MEDICARE-MEDICAID COORDINATION OFFICE

FY 2018

Report to Congress

INTRODUCTION

The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office, hereinafter MMCO) was established by statute 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). MMCO is submitting its annual report to Congress.

The Medicare and Medicaid programs were originally created as distinct programs with different purposes. Not surprisingly, the programs have different rules for eligibility, covered benefits, and payment, and the programs have operated as separate and distinct systems despite a growing number of people who depend on both programs 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 providers, health plans, and states.

Efforts by MMCO and numerous partners in the public and private sectors have changed the Medicare and Medicaid care delivery and payment environments significantly, both within the Centers for Medicare & Medicaid Services (CMS) and more broadly. With more than 59 million individuals covered by Medicare and more than 75 million individuals covered by Medicaid in 2018, we are focused on integrated service delivery as a means toward improving quality, beneficiary-centered care, bending the health care cost curve, and using data to inform the design and continuous improvement of new initiatives.[1]

In this report, we discuss some of the ways in which we have carried out activities to better serve dually eligible individuals in 2018, including:

- implementing key changes to reduce improper billing of Qualified Medicare Beneficiaries;
- creating new opportunities for innovative, integrated care and streamlined processes for sharing Medicare data with states;
- supporting beneficiary choices and protections through enrollment options counseling and ombuds programs; and
- improving beneficiary outcomes, including major reductions in hospital readmissions for dually eligible individuals.

This year marked additional opportunity and responsibility for MMCO, as the Bipartisan Budget Act (BBA) of 2018 (Public Law No. 115-123), signed into law on February 9, 2018, established our Office as a "dedicated point of contact" for states to address misalignments between Medicare and Medicaid, and promote integration of dual eligible special needs plans (D-SNPs) and Medicaid.

Section 50311 of the BBA of 2018 also amends section 1859(f) of the Act to require the Department of Health and Human Services (HHS) to establish procedures, to the extent feasible as determined by the Secretary, unifying the Medicare and Medicaid grievances and appeals procedures for D-SNPs by 2021. A proposed rule for establishing such integrated procedures was published in the Federal Register on November 1, 2018 (83 Fed. Reg. 54,982). This requirement implements a recommendation in prior MMCO Reports to Congress to provide HHS with the authority to streamline the appeals communication requirements imposed on health plans that integrate payment and services for dually eligible individuals.

This report contains four legislative recommendations, which were also proposed in the President's Fiscal Year (FY) 2020 Budget. As we continue our work in collaboration with state and federal partners, and with beneficiaries and their caregivers, advocates, providers, and other stakeholders, we will continue to identify areas where regulatory or legislative changes are needed to improve care coordination and benefits.

ABOUT DUALLY ELIGIBLE INDIVIDUALS

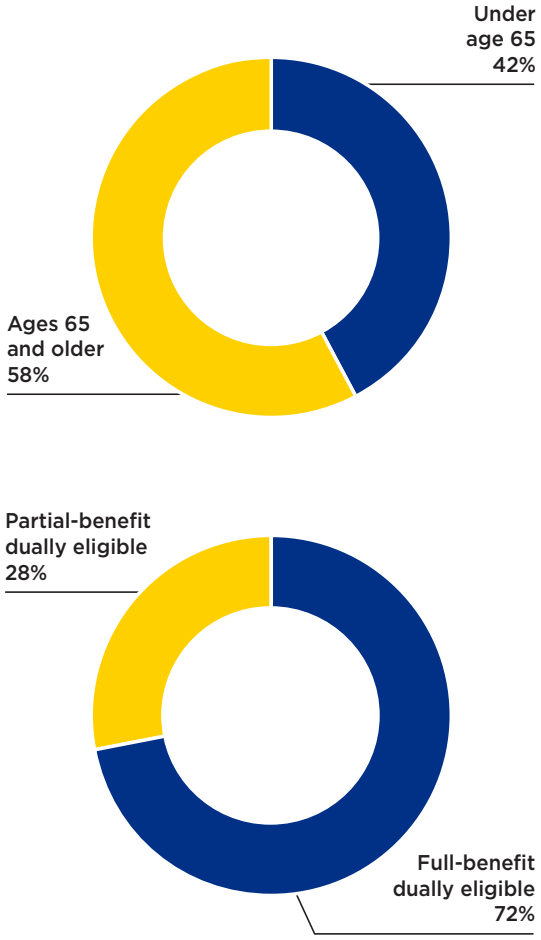
During 2017, 12.0 million Americans[2] were concurrently enrolled in both the Medicare and Medicaid programs. These individuals must navigate two separate programs: Medicare for the coverage of most preventive, primary, and acute health care services and drugs, and Medicaid for coverage of long-term services and supports, certain behavioral health services, and for help with Medicare premiums and cost sharing.

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, 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 cost sharing.

Overall, dually eligible individuals have a higher prevalence of many health conditions than their Medicare-only and Medicaid-only peers. In December 2016, the HHS Office of the Assistant Secretary for Planning and Evaluation 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 eligible status was the most powerful predictor of poor outcomes.[3] Historically, dually eligible individuals accounted for 20 percent of all Medicare enrollees, but 34 percent of the costs; similarly, they accounted for 15 percent of all Medicaid enrollees, but 33 percent of the costs.[4]

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. For example, state investments in Medicaid services to improve care for dually

Dually Eligible Individuals by Age and Type of Benefit

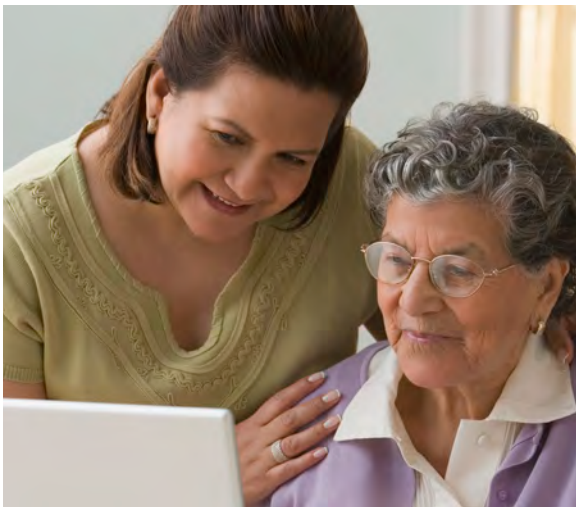


eligible beneficiaries (e.g., enhanced behavioral health or long-term services and supports (LTSS)) may result in savings that accrue to Medicare from lower acute care utilization. Historically, states have needed to shoulder the burden of such investments without sharing in the acute care savings. Dually eligible individuals could benefit from more integrated systems of care 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.

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

- **70% of dually eligible individuals have 3 or more chronic conditions (vs. 52% of Medicare-only beneficiaries)[4]**
- **41% have at least one mental health diagnosis (vs. 16% of Medicare-only beneficiaries)[4]**
- **40% are eligible for Medicare due to disability (vs. 8% of Medicare-only beneficiaries)[5]**

RECOMMENDATIONS FOR LEGISLATIVE ACTION



We recommend the following items for legislative actions that were proposed in the President's FY 2020 Budget[6]:

- **Permanently authorize a successful pilot on retroactive Medicare Part D coverage for low-income beneficiaries.**

  Under current law[7], low-income beneficiaries are assigned at random to a qualifying Part D plan, which is reimbursed based on the standard Part D prospective payment, regardless of their utilization of Part D services during this period. Under the demonstration, the plan is paid using an alternative methodology whereby payments are closer to actual costs incurred by beneficiaries during this period. The current demonstration, which runs through 2019, has

shown the proposed approach to both save money and be less disruptive to beneficiaries. This recommendation is intended to permanently authorize a current demonstration that allows CMS to contract with a single plan to provide Part D coverage to low-income beneficiaries while their Part D eligibility is processed. This plan serves as the single point of contact for beneficiaries seeking reimbursement for retroactive claims.

- **Allow CMS flexibility to determine the frequency of Programs of All-inclusive Care for the Elderly (PACE) program reviews.**

  This legislative proposal would give the Secretary of Health and Human Services the authority to conduct one comprehensive review of a new PACE organization during the first year of the three-year trial period instead of requiring the Secretary to conduct a review each year during the trial period, if the first year audit does not reveal significant noncompliance. Recognizing that some PACE organizations could benefit from additional oversight in the trial period, this legislative proposal would also amend the statute in order to give CMS the ability to conduct continuing reviews in any year following the first year of operation.

- **Clarify the Part D Special Enrollment Period (SEP) for dually eligible individuals.**

  Under current law[8], CMS is required to maintain a Special Enrollment Period (SEP) for full-benefit dually eligible beneficiaries. This recommendation would narrow, beginning in plan year 2020, the applicability of the SEP by specifying that the intent is to promote integration of Medicare and Medicaid coverage and to allow individuals to make alternative choices following auto-assignment into a Part D plan. The SEP would be limited to either a change of plan following auto-assignment into a Part D plan or enrollment into a health plan or other program (such as PACE) that integrates Medicare and Medicaid coverage. This recommendation is intended to allow CMS to apply the same annual election process for both dually eligible and non-dually eligible beneficiaries, but preserve the ability for dually eligible beneficiaries to use an SEP to opt into integrated care programs or to change plans following auto-assignment. Efficient use of the Part D SEP for full-benefit dual eligible beneficiaries reduces aggressive

marketing targeted to low-income beneficiaries, improves incentives to make investments in and provide care coordination for high-cost, often vulnerable beneficiaries, and reduces the administrative burden on health plans from beneficiary fluctuations between plans numerous times throughout the year.

- **Allow for federal/state coordinated review of Dual Eligible Special Needs Plan (D-SNP) marketing materials.**

  Under current law[9], marketing materials provided by D-SNPs to beneficiaries have to go through separate state and CMS review processes. This recommendation would allow for joint state and CMS review, building on CMS' experience with joint review conducted under current demonstration authority under the Medicare-Medicaid Financial Alignment Initiative and the Minnesota demonstration testing Medicare and Medicaid administrative alignment activities. The recommendation is intended to lower administrative burden on participating plans and enhance plans' ability to provide a uniform message to beneficiaries.

WHAT WE ARE DOING

REDUCING IMPROPER BILLING OF QUALIFIED MEDICARE BENEFICIARIES (QMBs)

The QMB program is a Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost sharing, including deductibles, coinsurance, and copayments. The federal government pays a share of these expenditures according to each state's Federal Medical Assistance Percentage.

By law, Medicare providers may not bill QMBs for Medicare Parts A and B cost sharing amounts. Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state's Medicare cost sharing payments. Nonetheless, improper billing and confusion about the QMB billing requirements among providers and beneficiaries persists. Feedback from Medicare providers and associations indicates that providers face barriers in identifying the QMB status of their patients. Internal CMS analysis found that our Medicare eligibility information sent to providers and notices issued to beneficiaries and providers after fee-for-service claims could be enhanced to indicate when an individual is a QMB and cannot be billed for Medicare cost sharing.

During FY 2018, we implemented key changes to address information gaps and empower beneficiaries, providers, and suppliers with information that we believe will better facilitate provider and supplier adherence to QMB billing requirements and better inform beneficiaries of their obligations and beneficiary protections:

- We are helping Medicare providers and suppliers better identify QMBs before they submit claims.
- When the claim is paid, we are notifying providers and suppliers not to bill the beneficiary.
- We are giving beneficiaries more accurate individualized information about their cost sharing liability and protections through the Medicare Summary Notice, the summary of claims we send to beneficiaries each quarter.

CREATING NEW OPPORTUNITIES FOR INNOVATIVE, INTEGRATED CARE

In recent years, we have partnered with states to develop innovative, integrated care and financing models. 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 financing, 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 1 summarizes the increase by program type in 2011 and 2018.

- **Medicare-Medicaid Financial Alignment Initiative.**[11]

  In 2018, the demonstrations under the Medicare-Medicaid Financial Alignment Initiative (the Financial Alignment Initiative) accounted for about half 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 September 1, 2018, there were 11 demonstrations in 10 states, serving over 400,000 dually eligible individuals.[12] We are also partnering with Minnesota to implement an alternative model testing Medicare and Medicaid administrative alignment activities, building on the longstanding Minnesota Senior Health Options program, and serving nearly 40,000 dually eligible individuals as of September 1, 2018.[13]

- **Dual Eligible Special Needs Plans (D-SNPs).**

  D-SNPs are specialized Medicare Advantage plans that exclusively serve dually eligible individuals. Several states have built integrated care programs by coupling Medicaid managed care organizations with D-SNPs.[14] These arrangements account for more than one third of integrated care enrollment in 2018. Additionally, in 2018 the BBA made D-SNPs a permanent feature of the Medicare program and created new possibilities to improve experiences for dually eligible individuals.

FIGURE 1

Total Integrated Care Enrollment by Program Type: 2011 and 2018[10]

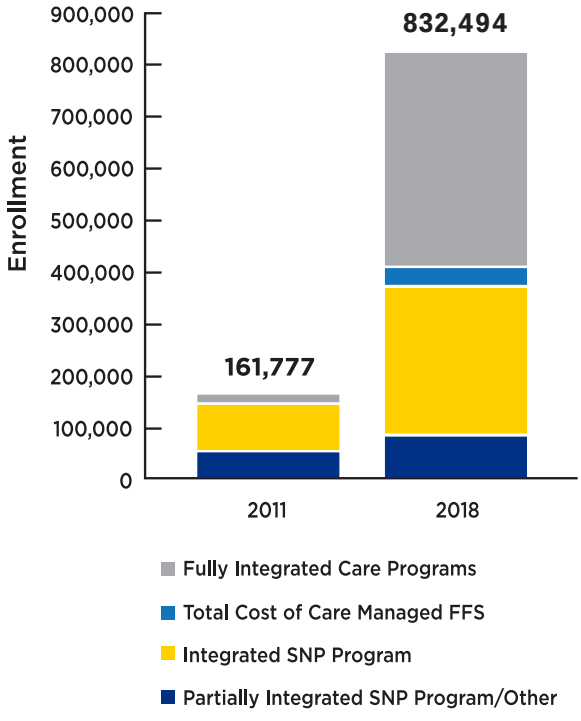
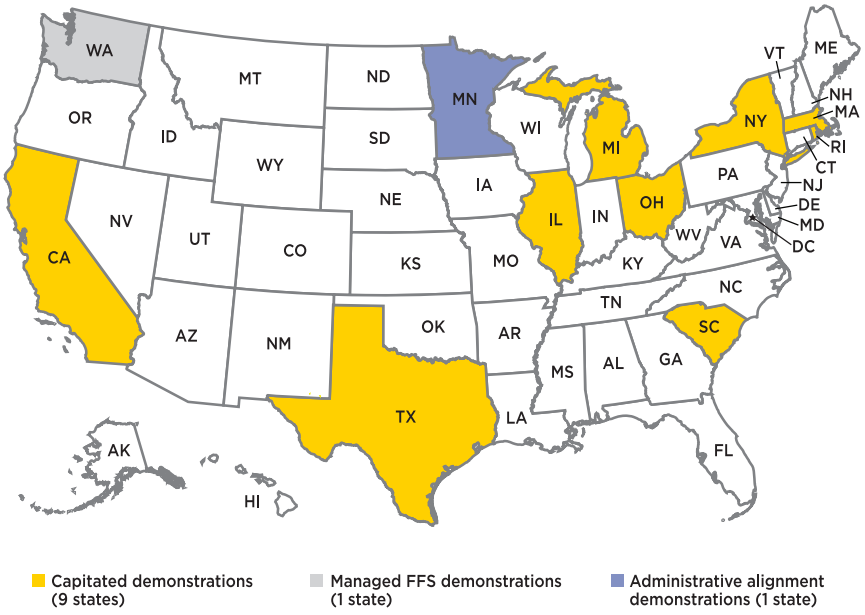


FIGURE 2

Demonstrations Under the Financial Alignment Initiative, 2018



- **Initiative to reduce avoidable hospitalizations among Nursing Facility Residents (NFI).**[15]

  Unnecessary hospitalizations can be disruptive and dangerous for nursing facility residents and costly for Medicare. Through NFI, we are testing strategies to reduce avoidable hospitalizations for Medicare and Medicaid enrollees who are long-stay residents of nursing facilities.

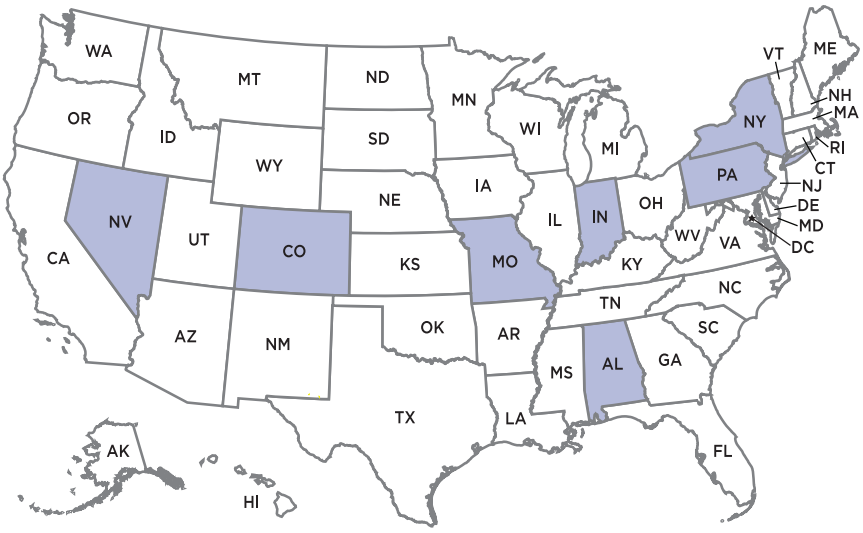
- **Data sharing with states.**[16]

  State efforts to better serve dually eligible individuals through innovative, integrated models require access to both Medicare and Medicaid data. Lack of access to Medicare data or the capacity to link Medicare and Medicaid data for individual beneficiaries can make it difficult to coordinate all Medicare and Medicaid services. In 2018, we have taken steps to unlock these important data and reduce the administrative burdens associated with obtaining them from CMS.[17] Twenty-nine Medicaid agencies currently receive Medicare data for the purposes of coordinating care for dually eligible individuals.

We have heard from states that they want opportunities to develop, revise, or continue the approaches to serving dually eligible individuals that work best for their populations.

FIGURE 3

Initiative to Reduce Avoidable Hospitalizations for Nursing Facility Residents, Participating Facility Locations, 2018



On December 19, 2018, we released a State Medicaid Director Letter[18] outlining opportunities — none of which require demonstrations or Medicare waivers — to better serve individuals dually eligible for Medicare and Medicaid, including through new developments in managed care, using Medicare data to inform care coordination and program integrity initiatives, and reducing administrative burden for dually eligible individuals and the providers who serve them. A number of these opportunities are newly available to states through CMS burden reduction efforts or Medicare rulemaking, including opportunities for states to increase enrollment in integrated D-SNPs by permitting the use of default enrollment of newly Medicare-eligible dually eligible individuals. Through default enrollment, Medicaid beneficiaries in capitated managed care — and who remain in Medicaid managed care upon newly gaining Medicare eligibility — may automatically enroll into a D-SNP affiliated with the individuals' Medicaid managed care.

SUPPORTING DUALLY ELIGIBLE INDIVIDUAL CHOICES AND PROTECTIONS

Through two separate-but-related programs for states participating in the Financial Alignment Initiative, we are providing support to assist beneficiaries with making enrollment decisions and with resolving care delivery or other concerns that may arise:

- **Support for Ombudsman Services.**

  We require states participating in the Financial Alignment Initiative to have dedicated ombudsman support. Ombudsman programs provide beneficiaries eligible for a demonstration under the Financial Alignment Initiative with person-centered assistance to resolve problems. Ombudsman programs also inform states, health plans, CMS, and other stakeholders regarding trends and identify areas for improvement within the demonstrations.

- **Support for State Health Insurance Counseling and Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs).**

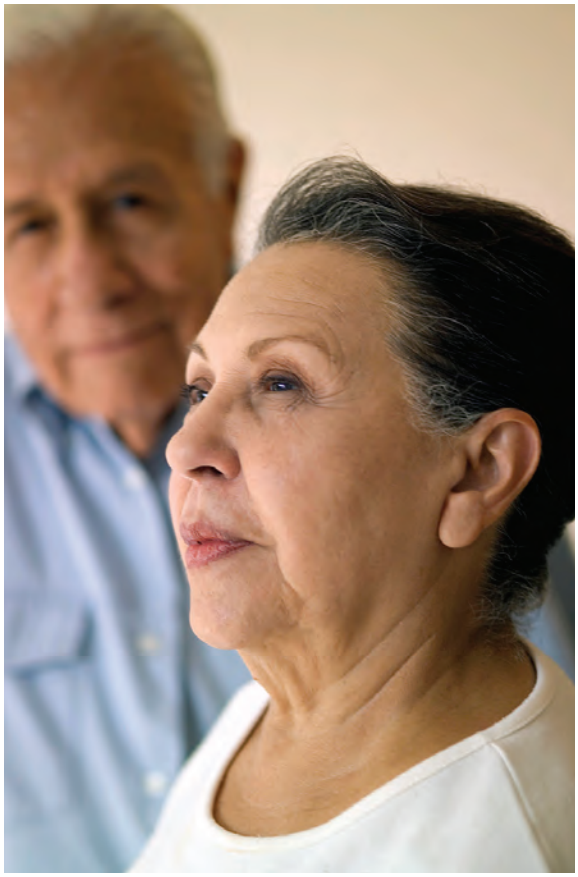
  One-on-one counseling programs, such as SHIPs and ADRCs, conduct outreach and provide education and assistance to beneficiaries regarding their insurance options. In states with demonstrations under the Financial Alignment Initiative, we provide additional support to local SHIPs and ADRCs so they can conduct beneficiary outreach and one-on-one options counseling to those eligible for the demonstrations.

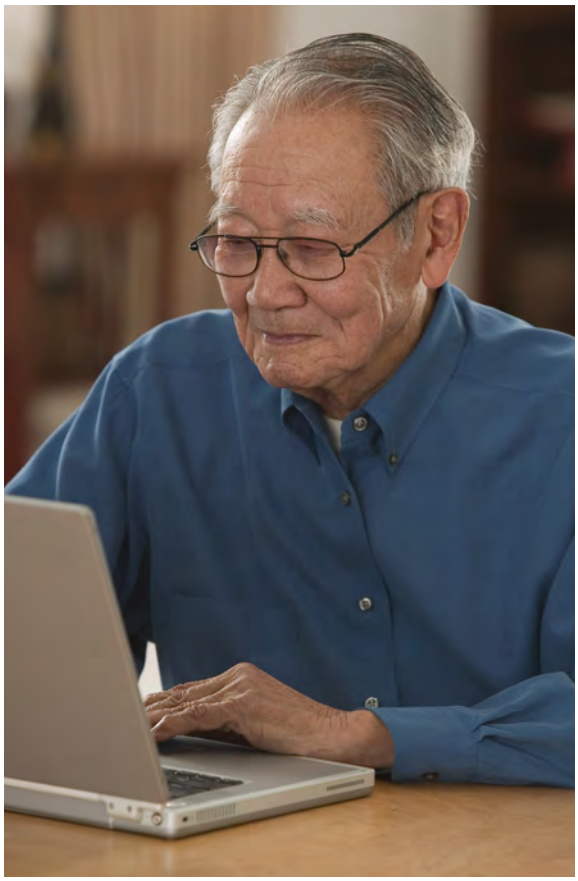
As of September 2018, we are providing support to nine state ombudsman and counseling programs, serving nearly 370,000 demonstration enrollees plus additional demonstration-eligible beneficiaries.[19]

We have also continued our work to improve communications with dually eligible individuals eligible for enrollment in integrated care programs. Leveraging our work from the Financial Alignment Initiative, we have expanded our efforts to integrate D-SNPs outside of the Financial Alignment Initiative — that is, those D-SNPs that provide Medicare and Medicaid benefits through the same managed care organization. For example, we developed and consumer tested a set of integrated model materials for use by D-SNPs participating in the Massachusetts Senior Care Options program in 2019.

ACHIEVING BETTER OUTCOMES

The demonstrations and other initiatives described in this report aim to improve quality and beneficiary experience for dually





The Washington demonstration under the Financial Alignment Initiative has achieved approximately 11% in gross Medicare savings over the first two performance years.

eligible individuals while bending the cost curve. We have seen some promising results, including:

- **Lower hospitalization rate in Medicare fee-for-service.**

  We are measuring the 30-day all-cause hospital readmissions rate for dually eligible individuals in Original Medicare as an outcome of better coordinated care and quality of care. Since 2012, the measure's baseline year, fee-for-service hospital readmissions for dually eligible individuals have declined by 9 percent, from 92.7 readmissions per 1,000 beneficiaries in 2012 to 83.7 per 1,000 beneficiaries in 2016.[20]

- **Lower hospitalization rate among long-stay nursing facility residents.**

  From 2013-2016, all seven sites in the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents reduced hospitalizations, with six of the seven achieving statistically significant improvement in all-cause hospitalizations, potentially avoidable hospitalizations, or both. An independent evaluation found "persuasive evidence of the Initiative's effectiveness in reducing hospital inpatient admissions, emergency department visits, and hospitalization-related Medicare expenditures."[21]

- **Lower hospitalization and skilled nursing facility (SNF) rates in integrated managed care.**

  All three of the capitated model demonstrations under the Financial Alignment Initiative with regression-based utilization results released through 2018 (Illinois, Ohio, and Washington) showed significant declines in inpatient and SNF utilization.[22]

- **Improved beneficiary experience in integrated managed care.[23]**

  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).[24] We have also seen increasing access to care coordination within the capitated model demonstrations, including a 21 percent increase in health risk assessment completion and an 18 percent increase in care plan completion from 2014 to 2016.[25]

- **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 approximately 11 percent in gross Medicare Parts A and B savings over the first two demonstration years, relative to a comparison group.[26]

CONCLUSION

In 2018, we worked to improve dually eligible beneficiary experiences with the Medicare and Medicaid programs in accordance with CMS strategic goals by integrating service delivery, improving communications, strengthening access to care, and aligning financial incentives. The legislative recommendations, if implemented, would help further these goals. We continue to examine other policy areas that have the potential to improve the experience of dually eligible individuals.

Through continuous collaboration with state and federal partners, and with beneficiaries and their caregivers, advocates, providers, and other stakeholders, we will continue to explore, implement, and improve approaches to integrate Medicare and Medicaid service delivery and financing. We look forward to continuing to work with the Congress and are committed to keeping the Congress and other stakeholders apprised of our work, and broader agency efforts, to promote quality, coordinated care for all dually eligible individuals.

NOTES

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/Downloads/CMS_Fast_Facts.zip

[2] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2017.pdf

[3] https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf

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

[5] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2017.pdf

[6] https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf

[7] Social Security Act §1860D-1(b)(1)(C), §1860D-15

[8] Social Security Act §1860D-1(b)(3)(D)

[9] Social Security Act §1851(h), § 1860D-1(b)(1)(B)(vi)

[10] Source: analysis performed by the Integrated Care Resource Center, under contract with CMS. "Fully Integrated Programs/Models" include MMP and PACE enrollment through July 2018. "Total Cost of Care Managed FFS" includes enrollment in the Washington Managed Fee-For-Service demonstration under the Medicare-Medicaid Financial Alignment Initiative. "Integrated SNP Program" and "Partially Integrated SNP Program" enrollment includes programs in which a Medicare-Medicaid enrollee receives both Medicare and Medicaid services from companion or aligned Medicare D-SNPs and Medicaid managed care plans, and "other" in this category refers to the North Carolina Medicare Health Care Quality Demonstration, for which no 2015-2018 information is included because the initiative had ended. "Integrated SNP Program includes "Legacy Medi-Medi Demo Programs" which are FIDE SNP programs in Massachusetts, Minnesota, and Wisconsin that began as demonstrations.

[11] 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

[12] CA, IL, MA, MI, MN, NY, OH, RI, SC, TX, WA

[13] 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 is separate and distinct from 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. For more information, see http://www.cms.gov/Medicare-Medicaid-CoordiNation/Medicare-and-Medicaid-CoordiNation/Medicare-Medicaid-CoordiNation-Office/FinancialAlignmentInitiative/Minnesota.html

[14] Additional information on these and other examples of how states have used the Medicare Improvement for Patients and Providers Act (MIPPA) contracts to integrate care are available through the Integrated Care Resource Center at https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues__Options.pdf

[15] For additional information about the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/AvoidableHospitalizationsamongNursingFacilityResidents.html

[16] For additional information about data sharing with states, see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources.html

[17] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf

[18] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf

[19] CA, CO, IL, MA, MI, NY, OH, RI, SC, VA, WA

[20] The methodology for the Duals Readmissions goal was updated in 2017 to reflect changes in the Yale readmissions measure used in Medicare's Hospital Readmissions Reduction Program (HRRP). This is the measure upon which this goal was developed. As a result of the revised methodology that eliminated the old data coding, CMS re-calculated the prior years' reports (including the 2012 baseline), since they were based on outdated Yale measure specifications. The new calculation ensures consistent methodology across all years. Note that the updated 2016 data will be released with the President's FY 2020 budget, released at the same time as this report

[21] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NFPAHFinalReport092017.pdf

[22] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html

[23] Through FY 2018, we released the first independent evaluation reports containing preliminary results for the Washington, Massachusetts, and Minnesota demonstrations. We expect to release additional reports in FY2019. The reports are available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html

[24] 2015 – 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results for Medicare-Medicaid Plans

[25] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

[26] https://innovation.cms.gov/Files/reports/fai-wa-secondevalrpt.pdf