qualified Medicare Beneficiaries for any balances that are not reimbursed by the state, commonly known as balance billing. Part A providers such as hospitals can collect bad debt payments for part of this difference in payment from Medicare; Part B providers and suppliers, however, including primary care physicians and specialists, are typically not eligible for bad debt payments. As indicated in our FY 2013 Report to Congress, CMS is currently studying the extent to which varying reimbursement amounts impact beneficiaries' access to services and the financial incentives to providers.

Quality Measures and Medicare-Medicaid Enrollees

In October 2014, CMS posted a Request for Information (RFI) to solicit feedback from stakeholders on whether plans that serve a disproportionate share of low income enrollees are impacted by the Medicare Advantage and Part D Star Rating System.²⁵ Specifically, CMS requested that stakeholders present analyses and research that demonstrate that serving more beneficiaries with dual-eligible status causes lower MA and Part D quality measure scores. Alternatively, CMS requested information on research that demonstrates that high quality performance in MA or Part D plans can be achieved in plans serving dual-eligible beneficiaries, including how that performance level is obtained. CMS received 67 responses to the RFI from multiple organizations and is currently analyzing the data and information submitted.

²⁵ RFI found here: <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Request-for-Information-About-the-Impact-of-Dual-Eligibles-on-Plan-Performance.pdf>

Review of 2014

In 2014, MMCO continued its work toward improving the care experience of Medicare-Medicaid enrollees nationwide. MMCO implements initiatives designed to better align the Medicare and Medicaid programs and achieve the goals outlined in statute.

MMCO's work is guided by the statutory framework through which the office was created:

- Improve quality, reduce costs, and improve the beneficiary experience.
- Foster full access to the services to which Medicare-Medicaid enrollees are entitled.
- Improve the coordination between the Federal Government and states.
- Identify and test innovative care coordination and integration models.
- Eliminate financial misalignments that lead to poor quality and cost shifting.

Alignment Initiative

CMS is continuing its work on the Alignment Initiative, which was launched through a Notice for Public Comment in the Federal Register in May of 2011 (FRN Doc. No. 2011-11848). Through this process, CMS identified twenty-nine opportunities to better align Medicare and Medicaid requirements in six topic areas, and solicited public feedback. Over the past three years, CMS has been addressing these opportunities for alignment. Some examples of this work are discussed below.

For some of these opportunities, solutions have been identified that can be effectuated through rulemaking or policy changes. Additionally, a number of solutions for these opportunities are being tested via demonstration projects and models. For example, through the Financial Alignment Initiative, beneficiaries are enrolled in coordinated care, providing Medicare-Medicaid enrollees with additional and more coordinated benefits. CMS is also testing improved coordination in quality, marketing, and appeals processes for D-SNPs in Minnesota's alternative model of the Financial Alignment Initiative.

MMCO is collaborating with interested states to consider how best to integrate care by using D-SNPs to improve the beneficiary experience. For example, CMS is continuing to support opportunities such as "seamless conversion", through which MA organizations may apply to

provide seamless enrollment in an MA plan for newly Medicare-eligible individuals who are currently enrolled in other health plans offered by the MA organization (such as Medicaid plans) at the time that the beneficiary becomes initially eligible for Medicare..

Additionally, CMS continues to raise awareness of the important protection against billing Qualified Medicare Beneficiaries for balances of beneficiary cost-sharing amounts not paid for by the states. CMS has alerted providers of this protection through periodic Medicare Learning Network Matters articles and states through an Informational Bulletins to State Medicaid Agencies in January, 2012. CMS is also conducting quantitative and qualitative studies to assess whether there is an impact on access to care in areas where providers do not receive reimbursement of the full amount of the beneficiary cost-sharing. CMS notes that it has the authority to impose civil sanctions for improper billing. This includes exclusion from the Medicare program.

New Models of Care

The Affordable Care Act gives CMS the ability to test innovative payment and service delivery models that have the potential to improve the quality of care furnished to beneficiaries while also reducing program expenditures in Medicare and Medicaid. CMS continues to utilize this authority to implement several initiatives²⁶ that work to advance a well-coordinated, person-centered, more efficient care delivery system for Medicare-Medicaid enrollees.

Medicare-Medicaid Financial Alignment Initiative and State Demonstrations

In 2011, CMS launched the Medicare-Medicaid Financial Alignment Initiative²⁷ to more effectively integrate the Medicare and Medicaid programs to improve the overall beneficiary

²⁶ Demonstrations and models discussed in this Report are conducted under the authority of the Center for Medicare and Medicaid Innovation, as described in section 3021 of the Affordable Care Act.

²⁷ 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: CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, and WI. Many of these States are pursuing

experience, as well as both quality and costs of care. Through this initiative and related work, CMS is partnering with states to test models intended to achieve those goals, including a capitated model and a managed fee-for-service model.²⁸ Although the approaches differ in each state demonstration, beneficiaries in every version of the model will receive all the current services and benefits they receive today from Medicare and Medicaid, with added care coordination, beneficiary protections, and access to enhanced services.²⁹

To date, CMS has entered into Memoranda of Understanding (MOUs) with 12 states to test new models.³⁰ Nine of these states are pursuing the capitated model.³¹ Colorado and Washington are implementing the managed fee-for-service model. Minnesota is implementing an alternative model, building on its longstanding Minnesota Senior Health Options (MSHO) program.³²

Approved demonstrations are at different stages of implementation for the capitated model. Plans in six states are serving beneficiaries currently enrolled in demonstrations. About 300,000 beneficiaries are being served in the capitated model demonstrations as of January 1, 2015.

one of the two models in the Financial Alignment Initiative, or are continuing to work with CMS on alternative models.

²⁸ As reported in previous Reports to Congress: under the capitated model, a state, CMS, and health plan or other qualified entity enter into a three-way contract through which the health plan or other qualified entity will receive a prospective blended payment to provide comprehensive, coordinated care. Under the managed fee-for-service model, a state and CMS enter into an agreement by which the state would invest in care coordination and be eligible to benefit from savings resulting from such initiatives that improve quality and costs. Both models are designed to improve quality and achieve state and Federal health care savings by improving health care delivery, encouraging high-quality, efficient care, and better streamlining services. The authority for these models and Demonstrations was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act) coupled with the relevant Medicaid authority. 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.

²⁹ 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.

³⁰ CA, CO, IL, MA, MI, MN, NY, OH, SC, TX, VA, and WA.

³¹ CA, IL, MA, MI, NY, OH, SC, TX, and VA.

³² CMS is also continuing to work with some states to pursue demonstrations designed to improve care for Medicare-Medicaid enrollees outside the two models of the Financial Alignment Initiative. Minnesota’s demonstration is separate and distinct from the Financial Alignment Initiative. Minnesota’s demonstration involves a set of administrative improvements that will simplify the process for beneficiaries to access the services for which they are eligible under Medicare and Medicaid. Accordingly, Minnesota’s demonstration will not use the passive enrollment approach applied in other states testing capitated models. Rather, the demonstration focuses on ways to improve the beneficiary experience in health plans that maintain separate contracts with CMS as D-SNPs and with the state. More information on the Minnesota demonstration is available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Minnesota.html>.

In California, beneficiary enrollment in the demonstration began in April 2014. There currently are nine Medicare-Medicaid plans in seven county service areas,³³ and beneficiaries are currently being served in six of those counties. As of January 1, 2015, about 123,000 beneficiaries are being served through the demonstration.

In Illinois, enrollment into the demonstration began in March 2014. There are currently eight Medicare-Medicaid plans across two regional services areas that span 21 counties in Greater Chicago and Central Illinois. As of January 1, 2015, about 64,000 beneficiaries are being served through the demonstration.

In Massachusetts, three Medicare-Medicaid plans began serving beneficiaries in October 2013 in nine counties.³⁴ As of January 1, 2015, about 18,000 beneficiaries are being served by this demonstration.

In New York, plans began serving beneficiaries on January 1, 2015. There are currently 21 Medicare-Medicaid plans in eight counties in the greater New York City region. As of January 1, 2015, about 300 beneficiaries are being served in New York City and Nassau County. More beneficiaries will continue to be enrolled throughout 2015, including beneficiaries in Suffolk and Westchester counties beginning on April 1, 2015.

In Ohio, plans began serving beneficiaries in May 2014. Five Medicare-Medicaid plans are serving beneficiaries in seven regional services areas³⁵ that span 29 counties. As of January 1, 2015, about 67,000 beneficiaries are being served under this demonstration.

In Virginia, plans began serving beneficiaries in April 2014. Three Medicare-Medicaid plans are serving beneficiaries across five regional service areas³⁶ and 107 localities. As of January 1, 2015, about 27,000 beneficiaries are being served under this demonstration.

Demonstrations in Michigan, South Carolina, and Texas are scheduled to begin serving beneficiaries in 2015. In all of the remaining states with signed MOUs, beneficiaries will begin enrollment at various points in 2015.

³³ San Mateo, Riverside, San Bernardino, San Diego, Los Angeles, Santa Clara, and Orange.

³⁴ Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.

³⁵ Central, East Central, Northeast, Northeast Central, Northwest, West Central, and Southwest Ohio.

³⁶ Tidewater, Central Virginia, Northern Virginia, Roanoke, and Western Virginia.

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

Monitoring, Oversight, and Infrastructure Investments

To prepare for successful implementation, CMS and the states continue to invest in monitoring and oversight activities designed to protect beneficiary rights and maximize the benefits of integrated care. These activities include the following:

- *Readiness Reviews* – Plans participating in the capitated model and states participating in the managed fee-for-service model must complete readiness reviews prior to the start of their participation in the demonstration. These comprehensive reviews help determine that each plan or state is ready to accept enrollments, provide the required continuity of care, offer access to the full spectrum of providers, and fully meet the diverse needs of the Medicare-Medicaid population.
- *Contract Management Teams* – For each capitated demonstration, CMS and the state establish a joint Contract Management Team (CMT), which represents Medicare and Medicaid in overseeing all aspects of the three-way contract. The CMT is responsible for day-to-day monitoring of the demonstration and conducts contract management activities related to ensuring access, beneficiary protections, quality, program integrity, and financial solvency.
- *Implementation Funding* – The states that previously received design contracts for a Demonstration to Integrate Care for Dual Eligible Individuals and also have a signed MOU for this demonstration are eligible for additional funding for implementation activities, with priority given to activities that promote beneficiary engagement and the protection of beneficiary rights. As of October 2014, CMS had made implementation awards to eight states.³⁷

³⁷ CA, CO, MA, MI, MN, NY, SC, and WA. Additional information is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ImplementationSupportforStateDemonstrations.html>.

- *Funding for Ombudsman Services* – In states with approved financial alignment demonstrations CMS provides funding for Ombudsman services. These Demonstration Ombudsman Programs, with technical support from the Administration for Community Living, provide beneficiaries with access to person-centered assistance in answering questions and resolving issues, monitor the beneficiary experience, and offer recommendations to CMS, the states, and participating plans. States participating in the Financial Alignment Initiative are required to have dedicated ombudsman support. As of October 2014, CMS had made awards to seven states through this funding opportunity.³⁸
- *Funding for State Health Insurance Counseling and Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs)* – This funding supports local SHIPs and ADRCs in providing beneficiary outreach and one-on-one options counseling in states participating in demonstrations. As of October 2014, CMS had made awards to five states.³⁹

Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

Research shows that nearly 45 percent of hospitalizations among Medicare-Medicaid enrollees are avoidable.⁴⁰ These avoidable hospitalizations can be disruptive and dangerous for beneficiaries, and costly for Medicare. Numerous researchers and policymakers have noted that payment structures in Medicare and Medicaid may fail to incentivize the provision of care that would reduce preventable hospital utilization. In particular, transferring Medicare-Medicaid enrollees receiving long-term care in nursing facilities to hospitals may create inappropriate

³⁸ CA, CO, IL, MA, OH, VA, and WA. Additional information is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html>

³⁹ CA, IL, MA, VA, and WA. Additional information is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOptionsCounselingforMedicare-MedicaidEnrollees-.html>

⁴⁰ 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.

financial incentives that may cause disruptions to beneficiaries and increase Medicare spending.⁴¹

To address this misalignment, in early 2012 CMS launched the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.⁴² The objectives of the initiative are to reduce the number and frequency of avoidable hospital admissions and readmissions, improve beneficiary health outcomes, provide better transition of care for beneficiaries between inpatient hospitals and nursing facilities, and promote better care at lower costs while preserving access to beneficiary care and providers.

In this initiative, CMS selected seven organizations, known as Enhanced Care and Coordination Providers (ECCPs),⁴³ to test strategies to reduce avoidable hospitalizations for Medicare and Medicaid enrollees who are long-stay residents of nursing facilities.⁴⁴ These organizations are partnering with the 146 nursing facilities to test evidence-based interventions, which will be implemented over a four-year period. The model began serving Medicare-Medicaid enrollees in February 2013, and serves about 16,000 beneficiaries as of October 2014.

Evaluation of the Initiatives

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

⁴¹ Medicare Payment and Advisory Commission June 2010 Report at page 141, available at: http://www.medpac.gov/documents/reports/Jun10_EntireReport.pdf?sfvrsn=0.

⁴² <http://innovation.cms.gov/initiatives/rahnfr/>

⁴³ The selected participants are in AL, NE, IN, MO, NY, PA, and NV. For a full list of these participants, please go to: <http://innovation.cms.gov/initiatives/rahnfr/>.

⁴⁴ 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.

beneficiary experience of care, care coordination, care transitions, and the caregiver experience, among many others. State-specific and aggregate evaluation plans for the Financial Alignment Initiative are available on the Financial Alignment Initiative website.⁴⁵

Quality Improvement

A primary goal of CMS and Congress is to improve quality of care for Medicare-Medicaid enrollees.

CMS continued work in improving quality measures for Medicare-Medicaid enrollees in partnership with a multi-stakeholder group convened by the national Quality Forum (NQF). This work builds upon a recommended starter set of quality measures, some of which have been incorporated into the Medicare-Medicaid Financial Alignment Demonstrations.

The NQF workgroup is exploring quality measures responsive to the needs of subpopulations of Medicare-Medicaid enrollees (*e.g.*, behavioral health measures) as well as delving into high priority measurement gaps in areas such as quality of life, coordination across clinical care and long term services and supports, and end stage renal disease. These efforts are all focused on assessing the most critically important aspects of care for Medicare-Medicaid enrollees. Based on recommendations from NQF, CMS has also begun work to develop and test expanded measure sets for community-based long term services and supports.⁴⁶

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

⁴⁵ Available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.

⁴⁶ http://www.qualityforum.org/Measuring_HCBS_Quality.aspx

In addition, CMS is partnering with new and established measurement programs to explore the stratification of existing, new, and proposed measures pertinent to the population and identified gap areas.

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

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

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

Enhancements to Available Medicare and Medicaid Data

The CMS Chronic Condition Warehouse (CCW) is a research database designed to make Medicare and Medicaid claims data, nursing home and home health assessment data, and Part D Prescription Drug Event data more readily available to support policymakers and research to improve the quality of care, reduce costs, and increase efficient utilization.⁴⁷ Researchers and both Federal and state government officials use the CCW to understand beneficiaries' utilization, demographics, and spending, as well as other key factors to identify and support policies and programs that promote a more effective and efficient delivery of services.

In separate waves spanning 2012 through 2014, CMS released three sets of new diagnostic condition flags (codes used to identify characteristics/demographics) for the CCW to more fully represent conditions prevalent among Medicare-Medicaid enrollees, and to expand the flags to the Medicaid population as well. The first of these condition sets focused on mental health conditions (*e.g.*, bipolar disorder, schizophrenia, etc.). The second set focused on conditions that are often associated with physical, intellectual, and developmental disability (*e.g.*, autism, intellectual disability, blindness, cerebral palsy, etc.). The third release included a more diverse

⁴⁷ The Chronic Condition Warehouse, available at: <http://www.ccwdata.org/index.htm>.

set of other physical and behavioral health conditions (*e.g.*, HIV/AIDS, liver disease, viral hepatitis, obesity, pressure ulcers, peripheral vascular disease, etc.), many of which many be considered preventable by nature. Across all three sets, these newly added condition flags support analysis to better understand beneficiaries and take into account the full beneficiary care experience. Through these updates, CMS strives to facilitate and streamline research on beneficiary conditions.

Integrated Medicare-Medicaid Data

To support enhanced care coordination, CMS developed and made available a new Medicare-Medicaid integrated data set, called the Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS), within the CCW that is now available to states, policymakers, and researchers.⁴⁸ MMLEADS 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. MMLEADS will assist researchers, as well as Federal and state policymakers, to better identify regions, populations, or interventions to improve the quality, cost, and utilization of care for Medicare-Medicaid enrollees, including for individuals who need long term supports and services. Additionally in 2014, a second and improved version of MMLEADS was developed and made available. This MMLEADS-v2.0, contains additional data elements and has multiple structural enhancements that further improve researchers' abilities to take advantage of these data and better study and understand the experiences of Medicare-Medicaid enrollees.

As described in the FY 2011 Report to Congress, 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.⁴⁹ In FY 2014, CMS continued this work, expanding to 35 the total number of states receiving or working with CMS to receive these

⁴⁸ The Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS): <http://www.ccwdata.org/data-dictionaries/index.htm#linkedfiles>.

⁴⁹ 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>.

data.⁵⁰ With the new integrated data set tool, states are better equipped to coordinate benefits and services in a seamless, cost-effective manner. In addition, CMS worked to expand State access to Medicare data for program integrity purposes.

State Data Resource Center

Supplementing efforts to increase access to Medicare and Medicaid data to support care coordination, CMS developed and launched the State Data Resource Center (SDRC) to provide more tools and support for states using the data referenced in the above sections.⁵¹ The SDRC assists states with their data requests, guides states on how to best use the data, provides technical consultation, and helps states maximize the use of data to set priorities and support care coordination. In 2014, this assistance included numerous webinars meant to share best practices and guide states through key steps in obtaining and utilizing this important data. The SDRC is open to all states and will further support states in their development of coordinated care initiatives. SDRC has updated its processes to include support for requests for use of Medicare data for program integrity purposes.

Integrated Care Resource Center (ICRC)

The ICRC serves as a technical resource center for states, supporting them in developing integrated care programs, and promoting best practices for better serving Medicare-Medicaid enrollees and other beneficiaries with chronic conditions.⁵² This resource is available to states at all levels of readiness to better serve beneficiaries, improve quality and reduce costs.

The ICRC assists states with program design, stakeholder engagement, data access and analysis, and other functions. The ICRC also facilitates the sharing of best practices across states.

⁵⁰ As of October 9 2014, 31 states (AZ, CA, CO, CT, FL, GA, IL, IA, IN, KS, KY, LA, MA, ME, MI, MN, MO, NC, NY, OH, OK, OR, PA, RI, SC, TN, TX, VA, VT, WA, and WI) have been approved for or are actively seeking Medicare A/B data. Twenty-seven states (AZ, CA, CO, CT, GA, IL, IA, LA, MA, ME, MI, MN, MO, NC, NY, OH, OK, OR, PA, RI, SC, TN, TX, VA, VT, WA, and WI) have been approved for or are actively seeking Medicare Part D data. Other states continue to request access and are working with CMS to receive data use agreements.

⁵¹ <http://www.statedataresourcecenter.com/>

⁵² <http://www.integratedcareresourcecenter.com/>

Conclusion

In its fourth year, MMCO continued making important strides toward its goals of improving the beneficiary experience with the Medicare and Medicaid programs across the entire continuum of care.

The legislative recommendations, if implemented, will help further these goals, improving, coordinating, and increasing access to care for Medicare-Medicaid enrollees. MMCO also continues examining other policy areas that have the potential to improve the experience of Medicare-Medicaid enrollees.

In addition to identifying legislative recommendations and policy areas of interest, MMCO, in partnership with the Innovation Center, is also implementing the Financial Alignment Initiative which aims to improve care coordination and quality of care that Medicare-Medicaid enrollees receive by helping enrollees access a more comprehensive set of Medicare and Medicaid benefits. Simultaneously, MMCO is focusing on improving care for beneficiaries residing in nursing facilities through the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents.

MMCO is also making important advances in data and analytics to improve our understanding of the Medicare-Medicaid enrollee population so that we may better serve the beneficiaries and meet their needs. This important work will help build our knowledge base to fulfill our mission of improving care and coordination for these beneficiaries.

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