Improving Care for Medicare-Medicaid Enrollees

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CMS Measures of Success

- **Better care and lowers costs:**
  Beneficiaries receive high quality, coordinated, effective, efficient care. As a result, health care costs are reduced.

- **Improved Prevention and population health:**
  All Americans are healthier and their care is less costly because of improved health status resulting from use of preventive benefits and necessary health services

- **Expanded Health Care Coverage:**
  All Americans have access to affordable health insurance options that protect them from financial hardship and ensure quality health care coverage.

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CMS Initiatives

- Value Based Purchasing
- Quality Reporting Programs
- Physician Value Payment Systems
- Shared Savings Program: Accountable Care Organizations (ACO)
- Center for Medicare and Medicaid Innovation Initiatives
- Medical Homes in Medicare
- Health Homes in Medicaid
- Transitional Care Initiatives
- Medicare-Medicaid Initiatives

Medicare-Medicaid Coordination Office

Section 2602 of the Affordable Care Act

Purpose: Improve quality, reduce costs and improve the beneficiary experience.

- Ensure Medicare-Medicaid enrollees have full **access** to the services to which they are entitled.
- Improve the **coordination** between the federal government and states.
- Identify and test **innovative** care coordination and integration models.
- Eliminate financial **misalignments** that lead to poor quality and cost shifting.

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Support for Care Coordination

- **Program Alignment Initiative:** Identify and address conflicting requirements between the Medicare and Medicaid programs that are potential barriers to seamless and cost effective care for beneficiaries.
- **Integrated Care Resource Center (ICRC):** Technical resource center for states. The ICRC supports states in developing integrated care programs and promoting best practices for better serving Medicare-Medicaid enrollees and other beneficiaries with chronic conditions.
- **Medicare Data to States:** Improved access to Medicare Parts A/B, and D data to support care coordination and improve quality for Medicare-Medicaid enrollees.
- **State Data Resource Center:** New resource to help assist states in use of Medicare data to support care coordination.

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Initiative to Reduce Avoidable Hospitalizations

Goal: To reduce preventable inpatient hospitalizations among residents of nursing facilities.

Overview: Initiative funded by the CMS Innovation Center. Selected organizations are partnering with 144 nursing facilities. Each organization will have on-site staff to partner with the existing nursing facility staff to provide preventive services as well as improve assessments and management of medical conditions. All organizations are currently serving beneficiaries.

Selected Organizations:

- Alabama Quality Assurance Foundation **(Alabama)**
- Alegent Health **(Nebraska)**
- The Curators of the University of Missouri **(Missouri)**
- Greater New York Hospital Foundation, Inc. **(New York)**
- HealthInsight of Nevada **(Nevada)**
- Indiana University **(Indiana)**
- UPMC Community Provider Services **(Pennsylvania)**

Opportunity for Care Coordination: Financial Alignment

Background: In 2011, CMS announced new models to integrate the service delivery and financing of both Medicare and Medicaid through a Federal-State demonstration to better serve the population.

Goal: Increase access to quality, seamlessly integrated programs for Medicare-Medicaid enrollees.

Demonstration Models:

- **Capitated Model:** Three-way contract among State, CMS and health plan to provide comprehensive, coordinated care in a more cost-effective way.
- **Managed FFS Model:** Agreement between State and CMS under which states would be eligible to benefit from savings resulting from initiatives to reduce costs in both Medicaid and Medicare.

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Financial Alignment Initiative Vision

The Financial Alignment Initiative will promote an improved experience for beneficiaries by:

- Focusing on person-centered models that promote coordination missing from today's fragmented system
- Developing a more easily navigable and simplified system of services for beneficiaries
- Ensuring beneficiary access to needed services and incorporating beneficiary protections into each aspect of the new demonstrations
- Establishing accountability for outcomes across Medicaid and Medicare
- Requiring robust network adequacy standards for both Medicaid and Medicare
- Evaluating data on access, outcomes and beneficiary experience to ensure beneficiaries receive higher quality, more cost-effective care

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Examples of Beneficiary Enhancements

- Person-centered care planning
- Choice of plans and providers
- Continuity of care provisions
- Care coordination and assistance with care transitions
- Enrollment assistance and options counseling
- One identification card for all benefits and services
- Single statement of all rights and responsibilities
- Integrated grievances and appeals process
- Maximum travel and distance times
- Limitations on wait and appointment times

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Support for Beneficiaries

- **State Health Insurance Counseling and Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs):** To ensure beneficiaries have access to information and counseling around this Demonstration, CMS announced a funding opportunity for both SHIPs and ADRCs in approved Demonstration states. This funding will support local SHIPs and ADRCs in providing beneficiary outreach and one-on-one options counseling.
- **Ombudsman Services:** CMS continues to work with states, advocates and other key partners to ensure Ombudsman services are available for beneficiaries in the Demonstration, and has awarded funding to provide support for these efforts.

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Other Key Demonstration Information

- **Rates:** Participating plans receive capitation rate reflecting the integrated delivery of Medicare and Medicaid benefits based on:
  - Baseline spending in both programs
  - Anticipated savings resulting from integration & improved care.
- **Readiness Reviews:** Ongoing process to assess plans' Medicare and Medicaid experience and Demonstration readiness:
  - Multi-step process that includes an onsite and desk review of participating plans
  - Readiness review protocols available on the MMCO website.

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Other Key Demonstration Information

- **Implementation and Monitoring:**
  - Ongoing milestones that allow CMS and states to monitor demonstration plan as enrollments begin
  - CMS and the State may stop enrollment at any time.
- **Evaluation:**
  - CMS has contracted with an independent evaluator (RTI); and
  - There will be state-specific evaluation plans for each demonstration.

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Demonstration Update

- **Overall:**
  - Ten states have approved capitated Demonstrations: Massachusetts, Illinois, Virginia, Ohio, California, New York, Michigan, South Carolina, Texas, and Washington.
  - Washington State and Colorado have approved managed fee-for-service Demonstrations.
  - Minnesota has an alternative model to integrate care for Medicare-Medicaid enrollees building on the state's current infrastructure.
  - In addition to the demonstrations, CMS is continuing to work with numerous states on initiatives to better integrate care.

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More Information

Medicare-Medicaid Coordination Office

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