

Developing Health Homes to Effectively Serve Medicare-Medicaid Enrollees

By Alice Lind and Allison Hamblin, Center for Health Care Strategies, and Brendan Hogan and Beth Waldman, Bailit Health Purchasing

The new Medicaid health home state plan option offers comprehensive, person-centered care for Medicaid beneficiaries with chronic conditions through providers who help to coordinate primary and acute care, behavioral health care, and long-term services and supports (LTSS). Medicare-Medicaid enrollees are particularly well suited to benefit from health home arrangements because of the prevalence of multiple chronic conditions in this population:

- More than 60 percent have multiple physical conditions;
- 20 percent have multiple mental health conditions; and
- 38 percent have both physical and mental health conditions.¹

The care provided to these individuals is often fragmented and poorly coordinated leading to lower quality of care and increased costs. For example, Medicare-Medicaid enrollees age 64-75 have avoidable hospitalization rates that are two to four times those of non-dual Medicare beneficiaries.²

States electing to provide health home services may not exclude Medicare-Medicaid enrollees.³ However, because Medicare pays for most of their acute care services (primarily hospital and physician services and prescription drugs), and because states have had limited access to data and information on these Medicare services, including Medicare-Medicaid enrollees in the design of health homes poses a number of challenges. This brief from the *Integrated Care Resource Center* (ICRC) outlines some of the challenges states may face related to serving Medicare-Medicaid enrollees in health homes, as well as considerations for developing health home programs that effectively meet the needs of this population.

Challenge #1: Managing Service Coordination Needs

Including Medicare-Medicaid enrollees in health homes necessitates that these programs are effectively designed to address the broad needs of this heterogeneous population, including LTSS and behavioral health.

IN BRIEF: The service needs of Medicare-Medicaid enrollees (also known as “dual eligibles”) make them particularly well suited for inclusion in the programs being developed under the new Medicaid health home state plan option under section 2703 of the Affordable Care Act (ACA). Including them in these programs offers potential benefits for both enrollees and states. However, their inclusion may pose several operational challenges for states, since most of their primary and acute care services are provided through Medicare rather than Medicaid. This technical assistance brief outlines the challenges facing states when including Medicare-Medicaid enrollees in health homes and details considerations for developing programs that will best meet the needs of this population.

Considerations

Long-Term Services and Supports

To ensure the effectiveness of health home models for Medicare-Medicaid enrollees, it will be particularly important to include mechanisms for addressing and coordinating enrollees’ LTSS needs, in addition to their medical and behavioral health conditions. Long-term services and supports account for 69 percent of Medicaid spending for Medicare-Medicaid enrollees.⁴ In addition to ensuring the provision of these services, it also is essential to develop connections between the health home and LTSS providers. This population uses a wide array of LTSS provided by nursing homes, home health agencies (HHA), area agencies on aging (AAA), aging and disability resource centers (ADRCs), and developmental disabilities services agencies, among others.

There are a number of examples of this coordination happening successfully in practice today. CareOregon health plan enrolls dual eligibles through its Medicare Special Needs Plan (SNP) contract and enrolls Medicaid-only members under its Care Coordination Organization contract with the state of Oregon. It piloted a model of shared information and care planning with the LTSS system⁵ and addressed the

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operational carve-out of LTSS by:

- Providing case manager training on LTSS services and eligibility;
- Offering training at Adult and Disability Services (ADS) offices on CareOregon's case management role;
- Updating eligibility software so case managers can view services that are provided;
- Providing the LTSS nurse care manager's name to CareOregon's care manager when dual eligibles are enrolled to facilitate co-case management; and
- Alerting the LTSS case manager to potential safety issues.

In addition, ADS and CareOregon share information to expedite authorization for needed services for their shared population. ADS is also working with CareOregon to do a "warm hand-off" from its hospital transition team to the CareOregon care manager to ensure that community placements are appropriate.

Washington State has developed a successful model of chronic care management for individuals receiving home- and community-based services (HCBS) that

coordinates both acute care and LTSS needs for enrollees. The Washington program, which serves as an important precursor for the health home model, is known as the Chronic Care Management program, and leverages nurse care managers from regional AAAs to lead care coordination and care management efforts.^{7,8} These models are informing development of the demonstrations for Medicare-Medicaid enrollees in those states. Some additional options include:

- States can implement shared accountability models to promote coordination across service areas. For example, some states pursuing the Financial Alignment Initiative through the Medicare-Medicaid Coordination Office and the Center for Medicare & Medicaid Innovation have proposed carving out services and are exploring using an array of targeted performance measures and associated incentives to ensure coordination. States pursuing health homes can implement a similar approach to encourage health home and LTSS providers to coordinate care across traditional silos;⁹
- States with inclusive models (e.g., through capitated managed care

Health Home Basics

The health homes state plan option was created by §2703 of the Affordable Care Act with the goal of promoting access to and coordination of primary and acute physical and behavioral health services and long-term services and supports. States establishing health homes receive an enhanced 90/10 federal match for providing health home services for the first eight fiscal quarters of the benefit. Health homes are not tied to a specific location – they may be based in primary care or behavioral health providers' offices; be virtual; or located in any range of settings that are best suited to beneficiaries' needs. Health homes receive a payment from the state or health plan to provide health home services, typically, although not necessarily, in the form of a per-member, per-month payment for each enrollee. These services must include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care/follow-up;
- Individual and family support;
- Referral to community and social support services; and
- Use of health information technology to link services.

Health home providers use person-centered care planning and coordination/integration of services to reduce fragmentation of care. To be eligible for health home services, an individual must be diagnosed with either: (1) two chronic conditions; (2) one chronic condition and risk for a second; or (3) a serious mental illness.⁶

arrangements) can centralize some aspects of care management for Medicare-Medicaid enrollees at the health plan level and require the health plan be responsible for ensuring that health home activities address LTSS service needs; and

- States can contract with LTSS providers to serve as the health home for beneficiaries with relevant care needs, including Medicare-Medicaid enrollees.

Behavioral Health

Because many Medicare-Medicaid enrollees have comorbid physical and behavioral health conditions, it is important to ensure the coordination, and to the extent possible, integration of medical care and behavioral health services within the health home model. Given the explicit opportunity under statute to target health home services to individuals with serious mental illness (SMI), many states are developing specialized health home models to serve this population. For example, Missouri and Rhode Island both have approved health home programs that serve individuals with SMI statewide. In both states, health homes are situated in community mental health centers, with specific requirements to promote primary care integration – in some cases including co-location of primary care professionals within the mental health setting. These models have a strong potential to improve coordination between physical and behavioral health services, and warrant specific consideration given that the SMI population includes substantial numbers of Medicare-Medicaid enrollees.¹⁰

Challenge #2: Leveraging Existing Care Management Resources

Medicare-Medicaid enrollees who frequently access LTSS and behavioral health services often have care managers for each of these specific services. As states are prohibited from paying for duplicate care management activities, they must identify ways to leverage existing care management structures in the development of their health home approach. States applying for new LTSS

funding opportunities under the ACA must ensure that care management services are on a pathway to being “conflict-free” (the entity providing case management services or conducting eligibility determinations is separate from the entity directly providing services). States may be motivated to comply with this requirement as they see the value of reducing the numbers of different case managers involved with any one individual. If health homes add a new care manager to the mix, it becomes even more important to create systems that decrease unnecessary complexity. For example, in designing Iowa’s health home program, the state created procedures specifically to avoid duplication of care management services. In Iowa an individual receiving care through a health home practice receives all care management through that practice.¹¹ In North Carolina, case management for the state’s health home program comes from its existing care management program, Community Care of North Carolina, whose activities include targeted education and care coordination.¹²

Considerations

Traditional LTSS providers, including HHAs, AAA, and ADRCs, play an essential role in the overall care of all Medicare-Medicaid enrollees, but particularly in providing services and care coordination assistance through community-based services for individuals with disabilities and frail elders. As states look to develop health home models that include Medicare-Medicaid enrollees, it is important to consider how these traditional LTSS providers can continue to participate in the provision of care. Behavioral health case managers are also an important resource that states should consider including as part of the health home team.

Describing Care Coordination Requirements

States’ proposals for health home state plan amendments must include definitions of the six required health home services, including comprehensive care management and care coordination. Similarly, states proposing to serve Medicare-Medicaid enrollees through the Medicare-Medicaid Financial Alignment Demonstration must describe how their

Health homes situated in community mental health centers that focus on coordinating physical and behavioral health services, may warrant closer consideration given that the population with serious mental illness includes substantial numbers of Medicare-Medicaid enrollees.

States planning to implement both health homes and Medicare-Medicaid integration programs in the next two years would be wise to develop service descriptions and definitions in a way that supports both programs.

programs will ensure person-centered care management. For example, the Massachusetts MOU includes this statement about person-centered, appropriate care:

“CMS, the Commonwealth, and Participating Plans shall ensure that all medically necessary covered benefits are provided to Enrollees and are provided in a manner that is sensitive to the beneficiary’s functional and cognitive needs, language and culture, allows for involvement of the beneficiary and caregivers, and are in a care setting appropriate to their needs, with a preference for the home and the community. CMS, the Commonwealth, and Participating Plans shall ensure that care is person-centered and can accommodate and support self-direction. Participating Plans shall also ensure that medically necessary covered services are provided to beneficiaries, in the least restrictive community setting, and in accordance with the Enrollee’s wishes and Individualized Care Plan.”¹³

States planning to implement health homes and pursuing the Medicare-Medicaid Financial Alignment Demonstration should develop these definitions in a way that supports both initiatives. For example, the health home methods of assessment, triage, and care management can be leveraged to work for the Medicare-Medicaid enrollee population, as long as there are mechanisms in place to connect the assessment and care management provided through the LTSS system back to the health home. Additionally, states need to delineate care manager roles in order to avoid duplication and conflict.

Key areas to focus on with respect to Medicare-Medicaid enrollees include:

- Managing transitions and providing the necessary education and care planning when a Medicare-Medicaid enrollee transitions from home to hospital or from hospital to nursing facility, given that hospital services are provided through Medicare.
- Providing education and follow-up when a prescriber makes any changes to an enrollee’s medication regimen.
- Establishing methods for sharing information between health home and

LTSS care managers when there is a significant change in condition.

- Putting mechanisms in place to ensure that beneficiary preferences for advanced directives or other goals for treatment are relayed to all providers involved in the care plan, including Medicare providers.

These important functions should be spelled out in health home provider requirements, as well as within contracts or MOUs between health home and other community-based providers. State officials can also identify associated performance measures, with incentive payments linked to the functions being carried out successfully.

Challenge #3: Addressing Financial Sustainability

Health homes are a Medicaid-funded initiative; however, most medical services for Medicare-Medicaid enrollees are covered by Medicare. Even with an enhanced federal match (90/10) for eight quarters, state Medicaid programs must still come up with 10 percent of the funding for health homes for the first two years and then provide ongoing funding based on the state’s federal medical assistance percentage (FMAP) after the enhanced match period ends. For Medicaid-only enrollees, most states would expect to cover health home service costs with savings achieved through more efficient use of medical care (e.g., reductions in avoidable hospitalizations and emergency department visits). However, for Medicare-Medicaid enrollees, making medical services more efficient will result in savings primarily for the Medicare program – not Medicaid. Historically, states have been reluctant to pursue enrolling Medicare-Medicaid enrollees in care management or disease management programs, absent a prospect for sharing in the savings that accrued to Medicare.

Considerations

Although savings related to acute care utilization would principally accrue to Medicare, states have other opportunities to benefit directly from reductions in health care utilization that might result from health home enrollment among Medicare-Medicaid

enrollees. For example, among those with serious mental illness, states may achieve significant savings in Medicaid-funded behavioral health services as a result of improved care management and care coordination. Similarly, states may also benefit from reductions in LTSS expenditures. To the extent that health homes effectively improve coordination and communication with LTSS providers – for example, improving transitions between settings of care and helping beneficiaries to prevent incidents such as falls that can lead to nursing home stays – health homes could achieve savings for Medicare-Medicaid enrollees that flow directly to Medicaid.

States that are developing health homes as part of either a capitated or a managed fee-for-service model Financial Alignment Demonstration through the Medicare-Medicaid Coordination Office and the Center for Medicare & Medicaid Innovation have the opportunity to share in savings. Incorporating health homes in these demonstrations can make the investment in health home services for Medicare-Medicaid enrollees much more attractive for states.

A number of states, including Missouri and Washington, have included health home-based models in their proposals to integrate care for Medicare-Medicaid enrollees.¹⁴

Challenge #4: Accessing Medicare Data and Information

It has been difficult for states to access and integrate historical Medicare data and real-time information on Medicare-covered services for Medicare-Medicaid enrollees. Access to historical data is very important for program design and the availability of real-time information is vital for care coordination and care transitions.

Considerations

Use of Medicare Data for Program Design

As states design health home models, it is important to understand patterns of Medicare-covered service use by the Medicare-Medicaid enrollee population to support effective targeting of individuals

who could benefit from the enhanced care coordination and care management services that such models provide. For example, health home eligibility is based on the presence of specified chronic conditions. Access to Medicare data would enable more comprehensive identification of enrollees with the targeted conditions, as these diagnoses may not always be represented in their Medicaid claims.

To assist states in requesting Medicare data, CMS has established the State Data Resource Center (SDRC) to facilitate state access to and use of Medicare data in care coordination of Medicare-Medicaid enrollees. The SDRC provides guidance to states on how to address limitations in CMS data, describes how to use Medicare data for care coordination efforts, and assists with the process of obtaining Medicare data.¹⁵

Use of Medicare Data and Information for Care Coordination

In addition to using data to identify beneficiaries for health home enrollment, states are also sharing data with providers to facilitate care coordination. In some cases, states are providing these data directly to the health homes; in other cases, they are requiring managed care organizations or other partners to make these data available to the health homes on a regular basis. For Medicare-Medicaid enrollees, the utility of claims data for care coordination relies on having access to both Medicare and Medicaid data, as Medicaid claims alone do not present the full picture of health needs or service utilization for these enrollees.

More importantly, real-time information on hospital and emergency room admissions and discharges, which is crucial for effective care coordination at the individual level, cannot be obtained from claims data, since providers often do not submit these claims for payment until weeks or months after the service is provided. Real-time information on these admissions and discharges must be obtained directly from hospitals for both Medicaid and Medicare-Medicaid enrollees.

For example, North Carolina is leveraging a system originally developed for bioterrorism alert purposes to share real-time information on hospitalizations with health home

Health homes that effectively improve coordination and communication with long-term services and supports and behavioral health providers could achieve savings for Medicare-Medicaid enrollees that flow directly to Medicaid.

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providers. Information on emergency department use and inpatient admissions is transmitted twice a day to health home providers to facilitate care transitions and better coordinate care.¹⁶

In Missouri, hospitals are required to notify the state, via accessing an online authorization tool, within 24 hours of a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. Under its health home initiative, the state is sharing this information with health home providers on a real-time basis. Since inpatient services are primarily covered under Medicare, states often do not have this real-time administrative information. The state is currently working on ways to receive real-time information on hospitalizations for Medicare-Medicaid enrollees.

Use of Medicare Data for Performance Measurement and Evaluation

States pursuing health homes are required to report on a set of core quality measures for all health home enrollees.¹⁸ These reporting requirements include measures of ambulatory-care sensitive condition admissions as well as hospital readmissions. In order for providers and/or states to be able to report on these measures for Medicare-Medicaid enrollees, they will need corresponding access to Medicare data.

In addition to the CMS-required measures, many states are proposing to include an array of additional metrics and tools to monitor and assess health home

performance. Other data sets that could be considered for both care coordination and performance measurement and evaluation for Medicare-Medicaid enrollees include the Outcome and Assessment Information Set (OASIS) used by home health agencies, the Long Term Care Minimum Data Set (MDS) used by nursing facilities, and surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Challenges Associated with Obtaining and Sharing Medicare Data with Downstream Users

Until recently, privacy concerns limited the ability of Medicare and states to share robust data sets with providers. Health home programs and demonstration programs to integrate care for Medicare-Medicaid enrollees offer opportunities to test how and when Medicare data can most effectively be shared with downstream users, particularly health home providers, to allow for both care coordination, project evaluation and ongoing quality improvement. The Medicare-Medicaid Coordination Office will help states to navigate data access and sharing issues. States pursuing these data use agreements should consider explicitly naming health home providers as downstream users for this purpose as permissible by data source.

Challenge #5: Identifying Quality Measures

States will be required to measure and report on the quality of care delivered under health homes; new systems may be

New Opportunities to Integrate Care for Dual Eligibles

In the past, integrating the care of Medicare-Medicaid enrollees was hindered by differences in the financial incentives and reimbursement models of the two programs, and limited opportunities for alignment. Today, states have new opportunities for integrating care that were created by the Affordable Care Act (ACA). The Medicare-Medicaid Coordination Office and Center for Medicare & Medicaid Innovation have established initiatives to support states in designing new person-centered approaches to better coordinate care for Medicare-Medicaid enrollees, including the capitated and/or managed fee-for-service (MFFS) financial alignment models. Twenty-six states submitted proposals to pursue the *Financial Alignment Initiative*, and as of August 2013, California, Illinois, Massachusetts, Ohio, Virginia, and Washington have signed Memoranda of Understanding with CMS. All demonstrations will all undergo a rigorous evaluation.¹⁷

needed to collect the necessary data for Medicare-Medicaid enrollees.

Considerations

The goals of both health homes and the financial alignment demonstrations are similar: to improve service delivery for those beneficiaries at risk for poor health outcomes through care management and coordination. Related to those goals, performance measures must be in place and monitored regularly. This is especially important because both initiatives are relatively new in design, and CMS is keenly interested in determining whether states' varied approaches result in the desired outcomes for beneficiaries. To assess the benefits of health homes, states are required to develop program goals, as well as quality measures that support those goals.

In addition to state-developed measures, CMS has developed a core set of eight quality measures for which states must report data, as described in a January 2013 State Medicaid Director letter (available at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-001.pdf>):

- Adult BMI Assessment;
- Ambulatory Care-Sensitive Admission;
- Care Transition – Transition Record Transmitted to Health Care Professional;
- Follow-Up After Hospitalization for Mental Illness;
- Plan All-Cause Readmission;
- Screening for Clinical Depression and Follow-Up Plan;
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment; and
- Controlling High Blood Pressure.

The core health home measures were developed with an eye toward alignment of the required measures across all CMS programs. As such, all but one of the core health home measures (ambulatory care-sensitive admission) aligns with the core set of Medicaid Adult Health Care Quality measures, and two of the measures are the same as those identified specifically for the

Medicare-Medicaid population, listed below.

For Medicare-Medicaid enrollee demonstrations, a national evaluation contractor will collect data from states to report on a set of common quality measures, but the states are expected to additionally track performance measures that are specific to their goals and the individual program design. States should ensure that their health home measures accommodate the needs of the Medicare-Medicaid enrollee population by: 1) tracking measures for which they have the necessary data available, or for which they can require data to be reported; and 2) selecting some measures that reflect the health needs and service use of Medicare-Medicaid enrollees.

Examples of important measures for the Medicare-Medicaid enrollee population include these identified by the National Quality Forum's Measurement Application Partnership (MAP) Dual Eligible Workgroup:¹⁹

- Screening for Clinical Depression and Follow-up Plan;
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey;
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement;
- Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) or Plan All-Cause Readmission;
- Falls: Screening for Fall Risk;
- Three-Item Care Transition Measure (CTM-3); and
- Optimal Diabetes Care.

Additionally, the NCQA MAP Dual Eligible Workgroup suggested another measure set for Medicare-Medicaid enrollee programs, the Medical Home System Survey, but states monitoring the quality of provider networks serving as health homes would meet the intent of this recommendation.

Conclusion

Data use agreements should explicitly name health home providers as downstream users.

There are a number of considerations for states developing health homes to ensure that the needs of Medicare-Medicaid enrollees are adequately met in these new models. The availability of new opportunities to pursue financial alignment with Medicare for this population, as well as the increased access to Medicare data for purposes of developing integrated care

models has created a compelling window of opportunity for states to invest in better care for the vulnerable and high-cost population of Medicare-Medicaid enrollees. As more and more states gain experience with health homes, additional best practices specific to the Medicare-Medicaid enrollee population will emerge, and hopefully, will spread rapidly across the country.

Endnotes

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¹⁴ Missouri and New York State's proposals are under review by CMS. Washington State signed a Memorandum of Understanding with CMS on October 24, 2012.

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