Medicare-Medicaid Coordination Office

FY 2021 Report to Congress

Introduction

Federal statute established the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office," hereinafter "MMCO") within the Centers for Medicare & Medicaid Services (CMS) to improve the coordination between the federal government and states to enhance access to quality services for individuals dually eligible for both Medicare and Medicaid benefits ("dually eligible individuals").[1] MMCO is submitting its annual report to Congress.

The Medicare and Medicaid programs are distinct programs with different rules for eligibility, covered benefits, and payment, and the programs have operated as separate and distinct systems despite a growing number of people who depend on both Medicare and Medicaid for their health care. There is an increasing need to align these programs to improve care delivery and the beneficiary experience for dually eligible individuals, while reducing administrative burden for beneficiaries, providers, health plans, and states.

In this report, we discuss ways in which we have carried out activities to better serve dually eligible individuals in 2021, including:

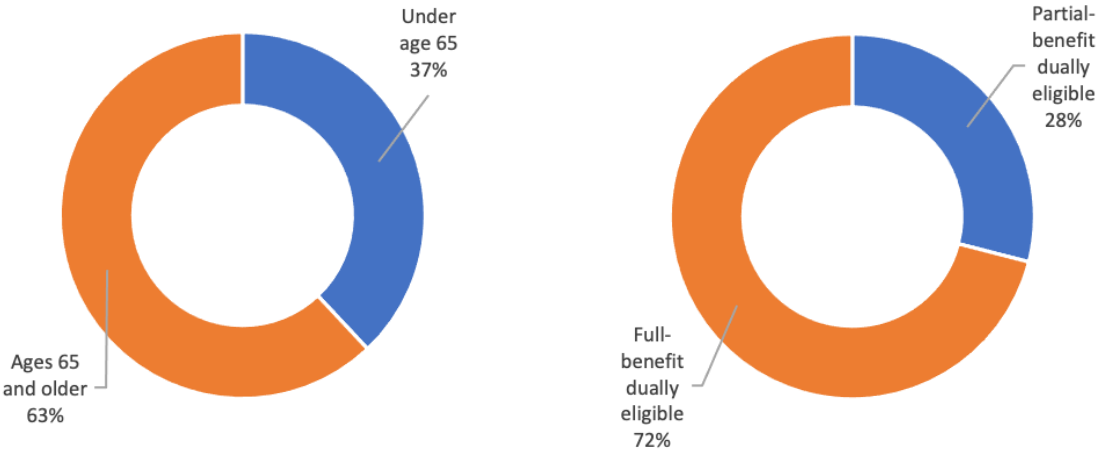
- Reducing poverty and improving access through the Medicare Savings Programs;
- Ensuring equity and reducing disparities; and
- Promoting integrated care.

About Dually Eligible Individuals

During 2021, more than 12 million[2] individuals were concurrently enrolled in both the Medicare and Medicaid programs. These individuals navigate two separate programs: Medicare for the coverage of most preventive, primary, and acute health care services and drugs, and Medicaid for coverage of long-term services and supports, certain behavioral health services, and for help with Medicare premiums and cost-sharing.[3]

Dually eligible individuals may either be enrolled first in Medicare by virtue of age or disability and then qualify for Medicaid on the basis of income and other eligibility factors, or vice versa. They may also be *full-benefit* dually eligible individuals, who qualify for the full range of Medicaid services, or *partial-benefit* dually eligible individuals, who receive assistance only with Medicare premiums and, in most cases, assistance with Medicare cost-sharing. Full-benefit dually eligible individuals often separately qualify for assistance with Medicare premiums and cost-sharing through the Medicare Savings Programs (MSPs).

Figure 1. Dually Eligible Individuals by Age and Type of Benefi [4]



Overall, dually eligible individuals have a higher prevalence of many health conditions than their Medicare-only and Medicaid-only peers. They often have unmet social needs that can lead to poor health outcomes, and are more likely than non-dually-eligible Medicare benefi iaries to report being in poor health.[5] In 2016, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) published a report that found Medicare beneficiaries with social risk factors had worse health outcomes on many quality measures, regardless of the providers they saw, and that dual eligibility was the most powerful predictor of poor outcomes.[6] A second ASPE report, published in 2020, confirmed these findings after accounting for additional social and functional risk factors.[7]

Given these complex needs and poor outcomes, dually eligible individuals account for a disproportionate share of spending in both Medicare and Medicaid. In 2019, dually eligible individuals accounted for 19 percent of all Medicare enrollees, but 34 percent of Medicare spending; similarly, they accounted for 14 percent of all Medicaid enrollees, but 30 percent of Medicaid spending. Combined Medicare and Medicaid spending on dually eligible individuals was $440.2 billion in 2019.[8]

Dually eligible individuals are more likely to be from racial and ethnic minority groups. In 2020, 48 percent of dually eligible individuals were from a racial or ethnic minority group.[9] Racial and ethnic minorities are more likely to have worse health outcomes, limited access to care, and lower quality of care than non-minorities.[10]

As of December 2021, preliminary data[11] show that dually eligible individuals have more than twice the rate of COVID-19 cases compared to Medicare-only beneficiaries. The disparity in COVID-19 hospitalizations is even wider, with about 2.5 times more hospitalizations per 100,000 beneficiaries among dually eligible individuals than among individuals eligible for Medicare only. Dually eligible individuals across demographic categories (race, age, sex, disability, end-stage renal disease (ESRD) status) were hospitalized with COVID-19 at considerably higher rates than their Medicare-only counterparts in the same demographic group.[12]

There are a number of drivers of poor outcomes for dually eligible individuals. A lack of alignment and cohesiveness between the Medicare and Medicaid programs can lead to fragmented and episodic care for dually eligible individuals and misaligned incentives for both payers and providers, resulting in reduced quality and increased costs to both programs and to enrollees. In particular, state investments in Medicaid services to improve care for dually eligible individuals (e.g., enhanced behavioral health or long-term services and supports (LTSS)) may result in savings that accrue to Medicare from lower acute care utilization. Historically, states have needed to shoulder the burden of such investments without sharing in the acute care savings. Dually eligible individuals could benefit from more integrated systems of care[13] that meet all of their needs—primary, acute, long-term, behavioral, and social—in a high quality, cost-effective manner. Better alignment of the administrative, regulatory, statutory, and financial aspects of these two programs holds promise for improving the quality and cost of care for this complex population.[14]

Dual eligibility also presents a number of administrative complexities for individuals, their families, providers, states, and CMS. In some cases, these complexities can become a barrier to accessing services. Streamlining the administrative aspects for dual eligibility can improve customer service, access to care, and economic security for low-income older adults and people with disabilities.[15,16]

The dually eligible population has a higher prevalence of chronic conditions and disability than Medicare-only beneficiaries:

- **27% of dually eligible individuals have 6 or more chronic conditions (vs. 15% of Medicare-only beneficiaries)[17]**
- **41% have at least one mental health diagnosis (vs. 16% of Medicare-only beneficiaries)[18]**
- **40% of dually eligible individuals are under age 65 with a disability (vs. 9% of Medicare-only beneficiaries)[19]**

What We are Doing

REDUCING POVERTY AND IMPROVING ACCESS FOR DUALLY ELIGIBLE INDIVIDUALS THROUGH THE MEDICARE SAVINGS PROGRAMS

Millions of Americans rely on the Medicare Savings Programs (MSPs) to help cover Medicare Parts A and B premiums and, often, cost-sharing. MSPs are part of states' Medicaid programs and provide assistance to individuals who need help paying their Medicare costs. MSPs can save beneficiaries over $2,000 a year just by covering Medicare Part B premiums—money beneficiaries can use for food, housing, or other necessities. States pay Medicare Part B premiums each month for over 10 million individuals and Part A premiums for over 700,000 individuals.

Millions more are eligible for the MSPs but not enrolled. For example, the Medicaid and CHIP Payment and Access Commission found that only 53 percent of eligible individuals are enrolled in the Qualifi d Medicare Beneficiary (QMB) program, which covers eligible beneficiaries' Medicare Parts A and B premiums as well as cost-sharing.[20] Longstanding operational friction in the MSPs can prevent individuals from getting the financial relief to which they are entitled, including complex and burdensome application and documentation processes, and inefficient or delayed data exchange between states, CMS, and the Social Security Administration for the state payment of Medicare premiums. A lack of public awareness about the MSPs and who is eligible for them is another barrier that prevents eligible individuals from enrolling. Lack of access to the MSPs and the financial relief they provide can result in lack of access to needed care.[21]

In 2021, we continued our work to improve the MSPs' effi iency and operation, and to expand dually eligible individuals' access to the MSPs.

Expanding Access to the MSPs by Eliminating Resource Requirements

As part of this work, we highlighted steps states are taking to improve access to the MSPs for eligible individuals, such as eliminating burdensome resource requirements. For example, in 2021 the New Mexico Human Services Department eliminated its resource requirement for low-income individuals to qualify for the MSPs. Previously, to qualify for the MSPs in the state, low-income individuals could not have resources with a value exceeding $9,360 for an individual or $14,800 for a couple. Very few low-income individuals in New Mexico have resources exceeding these limits, and there was considerable administrative cost associated with verifying asset information for every MSP applicant.[22] As a result of eliminating this requirement, more dually eligible individuals in the state will be able to enroll in the MSPs and applicants will no longer need to provide burdensome documentation on resources.

In 2021, CMS highlighted New Mexico's action for other state policymakers as a best practice,[23] and will continue to partner with states to expand access to the MSPs for eligible beneficiaries. CMS also promoted enrollment in New Mexico's MSPs by sharing information about this policy change with Medicare beneficiaries in the state.

Updates to Social Security Administration Program Operations Manual System

In 2021, CMS and the Social Security Administration (SSA) developed revisions to the SSA Program Operations Manual System (POMS) to refl ct updates and clarifications from the updated Manual for State Payment of Medicare Premiums that CMS released in September 2020. These revisions to the POMS describe financial implications for beneficiaries and options for SSA to grant financial relief when the state payment of Medicare premiums ends.[24]

Medicaid Enrollment of Medicare Providers to Improve Payment of Medicare Bad Debt

In August 2021, CMS finalized the FY 2022 Hospital Inpatient Prospective Payment System Final Rule, which included a provision that requires state Medicaid agencies to allow the enrollment of all Medicare-enrolled providers and suppliers that serve dually eligible individuals for purposes of processing claims for Medicare cost-sharing by January 1, 2023. [25]

Through the MSPs and Medicaid statutes, states cover Medicare cost-sharing for millions of dually eligible individuals. However, through what is commonly referred to as "lesser-of" policies, states can pay less than the full Medicare cost-sharing or, in certain circumstances, make no payment at all; 43 states currently have lesser-of policies for inpatient hospital cost-sharing.[26] If states pay less than such cost-sharing amounts, certain Medicare providers may submit these unpaid cost-sharing amounts to Medicare for payment as reimbursement for "bad debt." This change will make it easier for providers serving dually eligible individuals to claim Medicare bad debt for uncollectable cost-sharing amounts.

Maximum Out-of-Pocket (MOOP) Policy for Dually Eligible Individuals

In a notice of proposed rulemaking (NPRM) developed in 2021 and published in January 2022, CMS proposed to require that the maximum out-of-pocket (MOOP) limit (after which the plan pays 100 percent of MA costs) in all MA plans, including D-SNPs, be calculated based on the accrual of all Medicare cost-sharing in the plan benefit, whether that Medicare cost-sharing is paid by the beneficiary, Medicaid, or other secondary insurance, or remains unpaid because of state limits on the amounts paid for Medicare cost-sharing and dually eligible individuals' exemption from Medicare cost-sharing. Current guidance on calculation of the MOOP limit allows MA plans, including D-SNPs, the option to count only those amounts the individual enrollee is responsible for paying, net of any state responsibility or exemption from cost-sharing toward the MOOP limit, rather than the cost-sharing amounts for services the plan has established in its plan benefit package. In practice, this option does not cap the amount a state could pay for a dually eligible MA enrollee's Medicare cost-sharing and lowers payments to safety net providers serving dually eligible MA enrollees with high medical costs. CMS projects that the proposed change would save state Medicaid agencies $2 billion over 10 years while increasing payment to providers serving dually eligible individuals by $8 billion over 10 years.

Data Exchange Between States and CMS

In FY 2020, CMS finalized the Interoperability and Patient Access Rule,[27] which mandates daily submission of certain MSP payment and dual eligibility status files, as well as state payment of Medicare premiums files, by April 1, 2022. Currently, states are required to submit these files at least monthly to CMS. Without daily exchanges, CMS lags in its ability to automatically enroll individuals in Medicare drug plans; deem them automatically eligible for the low-income subsidy for Part D premiums, deductibles, and copayments; and terminate or activate state payment of Medicare premiums.

Increasing the frequency of federal-state data exchanges will improve beneficiaries' experience with their Medicare benefits and ensure they are affordable, reduce burden on states and providers to reconcile incorrect payments due to data lags, and improve provider compliance with the prohibition on billing QMBs for Medicare Parts A and B cost-sharing for Medicare-covered services.

By the end of 2021, 20 states were submitting files on dual eligibility status daily, and 23 states were exchanging data daily on state payment of Medicare premiums. CMS provides extensive technical assistance to states on this transition, including through the State Data Resource Center tip sheets, FAQs, and recorded webinars.

We are also working to improve the quality of the data exchanges between the states, CMS, and the Social Security Administration to facilitate state payment of Medicare premiums. By reducing errors and system rejections, we can reduce delays in coverage and access to care for beneficiaries while also reducing administrative burden for state and federal agencies. To do so, we provide targeted technical assistance[28] on how to reduce erroneous submissions and troubleshoot those that occur.

ENSURING EQUITY AND REDUCING DISPARITIES

The COVID-19 pandemic illuminated the health disparities that underlie our health system, making it urgently clear that people from racial and ethnic minority groups and other underserved groups experience worse health outcomes. For dually eligible individuals, who are more likely to be from a racial or ethnic minority group and are more likely to have a disability than Medicare-only beneficiaries, the pandemic had a disproportionate impact. There were about twice as many COVID-19 cases and hospitalizations among dually eligible individuals as there were among Medicare-only beneficiaries (see above, "About Dually Eligible Individuals").

In 2020, 48 percent of dually eligible individuals were from a racial or ethnic minority group, a

proportion that has increased seven percentage points since 2006. In comparison, in 2020, 22 percent of Medicare-only beneficiaries were from racial and ethnic minority groups, a five percentage-point increase since 2006. Racial and ethnic minorities are more likely to have worse health outcomes, limited access to care, and lower quality of care than non-minorities. Black, Hispanic, Asian Pacific Islander, and American Indian and Alaska Native Medicare beneficiaries have a higher prevalence of chronic conditions like high blood pressure, diabetes, kidney disease, and heart failure than white Medicare benefi iaries.[29] These racial and ethnic groups are overrepresented among dually eligible individuals. For example, in 2020, 21 percent of dually eligible individuals were Black compared to about eight percent of all Medicare benefi iaries. [30] About 18 percent of dually eligible individuals are Hispanic, compared to only about three percent of all Medicare beneficiaries.[31]

Dually eligible individuals are more likely than Medicare-only beneficiaries to have a disability.[32] Individuals with disabilities also experience disparities: they have worse health and less access to mental health care services than people who do not have a disability. Women with disabilities are less likely to receive preventive services like breast and cervical cancer screenings and more likely to develop cancer and be diagnosed at a later stage than women without disabilities.[33] Dually eligible individuals also have a higher prevalence of chronic

conditions, like diabetes, than Medicare-only beneficiaries.[34]

Dually eligible individuals often experience worse outcomes than non-dually eligible beneficiaries.[35] For example, among beneficiaries enrolled in the Medicare Advantage program in 2018, those who were dually eligible or eligible for the Part D Low-Income Subsidy had worse outcomes on more than half of Healthcare Effectiveness Data and Information Set clinical care measures. These measures included key diabetes care and behavioral health outcomes, such as follow-up after a hospitalization for mental illness.[36]

The work we do advances health equity by expanding and improving access to seamless, high quality health care for dually eligible individuals.

In FY 2021 and beyond, we are particularly focused on reducing disparities for dually eligible individuals in COVID-19 hospitalizations and vaccinations, influenza vaccinations, and diabetes outcomes.

COVID-19 Pandemic Response

As our pandemic response evolved, we worked to gather best practices and lessons learned, particularly on promoting vaccinations, data sharing, and combatting social isolation.

- **Promoting COVID-19 Vaccinations.** In the Financial Alignment Initiative, Medicare-Medicaid Plans (MMPs) conducted outreach to prioritize vaccinations for members with the highest level of needs, including those with chronic conditions and disabilities and those who are homebound. Through our contractor, Resources for Integrated Care, we created a COVID-19 vaccination blog[37] to disseminate promising practices shared by health plans and other experts. It features efforts by providers and health plans to connect hard-to-reach individuals with COVID-19 vaccination by addressing barriers such as complex healthcare issues, chronic conditions, and unmet social risk factors.

- **Promoting Influenza Vaccinations.** During the 2020-2021 flu season, CMS worked with the ten states and our MMP partners participating in the Financial Alignment Initiative to mail postcards directly to more than 440,000 beneficiaries reminding them to get their flu vaccination. The postcards were translated into 18 languages to reach beneficiaries in the primary language they speak at home. We also hosted a webinar, *Promising Practices for Promoting Flu Vaccinations for Dually Eligible Beneficiaries During COVID-19*, to an audience of more than 1,000 live attendees, including individuals from health plans and community-based organizations that provide care coordination and support to low-income Medicare beneficiaries. The webinar highlighted how health plans can play a key role in facilitating access to, and educating members on, the importance of annual flu vaccinations, featuring a panel discussion of health plans sharing promising practices for promoting flu vaccinations and how to adapt these strategies during the COVID-19 pandemic.

- **Data sharing to facilitate care coordination.** On August 9, 2021, CMS launched the Medicare COVID-19 Vaccination Data for Medicaid MCOs pilot.[38] Through this pilot, CMS is supporting equitable vaccinations by enabling Medicaid MCOs to request data to facilitate increased care coordination and additional services, such as transportation or in-home vaccination, to dually eligible individuals during the COVID-19 public health emergency. Eighteen selected Medicaid MCOs will have the opportunity to request certain dually eligible individuals' Medicare COVID-19 vaccination claims data on a weekly basis.

- **Combating social isolation.** Through contract management teams in the Financial Alignment Initiative, we shared MMP best practices for combatting social isolation during the pandemic, particularly for dually eligible individuals residing in nursing facilities. For example, some MMPs provided tablets to their members residing in nursing facilities to connect them to telehealth appointments as well as to family members; some MMPs conducted "window visits" with care coordinators to assess member needs.

Reducing Disparities in Health Outcomes Among Dually Eligible Individuals with Diabetes

Dually eligible individuals have a higher prevalence of diabetes than Medicare-only beneficiaries.[39] Individuals with diabetes are also at increased risk of severe illness and poor outcomes from COVID-19.[40] Given the levels of diabetes-related morbidity among dually eligible individuals, CMS is working to improve diabetes outcomes and reduce the disparities in those outcomes between dually eligible individuals and their Medicare-only peers.

- **Incentivizing health plans to support diabetes care management.** As part of the Financial Alignment Initiative demonstrations, CMS is withholding one percent of the Medicare parts A and B capitation rate paid to MMPs in Ohio and South Carolina contingent on improvements in the percent of enrollees with diabetes who had an A1C lab test during the year that showed their average blood sugar is under control. MMPs have an opportunity to earn back this one percent Medicare rate withhold by meeting a quality benchmark or closing the gap between their prior year performance and the benchmark by at least 33 percent.

- **Dually eligible individuals' experiences with diabetes care.** In late 2020 and early 2021, CMS conducted telephone interviews with enrollees in Ohio's five MMPs who have a primary or secondary diabetes diagnosis. Beneficiaries shared their perspective on effective diabetes management strategies, ways to improve access to healthy food and exercise support, and suggested additional benefits that could potentially enhance personal engagement in diabetes control. CMS shared these findings with the Ohio MMPs, and lessons learned enabled the MMPs to better understand and meet members' diabetes management needs.

  In May 2021, we hosted a webinar for 750 providers and health plan staff about diabetes care management during the COVID-19 pandemic. The webinar focused on clinical management and self-management education and support, including the use of telehealth, in diabetes management and strategies for connecting people with diabetes to resources like housing, food, medications and diabetes management supplies.

PROMOTING INTEGRATED CARE

Medicare and Medicaid were originally created as distinct programs with different purposes and have operated as separate systems despite a growing number of people who depend on both programs for their health care needs. This lack of coordination can lead to fragmented care for dually eligible individuals, misaligned incentives for payers and providers, and administrative inefficiencies and programmatic burdens for all.

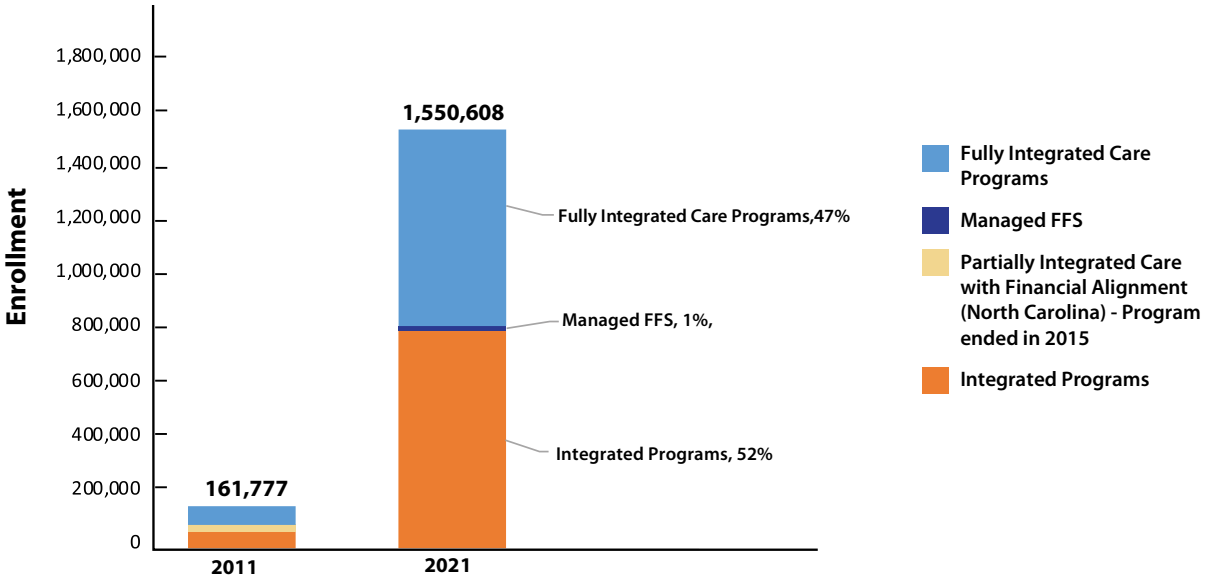
Integrated care leads to delivery system and financing approaches that maximize Medicare-Medicaid care coordination and mitigate cost-shifting incentives, including total-cost-of-care accountability across Medicare and Medicaid. Most importantly, it means a seamless experience for beneficiaries. Integrated care includes enrollment in Programs of All-Inclusive Care for the Elderly (PACE); Financial Alignment Initiative demonstrations; and managed care arrangements where the same organization covers both Medicare and Medicaid services. In 2021, about 18 percent of full-benefit dually eligible individuals were enrolled in integrated care.[41] We are working to increase this percentage in a variety of ways, including through existing and new platforms for integration.

In recent years, we have partnered with states to develop innovative, integrated care and financing models.[42] We have focused on initiatives to better integrate and strengthen access to care for dually eligible individuals and to eliminate unnecessary cost shifting between the Medicare and Medicaid programs.

There are a range of approaches to integrating Medicare and Medicaid benefits and/or fi ancing, including through new demonstrations and existing programs. Overall, the number of dually eligible individuals in integrated care and/or financing models has increased over time. Figure 2 summarizes the increase by program type between 2011 and 2021.

Figure 2. Total Integrated Care Enrollment by Program Type: 2011 and 2021[43] [44]

*See end note for a description of different types of integrated care initiatives in 2021.



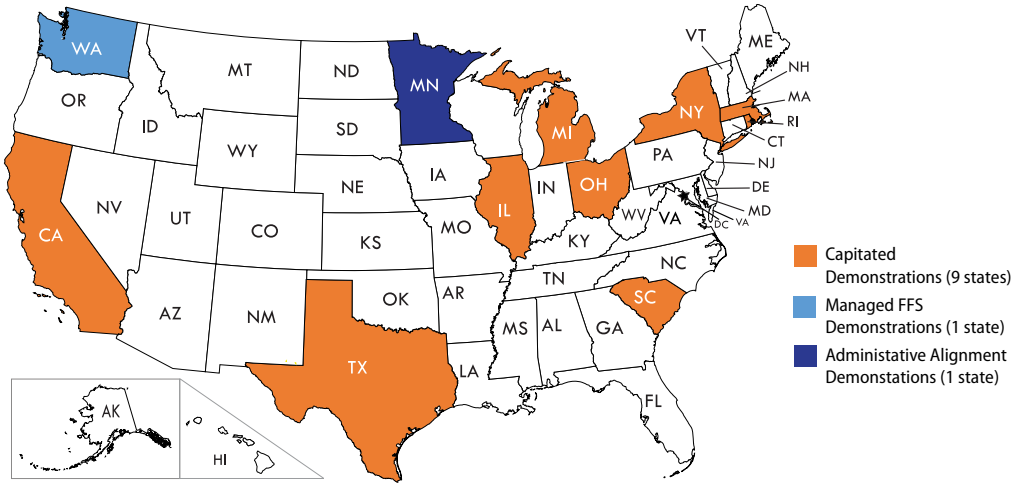
- **Medicare-Medicaid Financial Alignment Initiative.**[45] In 2021, the demonstrations under the Medicare-Medicaid Financial Alignment Initiative (the Financial Alignment Initiative) accounted for 27 percent of integrated care enrollment nationally. Through the Financial Alignment Initiative and related work, we are partnering with states to test demonstrations that integrate primary, acute, and behavioral health care, and long-term services and supports for dually eligible individuals. As of October 2021, there were 10 demonstrations in 10 states[46] serving more than 400,000 dually eligible individuals.[47] We are also partnering with Minnesota on an alternative model testing Medicare and Medicaid administrative alignment activities, building on the longstanding Minnesota Senior Health Options program, and serving over 41,000 dually eligible individuals as of July 2021.[48]

  In 2021, we effectuated extensions in the capitated model demonstrations under the Financial Alignment Initiative operating in Illinois, Michigan, South Carolina, and Massachusetts. In Illinois, the capitated model demonstration's

extension through 2023 also expanded the demonstration service area to include 81 new counties, making it statewide and allowing about 60,000 more beneficiaries the opportunity to enroll in an integrated product.

We continue to welcome state interest in exploring innovative approaches to better serve dually eligible individuals that work best for their populations.

Figure 3. Demonstrations under the Financial Alignment Initiative, 2021



- **Programs of All-Inclusive Care for the Elderly (PACE).** On January 19, 2021, CMS finalized regulatory changes to improve federal oversight and reduce administrative burden for PACE organizations, including changes to simplify service delivery request approvals and improve the participant appeals process.[49] This followed a rule[50] finalized in 2019 that updated and modernized the PACE program by strengthening protections and improving care for PACE participants, and providing administrative flexibility for PACE organizations. The majority of PACE participants are dually eligible individuals. As of July 2021, about 55,000 older adults were enrolled in 140 PACE organizations in 30 states,[51] and enrollment in PACE has increased by more than 130 percent since 2011.[52]

- **Dual Eligible Special Needs Plans (D-SNPs).** In 2020, CMS worked with states to implement the new D-SNP minimum integration requirements and unified appeals and grievance procedures established through the Bipartisan Budget Act of 2018 (Public Law No. 115-123).[53] As a result of this work, 37 states have established new processes for their contracted D-SNPs to notify the state (or state designees) when a targeted group of high-risk enrollees are hospitalized or enters a skilled nursing facility. States are using these processes to improve care coordination and care transitions for a range of high-risk dually eligible individuals, including individuals with behavioral health diagnoses and individuals receiving home- and community-based waiver services. For the 2022 plan year, 21 states are also using the new D-SNP contracting requirements to integrate the provision of Medicaid services, including behavioral health and long-term services and supports.

  In addition, the number of D-SNPs with exclusively aligned enrollment—in which all D-SNP members are in an affi iated Medicaid managed care organization—increased from 92 to 104 between the 2021 and 2022 plan years.[54]

  The 2021 Medicare Advantage and Part D final rule limits D-SNP "look-alikes" beginning in 2022. These D-SNP look-alikes have similar levels of enrollment of dually eligible individuals as D-SNPs but avoid the federal regulatory and state contracting requirements applicable to D-SNPs. Limiting D-SNP look-alikes will allow CMS and states to more meaningfully implement existing and new statutory

requirements from the Bipartisan Budget Act of 2018 to increase integration of D-SNPs.[55] For January 1, 2022, we approved the transition of approximately 60,000 beneficiaries from 15 D-SNP look-alike plans offered by five different parent organizations. These 15 D-SNPs are located in six different states: AR, CA, FL, LA, NV, and UT. More than 95 percent of beneficiaries in these 15 D-SNP look-alike plans are moving to D-SNPs in 2022. All transitions for enrollees in look-alike plans will be finalized in late 2022 for a January 1, 2023 effective date.

In 2021, CMS developed a notice of proposed rulemaking (NPRM) to further improve integration of Medicare and Medicaid programs for dually eligible individuals enrolled in D-SNPs. The provisions of the NPRM build on the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), Bipartisan Budget Act of 2018, experience administering the MA and Part D programs, and experiences with the Financial Alignment Initiative to better align and integrate benefits for dually eligible individuals. In the NPRM, we propose requirements for enrollee participation in D-SNP governance, standardized questions about housing, food insecurity, and transportation in all special needs plan health risk assessments, and new pathways toward greater transparency and accountability for D-SNPs. CMS published this NPRM in January 2022.[56]

- **Supplemental Benefits.** In May 2021, CMS released a frequently asked questions document[57] to help states and Medicare Advantage organizations better coordinate Medicaid benefits and Medicare supplemental benefi s, especially those offered through D-SNPs.

IMPROVING HEALTH OUTCOMES

The demonstrations and other initiatives described in this report aim to improve quality and beneficiary experience for dually eligible individuals while achieving cost savings. We have seen some promising results, including:

- **Lower hospitalization rate in Medicare fee-for-service.** CMS is engaged in numerous initiatives to lower hospital admissions and readmissions. We are measuring the 30-day all-cause hospital readmissions rate for dually eligible individuals in Medicare fee-for-service as an outcome of better coordinated care and quality of care. Fee-for-service hospital readmissions for dually eligible individuals have declined by almost nine percent from 2012 to 2019.[58]
- **Improved beneficiary experience in integrated managed care.** Over time, an increasing proportion of beneficiaries enrolled in health plans in capitated model demonstrations under the Financial Alignment Initiative have rated their health plans a 9 or 10 (with 10 being the best). In 2021, 68 percent of all demonstration survey respondents rated their health plan a 9 or 10.[59] We have also seen increasing access to care coordination within the capitated model demonstrations, including a 37 percent increase in health risk assessment completion and a 79 percent increase in care plan completion from 2014 to 2020.[60]
- **Medicare savings in Washington Health Home demonstration.** An independent evaluation of the Washington state demonstration under the Financial Alignment Initiative found that the initiative has achieved $293 million in gross Medicare Parts A and B savings over the first six demonstration years, relative to a comparison group.[61]

Recommendations for Legislative Action

This year's report does not include legislative recommendations. As MMCO continues this work in collaboration with state and federal partners, beneficiaries, advocates, and providers, we will continue to identify areas where regulatory or legislative changes would improve outcomes for Medicare-Medicaid enrollees. In doing so, MMCO will make advancing health equity and supporting underserved communities a priority, ensuring our programs and policies deliver benefits equitably to all dually eligible individuals.

We look forward to continuing to work with the Congress to promote quality, coordinated care for all dually eligible individuals.

Endnotes

1 Section 2602 of the Patient Protection and Affordable Care Act (P.L. 111-148) codified at 42 U.S.C. 1315b.

2 CMS Analysis. 12.5 million individuals were concurrently enrolled in Medicare and Medicaid as of 2020.

3 Cost-sharing includes Medicare Part A and B deductibles, copayments, and coinsurance.

4 CMS Analysis.

5 https://www.medpac.gov/document-type/data-book/

6 https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf.

7 https://aspe.hhs.gov/system/files/pdf/263676/Social-Risk-in-Medicare%E2%80%99s-VBP-2nd-Report-Executive-Summary.pdf.

8 https://www.macpac.gov/wp-content/uploads/2022/02/Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-February-2022.pdf

9 CMS Analysis.

10 https://www.cms.gov/files/document/paving-way-equity-cms-omh-progress-report.pdf

11 Note: These CMS data include Medicare claims and encounter data covering the period between January 1 and November 20, 2021, received through December 17, 2021. They may be considered preliminary, given lags in claims and encounter data submission.

12 https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf.

13 For example, see: Anderson, W. L., Long, S. K., & Feng, Z. (2020). Effects of integrating care for Medicare-Medicaid dually eligible seniors in Minnesota. Journal of Aging and Social Policy, 32(1), 31-54. https://doi.org/10.1080/08959420.2018.1485396.

14 https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2018.pdf.

15 https://www.macpac.gov/wp-content/uploads/2017/08/Medicare-Savings-Programs-New-Estimates-Continue-to-Show-Many-Eligible-Individuals-Not-Enrolled.pdf.

16 https://aspe.hhs.gov/basic-report/loss-medicare-medicaid-dual-eligible-status-frequency-contributing-factors-and-implications#results.

17 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts

18 https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NationalProfile_2012.pdf

19 https://www.medpac.gov/document/july-2021-data-book-section-4-dual-eligible-beneficiaries/

20 https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf

21 https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf

22 https://www.hsd.state.nm.us/2021/07/12/hsd-makes-it-easier-for-low-income-seniors-to-afford-medicare/

23 Integrated Care Resource Center E-Alert, "Integrated Care Updates – November 2021." Dec 3, 2021. https://www.integratedcareresourcecenter.com/about-us/e-alerts

24 The revised manual and POMs updates are available at the following links: State Payment of Medicare Premiums | CMS; SSA - POMS: HI 00815.021 - The End of State Payment of Medicare Premiums Under a Buy-in Agreement - 10/12/2021

25 https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf.

26 https://www.macpac.gov/publication/state-medicaid-payment-policies-for-medicare-cost-sharing/

27 https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and

28 See, for example, a tip sheet for states at https://www.cms.gov/files/document/statebuyinfileaccretionrejectionstipsheet.pdf.

29 https://www.cms.gov/files/document/paving-way-equity-cms-omh-progress-report.pdf

30 This includes Medicare beneficiaries enrolled in both FFS and Medicare Advantage.

31 https://www2.ccwdata.org/documents/10280/19099067/a1-medicare-enrollment-current-year-by-racial-group.jpg

32 https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2018.pdf

33 https://www.cms.gov/files/document/paving-way-equity-cms-omh-progress-report.pdf

34 https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/March-2017-Data-Highlight.pdf

35 https://www.aspe.hhs.gov/sites/default/files/migrated_legacy_files//195046/Social-Risk-in-Medicare%E2%80%99s-VBP-2nd-Report-Executive-Summary.pdf?_ga=2.191585635.855588658.1638472723-407190903.1638306094

36 https://www.cms.gov/files/document/2021-delis-national-disparities-stratifi d-report.pdf

37 https://www.resourcesforintegratedcare.com/ric-covid-19-vaccination-blog/

38 https://www.cms.gov/files/document/mcocovidvaxpilotsolicitation.pdf.

39 https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/March-2017-Data-Highlight.pdf

40 https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

41 CMS analysis. Data on number of full-benefit duals: https://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf. Count of duals in integrated care from Integrated Care Resource Center analysis.

42 For more information, see MMCO's Financial Alignment Initiative homepage: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.

43 Source: analysis performed by the Integrated Care Resource Center, under contract with CMS. "Fully Integrated Programs/Models" include enrollment in Programs of All-Inclusive Care for the Elderly (PACE); Capitated Financial Alignment Initiative demonstrations; and all Fully Integrated Dual-Eligible Special Needs Plans (FIDE SNPs), both Applicable Integrated Plan (AIP) FIDE SNPs and non-AIP

FIDE SNPs through July 2021. "Managed FFS" includes enrollment in the Washington Managed Fee-For-Service demonstration under the Medicare-Medicaid Financial Alignment Initiative with data through July 2021. "Integrated SNP Program" includes non-FIDE D-SNP enrollees who are also enrolled in affiliated Medicaid managed care plans that cover (generally) substantial behavioral health services or long-term services and supports or both. In 2021, this category included AIP HIDE SNP enrollment, other aligned HIDE SNP enrollment, and aligned enrollment in select Coordination-Only (CO) D-SNPs that are aligned with affiliated Medicaid managed care plans in certain states. "Partially Integrated Care with Financial Alignment" refers to the North Carolina Medicare Health Care Quality Demonstration, for which no 2021 information is included because the initiative ended in 2015.

44 Every year, we improve methodology for this census. The change from 2020 to 2021 includes new details attributable to our review of SMACs associated with implementing the BBA of 2018. About 75 percent of the increase in aligned enrollment comes from states where HIDE SNP data was previously uncounted.

45 For additional information about the Medicare-Medicaid Financial Alignment Initiative, see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

46 CA, IL, MA, MI, NY (FIDA-IDD), OH, RI, SC, TX, WA.

47 CMS Monthly Enrollment by Contract. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract

48 CMS is also continuing to work with some states to pursue demonstrations designed to improve care for Medicare-Medicaid enrollees outside the two models of the Financial Alignment Initiative. The Minnesota demonstration involves a set of administrative improvements to simplify the process for beneficiaries to access the services for which they are eligible under Medicare and Medicaid, focusing on ways to improve the beneficiary experience in health plans that maintain separate contracts with CMS (as D-SNPs) and with the state. http://www.cms.gov/Medicare-Medicaid-CoordiNation/Medicare-and-Medicaid-CoordiNation/Medicare-Medicaid-CoordiNation-Offi e/FinancialAlignmentInitiative/Minnesota.html.

49 https://www.federalregister.gov/documents/2021/01/19/2021-00538/medicare-and-medicaid-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare.

50 https://www.federalregister.gov/documents/2019/06/03/2019-11087/medicare-and-medicaid-programs-programs-of-all-inclusive-care-for-the-elderly-pace.

51 https://www.npaonline.org/sites/default/files/PDFs/5033_pace_infographic_update_july2021.pdf.

52 CMS analysis based on comparison of PACE enrollment as of November 2021 and November 2011. Source: CMS Monthly Enrollment by Contract Report, available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract.

53 We codified the Bipartisan Budget Act of 2018 provisions in the 2020 Medicare Advantage and Part D final rule, published in April 2019, at https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

54 See integration status for 2022 at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Offi e/D-SNPs

55 https://www.cms.gov/newsroom/fact-sheets/contract-year-2021-medicare-advantage-and-part-d-final-rule-cms-4190-f1-fact-sheet.

56 https://www.federalregister.gov/documents/2022/01/12/2022-00117/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

57 https://www.cms.gov/files/document/dsnpmedicaremedicaidcoordbenefitsfaqs.pdf

58 CMS analysis using data from the CMS Geographic Variation Database (Foundation of the Chronic Conditions Warehouse).

59 2021 CAHPS Survey Results. In all MMP contracts nationally, 68% of survey respondents rated their health plan a 9 or 10 on a scale of 0 to 10.

60 CMS analysis.

61 https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalReport3.pdf. We expect revised numbers to be available shortly to refl ct updates in the beneficiaries that the evaluation considers to be eligible for the demonstration, and adjustments to the evaluation methodology.