STATEMENT OF

MELANIE BELLA

DIRECTOR OF THE MEDICARE-MEDICAID COORDINATION OFFICE
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

EXAMINING MEDICARE AND MEDICAID COORDINATION FOR DUAL-ELIGIBLES

BEFORE THE

U. S. SENATE SPECIAL COMMITTEE ON AGING

JULY 18, 2012

U.S. Senate Special Committee on Aging

Examining Medicare and Medicaid Coordination for Dual-Eligibles

July 18, 2012

Ranking Member Corker, Chairman Kohl, and Members of the Committee, thank you for the invitation to discuss the Center for Medicare & Medicaid Services' (CMS) efforts to improve and integrate care for individuals who are enrolled in both the Medicare and Medicaid programs (Medicare-Medicaid enrollees). I appreciate the opportunity to be here today to update you on the many efforts underway at CMS to provide high quality, coordinated care for Medicare-Medicaid enrollees (commonly referred to as "dual eligibles").

Background

The Medicare and Medicaid programs were originally established in 1965 as distinct programs with different purposes. Medicare provides health insurance for 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 programs 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, the majority of Medicare-Medicaid enrollees must navigate three sets of rules and coverage requirements (Original Medicare, a Medicare Prescription Drug Plan, and Medicaid) 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, unnecessary spending and an inefficient system of care.

Today, more than 9 million Americans[1] 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.[2]

While pathways to becoming dually enrolled vary, Medicare-Medicaid enrollees either become eligible for Medicare first, e.g., when they turn 65 or qualify based on disability, and then later become eligible for Medicaid as a result of functional or financial decline; or become eligible for Medicaid initially, and then become eligible 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;[3]
- Are more likely to have low-incomes; and
- Are three times more likely to have a disability, and overall have higher rates of diabetes, pulmonary disease, stroke, Alzheimer's disease, and mental illness.[4]

As a result of the complexity of their health care needs, costs for individuals within this population are nearly five times greater than other individuals with Medicare.[5] Not surprisingly, Medicare-Medicaid enrollees are among the highest cost individuals within the Medicare and Medicaid programs. Total annual spending for their care exceeds $300 billion across both programs.[6] In the Medicaid program, Medicare-Medicaid enrollees represent 15 percent of

[1] 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.
[2] Kaiser Family Foundation, Medicaid's Role for Low-Income Medicare Beneficiaries, May 2011 Report *available at* http://www.kff.org/medicaid/upload/4091-08.pdf [hereinafter Kaiser, Medicaid's Role May 2011 Report]; Kaiser Family Foundation.
[3] 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
[4] 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 http://www.kff.org/medicaid/upload/8081.pdf.
[5] 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, http://www.kff.org/medicaid/upload/8081.pdf..*supra* note 4 at 1.
[6] 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.

enrollees but 39 percent of all Medicaid expenditures.[7] In Medicare, they represent 18 percent of enrollees and 31 percent of program expenditures.[8]

There are tremendous opportunities to strengthen the Medicare and Medicaid programs for Medicare-Medicaid enrollees by addressing inefficiencies and misaligned incentives. A fully integrated system of care that ensures all their needs - primary, acute, long-term care, behavioral and social- are met could better serve this population in a high quality, cost effective manner. This is consistent with the Medicare Payment Advisory Commission's (MedPAC) 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." 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.

Medicare-Medicaid Coordination Office

The Medicare-Medicaid Coordination Office was established by Congress through section 2602 of the Affordable Care Act to more effectively integrate the Medicare and Medicaid benefits and to improve the coordination between the Federal and State governments for individuals enrolled in both the Medicare and Medicaid programs.

Improving Care for Beneficiaries

The Medicare-Medicaid Coordination Office seeks to increase access to seamless, quality and person-centered care programs for Medicare-Medicaid enrollees. As part of this mission within CMS, the Medicare-Medicaid Coordination Office works closely with the Center for Medicare, the Center for Medicaid and Children's Health Insurance Program (CHIP) Services, and the Center for Medicare and Medicaid Innovation (Innovation Center) within CMS to foster significant reforms across the health care delivery system designed to improve the coordination

[7] Kaiser, Role of Medicare for People Dually Eligible, January 2011 Report, at 1.
[8] Medicare Payment Advisory Commission. A Data Book: Health Care Spending and the Medicare Program. June 2011.

of care for all patients, including low-income beneficiaries, many of whom are Medicare-Medicaid enrollees.

A major focus is working to improve the beneficiary's care experience with both the Medicare and Medicaid programs. As part of this, CMS continually engages with many national and local advocacy organizations to incorporate their input and the beneficiary perspective in its work. In addition to meeting on a regular basis with these advocacy organizations, CMS partnered in 2011 with the States of California, New Mexico, New York, Oregon, Pennsylvania, and Wisconsin to conduct beneficiary focus groups to asses and raise awareness of the beneficiary's care experience and needs in both the Medicare and Medicaid programs. As we work to better coordinate services, CMS will continue to work with advocacy organizations and other partners to ensure the beneficiary perspective is always a part of our work.

The Need for Coordinated Care

In 2008 Medicare-Medicaid enrollees accounted for approximately $128.7 billion[9] in combined Medicaid Federal and State spending– almost twice as much as Medicaid spent on all 29 million children it covered in that year.[10] While spending on Medicare-Medicaid enrollees varies by State, it accounts for more than 40 percent of all combined Federal and State Medicaid spending in 27 States.[11] These numbers demonstrate the critical need to build, sustain and strengthen Federal-State partnerships by better coordinating the benefits and services of the Medicare and Medicaid programs in a more efficient and cost-effective manner.

Medicaid is the major financing system for long-term services and supports (LTSS). In 2007, more than two-thirds (70 percent) of Medicaid expenditures for Medicare-Medicaid enrollees were for long-term services and supports (LTSS).[12] The average Medicaid spending per

[9] Kaiser Family Foundation, Medicaid's Role for Dual Eligible Beneficiaries in 2012. http://www.kff.org/medicaid/upload/7846-03.pdf
[10] Kaiser Family Foundation, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007. December 2010. http://www.kff.org/medicaid/7846.cfm
[11] Kaiser Family Foundation, Medicaid's Role for Dual Eligible Beneficiaries in 2012, at 11.
[12] Kaiser Family Foundation, Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries. May 2011. http://www.kff.org/medicaid/upload/4091-08.pdf

Medicare-Medicaid enrollee was $16,087 in 2008,[13] more than seven times higher than the comparable cost of a non-disabled adult covered by Medicaid ($2,296) in 2009.[14] This spending mostly reflects the significant costs associated with a population that tends to have multiple chronic conditions, and, compared to other Medicare beneficiaries, is more likely to be hospitalized and in need of emergency room treatment and LTSS. However, there are opportunities for improved care coordination, simplification, and alignment of the Medicare and Medicaid programs to support and sustain a better health care delivery system.

The current system of financing care for Medicare-Medicaid enrollees often provides a financial incentive to push costs back and forth between the States and the Federal Government. For example, payment structures in Medicare and Medicaid may fail to adequately incentivize nursing facilities to intervene to reduce preventable hospital utilization. In particular, transferring Medicare-Medicaid enrollees receiving long-term care in nursing facilities to hospitals may be financially advantageous to facilities and States but raises Medicare spending. More information on this cost-shifting and CMS' work to address it can be found in the *Initiative to Avoid Hospitalizations among Nursing Facility Residents* section of this testimony. Partnerships to facilitate coordination of services between States and the Federal Government will work to eliminate these incentives and find real solutions that improve the experience and quality of care for beneficiaries while reducing costs.

As part of this ongoing partnership between the Federal Government and States, in July 2011**,** CMS established the Integrated Care Resource Center (ICRC). Through the ICRC, CMS 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 provides 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 then works with the States to answer questions, provides technical assistance, and works with CMS to

[13] Kaiser Family Foundation, Medicaid's Role for Dual Eligible Beneficiaries. April 2012. http://www.kff.org/medicaid/upload/7846-03.pdf

[14] Kaiser Family Foundation, State Health Facts. http://statehealthfacts.org/comparemaptable.jsp?ind=183&cat=4

meet the State's needs. 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.[15]

Initiatives to Date

The Medicare-Medicaid Coordination Office has been working on a variety of initiatives to meet its Congressional charge and to further partner with States and other stakeholders to improve access, coordination, and cost of care for Medicare-Medicaid enrollees. Work falls into the following broad areas to support the overarching goals and mission of improving care, improving the health status of beneficiaries, and lowering costs:

- Program Alignment
- Data and Analytics
- Models and Demonstrations

Program Alignment

Although established at the same time in 1965, the Medicare and Medicaid programs were designed with distinct purposes, which often create barriers for beneficiaries eligible for both programs to receive coordinated quality care and also complicates the administration of a more cost-efficient system.

An example of this fragmentation occurs with 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

[15] CMS Integrate Care Resource Center: http://www.integratedcareresourcecenter.com/

cost-shifting.[16] To the extent current systems create waste, confusion or poor care, CMS' mission is to reduce or eliminate their underlying sources, creating a more streamlined system that delivers appropriate, quality, cost-effective care.[17]

To address such program inefficiencies, CMS launched the "Alignment Initiative" to facilitate development of a better, more cost-effective system of care that strengthens Medicare and Medicaid for beneficiaries, their caregivers, providers, States and the Federal Government.

As part of this effort, CMS compiled a wide-ranging list of opportunities for statutory, regulatory, and policy alignment and published it in the Federal Register to ensure public input in program development.[18] CMS received 108 public comments in response to the Federal Register posting. Feedback ranged from large-scale and broad reforms, to more issue-specific proposals, such as altered timeframes for appeals and an aligned Medicare and Medicaid mental health provider credentialing process. A common theme among comments was the basic need for increased communication and coordination between Medicaid and Medicare, as well as with States and Federal Government, to assure that beneficiaries have a seamless care experience across the two programs.

Since its development, the Alignment Initiative has served as CMS' guide for streamlining Medicare and Medicaid program rules, requirements, and policies. Department and agency-wide Medicare-Medicaid enrollee policy workgroups have been formed to continually engage, coordinate, and build upon opportunities for alignment. For example, an area identified in the Alignment Initiative was the practice of balance billing[19] Qualified Medicare Beneficiaries

[16] MedPAC June 2010 Report. Coordinating the Care for Dual Eligibles, Chapter 5. http://www.medpac.gov/documents/jun10_entirereport.pdf; Kaiser Family Foundation, Health Reform Opportunities: Improving Policy for Dual Eligibles (August 2009). http://www.kff.org/medicaid/upload/7957.pdf

[17] Section 2602 (c)(1)-(8) of the Affordable Care Act specifically delineates the goals.

[18] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FederalRegisterNoticeforComment052011.pdf

[19] Balance billing refers to a practice where providers bill beneficiaries the unpaid co-pay or cost-share from services received. Section 1902(n)(3)(B) of the Social Security Act (the Act), as modified by section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance-billing QMBs for Medicare cost-sharing.

(QMBs)[20], which is prohibited by law. Conversations within CMS and with external stakeholders such as beneficiary advocacy groups, providers, and others demonstrated a lack of awareness on this issue. In direct response, CMS issued both an Information Bulletin and Medicare Learning Network Article[21] to better inform partners and provide best practices to address. Other areas of the Alignment Initiative have also informed CMS work, including but not limited to, consideration of potential opportunities to improve the Program of the All-Inclusive Care for the Elderly (PACE) as well as for alignment in the appeals process, both of which were identified in our FY 2011 Report to Congress. The Alignment Initiative has also informed the development of Medicare and Medicaid program policy areas within our demonstrations, which are discussed in the Models and Demonstrations section of this testimony.

Improved coordination of the Medicare and Medicaid program rules, requirements and policies could help to create a more seamless, quality, and cost-effective system of care. The Alignment Initiative has provided CMS with important public input on this effort and will continue to act as our guide to strengthening the programs to better serve this population.

Data and Analytics

Medicare Data to States Initiative

Another opportunity to support care coordination occurs in improved access to Medicare data, which 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 has prevented 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 identify unnecessary duplicative services that could be harmful to the individual and costly to both Medicare and Medicaid. States have asked CMS to expand access to timely Medicare data to help them better analyze, understand, and coordinate a beneficiary's care.

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

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

Through this initiative, CMS used existing regulatory and statutory authority to address these data challenges directly. Specifically, CMS established a new process for States[22] to access Medicare data to support care coordination, while also protecting beneficiary privacy and confidentiality by assuring compliance with the Privacy Act and Health Insurance Portability and Accountability Act (HIPAA). CMS works with States throughout the entire process of requesting and receiving the data. Currently, 25 States have already received or are in the process of actively seeking Medicare Parts A and B data and 20 States are in the same position regarding Medicare Part D data.[23] The process begins with a Data Use Agreement (DUA) that identifies and approves users to ensure data are used for care coordination purposes while requiring strict privacy and security safeguards. Medicare data will enable States to provide better, safer care based on the specific care needs of each Medicare-Medicaid enrollee.

State access to Medicare data for Medicare-Medicaid enrollees allows States to make more informed policy and program decisions. Nationally, States have varying levels of capacity to receive and analyze Medicare data but we are encouraged with the number of States that are working with CMS to actively seek Medicare data. We also plan to create opportunities for States to engage with and learn best practices from innovator States as they move forward on their respective data initiatives to improve coordination between Medicare and Medicaid. CMS will also continue to provide 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.

Medicare-Medicaid Enrollee State Profiles

As part of our efforts to better coordinate the Medicare and Medicaid programs, in June, 2012 CMS released Medicare-Medicaid Enrollee State Profiles[24] (State Profiles). CMS hopes these

[22] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/MedicareDataforStates.html

[23] Note: As of June 6, 2012, 20 States (Arkansas, California, Colorado, Connecticut, Iowa, Massachusetts, Michigan, North Carolina, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Vermont, Washington, and Wisconsin) have been approved for Medicare A/B data. Twelve States (California, Connecticut, Massachusetts, North Carolina, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Vermont, Washington and Wisconsin) have been approved for Medicare Part D data. Other States continue to request access and are working with CMS to receive data use agreements.

[24] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html

State Profiles will help provide policymakers, researchers, and other interested parties with a greater understanding and awareness of the population to foster program improvement. The information released includes a national summary and overview of data methodology underlying the analysis, along with individual profiles for each of the 50 States and the District of Columbia. State-level profiles contain demographic characteristics, utilization and the spending patterns of the Medicare-Medicaid enrollees and the State Medicaid programs that serve them while the national summary provides a composite sketch of Medicare-Medicaid enrollees including demographics, selected chronic conditions, service utilizations, expenditures and availability of integrated delivery programs. CMS expects to update the State Profiles annually and continually engage with States and other key stakeholders to improve the data to better inform policy.

Demonstrations and Models

The Medicare-Medicaid Coordination Office, in coordination with CMS' program components, has created opportunities to develop, test, and rapidly deploy innovative and effective care models for Medicare-Medicaid enrollees. In 2011 CMS announced several new opportunities and resources: State Design Contracts to Integrate Care for Medicare-Medicaid Enrollees, the Financial Alignment Initiative, and the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. These initiatives are designed to improve the overall beneficiary care experience and coordination of services while addressing inefficiencies in care delivery that may result in health care savings.

State Design Contracts to Integrate Care for Medicare-Medicaid Enrollees

As a first step to partnering with States to better integrate care, in April 2011 CMS awarded 15 States[25] up to $1 million each to design person-centered approaches to coordinate care across primary, acute, behavioral health, prescription drugs, and LTSS for Medicare-Medicaid enrollees.[26] These States were selected to develop new ways to meet the often complex and costly needs of Medicare-Medicaid enrollees. Early work with these States confirmed that a key component of a fully integrated system would be testing new payment and service delivery

[25] CMS awarded contracts to the following 15 States: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.

[26] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html

models to promote better care and align the incentives for improving care with lowering costs for Medicare and Medicaid. Each of the 15 States has submitted a demonstration proposal to CMS, the majority of which are for one of the two models described in the Financial Alignment Initiative below.

Financial Alignment Initiatives

In July 2011, CMS announced the Financial Alignment Initiative, an opportunity for Medicare and Medicaid programs to test cost-effective integrated care and payment systems to better coordinate care for Medicare-Medicaid enrollees. The Initiative seeks to align the service delivery and financing of the programs to better align incentives for improving quality and costs between Medicare and Medicaid.

Medicare benefits focus primarily upon the acute medical care needs of beneficiaries, resulting in little incentives 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 primarily accrue to the Medicare program. This financial misalignment between the two programs has been a major barrier to better serving Medicare-Medicaid enrollees.

Through the Financial Alignment Initiative, CMS offered two models to test alignment of the payment and service delivery between the Medicare and Medicaid programs while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees.[27] The first is a capitated model in which a State, CMS, and health plan or other qualified entity will enter into a three-way contract through which the health plan or other qualified entity will receive a prospective blended payment to provide comprehensive, coordinated care. The second is a managed fee-for-service model (MFFS) under which a State and CMS will enter into an agreement by which the State would support care coordination networks in a fee-for-service context and would be eligible to benefit from savings resulting from MFFS initiatives that improve quality and reduce costs for both Medicare and Medicaid. Both models are designed to

[27] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html

achieve State and Federal health care savings by improving health care delivery, encouraging high-quality, efficient care, and better streamlining services.

Twenty-six States,[28] after extensive consultation with and public comment from a range of stakeholders (including providers, beneficiaries, and their advocates), submitted Financial Alignment Demonstration (Demonstration) proposals to CMS. Of these States, eighteen are pursuing the capitated model, six the MFFS model, and two are pursuing both models. State approaches to financial alignment vary by scope, population, and model of care coordination, among other key factors. In some instances, States are building and leveraging existing programs and resources, such as Medicaid health homes,[29] to coordinate services for which Medicare is the primary payer (e.g., inpatient hospital stays and home health services). Other States are utilizing the demonstration to expand existing care management programs to serve Medicare-Medicaid enrollees. The Demonstrations recognize the diversity of different States in serving the Medicare-Medicaid enrollee population, and afford an opportunity to test better coordination of services in a multitude of settings.

As part of this effort, States in the Demonstrations must establish a fully integrated delivery system that provides more easily navigable and seamless path to care for beneficiaries. Every Demonstration approach must have strong beneficiary protections and safeguards. To that end, on both January 25, 2012[30] and March 25, 2012[31] CMS released Demonstration Guidance to establish baseline program requirements for States and entities participating under the capitated model.

---

[28] These 26 States are: Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Iowa, Massachusetts, Michigan, Minnesota, Missouri, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, and Wisconsin.

[29] Note: The Affordable Care Act 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.

[30] Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans. January 25, 2012. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

[31] Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013. March 25, 2012. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MarchGuidanceDocumentforFinancialAlignmentDemo.pdf

Demonstration Guidance released in January focused on payment principles and standards in key programmatic areas, such as appeals, enrollment, network adequacy, and other key programmatic standards. Guidance also provided States and potential participating plans with further information about the Demonstration approval process and timeline. These requirements establish the operational framework to be utilized in key Demonstration areas. Any variation from these standards will have to be equally or more robust from a beneficiary perspective. One such area is network adequacy standards, where the Demonstration requires aligning Medicare and Medicaid network standards to provide beneficiaries with more comprehensive access to necessary services by incorporating the strongest protections and aspects from both programs. Generally, State Medicaid standards will be used for LTSS, while Medicare standards will be used for Medicare prescription drugs and other services for which Medicare is primary. Where either program requires a more rigorous network adequacy standard than would otherwise apply (including time, distance, and/or minimum number of providers or facilities), the more rigorous standard will be used. In addition, for the prescription drug benefit, as noted in the guidance,[32] States will be required to meet Medicare Part D requirements regarding beneficiary protections, protected classes, and network adequacy. No participating States will be permitted to alter standards in a manner that is less beneficiary-friendly or reduces access. In the March Guidance, CMS outlined the Medicare Plan Selection Requirements and other key Demonstration areas, such as Model of Care (MOC) requirements. As with the January Guidance, these standards guide the operations for indicated program areas under the Demonstration.

CMS is fully committed to an open and transparent process for the Financial Alignment Demonstrations. As a result, a robust public engagement process was required as part of the Demonstration proposal process. States held public forums, workgroups, focus groups, and other meetings to obtain public input on the development of their demonstration proposal. Each State was required to publicly post a draft demonstration proposal for a 30-day public comment period prior to submitting a proposal to CMS. After this 30-day period, States worked to address and incorporate public feedback in proposals before officially submitting their proposal to CMS. Once a State formally submitted its proposal to CMS, CMS then posted the proposal to the CMS

[32] January 25, 2012 Guidance, page 17.

website for a subsequent 30-day public comment period in order to solicit stakeholder feedback directly.

CMS will evaluate the care improvement resulting from these models, and implement rigorous Federal oversight and monitoring to assess the models' impact on beneficiary experience, quality and costs. CMS has contracted with an external independent evaluator to measure, monitor, and evaluate the overall impact of the Demonstrations including impacts on program expenditures and service utilization changes. The evaluator will design unique, State-specific evaluation plans for each individual State participating in the Demonstration, as well as an aggregate analysis that will look at the Demonstration overall including Demonstration interventions and impact on key subpopulations within each State. There will also be a CMS-State contract management team that will ensure access, quality, program integrity, and financial solvency under the capitated model, including reviewing and acting on data and reports, conducting studies, and taking quick corrective action when necessary. In addition, CMS will apply Part D requirements regarding oversight, monitoring, and program integrity to Demonstration plans in the same way they are currently applied for Part D for sponsors. CMS is working with individual States to develop a fully integrated oversight process, using the process currently employed in the Medicare Advantage and Part D programs as a starting point.

The overarching goal of the Demonstrations is to leverage the strengths of the Federal Government and States in a manner that incorporates the strongest aspects from each to best meet the needs of beneficiaries, their caregivers and providers.

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.[33] Preventable hospitalizations among nursing facility residents stem from multiple system failures, including inadequate primary care, poor quality of care, poor

[33] 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.

communications, family preferences, lack of advance care planning, and other issues.[34] 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.[35]

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.[36] 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.

To address these problems, CMS announced a new initiative to improve the quality of care for residents of nursing facilities by reducing preventable inpatient hospitalizations.[37] Through this 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. Applications for this demonstration were due June 14, 2012. CMS received applications from organizations in 29 States, including health plans, hospitals, Area Agencies on Aging, hospice groups, and other types of care management organizations. CMS is currently reviewing those applications and intends to start these demonstrations before the end of the year.

---

[34] *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.

[35] Page 141 of June 2010 MedPAC Report; 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.

[36] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Insight-Briefs/downloads/pahinsightbrief.pdf

[37] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/ReducingPreventableHospitalizationsAmongNursingFacilityResidents.html

Conclusion

Congress has provided a unique opportunity for undertaking a number of initiatives to create a more seamless and efficient delivery system for Medicare-Medicaid enrollees. These initiatives are designed to enhance care coordination and person-centered care programs, focus on increased access to needed services, promote keeping individuals in the home and community, support a much needed focus on improving the quality of care received by beneficiaries, and achieve health care savings for both States and the Federal Government through better care management. While exploring new models through Demonstrations are a part of this effort, CMS is also working to improve and enhance existing programs that serve Medicare-Medicaid enrollees. In addition, we seek to better understand the population to provide Congress and other policy makers with robust data about the care experience, quality, and spending for this population.

We thank the Committee for its interest in improving care for Medicare-Medicaid enrollees. With your continued support, we will keep working as partners with States and other stakeholders to advance high quality, coordinated care for these individuals.