ADDENDUM B—FY 2012 WAGE INDEX FOR RURAL AREAS—Continued

CBSA code	Nonurban area	Wage index
19	Louisiana	0.8000
20	Maine	0.8892
21	Maryland	0.9500
22	Massachusetts[2]	1.2186
23	Michigan	0.8858
24	Minnesota	0.9358
25	Mississippi	0.8000
26	Missouri	0.8000
27	Montana	0.8819
28	Nebraska	0.9227
29	Nevada	0.9681
30	New Hampshire	1.0569
31	New Jersey[1]	.....
32	New Mexico	0.9227
33	New York	0.8475
34	North Carolina	0.8655
35	North Dakota	0.7856
36	Ohio	0.8864
37	Oklahoma	0.8139
38	Oregon	1.0384
39	Pennsylvania	0.8781
40	Puerto Rico[3]	0.4654
41	Rhode Island[1]	.....
42	South Carolina	0.8711
43	South Dakota	0.8838
44	Tennessee	0.8165
45	Texas	0.8083
46	Utah	0.8955
47	Vermont	0.9931
48	Virgin Islands	0.8276
49	Virginia	0.8119
50	Washington	1.0545
51	West Virginia	0.8000
52	Wisconsin	0.9512
53	Wyoming	0.9866
65	Guam	0.9952

[1] There are no rural areas in this State or District.

[2] There are no hospitals in the rural areas of Massachusetts, so the wage index value used is the average of the contiguous Counties.

[3] Wage index values are obtained using the methodology described in this proposed rule.

[FR Doc. C1–2011–10689 Filed 5–13–11; 8:45 am]

BILLING CODE 1505–01–D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Chapter IV

[CMS–5507–NC]

Medicare and Medicaid Programs; Opportunities for Alignment Under Medicaid and Medicare

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for information.

SUMMARY: This document is a request for comments on opportunities to more effectively align benefits and incentives to prevent cost-shifting and improve access to care under the Medicare and Medicaid programs for individuals with both Medicare and Medicaid ("dual eligibles"). The document also reflects CMS' commitment to the general principles of the President's Executive Order released January 18, 2011, entitled "Improving Regulation and Regulatory Review."

DATES: *Comment Date:* To be assured consideration, comments must be received at one of the addresses provided below no later than 5 p.m. July 11, 2011.

ADDRESSES: In commenting, please refer to file code CMS–5507–NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this documentto *http://www.regulations.gov*. Follow "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–5507–NC, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services,

Attention: CMS–5507–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to one of the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT: Edo Banach, Division of Program Alignment, Federal Coordinated Health Care Office, at (410) 786–8911 or *Edo.Banach@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments [insert instructions link].

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

The Medicare and Medicaid programs generally cover different populations, but an estimated 9.2 million low-income Americans were eligible for both programs in 2008.[1] Two-thirds of dual eligible beneficiaries are over age 65, while one-third qualify through a disability.[2] Dual eligible beneficiaries represent some of the most chronically

[1] Data based on Centers for Medicare & Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office of Research, Development and Information, July 2010.

[2] CMS FFY 2007 MSIS Data; Medicare Payment Advisory Commission, Aligning Incentives (June 2010), Coordinating the Care of Dual-Eligible Beneficiaries, Chapter 5, 133.

ill and costly individuals within both the Medicare and Medicaid populations. More than half of dual eligible beneficiaries have incomes below the poverty line [3] compared with 8 percent of non-dual eligible Medicare beneficiaries.[4] Many have multiple severe chronic conditions, long-term care needs, or both. Forty-three percent of dual eligibles have at least one mental or cognitive impairment,[5] while 60 percent of dual eligibles have multiple chronic conditions.[6] Nineteen percent live in institutional settings compared to only 3 percent of non-dual Medicare beneficiaries. Approximately 1.5 percent of dual eligibles with chronic conditions and functional limitations live in their communities and represented 6 percent of the nation's health care expenditures in 2006.[7] Furthermore, dual eligibles account for a disproportionately large share of expenditures in both the Medicare and Medicaid programs. Dual eligible beneficiaries account for 16 percent of Medicare enrollees but 27 percent of Medicare spending; [8] in the Medicaid program, dual eligible beneficiaries make up 15 percent of the program enrollees but account for 39 percent of program spending.[9]

There are tremendous opportunities for CMS to partner with States, providers, beneficiaries and their caregivers, and other stakeholders to improve access, quality, and cost of care for people who depend on these two programs.

Section 2602 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010, and Pub. L. 111–152 hereinafter collectively referred to as the "Affordable Care Act") created the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office") and charged the new office with more effectively integrating Medicare and Medicaid benefits and with improving the coordination between the Federal and State Governments for dual eligible beneficiaries. Under sections 2602(c)(5) and 2602(c)(7) of the Affordable Care Act, the goals of the Medicare-Medicaid Coordination Office include eliminating regulatory conflicts and cost-shifting between Medicare and Medicaid and among related health care providers. Sections 2602(c)(1) through (4) of the Affordable Care Act further charge the Medicare-Medicaid Coordination Office with addressing issues relating to quality of care and beneficiary understanding, beneficiary satisfaction, and access under Medicare and Medicaid.

II. The Alignment Initiative

As part of the Medicare-Medicaid Coordination Office's efforts to meet its responsibilities and goals, as outlined in the Affordable Care Act, and in direct support of Executive Order 13563 [10] (Improving Regulations and Regulatory Review), which directs us to identify existing "rules that may be outmoded, ineffective, insufficient, or excessively burdensome, and to modify, streamline, expand, or repeal them" as appropriate, the Office is undertaking an initiative to identify and address conflicting requirements between Medicaid and Medicare that potentially create barriers to high quality, seamless, and cost-effective care for dual eligible beneficiaries ("the Alignment Initiative"). The goal is to create and implement solutions in line with the CMS three-part aim, which includes, solutions that advance better care for the individual, better health for populations, and lower costs through improvement. 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 dual eligible beneficiaries' understanding of, interaction with, and access to seamless, high quality care that is as effective and efficient as possible. Medicare and Medicaid were designed with distinct purposes, which naturally results in numerous differences between the two programs in terms of eligibility, payment, and covered benefits. The Medicare program is administered by the Federal Government, and is generally available to elderly individuals or individuals with disabilities. Medicare covers a wide range of health care services and supplies, including acute, post-acute, primary, and specialty care services, as well as prescription drugs. Medicaid is a joint Federal and State program that is administered by States for certain categories of low-income individuals. Although specific benefits may vary by State, in general Medicaid covers acute care, primary and specialty care, behavioral health care, and long-term care supports and services.

For dual eligible beneficiaries, Medicare generally is the primary payer for benefits covered by both programs. Medicaid may then be available for any remaining beneficiary cost sharing. Medicaid may also provide additional benefits that are not (or are no longer) covered by Medicare. For example, Medicare covers skilled nursing facility services when a dual eligible beneficiary requires skilled nursing care following a qualifying hospital stay. During this time, Medicaid benefits may be available for amounts that are not paid by Medicare. Once the beneficiary no longer meets the conditions of a Medicare skilled level of care benefit, Medicaid may cover additional nursing facility services, including custodial nursing facility care. Although the two programs can work well together in financing health care for eligible beneficiaries, in some cases differential requirements between the two programs may create barriers to seamless, high quality care, creating a cost-shift between the two programs that may impede access to appropriate care.

The first step of the Alignment Initiative is to identify opportunities to align potentially conflicting Medicaid and Medicare requirements. This document represents the first step. We have compiled what we believe to be a wide-ranging list of opportunities for legislative and regulatory alignment on areas identified to date. We are seeking public comment on the list of alignment opportunities.

The list of alignment opportunities is intended to be a productive tool, with issues publicly shared for the purpose of improvement going forward. We believe public input in this early stage of the Alignment Initiative is critical to creating a foundation for future collaboration to address these issues. Comments from the public further the Alignment Initiative by engaging stakeholders in our work plan as future

[3] In 2011, poverty is defined as $10,890 for an individual and $14,710 for married couples. **Federal Register** Notice, Vol. 76, No.13 Thursday, January 20, 2011. *Available at: http://aspe.hhs.gov/poverty/11fedreg.pdf.*

[4] Medicare Payment Advisory Commission, Aligning Incentives in Medicare (June 2010), Coordinating the Care of Dual-Eligible Beneficiaries Chapter 5, 132. Available at: *http://medpac.gov/documents/Jun10_EntireReport.pdf.*

[5] 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.*

[6] *Id,* at 1.

[7] The Lewin Group, *Individuals Living in the Community with Chronic Conditions and Functional Limitations: A Closer Look* (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, USDHHS, January 2010), at p. 22. *http://aspe.hhs.gov/daltcp/reports/2010/closerlook.pdf.*

[8] 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.*

[9] 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.*

[10] *See* Exec. Order No. 13563, 76 FR 14 (Jan. 18, 2011). *Available at: http://www.whitehouse.gov/the-press-office/2011/01/18/improving-regulation-and-regulatory-review-executive-order* ("Improving Regulation and Regulatory Review").

partners, while facilitating productive discussions on how Medicare and Medicaid can work more effectively and efficiently for dual eligible beneficiaries and those who care for them.

Seeking public comment on the list of alignment opportunities is also in keeping with the President's directive of January 26, 2009, to promote accountability, encourage collaboration, and provide information to Americans about their Government's activities.[11] Please see Section III of this document for a more detailed discussion of this first step.

Once we receive public comments on the list of alignment opportunities, the next step in the Alignment Initiative is to continue to engage stakeholders, including beneficiaries, payers, providers, and States, to determine the barriers and sources of the current misalignments. We will then determine which issues to address and in what order and timeframe. All areas are important, but given the scope of the issues already identified, we recognize we cannot address all issues at once, and some may take longer than others. We will identify and address those opportunities that we have the resources and authority to address, and will consider including those alignment opportunities that would require a statutory change to address in the Secretary's annual Report to Congress under section 2602(e) of the Affordable Care Act.

We are committed to an open, transparent, and accountable process. We seek comment on this initiative generally, as well as the further areas for exploration for alignment specifically (see Section III. of this notice). We will provide periodic updates on the Alignment Initiative on our Web site at *http://www.cms.gov/medicare-medicaid-coordination/* and intend to keep the public apprised of our work.

III. Specific Alignment Opportunities

In an effort to advance the goals identified in the Affordable Care Act, and in line with the CMS three-part aim—better care for individuals, better health for populations and lower costs through improvement—the Medicare-Medicaid Coordination Office has been engaged in ongoing discussions with numerous and diverse stakeholders. The Medicare-Medicaid Coordination Office has used input from these discussions to develop a comprehensive list of areas in which the Medicare and Medicaid programs have conflicting requirements that prevent dual eligible individuals from receiving seamless, high quality care. Those areas fall into the following broad categories:

(1) Coordinated Care.
(2) Fee-for-service benefits (FFS).
(3) Prescription Drugs.
(4) Cost Sharing.
(5) Enrollment.
(6) Appeals.

Each of these broad categories and the specific opportunities for alignment identified to date can be found in Addendum 1. We invite public comment on these opportunities. These include opportunities to align existing program requirements, as well as preventing future conflicts when new programs are scheduled to be implemented (for example, coordinating seamless transitions between Medicaid, Medicare, and coverage under the Health Insurance Exchanges that will be established under section 1311 of the Affordable Care Act). This list will be continually updated as progress is made and new opportunities are identified. We look forward to continued collaboration with stakeholders as the Alignment Initiative proceeds.

IV. Questions and Comments

We are interested in your comments on this initiative. As you consider your comments, we are particularly interested in your feedback concerning how misalignments between specific Medicare and Medicaid requirements impact access to high-quality care. We offer the following questions to help guide your consideration of this issue and review of this notice. These questions are framed by the various goals and requirements that Congress articulated in establishing the Federal Coordinated Health Care Office.

- How can the Medicare and Medicaid programs better ensure dual eligible individuals are provided full access to the program benefits?
- What steps can CMS take to simplify the processes for dual eligible individuals to access the items and services guaranteed under the Medicare and Medicaid programs?
- Are there additional opportunities for CMS to eliminate regulatory conflicts between the rules under the Medicare and Medicaid programs?
- How can CMS best work to improve care continuity and ensure safe and effective care transitions for dual eligible beneficiaries?
- How can CMS work to eliminate cost-shifting between the Medicare and Medicaid programs? How about between related health care providers?

Authority: Section 2602 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010).

Dated: March 16, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

BILLING CODE 4120–01–P

[11] *See* Memorandum for the Heads of Executive Departments and Agencies, 74 FR 15, 3825 (Jan. 26, 2009). *Available at: http://edocket.access.gpo.gov/2009/pdf/E9-1777.pdf* ("Transparency and Open Government").

ADDENDUM 1: List of Alignment Opportunities

(all regulatory references refer to 42 CFR)

Acronyms used in Addendum 1	
ACO	Accountable care organization
ALJ	Administrative Law Judge
BBA	Balanced Budget Act of 1997 (Pub. L. 105-33, enacted on August 5, 1997)
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CORF	Comprehensive outpatient rehabilitation facility
DME	Durable medical equipment
DRG	Diagnosis-related group
FFP	Federal financial participation
FFS	Fee-for-service
HCBS	Home and Community-Based Services
IRE	Independent review entity
LIS	Low income subsidy
MA	Medicare Advantage
MAC	Medicare Appeals Council
MCO	Managed care organization
MIPPA	Medicare Improvement for Patients and Providers Act (Pub. L. 110-275, enacted on July 15, 2008)
MSP *	Medicare savings program
NF	Nursing facility
PACE	Program of All Inclusive Care for the Elderly
PBP	Plan benefit package
PDP	Prescription Drug Plan
QI *	Qualifying individual
QIO	Quality improvement organization
QMB*	Qualified Medicare beneficiary
SLMB *	Specified Low-income Medicare beneficiary
SNF	Skilled nursing facility
SNP	Special needs plan
SSA	Social Security Administration
the Act	the Social Security Act
VTC	Video teleconferencing

* Under the Medicare Savings Programs (MSP), Medicaid pays for some or all of a low-income beneficiary's Medicare cost sharing. Individuals with incomes up to 100 percent FPL who meet the relevant resource test can qualify for QMB; in this program, Medicaid pays for their Medicare Part A and B premium, deductibles, coinsurances, and copayments. Individuals with incomes under 120 percent FPL who meet the relevant resource test can qualify for SLMB, and individuals with incomes under 135 percent FPL who meet the relevant resource test can qualify for QI; in these two programs, Medicaid pays for the Part B premium only.

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
Coordinated Care -- Enrollment	Models already exist that integrate care for dual eligibles, but enrollment in these programs remains very low.	Federal Medicaid requirements vary by type of coordinated care program. There may be additional State requirements. Medicaid may mandate enrollment into coordinated care programs; for dual eligibles mandatory enrollment applies to their Medicaid benefits only.	Traditionally, there have been few options for Medicare to increase enrollment in coordinated care.
Coordinated Care -- Options	Medicaid can cover care coordination in FFS as well as through capitated managed care organizations. Medicare primarily covers care coordination through capitated managed care organizations. New models for seamless care (for example, ACOs and health homes) do not necessarily have to coordinate care for dual eligibles across both benefits.	FFS: Medicaid provides FFP for optional services related to care coordination in FFS. Examples include targeted case management, Primary Care Case Management programs, and health home programs. Under the Affordable Care Act, Medicaid now provides FFP for the optional services of health homes. States may not exclude dual eligibles. Managed Care: FFP is also available for capitated managed care (for example, MCOs for comprehensive services package, "carve outs" such as behavioral health).	FFS: Medicare covers care coordination within certain benefits (for example, hospital, physician office visits, hospice, and home health), but doesn't pay separately for care coordination as a standalone benefit. Under the Affordable Care Act, Medicare may share savings with ACOs. In addition, under demonstration authority and the Center for Medicare and Medicaid Innovation, Medicare continues to test promising payment approaches, including medical home services. Part C: Medicare Advantage plans that are coordinated care plans include care coordination services.
Coordinated Care -- MA Cost sharing information in standard Summary of Benefits	CMS' model for the MA "Summary of Benefits" has information, including cost-sharing, that is presented at the plan level, not the beneficiary level. Dual eligible beneficiaries may not be aware that there is dual eligible-specific information in later sections of the Summary of Benefits.	Medicaid generally pays for Medicare cost-sharing for QMBs and full benefit dual eligible beneficiaries in MA plans.	CMS' systems generate a "Summary of Benefits" that is applicable at the plan rather than beneficiary level; these data also appear at www.Medicare.gov. Section 3 of the Summary of Benefits provides a plan with an area to insert free form text, for example, cost-sharing specific to dual eligibles. Dual eligible SNPs must use section 4 of the Summary of Benefits to provide a comprehensive description of dual-eligible cost-sharing, as well as a description of both Medicaid and Medicare benefits to which they are entitled.

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
Coordinated Care -- MA -- Seamless conversion	Medicare permits seamless conversion of Medicaid-only individuals enrolled in a Medicaid MCO into a MA plan offered by same organization when the person becomes Medicare eligible with the option for beneficiaries to opt out, but few plans avail themselves of this option. Plans may have difficulty identifying those in their Medicaid managed products who are about to become Medicare eligible.	Medicaid programs have the option to offer managed care to dual eligibles, and to permit voluntary enrollment or mandate it for their Medicaid benefits.	Medicare statute and regulation permit seamless conversion with the option to opt out.
Coordinated Care -- PACE -- External appeals	While there is an integrated appeals process for internal appeals, dual eligible PACE participants may choose the Medicare or Medicaid managed care appeal processes for pursuing an external appeal (but not both). PACE organizations must inform the dual eligible beneficiary of his or her appeal rights under Medicare and Medicaid managed care, and assist the participant in choosing which to pursue and forward the appeal to the appropriate entity. §460.124.	Some States provide access to Ombudsman or Independent Review Entities for those enrolled in managed care. All States must provide access to a State Fair Hearing to individuals entitled to a hearing under the Medicaid managed care rules. §460.124 and 42 CFR Part 438, subpart F; section 1932(b)(4) of the Act.	Medicare beneficiaries have access to the Medicare external appeals route through the Independent Review Entity that contracts with CMS to resolve Medicare Advantage appeals. §460.124; see also §422.592 *et seq.*
Coordinated Care- - - Low income Medicare beneficiaries at risk of declining to point of qualifying for Medicaid	For low income Medicare-only beneficiaries, Medicare FFS has limited flexibility to help prevent people from declining to a point where they need/qualify for Medicaid, particularly in instances where they may have been able to avoid nursing home care with appropriate community supports.	State Medicaid programs can't receive FFP for services provided to people who are not eligible for full Medicaid benefits (that is, those who are only on Medicare Savings programs).	Medicare FFS does not cover care coordination services as a standalone benefit.
Coordinated Care – Special Need Plans -- Current contracting issues	The Federal Medicare and Medicaid programs stipulate contracting requirements, as do State Medicaid programs. These contracting requirements may conflict. For example, Medicare and Medicaid may have different reporting requirements.	There are Federal contracting requirements for Medicaid managed care contracts. 42 CFR part 438 *et. seq.* provides general Federal guidance. State Medicaid requirements vary by State. These requirements would apply to a SNP that has a contract with a State Medicaid agency to cover Medicaid benefits.	There are separate contracting requirements for MA. §422.504.

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
Coordinated Care – Managed Care SNP -- Enrollment requirements	Medicare and Medicaid both have requirements governing enrollment into managed care plans and these may conflict, including: • When a beneficiary can enroll in and disenroll from plan. • When and how often a beneficiary can change plans. • Cutoff dates for requesting enrollment. • Effective date of enrollment. • Mandatory vs. voluntary enrollment in plans. • Type of entity that can accept enrollment.	• States are permitted to mandate enrollment and limit disenrollment to certain reasons. • States may vary on cutoff for requesting enrollment and effective date of enrollment. • States vary in entities they permit to accept enrollment (for example, enrollment broker; may not permit plans to directly accept).	• Dual eligibles may change Part C and D plans at any time. • Enrollments may be received by MA plans themselves, or by calling 1-800-Medicare. Cutoff dates for electing a plan, and effective date of that election, vary by which election period applies.
Coordinated Care -- SNP -- Future contracting issues	Dual eligible SNPs must have a contract with State Medicaid agencies starting in 2010 (for expanding and new plans) and 2013 (for all dual eligible SNPs, including existing and new plans).	States may selectively contract with managed care plans based on State-specified criteria.	Although plans will be required to have a contract with the State Medicaid agency per section 164 of MIPPA, as modified by section 3205 of the Affordable Care Act, Medicare cannot require States to contract with SNPs. In limited instances, MA organizations offer a single SNP in a metropolitan area that crosses State lines. CMS has been asked to consider permitting the SNP in this situation to split a single plan into two to support the need for different plans to contract with two different States.
Coordinated Care -- SNP -- Internal grievances and appeals	Medicare and Medicaid differ in their requirements related to internal appeals and grievances for beneficiaries enrolled in managed care plans. Examples include: • Grievances (complaints). • Appeals (processes, timeframes). • Continuation of services during appeal. • External entity (State fair hearing versus Medicare independent review entity). • Required notices.	States may have varying requirements, on top of Federal Medicaid requirements. See appeals discussion, below.	Medicare has its own regulations. See appeals discussion, below.

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
Coordinated Care -- SNP – Marketing	Medicare and Medicaid both have requirements related to marketing. Examples include: • Differing requirements related to the definition of what constitutes marketing. • Content of marketing material. • Process to approve marketing material. • Standards for reading level, health literacy, and criteria prompting materials to be translated into other languages.	Federal Medicaid requirements have more stringent readability/translation requirements; and define marketing more narrowly than Medicare. A given State may have its own, State-specific requirements on reading level, translation, and approval process, in addition to Federal guidelines.	There are a broad range of standard or model documents under the MA program, some of which apply generally to all MA plans, but some of which were designed specifically for SNPs. Model language in documents designed for the Medicare program may be written at a higher reading level. However, plans may request approval for alternate language at a lower reading level. Medicare requires MA plans to make specific marketing material available in any language that is the primary language of more than 10 percent of the plan's service area.
Coordinated Care -- SNP -- Quality requirements	Medicare and Medicaid have different requirements for quality improvement efforts, types of quality data required to be submitted, and requirements for treatment plans or models of care.	CMS Medicaid regulations at §438.240(d) include specific performance improvement program requirements. States may require additional performance measures, to be reported on State contracting cycles (which may differ from Federal cycles). States must contract with an External Quality Review Organization for each contract. Federal regulations require Medicaid MCOs to have treatment plans for enrollees with special health care needs. (§438.208). States have some discretion to waive these requirements for dual eligibles enrolled in an MA plan.	MA regulations at §422.152(b) require that MA organizations conduct quality improvement projects. Under §422.152(b)(3), the SNPs are required to measure performance under the plan, using the measurement tools required by CMS, and report performance to CMS. They must also provide outcome measures that are reported as part of materials beneficiaries use to select plans. Under the Affordable Care Act, SNPs must be approved by NCQA beginning in 2012. Under the MA program, a SNP is required to have a model of care, as well as standard MA requirements for care coordination. In addition, the SNP is required to have a medication therapy management program for the Part D benefit.
Coordinated Care -- SNP -- Seamless delivery of services	SNPs have different coverage limits and criteria.	States' Medicaid coverage of items and services varies.	Medicare has its own requirements for coverage of items and services.

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
FFS Benefits -- Behavioral health	Medicaid and Medicare differ in coverage of behavioral health care providers and services.	Some States may cover a broader range of behavioral health services, including community based behavioral services and providers, for example, Assertive Community Treatment for severe mental illness, intensive outpatient treatment and ambulatory detoxification for substance abuse treatment. Medicaid covers inpatient psychiatric hospital services only for individuals under age 21 and covers inpatient hospital services for persons age 65 or older with mental illness in institutions for mental diseases. Specialty inpatient psychiatric care is not covered for adults age 21-64.	Medicare covers reasonable and necessary "partial hospitalizations," traditional outpatient and inpatient visits to behavioral professionals and providers.
FFS Benefits-- DME	Medicare and Medicaid have different rules for qualifying for DME coverage for those receiving care in the community. In addition, each program may have different formularies governing what DME it covers.	Medicaid covers DME in the home care context (§440.70). DME must be determined to be "medically necessary" and not experimental. There is no clear Federal definition of covered DME, so many but not all States have adopted some form of the Medicare definition.	Medicare covers DME that: • Can withstand repeated use; • Is primarily and customarily used to serve a medical purpose; • Generally is not useful to a person in the absence of an illness or injury; and • Is appropriate for use in the home (under §410.38). See generally section 1861(n) of the Act; §414.202.
FFS Benefits -- Home health	Medicare covers home health services for patients who have a skilled need. Specifically, the patient must need skilled nursing care on an intermittent basis or need skilled therapy services. Medicaid generally covers both acute and longer term needs.	Medicaid covers skilled nursing/therapy/ home health aide services and/or personal care services. Certain services under the home health benefit are optional and may not be covered in certain States. The benefit is intermittent (that is less than 24 hours/day) and typically has limits, depending on the States. States may also offer HCBS services that provide additional home care, but these are usually targeted at particular populations.	To qualify for the Medicare home health benefit, a Medicare beneficiary must be under the care of a physician, and have an intermittent need for skilled nursing care, need physical or speech therapy, or continue to need occupational therapy. The beneficiary must be homebound and receive home health services from a Medicare approved home health agency. Medicare pays home health agencies a 60-day case mix adjusted episode bundled payment for all nursing, therapy, home health aide services, medical social services, and routine and non-routine medical supplies.

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
FFS Benefits -- Nursing home-hospital transfers	Reimbursement policies between Medicare and Medicaid incentivize nursing homes to transfer dual eligibles to hospitals and vice versa. Nursing homes are reimbursed by Medicaid for custodial care, and may not have the staff to diagnose/treat more acute conditions in-house, especially after business hours. In addition, they are reimbursed at a higher rate by Medicare when the person is discharged from a hospital and qualifies for SNF level of care. Medicare reimburses hospitals on a per discharge basis, incentivizing them to discharge beneficiaries to nursing facilities. Inappropriate and/or avoidable hospital admission and re-admissions put beneficiaries at risk of exposure to hospital-acquired conditions, fragmented care, medical errors, medication mismanagement, and poor follow-up care.	Medicaid covers long term NF stays (that is, that don't meet SNF level of care), and generally pays with a FFS methodology (per day) that is generally lower than Medicare payment. There is an incentive to transfer dual eligibles with higher costs to hospitals, rather than manage them in-house, in order to re-qualify the individual for Medicare coverage. States also may pay for bed holds (meaning States continue to pay the reduced rate while the person is in hospital) so that the individual is guaranteed to be able to return to the facility.	Medicare is generally the primary payer for hospital stays. Most short-term, acute care hospitals are paid on a per-discharge basis under the IPPS using DRG payment rates. Medicare's post-acute care transfer policy (which reduces hospital payments for patients with certain diagnoses when the patient is transferred relatively early) was designed to avoid providing an incentive for a hospital to transfer certain patients early in their stay to minimize costs while still receiving the fully payment for the specific MS-DRG. Medicare generally covers up to 100 days of SNF care in each benefit period for beneficiaries who meet coverage requirements. Generally, Medicare reimbursement for a SNF level of care is higher than Medicaid's reimbursement for NF stay. In order for Medicare to cover a SNF stay, the beneficiary must have had a prior inpatient hospitalization of at least 3 days.
FFS Benefits -- Skilled therapies	Medicare and Medicaid differ in their provider definitions and qualifications for skilled therapies.	Medicaid requirements at § 440.110 include requirements for Medicaid physical therapist credentials.	Medicare amended §484.4 in 2008, revising physical therapy provider definitions and increasing the number of credentialing organizations recognized by Medicare for purposes of reimbursement.
Prescription Drugs -- Access for new full duals	States are required to submit data monthly to CMS to identify new dual eligibles.	CMS requires States to submit dual eligible enrollment and eligibility data monthly, but States have discretion to submit more frequently.	LI NET demonstration will cover those new duals not yet auto-enrolled at the point of sale, that is, a pharmacist can bill a specialized PDP available under the demonstration and get immediate confirmation of payment, facilitating immediate dispensing of the drug.

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
Cost-sharing -- Crossover claims	When Medicare pays a claim for certain dual eligible beneficiaries, it automatically sends it to Medicaid as a "crossover" claim to assist State Medicaid agencies in their obligation to pay any Medicare cost-sharing on those claims.	Under section 1905(p)(3) of the Act, State Medicaid agencies are liable for QMB cost sharing. Medicaid is required to pay Medicare cost-sharing for dual eligibles who are QMBs, regardless of whether the service is normally covered under Medicaid, or whether the provider is enrolled as a Medicaid provider. In some States, where the provider is not enrolled as a Medicaid provider, the State's Medicaid claims processing system will reject the claims. Federal law permits States to cover the Medicare cost-sharing for QMBs up to the Medicaid payment rate. If the State's rate is equal or lower than the total reimbursement already received from the Medicare program, then the State is not required under current law to pay the Medicare cost-sharing. In these instances Federal guidance requires States to issue remittance advice.	Medicare automatically sends "crossover" claims to State Medicaid agencies for purposes of paying the provider for a dual eligible beneficiary's Medicare cost-sharing liability. Medicare rules require that a State's Medicaid Agency must issue a remittance advice with zero reimbursement for cost-sharing, in order for a facility to report this on its Medicare cost report and receive an adjustment, providing offset of some of the loss. If the State does not issue a remittance advice, the facility cannot receive such an adjustment.
Cost-sharing -- Balance billing for QMB	Providers have difficulty identifying beneficiaries who are QMB. Medicare providers do not always understand they are not permitted to balance bill QMB beneficiaries.	Medicaid providers must accept Medicaid payment as payment in full. §447.15	Medicare generally requires beneficiaries to pay applicable deductibles, coinsurance, and/or copayments for many of its services. However, individuals who are full dual eligibles or QMBs may not be billed by providers for Medicare coinsurance, copayments or deductibles for Medicare-covered items or services.

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
Enrollment -- Medicare Part A buy-in	States are required to pay Part A premiums for QMBs and may opt to pay for the Medicare Part A premium for other dual eligibles; States that do not, may be paying for services that could be billed to Medicare Part A.	35 States and the District of Columbia have opted to buy in for Part A for non-QMBs, though not all necessarily enroll all eligible participants.	Medicare Part A covers inpatient services, including hospital, SNF, and hospice. Beneficiaries who have worked 40 quarters of Medicare-covered employment (or who have a spouse who has) receive premium-free Part A. Individuals who have not worked 40 quarters may "buy in" to Part A by paying a monthly premium. The Qualified Disabled Working Individual (QDWI) program helps pay Medicare Part A premiums for disabled individuals with Medicare who have returned to work.
Enrollment -- Re-certification requirements for Medicaid	States may require in-person interviews or documentation at annual reviews to re-certify for Medicaid and/or MSP.	States have the discretion to require in person interviews. Some States have removed the recertification interview from the process and reported administrative cost savings (Wisconsin, Louisiana, Arizona), and some States utilize passive or ex parte recertification.	In general, people who are entitled to Part A are automatically enrolled in the program. Individuals have an opportunity to decline enrollment in Part B the first time they become eligible for it. If they do not decline, they are enrolled. No annual re-enrollments are necessary.
Enrollment -- Medicare Savings Program asset test	Beneficiaries are often required to provide asset information and documentation as part of the Medicare Savings Programs application .	Medicaid has limits on assets or resources for most individuals who are eligible on the basis of age or disability, for whom States are generally required under section 1902(a)(17) of the Act to apply the rules of the Supplemental Security Income program. State Medicaid agencies have discretion to disregard some or all assets for the Medicare Savings Programs under section 1902(r)(2) of the Act.	There is no asset test for the Medicare program itself, though there is one for the low income subsidy in the Part D benefit.

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
Appeals -- Timeframes for filing an appeal related to benefits	Medicare and Medicaid (both in FFS and private health plans) have different timeframes for filing of initial and subsequent appeals.	FFS: An individual has a right to request a fair hearing or appeal. The agency must provide a reasonable time to the applicant or recipient, not to exceed 90 days from the date the notice is mailed (as determined by the State). §431.221. Managed Care: Appeals may be filed via the State fair hearing process (sometimes after exhaustion of plan appeals) anywhere between 20 and 90 days (varies by States). §438.408.	Parts A and B: Requests for a redetermination may be filed within 120 days of the date the party receives notice of the initial determination. Requests for reconsideration of that redetermination must be filed within 180 days of the date the party receives the notice of the redetermination. Requests for ALJ, MAC and Court reviews must be filed within 60 days after the receipt of the notice of the decision at the previous level of review. Parts C and D: Appeals must be filed within 60 days. Subsequent appeals (to IRE, ALJ, MAC and Court) must also be filed within 60 days.
Appeals -- Access to State level or external review	Medicare and Medicaid vary in the degree to which they allow a beneficiary to access a parallel external appeals process, separate and apart from the normal appeals system.	All States must provide access to a State Fair Hearing, either directly or (if the State requires exhaustion of the health plan level of appeal) after an initial appeal to the health plan. §431.205 and §438.408; and section 1902(a)(3) of the Act. Some States provide access to Ombudsman or Independent Review Entities for those enrolled in managed care.	Parts A and B: A Qualified Independent Contractor is responsible for Part A and B reconsiderations. Beneficiaries who receive a Medicare Notice of Non-Coverage in a CORF, SNF, Home Care or hospice, or an important message from Medicare in a hospital, may access a Medicare QIO, which may conduct an independent review. §405.1200 et. seq. Parts C and D: Medicare allows beneficiaries in private health plans to access Independent Review Entities, but only after the filing of an initial appeal to a plan. §422.578 and §422.592. Part C beneficiaries also have the opportunity to have a QIO review a termination or reduction of services

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
Appeals -- Continuation of benefits pending appeal	Medicare and Medicaid differ in terms of whether benefits continue to be provided while a coverage appeal is in process.	Medicaid benefits generally continue and are covered pending a timely appeal (FFP is available for these costs), when the appeal is requested within a certain timeframe. States also may reinstate benefits if requested within 10 days of the date of action (although States may vary). §431.231. The basis of this rule is both regulatory and constitutional (due process clause), as interpreted by Supreme Court in Goldberg v. Kelly and its progeny. Section 1902(a)(3) of the Act; §431.205; §438.420 (managed care). The State may seek recovery against the beneficiary if he or she loses the appeal.	Benefits generally do not continue during the entire pendency of a Medicare appeal involving reduction or termination of services.
Appeals -- Document notifying beneficiaries of appeal rights	Medicare and Medicaid differ in the way in which documents provide notification of appeal rights.	Various documents may be used to notify beneficiaries of their appeal rights depending upon the State. Regulations require that information about appeals be included at the time of application, with a notice of adverse action on a claim, at the time of transfer or discharge from a SNF. §431.206. Also there are requirements of providing notice to beneficiaries enrolled in managed care organizations during terminations, suspensions, reductions in service, denial of payment, among others. §438.404.	Medicare Parts A and B: For standard appeals -- "Medicare Summary Notice" is sent to beneficiaries to notify them of their appeal rights. For expedited appeals -- Medicare Notice of Non-Coverage or important message from Medicare notifies beneficiaries of their appeals rights. Medicare Part C: A notice of non-coverage is delivered to beneficiaries to notify them of their appeal rights. Medicare Part D: A notice Denial of Medicare Prescription Drug Coverage is delivered to beneficiaries to notify them of their appeal rights.

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
Appeals -- Timeframes for resolution of an appeal related to benefits	Medicare and Medicaid vary in the time that a payer has to make a decision once an appeal is received.	FFS: Rules vary by State. Generally within 90 days of date of filing the appeal. §431.244. Managed Care: Standard appeals must generally be handled within 45 days, with extensions available in certain circumstances. Expedited appeals are to be handled within 3 working days, with extensions up to 14 calendar days in certain circumstances. §438.402, and §438.408.	Parts A and B: For standard, non-expedited appeals, different periods of time apply depending upon the stage of the review process. At the early stages, contractors generally have 60 days for review. At the ALJ/MAC Stage the review period is 90 days, and failure to meet the required time frame allows the party to escalate the appeal to the next higher level. Section 1869 of the Act; §405.1000 et seq. For timely filed expedited appeals, the time periods at the initial stages are more abbreviated (and generally not longer than 72 hours). Section 1869 of the Act; §405.1202, §405.1204, and §405.1206. Parts C and D: Standard plan reconsiderations must be resolved within 7 days (Part D) or 30 days (Part C). Expedited reviews are to be conducted within 72 hours.

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DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

49 CFR Parts 385, 386, 390, and 395

[Docket No. FMCSA–2004–19608]

RIN 2126–AB26

Hours of Service of Drivers

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice; availability of supplemental documents; reopening of comment period; correction.

SUMMARY: This document corrects the docket number referenced in the Addresses and Instructions paragraphs to a proposed rule's notice of availability of supplemental documents published in the **Federal Register** of May 9, 2011, regarding Hours of Service of Drivers. This correction replaces an incorrect docket number with the correct docket number for the public to