STATEMENT OF

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ON

"IMPROVING CARE FOR DUALLY-ELIGIBLE BENEFICIARIES: A PROGRESS UPDATE"

BEFORE THE

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"Improving Care for Dually-Eligible Beneficiaries: A Progress Update"

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Chairman Baucus, Ranking Member Hatch, and Members of the Committee, thank you for the invitation to continue our discussion about 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), commonly referred to as "dual eligibles." I appreciate your ongoing interest in the work of the CMS Medicare-Medicaid Coordination Office to provide high quality, coordinated care for Medicare-Medicaid enrollees.

I am pleased to report that CMS continues to make progress in our efforts to create a more streamlined system that delivers appropriate, quality, cost-effective care. The Medicare-Medicaid Coordination Office has been working on a variety of initiatives to meet its mandate and to further partner with States and other stakeholders to improve access, coordination, and cost of care for Medicare-Medicaid enrollees. Since I last appeared before this Committee on September 21, 2011, CMS has announced agreements with States to test new models to better align the Medicare and Medicaid programs and undertaken numerous initiatives to further its work to improve care coordination and quality of care for Medicare-Medicaid enrollees, including providing new tools to gain a better understanding of the population, increasing access to Medicare data, and partnering with organizations to reduce avoidable hospitalizations.

Background

The Medicare and Medicaid programs were originally established in 1965 as separate programs with different purposes. Medicare provides health insurance for qualified individuals over the age 65 and people with disabilities. Medicaid provides coverage for low-income families including children, pregnant women, parents, seniors and people with disabilities. While Medicare and Medicaid are separate programs, a growing number of people depend on both programs for their care, creating a greater need for both programs to work together. 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. In many cases, they are among the poorest and sickest people covered by either program.[2] 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 payers and providers, resulting in cost-shifting, unnecessary spending and an inefficient system of care.

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

A major focus of our work is to improve beneficiaries' experience with both the Medicare and Medicaid programs. To that end, 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 with these organizations on a regular basis, CMS partnered with California, New Mexico, New York, Oregon, Pennsylvania, and Wisconsin to conduct beneficiary focus groups to assess and increase understanding of the beneficiary experience and needs in both programs. As we work to better coordinate services and improve beneficiary health outcomes, CMS will continue to work with these organizations and other stakeholders to ensure the beneficiary perspective is always informing every aspect of our work.

Financial Alignment Initiative

In July 2011, CMS launched the Financial Alignment Initiative to more effectively integrate the Medicare and Medicaid programs to improve the quality and costs of care, as well as the overall

[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.

beneficiary experience. Through this Initiative, CMS offers States the opportunity to test two models to align payment and service delivery between the Medicare and Medicaid programs while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees. The first is a capitated model in which a State, CMS, and health plan or other qualified entity will enter into a three-way contract through which the health plan or other qualified entity will receive a prospective blended payment to provide comprehensive, coordinated care. The second is a managed fee-for-service model under which a State and CMS will enter into an agreement by which the State would invest in care coordination and be eligible to benefit from savings resulting from such initiatives that improve quality and costs. Both models are designed to help beneficiaries by improving health care delivery, encouraging high-quality, efficient care and better streamlining services and achieving State and Federal health care savings.

All approved Demonstrations will include critical beneficiary protections that will ensure high-quality care is delivered. In addition, for the prescription drug benefit, approved Demonstrations will be required to meet all Medicare Part D requirements regarding beneficiary protections, protected classes, and network adequacy. No participating States will be permitted to alter Demonstration standards in a manner that is less beneficiary-friendly or reduces access.

CMS recognizes the diversity of States in serving the Medicare-Medicaid enrollee population, and the Demonstrations afford an opportunity to test better coordination of services in a multitude of settings. Since the Committee's previous hearing on this issue, CMS has announced agreements with the first States to test models to improve health care for Medicare-Medicaid enrollees. CMS is partnering with Massachusetts[3] to provide care under the capitated model and with the State of Washington[4] under the managed-fee-for-service payment model. CMS continues to work with 23 other States[5] that have submitted proposals.

[3] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf
[4] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf
[5] At the time this testimony was submitted, both Washington and Massachusetts have approved Demonstration agreements. CMS continues to work with the following States on their coordinated care approaches: Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Iowa, Michigan, Minnesota, Missouri, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, and Wisconsin.

To support these Demonstrations, on August 23, 2012,[6] CMS announced a new funding opportunity for participating States to provide support through Aging and Disability Resource Centers (ADRC) and State Health Insurance Assistance Program (SHIP) infrastructure for direct person-centered counseling and State information-sharing over a three-year period. This opportunity is being jointly coordinated by CMS and the Administration for Community Living.

Massachusetts – Capitated Medicare-Medicaid Demonstration

On August 23, 2012, Secretary Sebelius announced that Massachusetts is the first State to partner with CMS in this Demonstration to test the capitated model and provide Medicare-Medicaid enrollees with a more coordinated, person-centered care experience. Massachusetts and CMS will contract with Integrated Care Organizations (ICOs) to oversee and be accountable for the delivery of Medicare, Medicaid, and expanded services, such as dental care, vision and durable medical equipment, as well as behavioral health services and community supports, for participating Medicare-Medicaid enrollees aged 21 to 64. The new program is scheduled to launch in 2013, and will help provide 110,000 Medicare-Medicaid enrollees with access to these expanded services. In addition, all ICOs will include Medicare-Medicaid enrollee participation in their governance structure.

Medicare-Medicaid enrollees participating in the new demonstration will have the ability to shape and direct their care through a person-centered model built around their needs and preferences. Care will be delivered through teams that include a primary care provider, care coordinator, independent long-term services and supports coordinator, and other care providers at the discretion of each beneficiary. The beneficiary and his/her team will develop, implement and maintain individualized care plans. Medicare-Medicaid enrollees will have access to the new and enhanced services previously described to promote alternatives to long-term institutional services.

Washington State – Managed FFS Medicare-Medicaid Demonstration

On October 25, 2012, CMS announced that the State of Washington would become the first State partner to test the Managed FFS Demonstration model, building on its planned Medicaid Health

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

homes to provide better coordinated care and enhanced services for Medicare-Medicaid enrollees with chronic health conditions or a serious and persistent mental health condition. More than 20,000 Medicare-Medicaid enrollees in Washington will be eligible to receive improved care through integrated service delivery across primary, acute, prescription drugs, behavioral health and long-term services and supports. Washington will be eligible to receive a performance payment depending on its performance on beneficiary experience, quality and savings criteria.

Leveraging its innovative predictive risk model,[7] Washington will be able to identify Medicare-Medicaid enrollees' health care needs and target those with chronic conditions or serious and persistent mental health conditions. Medicare-Medicaid enrollees will be able to shape and direct their care with access to a care coordinator, working with a multidisciplinary care team, who is responsible for their overall care coordination and comprehensive care management. Enrollees will be free to choose whether to receive these new services, and will continue to have access to the same Medicare and Medicaid benefits.

Open and Transparent Development of Proposals for the Financial Alignment Initiative

CMS is fully committed to an open and transparent process for these 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 website for a subsequent 30-day public comment period in order to solicit stakeholder feedback. CMS continues to accept and discuss public comments on the development of these Demonstrations proposals. All Memoranda of Understanding and Final Demonstration Agreements will be made public and CMS will continue to engage with the public on this work.[8]

[7]Washington's modeling system is calledPredictive Risk Intelligence System (PRISM). More information is available here: http://www.agingwashington.org/docs/strategic-planning/PRISM-Explained.pdf

[8] Massachusetts: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf

Evaluation of the Demonstrations

CMS is funding and managing the evaluation of each approved Demonstration. CMS has contracted with an external independent evaluator, RTI International, to measure, monitor, and evaluate the overall impact of the demonstrations, including impacts on Medicare-Medicaid enrollees, expenditures and service utilization. The evaluator will design unique, State-specific evaluation plans for each individual State participating in the Demonstration, as well as an aggregate analysis that will look at the Demonstration overall including Demonstration interventions and impact on key subpopulations within each State. The MOUs for Massachusetts and Washington provide examples of the types of areas that will be measured in all Demonstrations, including beneficiary experience of care, care coordination, care transitions, support of community living, access to services, and the caregiver experience, among many others. The evaluations in Washington and Massachusetts will also use comparison groups to identify and analyze the impact of the Demonstrations.

In addition, in the capitated model, a CMS-State contract management team will ensure access, quality, program integrity, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking quick corrective action when necessary. 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.

Initiative to Reduce Preventable Hospitalization among Nursing Facility Residents

On March 15, 2012, the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation announced the *Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents*. Through this initiative, CMS is partnering with seven organizations[9] to implement strategies to reduce avoidable hospitalizations for Medicare-Medicaid enrollees

Washington: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf

[9]For a full list of the selected participants in the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, please go to: http://www.innovations.cms.gov/Files/fact-sheet/rahnfr-factsheet.pdf

who are long-stay residents of nursing facilities.

These avoidable hospitalizations can be disruptive, dangerous and costly. Research shows that nearly 45 percent of hospitalizations among Medicare-Medicaid enrollees in nursing facilities are potentially avoidable, meaning they could have been prevented with adequate monitoring and treatment in the nursing facility setting.[10]

The initiative directly supports CMS' ongoing work to reduce avoidable hospitalizations for Medicare-Medicaid enrollees. The goals of this initiative are to:

- Reduce the number of 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.

On September 27, 2012 CMS announced the seven selected organizations, including two universities, hospital networks, and other professional organizations, to participate in the program. The selected organizations are partnering with CMS to implement evidence-based interventions to accomplish these goals and will implement and operate proposed interventions over a 4-year period. In addition, each organization is required to partner with a minimum of 15 Medicare-Medicaid certified nursing facilities in the same State where the intervention will be implemented. Nursing facility participation is voluntary.

The initiative did not prescribe a specific clinical model for these interventions. However, all interventions must:

- Improve beneficiary safety by better coordinating management of prescription drugs
- Bring onsite staff to collaborate and coordinate with existing providers, including residents' primary care providers and the staff of the nursing facility.

[10]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.

- Demonstrate a strong evidence base for the proposed intervention and potential for replication and sustainability in other communities and institutions across the country.
- Supplement (rather than replace) existing care provided by nursing facility staff.
- Allow for participation by nursing facility residents without any need for residents or their families to change providers or enroll in a health plan. Residents will be able to opt-out from participating, if they choose.

As an example, one selected organization, HealthInsight of Nevada, will use tools to assess beneficiaries' risk levels to assign each beneficiary the appropriate level of enhanced care and attention in order to reduce acute care transfers. It expects to implement an intervention in 25 nursing facilities across the State. Another organization, the Alabama Quality Assurance Foundation, will implement an intervention in 23 facilities by supplementing the facilities' staff with registered nurses who will train staff on managing workplace demands and increasing awareness of residents' status and needs. Upon implementation, we estimate the awarded interventions will initially reach more than 17,000 beneficiaries over the four years of the initiative. As with the Financial Alignment Initiative, CMS has contracted with an external independent evaluator to measure and evaluate the overall impact of this demonstration on the quality of care received by Medicare-Medicaid beneficiaries and the costs to the two programs.

Fostering a Better Understanding of Medicare-Medicaid Enrollees

In the last year, CMS has undertaken numerous efforts to improve access to and the quality of data that exists to support better care for Medicare-Medicaid enrollees. A lack of such data has been a long-standing barrier to care coordination.

New Tools to Support Better Research to Understand Medicare-Medicaid Enrollees

The Chronic Condition Data Warehouse (CCW) is a research database designed to make Medicare, Medicaid, Assessment, and Part D Prescription Drug Event data readily available to support research designed to improve the quality of care and reduce costs and utilization. Traditionally, researchers and both Federal and State governments use the CCW to understand beneficiaries' utilization, demographics, spending and other key factors to support a more efficient delivery of services.

This November, CMS made available new diagnostic conditions flags[11] (coding used to identify characteristics/demographics) to represent those conditions prevalent among Medicare-Medicaid enrollees. These diagnostic condition flags facilitate and streamline research on beneficiary conditions and allow for a more targeted use of resources.

Historically, conditions focused on prevalent characteristics in the Medicare-only, over-65 population. With the newly released condition flags, both State and Federal policymakers will be able to focus efforts on mental health conditions more prevalent among Medicare-Medicaid enrollees, as well as better understand the population with intellectual and developmental disabilities. For example, bipolar disorder and schizophrenia are newly added condition flags that can now be used to better understand this population and take into account the full beneficiary experience.

Integrated Medicare-Medicaid Data Set

In addition, CMS developed a new Medicare-Medicaid integrated data set.[12] This data set supports all States by providing preliminary tools to determine and understand new opportunities for care coordination, including information on eligibility, enrollment, beneficiary conditions, service use and expenditures for both the Medicare and Medicaid programs. The data set will better assist researchers, as well as Federal and State policymakers, to identify regions, populations or necessary interventions to improve the quality of care for Medicare-Medicaid enrollees.

Medicare-Medicaid Enrollee State Profiles

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

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

As part of these improved data efforts, CMS released Medicare-Medicaid Enrollee State Profiles (State Profiles).[13] CMS hopes these State Profiles will help provide policymakers, researchers, and other interested parties with yet another opportunity 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. The national summary provides a composite sketch of the population 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.

Medicare Data to States to Support Care Coordination

State access to Medicare data facilitates more informed policy and program decisions for Medicare-Medicaid enrollees.

To that end, CMS established a process for States 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.[14] To date, 28 States have received or are in the process of actively seeking Medicare Parts A and B data,[15] and 24 States are in the same position regarding Medicare Part D data.[16] Other States continue to request access and are working with CMS to receive data use agreements.

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

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

[15] As of November 20, 2012, these States are Arkansas, California, Colorado, Connecticut, Indiana, Illinois, Iowa, Kansas, Louisiana, Massachusetts, Maine, Michigan, Minnesota, Missouri, North Carolina, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Vermont, Washington, and Wisconsin.

[16] As of November 20, 2012, these States are Arizona, California, Connecticut, Massachusetts, Maine, Michigan, Missouri, North Carolina, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, Vermont, Washington, and Wisconsin.

Supplementing this work, this month, CMS has made available the State Data Resource Center (SDRC) to provide more tools to support data use. This Center furthers work from the Integrated Care Resource Center (ICRC), and expands resources and efforts to guide States in their use of the Medicare data. The SDRC is open to all States and will further support States in their development of coordinated care initiatives.

The Integrated Care Resource Center

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 meet States' 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.[17]

Conclusion

The Medicare-Medicaid Coordination Office has been diligently working to improve the beneficiary experience with the Medicare and Medicaid programs as well as the partnership with States and other stakeholders to improve the quality, coordination, and cost-effectiveness of care for this vulnerable population. These initiatives have been designed to enhance care coordination and advance person-centered care programs, focus on increased access to needed beneficiary services, promote keeping individuals in their homes 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 is a part of this effort, CMS is also working to improve and enhance existing care programs that serve this population. A major part

[17] http://www.integratedcareresourcecenter.com/

of this effort is supporting and developing a better understanding of the Medicare-Medicaid enrollee population and the current programs that serve them. In doing so, CMS seeks to improve care for Medicare-Medicaid enrollees by providing Congress, States, and other policymakers with more robust information about the beneficiary experience, quality, and spending. We are committed to continuing to work with Congress, States, advocates, and other key stakeholders in furtherance of this needed work.

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