

STATEMENT OF

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ON

DUALLY-ELIGIBLE BENEFICIARIES: IMPROVING CARE WHILE LOWERING COSTS

BEFORE THE

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Chairman Baucus, Ranking Member Hatch, 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). The Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office, was established by 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. A Federal Register notice officially establishing the Medicare-Medicaid Coordination Office was published on December 30, 2010.

Background

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 40 years, the Medicare and Medicaid programs have remained 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 because of their age or disability, 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 that they better serve enrollees.

Today, more than 9 million Americans are enrolled in both the Medicare and Medicaid programs; two-thirds of this population are low-income elderly, and one-third are people who are under 65 and are disabled.¹ Additionally, Medicare-Medicaid enrollees include higher proportions of women, African-Americans, and Hispanics than in the Medicare-only population.

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.

Medicare-Medicaid enrollees must navigate two separate programs for their care—Medicare for coverage of basic acute health care services and prescription drugs, and Medicaid for coverage of supplemental benefits such as long-term care supports and services. Medicaid also provides help to those with low incomes to pay their Medicare premiums and cost-sharing. 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.

People enrolled in both Medicare and Medicaid tend to have the most complex, chronic illnesses, and therefore they are some of the highest cost individuals within the Medicare and Medicaid programs. Total annual spending for their care is estimated at \$300 billion across both programs. In the Medicaid program, these people represent 15 percent of enrollees but 39 percent of all Medicaid expenditures.² In Medicare, they represent 16 percent of enrollees and 27 percent of program expenditures.³ Medicare-Medicaid enrollees' health costs are nearly five times greater than all other people with Medicare. Compared with all other Medicaid enrollees, Medicare-Medicaid enrollees' health costs are nearly 6 times greater. They are three times more likely to have a disability, and overall these individuals have higher rates of diabetes, pulmonary disease, stroke, Alzheimer's disease, and mental illness.⁴ These statistics demonstrate the tremendous opportunities available to improve the individual care experience by raising quality and lowering costs through improved health outcomes for this population.

Too often, the care delivered to Medicare-Medicaid enrollees is fragmented and uncoordinated which can result in poor health outcomes. These Americans could benefit the most from more integrated systems of care that ensure all their needs – primary, acute, long-term care, behavioral and social – are met in a high quality, cost effective manner. Better alignment of the administrative, regulatory, statutory, and financing aspects of these two programs promises to improve the quality and cost of care for this complex population.

² Kaiser Family Foundation, The Role of Medicare for the People Dually Eligible for Medicare and Medicaid. January 2011. Available at: <http://www.kff.org/medicare/upload/8138.pdf>

³ The Medicare Payment Advisory Committee (MedPAC), A Data Book: Healthcare spending and the Medicare program, June 2010. Available at: http://www.medpac.gov/documents/Jun10_EntireReport.pdf .

⁴ 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. Kaiser Family Foundation. July 2010. Available at: <http://www.kff.org/medicaid/upload/8081.pdf>

The Medicare-Medicaid Coordination Office's mission is to address and improve the experiences, access to care, quality of care, and cost of benefits for individuals enrolled in both the Medicare and Medicaid programs. To that end, the Medicare-Medicaid Coordination Office is engaged in ongoing discussions with key internal and external stakeholders, including beneficiary advocates, provider organizations, Medicare Payment Advisory Commission (MedPAC), the Medicaid and CHIP Payment and Access Commission (MACPAC), and State Medicaid agencies, to work together to advance high quality, seamless care for Medicare-Medicaid enrollees. The Office is also working to improve collaboration and communication between Medicare and Medicaid program offices within CMS and across other Federal agencies.

The Need for Coordinated Care

Partnerships with the States

The 9 million Medicare-Medicaid enrollees accounted for approximately \$120 billion in combined Medicaid Federal and State spending in 2007 – almost twice as much as Medicaid spent on all 29 million children it covered in that year.⁵ 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 26 States. These numbers demonstrate the critical need to build, sustain and strengthen Federal-State partnerships by improving care coordination for this population.

State Medicaid programs alone spent more than \$50 billion in 2007 to support the health and long-term care costs of people enrolled in Medicare. The average Medicaid spending per beneficiary on Medicare-Medicaid enrollees was \$15,459 in 2007, more than six times higher than the comparable cost of a non-disabled adult covered by Medicaid (\$2,541).⁶ This spending mostly reflects the significant costs associated with a population with low income and high health care needs; however, there are opportunities for savings through improved care coordination, simplification, and alignment of some Medicare and Medicaid rules.

⁵ Kaiser Family Foundation, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007. December 2010. <http://www.kff.org/medicaid/7846.cfm>

⁶ Kaiser Family Foundation, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007. December 2010. <http://www.kff.org/medicaid/7846.cfm>

Too often, the current approach to financing care for those eligible for Medicare and Medicaid provides a financial incentive to push costs back and forth between the States and the Federal government. Better coordination and partnerships between the two levels of government will eliminate these incentives and focus on finding the care setting that is most appropriate for the beneficiary, independent of who is paying for it. We are collaborating with States to find real solutions that, through better care coordination, will improve the experience and quality of care for beneficiaries and reduce costs. The Medicare-Medicaid Coordination Office is working to facilitate innovation by nurturing these vital State-Federal relationships.

Better Care for People

The Medicare-Medicaid Coordination Office has been working to improve Medicare-Medicaid enrollees' satisfaction, program awareness, health, functional status, and well-being. Most individuals enrolled in both Medicare and Medicaid are not receiving coordinated care. Our goal is to assure that Medicare-Medicaid enrollees are receiving high quality and person-centered acute, behavioral, and long-term care services and supports.

To further this mission, our Office has worked in concert with the new Medicare and Medicaid Innovation Center, the Center for Medicaid, CHIP and Survey & Certification, and the Center for Medicare within CMS to foster significant reforms across the health care delivery system that will improve the coordination of care for all patients, including low-income beneficiaries, many of whom are Medicare-Medicaid enrollees. One example of such an initiative is the Partnership for Patients, an investment of up to \$1 billion in patient safety initiatives that are designed to improve coordination of care and reduce preventable hospital-acquired conditions. The Partnership for Patients hopes to take these safety efforts to scale, which could save tens of thousands of lives, avoid millions of preventable injuries, and save Medicare and Medicaid billions of dollars over time.

The Partnership for Patients, which aims to prevent hospital readmissions and hospital-acquired conditions, will help drive better care for Medicare-Medicaid enrollees. In a recent CMS study, 27 percent of the Medicare-Medicaid enrollees were hospitalized at least once during the year,

totaling almost 2.7 million hospitalizations.⁷ More than a quarter of these hospital admissions may have been avoidable, 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). This also includes hospitalizations from skilled nursing facilities, the setting from which potentially avoidable hospitalizations were most likely to occur. The study projects that the total costs for potentially avoidable hospitalizations for Medicare-Medicaid enrollees will be between \$7 and \$8 billion for 2011.⁷ Providing appropriate, coordinated and integrated care may be able to prevent unnecessary hospitalizations, which would allow individuals to remain independently at home while saving scarce health care resources. Our office is furthering work to prevent inpatient hospitalizations from nursing facilities through a new demonstration project, which will be discussed in the *Models and Demonstrations* section of this testimony.

Benefits of Integrated Care

A real-life example of the significant benefits of integrated care for people enrolled in both Medicare and Medicaid is evident in the care of a 77 year old woman named Mattie. Mattie is a fiercely independent woman who lives alone but requires significant personal assistance to maintain independence. She has diabetes, depression, and hypertension, and over the years has suffered three strokes, resulting in weakness and limited mobility. Before receiving care in an integrated program, she fell frequently, had inadequate food intake, and suffered three potentially avoidable hospitalizations that resulted from poorly controlled diabetes. In addition, she faced difficulties making her medical appointments because of mobility limitations, challenges accessing and managing personal care attendant services, and problems obtaining mental health services. In order to receive routine medical care, Mattie had to navigate and manage three separate health care systems—one for Medicare, one for her prescription drug coverage, and one for Medicaid. She had multiple care providers that rarely communicated with one another, and her health care decisions were rarely coordinated and were not made from a patient-centered

⁷ Centers for Medicare & Medicaid Services, Center for Strategic Planning, Policy and Data Analysis Group Policy Insight Report: Dual Eligibles and Potentially Avoidable Hospitalizations, 2011. Available at: http://www.cms.gov/reports/downloads/Segal_Policy_Insight_Report_Duals_PAH_June_2011.pdf.

perspective. As a result of these challenges, her care was fragmented and she was considering nursing home care.

Fortunately, Mattie was able to enroll in a special program that integrates her Medicare and Medicaid covered services and which has at its core a multi-disciplinary care team that assumes full responsibility for all of her care needs. She now has access to the full range of services to meet her needs and keep her at home, including necessary nutrition support, mental health services, and durable medical equipment. In this program, Mattie only has to manage one set of benefits, and has a single insurance card. One year after enrolling in this program her health has improved, and her care costs have been reduced: she has had no falls, achieved diabetic control, improved her mobility, reduced her personal care attendant support needs, and has had no hospital or emergency department contacts since enrollment in the program. Coordinated care has meant that Mattie can maintain her independence and receive high quality care, while Medicare and Medicaid have avoided the high costs of preventable hospitalizations and nursing home care. These outcomes are the care we want to make available to everyone.

Initiatives to Date

The Medicare-Medicaid Coordination Office has already launched a variety of initiatives to meet its Congressional charge to improve access, coordination and cost of care for Medicare-Medicaid enrollees. Our work falls into the following broad areas:

- Program Alignment
- Data and Analytics
- Models and Demonstrations

Program Alignment

On May 11, 2011, the Medicare-Medicaid Coordination Office launched the Alignment Initiative, an effort to more effectively integrate benefits under the Medicare and Medicaid programs.⁸ As stated previously, the lack of alignment between the programs too often leads to fragmented or episodic care for people enrolled in Medicare and Medicaid, which can reduce quality and raise costs. For example, Medicare and Medicaid have different coverage standards

⁸ http://www.cms.gov/medicare-medicare-coordination/07_AlignmentInitiative.asp#TopOfPage

for those accessing durable medical equipment. These differences can lead to fragmented care and coverage gaps that could result in patients losing access to the treatments and equipment that help them live at home or in the community. Even temporary coverage gaps can be disruptive and potentially even life-threatening if patients no longer have coverage for wheelchairs or other medical care.

The Alignment Initiative is not simply an effort to catalogue the differences between Medicare and Medicaid, or to make the two programs identical. Rather, it is an effort to advance beneficiaries' understanding of, interaction with, and access to seamless, high quality care that is as effective and efficient as possible. Better alignment of the two programs can reduce costs by improving health outcomes and more effectively and efficiently coordinating care.

The first step in the Alignment Initiative was to identify opportunities to align potentially conflicting Medicare and Medicaid requirements. The Medicare-Medicaid Coordination Office compiled a wide-ranging list of opportunities for legislative and regulatory alignment on areas identified through numerous stakeholder discussions. Those areas fall into the following broad categories: care coordination, fee-for-service benefits, prescription drugs, cost sharing, enrollment, and appeals. This list was published in the Federal Register on May 16, 2011 and the public comment period closed on July 11, 2011.

Through the Alignment Initiative, we facilitated a national conversation on improving care for Medicare-Medicaid enrollees. The public solicitation for comments brought in over 100 responses from beneficiaries, advocates, professional health associations, plans and States. In addition, CMS conducted local listening sessions, which were attended by over 500 stakeholders. These sessions provided stakeholders an opportunity to contribute their experiences and suggestions to the discussion. Section 2602(c) of the Affordable Care Act established specific goals for our office, and the Alignment Initiative has provided an effective means to engage the public to ensure that these goals are met. We are committed to being open and transparent in our efforts to better streamline these programs to ensure more efficient and effective care, and will continue to engage the public as we move forward on this Initiative.

Data to Support Goals

On May 11, 2011, the Medicare-Medicaid Coordination Office also announced a new process to provide States access to Medicare data to support care coordination for individuals enrolled in both Medicare and Medicaid.⁹ Access to Medicare data is an essential tool for States seeking to coordinate care, improve quality, and control costs for their highest cost beneficiaries. Already, CMS has actively engaged and begun to work with many States on accessing Medicare data, creating new State pathways to better integrate care for Medicare-Medicaid enrollees. For example, a State that wants to expand its long-term care and behavioral health care management program to serve low-income seniors and people with disabilities needs data on its Medicare-covered hospital, physician, and prescription drug use. With Medicare data, States can identify high risk and high cost individuals, determine their primary health risks, and provide comprehensive Medicare-Medicaid enrollee profiles to their care management contractors to tailor interventions. The ability to access the entire spectrum of information on Medicare-Medicaid enrollees enables States to better analyze, understand, and coordinate a person's experience within the Medicare and Medicaid programs.

The Medicare-Medicaid Coordination Office has been focused on understanding the utilization profiles and care experience of individuals eligible for Medicare and Medicaid. As a foundation for this goal, we will be preparing an analysis of individuals eligible for Medicare and Medicaid in each State, including demographics, service utilization, and availability of benefits. Our Office also seeks to go beyond data and actually speak with beneficiaries to gain a better understanding of their experiences from their perspectives. To build on ongoing efforts to better understand the needs of Medicare beneficiaries under the age of 65, we are in the process of conducting focus groups across the country with individuals with disabilities enrolled in both Medicare and Medicaid to understand the impact of integrated care on beneficiary experience and health outcomes. Finally, the Medicare-Medicaid Coordination Office will monitor and report on issues from a national viewpoint, including annual total expenditures, health outcomes, and access to benefits for individuals enrolled in Medicare and Medicaid.

⁹ http://www.cms.gov/medicare-medicare-coordination/06_MedicareDataforStates.asp#TopOfPage

Models and Demonstrations

The Medicare-Medicaid Coordination Office is working to support improvements in the quality and cost of care for Medicare-Medicaid enrollees. To that end, the Medicare-Medicaid Coordination Office recently announced several opportunities through demonstrations of delivery and payment models to improve the quality of care Medicare-Medicaid enrollees receive by expanding access to seamless, integrated programs, and better care management.

The first demonstration supports this objective by allowing States to coordinate and align Medicare and Medicaid benefits. Partnering with the Center for Medicare and Medicaid Innovation (Innovation Center), the Medicare-Medicaid Coordination Office has awarded contracts of 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.¹⁰ The 15 States selected for the design contracts are: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. The overall goal of this contracting opportunity is to identify delivery system and payment integration models that can be rapidly tested and, upon successful demonstration, replicated in other States. CMS will work with the States to develop models and interventions that can be implemented in future phases.

It is important to note, however, that a CMS contract with a State to design a coordinated care model does not confer authority to implement, or endorsement of, the particular model. Only after a State has submitted a coordinated care model design that meets CMS' specifications and is consistent with its contract will the model receive further consideration by CMS for implementation. We will also take recommendations that MedPAC has shared with us into consideration. These include testing capitated payment models, collecting consistent quality and cost data across demonstrations, assessing ways to increase enrollment, preserving beneficiary protections, and promoting the appropriate use of Federal funds. We will assess State proposals

¹⁰ http://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage

with these concerns in mind to ensure models that are tested improve the quality of care while ensuring appropriate use of program funding.

On July 8, 2011, the Medicare-Medicaid Coordination Office, again in partnership with the Innovation Center, announced the *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*. Through this financial alignment initiative, CMS provided initial guidance on two streamlined approaches for States interested in testing models to align financing between the Medicare and Medicaid programs.¹¹ Our early work with the 15 States selected for design contracts confirms that a key component of a fully integrated system will be testing new payment and financing models to promote better care and align the incentives for improving care and lowering costs between the programs.

The financial alignment initiative will test two new payment and service delivery models to reduce program expenditures under Medicare and Medicaid, while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees. Through the first model, a State, CMS, and health plan enter into a three-way contract wherein the health plan receives a prospective blended payment to provide comprehensive, coordinated care. In the second model, a State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from managed fee-for-service initiatives designed to improve quality and reduce costs for both Medicare and Medicaid. We will evaluate whether these models improve care for this population while also lowering costs. All States are eligible for this initiative; however, in order to be considered, States must submit letters of intent for these two models by close of business on October 1, 2011. States meeting the necessary criteria will have an option to pursue either or both of these financial alignment models. Beyond these models, technical assistance will be available to all States through the Integrated Care Resource Center, which will support our State partners as they develop models that better serve Medicare-Medicaid enrollees.

A third initiative, also announced July 8, 2011, is a new demonstration focused on improving the quality of care received by nursing home residents by reducing preventable inpatient

¹¹ http://www.cms.gov/medicare-medicaid-coordination/08_FinancialModelstoSupportStatesEffortsinCareCoordination.asp#TopOfPage

hospitalizations. As previously stated, hospitalizations are often expensive, disorienting, and dangerous for frail elders and people with disabilities, and cost Medicare billions of dollars each year. Starting this fall, CMS will competitively select independent organizations to partner with and implement evidence-based interventions at interested nursing facilities. This demonstration supports the Administration's Partnership for Patients goal of reducing hospital readmission rates by 20 percent by the end of 2013 and furthers our work in improving quality for Medicare-Medicaid enrollees.

Collaborative Efforts

The Medicare-Medicaid Coordination Office is also facilitating a collaborative effort across the Medicare and Medicaid programs, and with external partners, to evaluate and promote the development of quality measures to better assess beneficiary access to care to reflect the unique circumstances of individuals eligible for Medicare and Medicaid. CMS will engage partners to review the availability of appropriate quality and access measures, and assist in the development of measures which accurately reflect the quality of care received by individuals eligible for Medicare and Medicaid. Our partners will move forward in strategic development of such measures in a manner that streamlines quality measurement across Medicare and Medicaid for individuals receiving care under both programs.

Additionally, the Medicare-Medicaid Coordination Office has consulted and coordinated with both the MedPAC and the Medicaid and CHIP Payment and Access Commission (MACPAC), including presenting at the MACPAC public meeting in October 2010. The Medicare-Medicaid Coordination Office will continue to collaborate with staff and members of both Commissions on important issues related to data analysis, care model demonstrations, and policy alignment opportunities for Medicare-Medicaid enrollees.

Conclusion

CMS, through the Medicare-Medicaid Coordination Office, is working to ensure better health, better care, and lower costs for individuals that are enrolled in both Medicare and Medicaid. Over the years, a lack of coordination for this population has led to fragmented and episodic care, which can lead to lower quality and higher costs. With the creation of the Office, we have

a tremendous opportunity to better integrate the programs and better serve this population. With your continued support, we will keep working as partners with States and other stakeholders to advance high quality, coordinated care for these individuals who need it the most.