

Update on Medicare-Medicaid Alignment Initiative

June 2017

Alignment efforts in process. This is an update on the recent progress of the Alignment Initiative, an ongoing CMS initiative to streamline and align a wide variety of Medicare and Medicaid rules, requirements, and policies. Through the Alignment Initiative, CMS has identified areas of opportunity in which conflicting requirements and incentives exist between the Medicare and Medicaid programs, taking action to address those policies in an effort to promote seamless, high quality, and cost-effective care for beneficiaries dually eligible for Medicare and Medicaid. While CMS continues to explore new avenues and opportunities for alignment, this document highlights the progress on a number of key issue areas to date.

Coordinated Care: Options.

- CMS continues to expand and update a range of coordinated care options available to beneficiaries, including:
 - Since the enactment of the PACE Innovation Act in November 2015, CMS has been exploring options for testing an adapted PACE model for individuals not currently eligible for PACE, including Medicare-Medicaid enrollees under age 55. **NEW:** In December 2016, CMS released a Request for Information on potential model tests under the PACE Innovation Act and received comments from states, beneficiary advocates, PACE organizations, and other providers.¹
 - The CMS Innovation Center continues to develop and implement multi-payer models through which Medicare and Medicaid (and other payers) make common incentive or performance payments. This includes the Comprehensive Primary Care Plus (CPC+) program, which builds upon earlier Innovation Center models to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformations. **NEW:** In January 2017, CMS launched the first round of CPC+ throughout 14 regions, with a second round of CPC+ beginning in January 2018.
 - **NEW:** In December 2016, the CMS Innovation Center announced a new Accountable Care Organization (ACO) model focused on improving care and reducing costs for beneficiaries who are dually eligible for Medicare and Medicaid. Through the Medicare-Medicaid ACO model, CMS intends to partner with interested states to offer ACOs the opportunity to take on accountability for both Medicare and Medicaid costs and quality for beneficiaries.²
 - Through the Financial Alignment Initiative, the Medicare-Medicaid Coordination Office (MMCO) continues to implement the managed fee-for-service model in Washington and Colorado. Recent results from the first annual evaluation report for Washington are encouraging, with the demonstration improving access to Medicaid health home services while reducing Medicare spending by \$21.6

¹ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACEInnovationAct.html>

² <https://innovation.cms.gov/initiatives/medicare-medicicaid-aco-model/>

million during the first demonstration performance period (July 2013 to December 2014), resulting in net Medicare savings of approximately 3%.³

NEW: Building on this early success, CMS and Washington extended the scheduled end date of the demonstration by an additional two years, while also incorporating new counties to bring the managed fee-for-service health home model statewide.

- MMCO also continues to implement demonstrations using the Medicare-Medicaid capitated financial alignment model. Beneficiaries are currently receiving services through eleven capitated model demonstrations across ten states. In September 2016, MMCO posted the first annual evaluation report containing early results of the Massachusetts capitated model demonstration – One Care – during the first demonstration performance period (October 2013 – December 2014).
- **NEW:** In March 2017, MMCO published an evaluation report on the successes and challenges of providing care coordination services for capitated model demonstrations in nine states. This evaluation report included descriptions of the key elements of the care coordination models, health risk assessments, individualized care plans, and integrated care coordination data systems.⁴ Additional evaluation reports examining beneficiary experience⁵ and special populations⁶ enrolled in the Financial Alignment Initiative demonstrations have also been published.
- Highly integrated, high performing Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) have the ability to offer non-medical supplemental benefits, primarily long term services and supports, to help support community living. In January 2016, CMS provided guidance to D-SNPs that clarified how these plans can offer these non-medical supplemental benefits to plan enrollees that are not eligible to receive Medicaid long terms services and supports.⁷

Coordinated Care: Enrollment.

- **NEW:** Between 2011 and 2016, the estimated number of Medicare-Medicaid enrollees served by integrated care models rose from approximately 162,000 to more than 720,000, which includes new models in several states as part of the Financial Alignment Initiative.

Coordinated Care: Integrated Information in Beneficiary Communications Materials.

As part of the Financial Alignment Initiative, CMS and each of the participating states integrate benefits and other programmatic information in beneficiary communication materials through the capitated financial alignment model.

³ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAFirstAnnualEvalResults.pdf>

⁴ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf>

⁵ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf>

⁶ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SpecialPopulationsIB508032017.pdf>

⁷ http://www.chcs.org/media/CY-2017-D-SNP-Benefit-Flexibility_01082016.pdf

- Through a demonstration in Minnesota, conducted in partnership with the state and D-SNPs in the Minnesota Senior Health Options program, CMS is testing a variety of required beneficiary communications materials used by health plans, including a Summary of Benefits, integrated formulary, Member Handbook (Evidence of Coverage), Annual Notice of Change, Formulary, Low Income Subsidy (LIS) Rider, and Provider and Pharmacy Directory, all of which better integrate the descriptions of Medicare and Medicaid services and cost-sharing. These model templates are based on those used by Medicare-Medicaid Plans under the Financial Alignment Initiative.
- As indicated in both the Contract Year (CY) 2016 and CY 2017 Final Call Letters for Medicare health plans, CMS continues to work toward streamlined, integrated marketing materials that provide the full array of Medicaid and Medicare benefits for integrated D-SNPs outside the Minnesota demonstration. As part of that effort, CMS is exploring the feasibility of allowing integrated D-SNPs to use many of the same integrated model templates that are used in the demonstration and in the Financial Alignment Initiative, in lieu of the Medicare Advantage and Part D templates. Beginning in CY 2017, integrated D-SNPs have additional flexibilities to describe their Medicare and Medicaid benefits in an integrated way in the required Summary of Benefits document. **NEW:** In May 2017, CMS issued updated Annual Notice of Change and Evidence of Coverage model materials that provide integrated D-SNPs with additional flexibilities to better integrate their benefit descriptions.
- MMCO continues to test beneficiary communications materials used in various demonstrations to improve upon them and to inform improvements to materials used by other integrated health plans outside the demonstrations.

Coordinated Care: State and CMS Review of Beneficiary Communications and Marketing Materials.

- In addition to our work to integrate the content of beneficiary communications materials, CMS continues to work toward a unified and concurrent process for reviewing these materials by CMS and state reviewers, including:
 - As part of the Financial Alignment Initiative and the Minnesota demonstration, CMS and our state partners are working more closely together to review beneficiary communications and marketing materials. These reviews are conducted concurrently in one system.
 - CMS has also leveraged the current processes conducted as part of the Financial Alignment Initiative for joint CMS and State review of integrated marketing materials for PACE organizations.
 - The MMCO FY 2014 and FY 2015 Reports to Congress and the President's FY 2016 and 2017 Budgets have included a legislative recommendation to facilitate joint state and CMS review of D-SNP marketing materials.

Coordinated Care: Contracting Issues.

- CMS, in partnership with states, successfully facilitated D-SNPs' efforts to meet the new contracting requirement with state Medicaid agencies starting with the 2013 contract year. All D-SNPs now have contracts with the state Medicaid agency. Under contract with CMS, the Integrated Care Resource Center has catalogued for states examples of best practices in state D-SNP contracting to improve oversight, support quality

measurement, and promote Medicare-Medicaid coordination.⁸ In addition, under the Financial Alignment Initiative, CMS is allowing Medicare-Medicaid Plans the flexibility to conduct early Health Risk Assessments (HRAs) – that is, assessments conducted prior to an individual’s enrollment effective date – for both opt-in and passive enrollees. Conducting HRAs prior to members’ enrollment in the plan enhances their ability to effectively meet those individuals’ care needs beginning on their first day of coverage and improves compliance with timelines for conducting HRAs. Beginning in 2016, Medicare Advantage Special Needs Plans (SNPs) have been able to conduct an HRA starting 90 days prior to, and ending 90 days after, a member’s effective date of enrollment, to allow for better alignment of the Medicare and Medicaid assessment processes.

Coordinated Care: Medicare Advantage Seamless Conversion.

- CMS has worked with states to leverage this enrollment mechanism to promote continuity and access to integrated D-SNPs. Under contract with CMS, the Integrated Care Resource Center disseminated a paper for states on seamless conversion and other Medicare Advantage enrollment policies that may impact integrated care programs. CMS is reviewing its policies for this enrollment mechanism, its use by Medicare Advantage organizations, and the beneficiary protections currently in place. In October 2016, CMS announced a temporary moratorium on approval of any new seamless enrollment proposals while the agency reviews its policies.

Coordinated Care: Special Needs Plans (SNP) Requirements.

- While some misalignments remain, CMS has successfully tested state participation in the model of care submission and review process in Minnesota and in demonstrations using the capitated financial alignment model. In 2016, Minnesota D-SNPs administered a combined Medicare and Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, rather than sending two separate surveys. In the 2017 Call Letter, CMS announced our intent to create a process to provide states a greater role in the content and review of the Model of Care used by integrated D-SNPs to ensure it reflects state requirements for delivery of managed long-term services and supports. As part of the 2016 Medicaid and CHIP Managed Care Final Rule, CMS clarified that states may allow plans that exclusively serve Medicare-Medicaid beneficiaries to substitute a Medicare Advantage quality improvement project for one or more required Medicaid performance improvement projects, helping to streamline administrative requirements for such plans.
- **NEW:** In 2017, CMS sought public comment on the potential benefits of establishing separate network adequacy evaluations for SNPs. Based on the feedback from commenters, CMS announced in the 2018 Call Letter our intention to move forward in developing a SNP-specific network adequacy evaluation in an effort to address the different needs of the SNP populations.

⁸ <http://www.chcs.org/media/ICRC-Issues-and-Options-in-Contracting-with-D-SNPs-FINAL.pdf>

Cost-Sharing: Reducing Inappropriate Billing of Qualified Medicare Beneficiaries.

- In 2016, CMS launched a three-pronged effort to reduce inappropriate billing of Qualified Medicare Beneficiaries (QMBs), including (1) promoting beneficiary awareness and strengthening CMS supports; (2) clarifying rules for plans and providers; and (3) developing administrative reforms to promote compliance. Highlights of each include:
 - **Information and Supports for Qualified Medicare Beneficiaries: *NEW*:** In January 2017, CMS and the Consumer Financial Protection Bureau issued a joint Consumer Advisory which included information and tips to assist QMB enrollees in responding to wrongful billing for Medicare cost sharing and debt collection attempts.⁹ A Spanish language version is also available.¹⁰ In September 2016, the Medicare & You Handbook sent to all beneficiaries included new language to advise individuals enrolled in the QMB program about their billing protections and to call 1-800-MEDICARE if they cannot resolve billing problems with providers. 1-800-MEDICARE customer service representatives can newly identify callers' QMB status and advise them about their billing rights. In 2016, CMS worked with the Administration on Community Living and the State Health Insurance Counseling Program (SHIP) TA Center to conduct a webinar (March 2016), release newsletter articles (May 2016 and March 2017), and lead a session at the Annual SHIP conference (August 2016) for counselors regarding QMB billing protections. CMS has also participated in ad hoc opportunities to increase awareness about balance billing rules among beneficiaries and advocates, including Justice in Aging webinars in June 2015, February 2016, and February 2017, the National Council on Aging 2017 Enrollment Benefits Conference (April 2017) and the August 2015 CMS National Training Partnership in Baltimore.
 - **Administrative Reforms to Promote Compliance: *NEW*:** In February 2017, CMS announced a modification to the Medicare fee-for-service claims processing system that assists providers and beneficiaries in determining which individuals are enrolled in QMB. This modification establishes an indicator of QMB status within the claims processing system, thereby generating notifications to Medicare providers and beneficiaries regarding QMB status and a lack of liability for Medicare cost-sharing.
 - **Education for Medicare Providers regarding QMB Billing Rules: *NEW*:** In February 2017, CMS published a Medicare Learning Network Matters article announcing modifications to the Medicare claims processing system to help providers more readily identify the QMB status of patients and to support providers' ability to follow QMB billing requirements.¹¹ CMS has previously used the Medicare Learning Network articles¹² to raise awareness of important

⁹ <https://blog.medicare.gov/2017/01/18/qualified-medicare-beneficiary-program/>

¹⁰ https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/SPA3tipsforpeopleinthequalifiedmedicarebeneficiaryHLOWithaddendum_4_06_17.pdf

¹¹ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9911.pdf>

¹² <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf>

protections for QMB beneficiaries and reiterating the requirements to states through an Informational Bulletin to State Medicaid Agencies in January 2012.¹³ Starting in fall 2014, similar information has been included in the annual “Dear Doctor” letter sent to all Medicare providers. In July 2016, CMS reminded Medicare providers of the QMB billing protections for individuals enrolled in QMB as part of the CY 2017 Physician Fee Schedule Proposed Rule.

- **Promotion of QMB Protections for Medicare Advantage Plans:** In April 2016, CMS updated the Medicare Managed Care Manual to clarify that Medicare Advantage providers cannot refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a Medicaid program, such as Medicare Savings Programs.¹⁴ In addition, as part of the CY 2017 Call Letter, CMS reminded Medicare Advantage plans of their legal obligations to protect QMB individuals from inappropriate charges by educating providers about applicable billing rules. In September 2016, CMS presented on QMB billing and antidiscrimination rules at the Medicare Advantage Fall Conference.
- **Analysis of QMB Billing Issues:** In August 2015, CMS released a report entitled: *Access to Care Issues among Qualified Medicare Beneficiaries (QMB)*.¹⁵ This report combines both qualitative and quantitative analysis on access to health care services among QMB beneficiaries. The qualitative study describes the experience of QMB beneficiaries who had been balance billed. The quantitative study found some evidence of decreased access to health services among states that have adopted a “lesser-of payment policy” (i.e., states opting to limit reimbursement to the lesser of either the Medicaid state plan rate [reduced by the payment already received by the provider from Medicare] or the cost-sharing amount established by Medicare). This CMS report echoed the findings of a November 2014 MACPAC report entitled “Effect of State Payment Policies for Medicare Cost Sharing on Access to Care for Dual Eligibles.”¹⁶

Cost-Sharing: Crossover Claims.

- CMS reiterated and clarified crossover payment policies in a June 2013 Informational Bulletin to State Medicaid Agencies.¹⁷ In May 2016, CMS published the final Medicaid and CHIP Managed Care Rule, which included requirements that Medicaid managed care organizations automate crossover payment processes in all states that currently have automated crossover processes in their fee-for-service systems.

Enrollment: Medicare Savings Program.

- The Center for Medicaid and CHIP Services (CMCS) and MMCO issued a joint Informational Bulletin¹⁸ in January 2015 describing existing enrollment and retention flexibilities that can: 1) assist states in meeting their obligations to screen Medicaid

¹³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf>

¹⁴ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>

¹⁵ https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf

¹⁶ <https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid-Payment-for-Cost-Sharing.pdf>

¹⁷ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-06-07-2013.pdf>

¹⁸ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib071516.pdf>

enrollees for Medicare Savings Programs and other categories of Medicaid when the enrollees become Medicare-eligible; and 2) improve the stability and continuity of Medicare Savings Program coverage.

Enrollment: Transitioning from Medicaid/Marketplace to Medicare.

- CMS has identified opportunities to support a smooth transition for those shifting from health care coverage through Medicaid and the Health Insurance Marketplace into Medicare coverage, including:
 - In April 2016, CMS updated the Medicare-Marketplace Master FAQ document on CMS.gov. The FAQ document includes information regarding the intersection of Medicare and the Health Insurance Marketplace, including information on general enrollment, End Stage Renal Disease, and coordination of benefits.¹⁹
 - In July 2015, CMS held an Assister webinar entitled: *Preventing Gaps in Health Care Coverage Mini-Series: Transitioning from a Medicaid Coverage to Other Health Coverage* to explain how assisters can help consumers avoid gaps in their health coverage when they transition from Medicaid coverage to other types of health coverage, including Medicare.²⁰
 - In August 2015, CMS posted a blog entry²¹ to raise awareness about programs that provide subsidies to lower income populations to help pay for Medicare premiums and cost-sharing. The blog provides information about the Medicare Savings Programs to help individuals cover their Medicare costs, and the Low Income Subsidy, otherwise known as Extra Help, to assist with paying for drugs.
 - In August 2015, CMS released an online toolkit for Navigators and other Marketplace assisters that includes key messages for Marketplace enrollees who newly qualify for Medicare.²²
 - In September 2016, CMS began reaching out to the small number of consumers enrolled in both Medicare and Marketplace coverage with financial assistance. CMS is doing this to make sure consumers take action to end their Marketplace coverage with advance payments of the premium tax credit (APTC) because they are receiving Minimum Essential Coverage through Medicare, and thus are not eligible for this financial assistance. Consumers were sent paper notices which included instructions on Medicare enrollment and premium status.²³ A similar effort for those enrolled in Medicaid and Marketplace coverage is being expanded to automatically end APTC and cost sharing reductions.²⁴ **NEW:** In March 2017, a second round of notices was sent to consumers that were dually enrolled in both a Marketplace plan and Medicare. This notice also included information for those that may qualify for the Medicare Savings Programs.

¹⁹ <http://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html>

²⁰ <https://marketplace.cms.gov/technical-assistance-resources/transitioning-from-medicaid.pdf>

²¹ <http://blog.medicare.gov/2015/08/28/dual-medicare-medicaid-transition-and-cost-help/>

²² <https://marketplace.cms.gov/technical-assistance-resources/assisters-roadmap-to-resources.pdf>

²³ https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/PDM-for-Consumers-with-Medicare_Webinar-FINAL508C.pdf

²⁴ <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/PDM-Round-3-FAQ-8-1-16.pdf>

- **NEW:** In February 2017, CMS began offering equitable relief to certain Medicare beneficiaries who have premium-free Medicare Part A and are dually-enrolled in both Medicare and the Marketplace. For a limited time, eligible individuals can request equitable relief to enroll in Medicare Part B without penalty or to reduce their Part B late enrollment penalty. This relief is considered on a case-by-case basis for beneficiaries that are currently or previously dually-enrolled in both Medicare and the Marketplace.²⁵

FFS Benefits: Home Health.

- CMS published final regulations in 2016 to align Medicaid and Medicare requirements for face-to-face interactions between the prescribing physician and the beneficiary. The rule reiterates the long-standing policy that Medicaid agencies cannot apply the Medicare “homebound” requirement for home health services. These regulations took effect July 1, 2016, and the rule generally provides for a one year compliance timeframe in most states.

FFS Benefits: Nursing Home-Hospital Transfers.

- In July 2015, CMS implemented the requirement under the Protecting Access to Medicare Act of 2014, to adopt a skilled nursing facility (SNF) all-cause all-condition hospital readmission measure. CMS is currently developing a SNF Value-Based Payment program whereby SNF payments will vary based on this and other measures beginning in FY 2019.
 - As part of CMS’ *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents*, the Innovation Center and MMCO have partnered to test new models to improve care for long-stay residents within long term care facilities and reduce avoidable hospitalizations. **NEW:** In March 2017, CMS released a new evaluation report demonstrating that for the second year in a row, partnering long-term care facilities at all seven sites collectively showed a decline in all-cause hospitalizations and potentially avoidable hospitalizations, relative to a comparison group.²⁶ Five sites show statistically significant reductions in at least one of the hospitalization measures. Six of the seven sites also collectively showed reductions in Medicare expenditures relative to a comparison group, with statistically significant declines in total Medicare expenditures at four sites.
 - Building on early successes of the initiative, CMS began Phase Two in October 2016, providing additional funding opportunities for participating organizations to test new payment models to improve the quality of care by reducing avoidable hospitalizations, while also lowering combined Medicare and Medicaid spending.
 - CMS is updating nursing home quality measures to better distinguish high performing facilities for consumers. CMS is also working with nursing homes to reduce the inappropriate use of antipsychotics for residents with dementia as part

²⁵ <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Limited-Equitable-Relief-Fact-Sheet.pdf>

²⁶ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativeToReduceAvoidableHospitalizations/Evaluation-.html>

of the *National Partnership to Improve Dementia Care in Nursing Homes*. Since the launch of the National Partnership in 2012, there has been a 27 percent decrease in the prevalence of antipsychotic medication use among long stay nursing home residents nationwide.²⁷

- Certain Accountable Care Organizations (ACOs) now have the opportunity to waive the three-day hospital stay rule for certain beneficiaries under certain circumstances (although not for nursing facility residents). Medicare Advantage plans have long used flexibility to waive the three-day stay rule, as have certain Medicare-Medicaid Plans participating in demonstrations using the capitated financial alignment model. Collectively, more Americans than ever before are in systems of care that better incentivize and offer the flexibilities necessary to address this misalignment.

FFS Benefits: Same Requirements for Skilled Therapies.

- In 2012, CMS aligned the fee-for-service Medicaid provider requirements for skilled therapies with Medicare requirements.

FFS Benefits: Durable Medical Equipment.

- In June 2016, CMS requested comments from states and stakeholders on methods to improve access to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for Medicare-Medicaid enrollees. Specifically, CMS solicited feedback on current obstacles to the timely receipt of needed DMEPOS and repairs due to conflicting program requirements, challenges faced by Medicaid enrollees who become eligible for Medicare, and whether access problems are more pronounced for certain categories of equipment. In addition, CMS requested comments on potential regulatory and legislative proposals to address DMEPOS program misalignments.²⁸
 - In February 2016, CMS finalized regulations clarifying the coverage and definition of Medicaid home health benefits for medical supplies, equipment, and appliances. This regulation provides for greater alignment of the definition of Medicaid home health DMEPOS with the Medicare definition, streamlining beneficiaries' access to receive needed items and providing clear guidance to states to ensure consistent application of benefits. This definition clarified that Medicaid DMEPOS benefits are suitable in any non-institutional setting in which normal life activities take place, and cannot be denied on the grounds that it is for use outside of the home.²⁹
 - **NEW:** In January 2017, CMS issued an Informational Bulletin to state Medicaid agencies providing strategies to support access to DMEPOS for beneficiaries that are dually eligible for Medicare and Medicaid. This Bulletin described strategies to promote the timely access to needed DMEPOS while fulfilling the states' obligations to ensure Medicaid is the payer of last resort.³⁰

²⁷ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SC-Letter-16-28-Partnership-Update-Report.pdf>

²⁸ <https://www.gpo.gov/fdsys/pkg/FR-2016-06-30/pdf/2016-15188.pdf>

²⁹ <https://www.gpo.gov/fdsys/pkg/FR-2016-02-02/pdf/2016-01585.pdf>

³⁰ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib011317.pdf>

Appeals: Integrated Denial Notice for Medicare-Medicaid and Medicare Advantage Plans.

- Medicare health plans are required to provide enrollees with a written notice that explains the plan’s reasons for denying a request for payment or a service the enrollee has already received and appeals rights. Because Medicare and Medicaid have different requirements, plans that contract with both had to use two separate forms to issue a denial notice. After two rounds of public comment, an updated version of the Medicare notice for denials of both coverage and payment request began to include a separate section that can be used to address denial of Medicaid services. An integrated notice was finalized in late 2013, and CMS began another round of public comments in late 2015.³¹ **NEW:** In February 2017, CMS issued an updated IDN, which is currently in use by plans nationwide.

Appeals: Integrated Appeals Process.

- The Financial Alignment Initiative demonstration in New York is testing an integrated appeals process. The 2016 Medicaid and CHIP Managed Care Final Rule also takes a number of steps to better align Medicaid managed care appeals with Medicare, including aligning appeals timeframes and requiring a plan-level administrative review for all service appeals.

Appeals: Continuation of Benefits Pending Appeal.

- CMS has approved eleven demonstrations using the Medicare-Medicaid capitated financial alignment model. In each demonstration, health plans are required to continue both Medicare and Medicaid benefits during an appeal (commonly called “aid-paid pending”). These demonstrations currently serve approximately 390,000 beneficiaries.

Quality: Measurement.

- In 2012, the National Quality Forum (NQF) convened a group of stakeholders to develop a quality measurement framework for Medicare-Medicaid enrollees. Home and community based services and care coordination were identified as areas with major measurement gaps for both Medicare-Medicaid and Medicaid-only populations. In an effort to close those measurement gaps, MMCO has partnered with the NQF, the Administration for Community Living (ACL), and other stakeholder organizations to develop a conceptual framework and perform an environmental scan to address performance measure gaps in home and community-based services to enhance the quality of community living. In September 2015, MMCO, in partnership with CMCS, awarded a quality measure development contract to further close measurement gaps for Medicare-Medicaid and Medicaid-only beneficiaries in the areas of care coordination, managed long term services and supports, community integration, substance use disorder, and other identified gap areas. In 2016, this contractor convened a Technical Expert Panel to help guide the development process. To date, the Technical Expert Panel has provided extensive feedback on measure development for Medicare-Medicaid enrollees, as well as input on stratifying existing measures for the population. The contractor also released for

³¹ <https://www.federalregister.gov/documents/2015/10/16/2015-26390/agency-information-collection-activities-proposed-collection-comment-request>

public comment the measure specifications and justifications for several measure concept areas specific to Medicare-Medicaid enrollees, including beneficiaries with physical-mental health integration needs and beneficiaries using home and community-based services. **NEW:** In April 2017, the contractor requested public comment on two new quality measures under development measuring Medicare-Medicaid enrollees' non-acute mental health service utilization and healthy days in the community.³² In addition, in March 2017, the NQF Measure Application Partnership Dual-Eligible Beneficiaries Workgroup met to provide updates to the existing Dual-Eligible Beneficiary family of measures. The revised family of measures will include the newly NQF-endorsed CAHPS Home and Community-Based Services measures.

Access to Care: Accessibility.

- Since May 2015, MMCO, the Center for Clinical Standards and Quality (CCSQ), Office of Minority Health (OMH), and Office of Communications (OC), in conjunction with the ACL, have been exploring opportunities to better collect and disseminate information on physical accessibility to aid individuals in making more informed decisions when they choose providers. In 2016, MMCO, OMH, and ACL have hosted listening sessions with stakeholders aimed at understanding the needs of individuals with disabilities and barriers to accessing health care facilities and services; identifying mechanisms, including the role of payments and monitoring, that can be leveraged to increase physical accessibility of health care services for people with disabilities; and determining existing vehicles that can be utilized more broadly to collect data on physical accessibility of provider offices. Supporting the CMS *Equity Plan for Improving Quality in Medicare*, these efforts also align with MMCO's goals of providing Medicare-Medicaid enrollees full access to entitled benefits and simplifying processes to access entitled items and services.

³² <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html#11111>