



Medicare-Medicaid Coordination Office

FY 2020 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 2020, including modernizing the Medicare Savings Programs (MSPs); creating new opportunities for innovative, integrated care; and improving beneficiary outcomes. We also highlight the disproportionate impact the COVID-19 pandemic has had on dually eligible individuals and efforts we are making to mitigate that impact in partnership with states, providers, advocates, beneficiaries and their caregivers, and other stakeholders.

ABOUT DUALY ELIGIBLE INDIVIDUALS

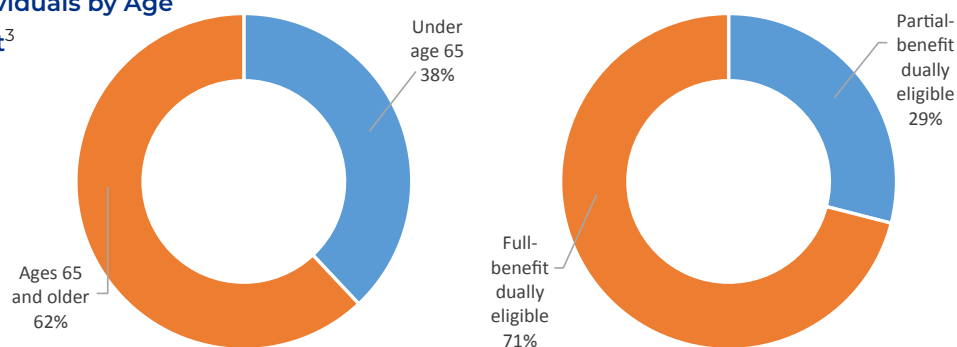


During 2020, about 12.3 million² individuals were concurrently enrolled in both the Medicare and Medicaid programs. These individuals navigate two separate programs: Medicare for the coverage of most preventive, primary, and acute health care services and drugs, and Medicaid for coverage of long-term services and supports, certain behavioral health services, and for help with Medicare premiums and cost sharing.

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 Medicare cost sharing. Full-benefit dually eligible individuals often separately qualify for assistance with Medicare premiums and cost-sharing through MSPs.

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. In December 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.⁴ A second ASPE report, published in May 2020, confirmed these findings after accounting for additional social and functional risk factors.⁵ Given these complex needs and poor outcomes, dually eligible individuals account for a disproportionate share of spending in both Medicare and Medicaid. 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.⁶

Dually Eligible Individuals by Age and Type of Benefit³



The COVID-19 pandemic is disproportionately impacting dually eligible individuals. As of April 2021, preliminary data⁷ show more than twice as many COVID-19 cases among dually eligible beneficiaries compared to Medicare-only beneficiaries, with 12,193 per 100,000 beneficiaries compared to 5,239 per 100,000 beneficiaries, respectively. The disparity in COVID-19 hospitalizations is even wider, with 3,660 hospitalizations per 100,000 beneficiaries among dually eligible individuals compared to 1,418 per 100,000 beneficiaries among individuals eligible for Medicare only. As of April 2021, preliminary data also show dually eligible individuals across demographic categories (race, age, sex, disability, ESRD status) were hospitalized with COVID-19 at considerably higher rates than their Medicare-only counterparts in the same demographic group.⁸

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

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.⁹

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.^{10,11}

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)⁶**
- **41% have at least one mental health diagnosis (vs. 16% of Medicare-only beneficiaries)⁶**
- **38% are eligible for Medicare due to disability (vs. 8% of Medicare-only beneficiaries)²**



WHAT WE ARE DOING

In 2020, our work focused on ways to integrate service delivery to improve quality and outcomes, promote beneficiary-centered care, bend the health care cost curve, and use data to inform the design of, and continuously improve, new initiatives. Our efforts fell into two primary areas:

1. Modernizing Medicare Savings Programs and state data exchange, and
2. Creating new opportunities for innovative, integrated care.

We also highlight some of the promising results of this work in this section.

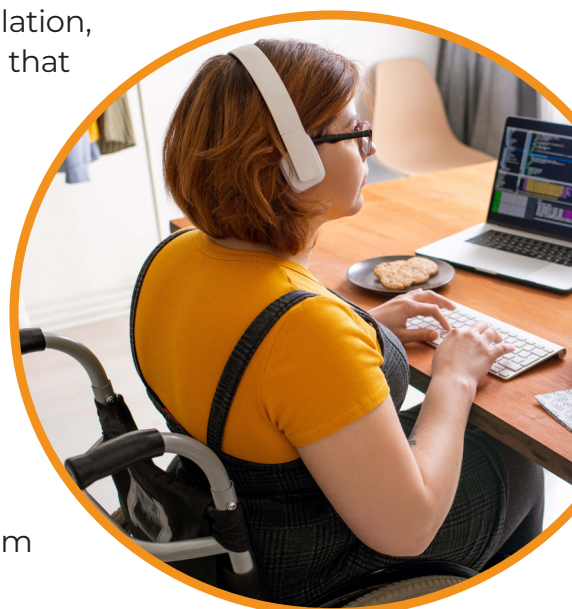
Modernizing the Medicare Savings Programs

Millions of Americans rely on the Medicare Savings Programs (MSPs) to help cover Medicare Parts A and B premiums and/or cost sharing. MSPs are state-run programs for dually eligible individuals who need help paying their Medicare costs. MSPs can save beneficiaries over \$1,600 a year just by covering Medicare Part B premiums—money beneficiaries can use for food, housing, or other necessities. However, payment and coordination of benefits in the MSPs can include substantial inefficiencies for all parties. Differences between Medicare and Medicaid coding, payment, and documentation requirements, as well as outdated guidance, only exacerbate coordination challenges and contribute to beneficiary access problems.

STATE PAYMENT OF MEDICARE PREMIUMS

On September 8, 2020, CMS released an updated version of the Manual for State Payment of Medicare Premiums (formerly called “State Buy-in Manual”).¹² The manual updates information and instructions to states on federal policy, operations, and systems concerning the payment of Medicare Parts A and B premiums for individuals dually eligible for Medicare and Medicaid.

States pay Medicare Part B premiums each month for over 10 million individuals and Part A premiums for over 700,000 individuals. However, the prior version of this manual had not been fully updated since the 1990s, nor fully available on-line. The revised manual clarifies various provisions of statute, regulation, and operations that have evolved over time. To educate states about the updated guidance, CMS released training materials that highlight key instructions from the manual.¹³



We are also working to improve the data exchanges between the states, CMS, and the Social Security Administration to facilitate state payment of Medicare premiums. By reducing 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 assistance¹⁴ on how to reduce erroneous submissions and troubleshoot those that occur.

DATA EXCHANGE BETWEEN STATES AND CMS

In 2020, CMS finalized the Interoperability and Patient Access Rule, which mandates daily submission of certain MSP payment and dual eligibility status 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 Qualified Medicare Beneficiaries (QMBs) for Medicare Parts A and B cost-sharing.

By the end of 2020, 19 states were submitting files on dual eligibility status daily, and 23 states were exchanging data daily on state payment of Medicare premiums. CMS provides technical assistance to states through the State Data Resource Center, including tip sheets, FAQs, and recorded webinars.

Creating New Opportunities for Innovative, Integrated Care

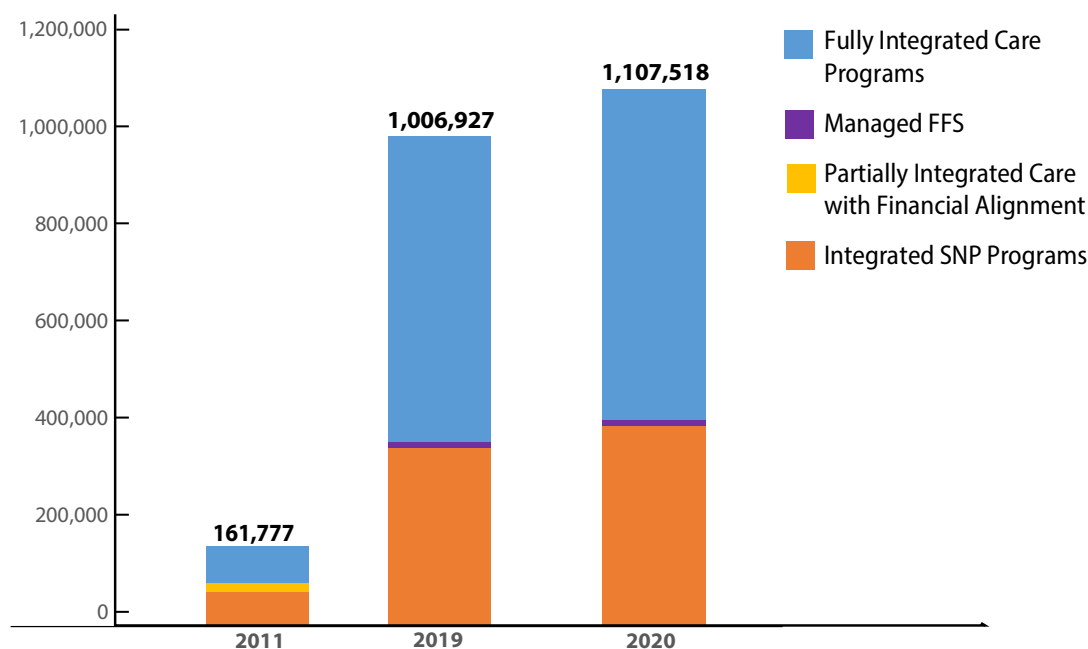
Medicare and Medicaid were originally created as distinct programs with different purposes and have operated as separate systems despite a growing number of people who depend on both programs for their health care needs. This lack of coordination can lead to fragmented care for dually eligible individuals, 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. In 2020, about 12% of full-benefit dually eligible individuals were in integrated care.¹⁵ 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. 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 between 2011 and 2020.

Figure 1. Total Integrated Care Enrollment by Program Type: 2011, 2019, and 2020¹⁶



*See end note for a description of different types of integrated care initiatives in 2020.

■ **Medicare-Medicaid Financial Alignment Initiative.**¹⁷

In 2020, the demonstrations under the Medicare-Medicaid Financial Alignment Initiative (the Financial Alignment Initiative) accounted for 35% 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 July 2020, there were 10 demonstrations in 10 states serving more than 400,000 dually eligible individuals.¹⁸ 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 nearly 41,000 dually eligible individuals as of July 2020.¹⁹

■ **At the start of the COVID-19 pandemic, we issued guidance for integrated Medicare-Medicaid Plans participating in the Financial Alignment Initiative,**

allowing for flexibility to suspend or limit face-to-face care management activities and use alternative approaches to meet enrollee needs.

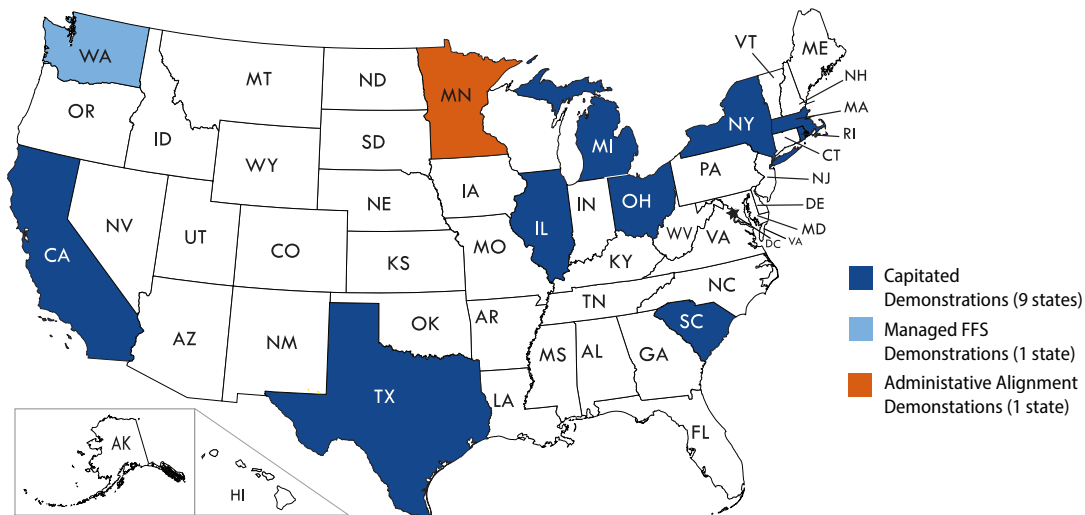
We have worked closely with our state and federal partners, as well as with providers, throughout the public health emergency to ensure dually eligible individuals retain access to needed services. Integrated care has allowed our partners to pivot quickly to continue providing high-quality care during the public health emergency. For example, Medicare-Medicaid Plans were well-positioned to identify and address social determinants of health needs—such as food insecurity and social isolation—that arose among their dually eligible members due to COVID-19 given the plans’ comprehensive, coordinated care models.

In 2020, we effectuated extensions in the capitated model demonstrations under the Financial Alignment Initiative operating in Massachusetts, Michigan, Rhode Island, and South Carolina. In New York, the capitated model demonstration transitioned to one

focused on an integrated appeals and grievances process for individuals enrolled in Medicaid managed care plans that are aligned with Dual Eligible Special Needs Plans (D-SNPs). We continue to welcome state interest in exploring innovative approaches to better serve dually eligible individuals that work best for their populations.

■ **Programs of All-Inclusive Care for the Elderly (PACE).** On February 5, 2020, CMS proposed 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.²¹ This followed a rule²² finalized in 2019 that updated and modernized the

Figure 2. Demonstrations under the Financial Alignment Initiative, 2020



■ **Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents.**²⁰ Unnecessary hospitalizations can be disruptive and dangerous for nursing facility residents and costly for Medicare. Through this initiative, we tested strategies to reduce avoidable hospitalizations for Medicare and Medicaid enrollees who are long-stay residents of nursing facilities. During the COVID-19 pandemic, our initiative partners, called enhanced care and coordination providers or ECCPs, faced challenges but leveraged their work to support nursing facility staff and residents. They adapted their approaches to respond to the pandemic. Adaptations to ECCP models included partnering with states to provide clinical and educational support within nursing facilities, communicating status updates with family members on behalf of nursing facilities, and assisting with COVID-19 testing and obtaining personal protective equipment. The initiative came to a close in October 2020.

PACE program by strengthening protections and improving care for PACE participants, and providing administrative flexibility and regulatory relief for PACE organizations. The final rule reflected updates based on best practices in caring for frail and elderly individuals. The majority of PACE participants are dually eligible individuals. As of September 2020, more than 49,000 older adults²³ were enrolled in more than 100 PACE organizations in 31 states,²⁴ and enrollment in PACE has increased by more than 120 percent since 2011.²⁵ Given the vulnerability of PACE participants, it is important to ensure they continue to receive care safely during the COVID-19 pandemic. At the start of the pandemic, MMCO issued guidance for PACE organizations, allowing flexibility to limit or suspend in-person care management activities.²⁶

■ **Dual Eligible Special Needs Plans (D-SNPs).** In 2020, MMCO worked with our technical assistance contractor, the Integrated Care Resource Center, to help states implement the new D-SNP integration and unified appeals and grievance procedures established through the Bipartisan Budget Act of 2018 (Public Law No. 115-123).²⁷ As a result of this work, 30 states established new processes for their contracted D-SNPs to notify the state (or state designees) when a high-risk enrollee is 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. States also used the new D-SNP contracting requirements to integrate the provision of Medicaid services, including behavioral health and long-term services and supports. In addition, in 10 states and Puerto Rico, 95 fully integrated D-SNPs and highly integrated D-SNPs with exclusively aligned enrollment (in which all D-SNP members are in an affiliated Medicaid managed care organization) will implement unified appeals and grievance procedures for their members in 2021.²⁸

■ **On May 22, 2020, CMS issued the 2021 Medicare Advantage and Part D final rule, which 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 in order to increase integration of D-SNPs.²⁹ At the end of 2020, MMCO transitioned dually eligible members of two D-SNP look-alikes in Florida to highly integrated D-SNPs offered by the same company for 2021. We anticipate additional transitions at the end of 2021 and 2022.

Achieving Better Outcomes

The demonstrations and other initiatives described in this report aim to improve quality and beneficiary experience for dually eligible individuals while bending the cost curve. 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 more than nine percent from 2012 to 2018.³⁰

■ **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 2019, 66 percent of all demonstration survey respondents rated their health plan a 9 or 10.³¹ We have also seen increasing access to care coordination within the capitated model demonstrations, including a 36 percent increase in health risk assessment completion and a 66 percent increase in care plan completion from 2014 to 2019.³²

- **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 \$150 million, or approximately 11 percent, in gross Medicare Parts A and B savings over the first three demonstration years, relative to a comparison group.³³

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 racial equity and supporting underserved communities a priority, ensuring our programs and policies deliver benefits equitably to 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 <https://www.cms.gov/files/document/medicaremedicaiddualenrollmentteverenrolledtrendsdatabrief.pdf>.
- ³ <https://www.cms.gov/files/document/medicaremedicaiddualenrollmentteverenrolledtrendsdatabrief.pdf>.
- ⁴ <https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf>.
- ⁵ <https://aspe.hhs.gov/system/files/pdf/263676/Social-Risk-in-Medicare%E2%80%99s-VBP-2nd-Report-Executive-Summary.pdf>.
- ⁶ https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NationalProfile_2012.pdf.
- ⁷ Note: These CMS data include Medicare claims and encounter data covering the period between January 1 and March 20, 2021, received through April 16, 2021. They may be considered preliminary, given lags in claims and encounter data submission.
- ⁸ <https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>.
- ⁹ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2018.pdf>.
- ¹⁰ <https://www.macpac.gov/wp-content/uploads/2017/08/Medicare-Savings-Programs-New-Estimates-Continue-to-Show-Many-Eligible-Individuals-Not-Enrolled.pdf>.
- ¹¹ <https://aspe.hhs.gov/basic-report/loss-medicare-medicicaid-dual-eligible-status-frequency-contributing-factors-and-implications#results>.
- ¹² <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019212>.
- ¹³ CMS posts technical assistance for state and other partners regarding the state payment of Medicare premiums at <https://www.cms.gov/medicare-medicicaid-coordination/medicare-medicicaid-coordination-office/state-payment-medicare-premiums>.
- ¹⁴ See, for example, a tip sheet for states at <https://www.cms.gov/files/document/statebuyinfileaccretionrejectiontipsheet.pdf>.
- ¹⁵ CMS analysis. Data on number of full-benefit duals: <https://www.cms.gov/files/document/medicaremedicaiddualenrollmentteverenrolledtrendsdatabrief.pdf>. Count of duals in integrated care from Integrated Care Resource Center analysis.
- ¹⁶ Source: analysis performed by the Integrated Care Resource Center, under contract with CMS. “Fully Integrated Programs/Models” include MMP, Fully Integrated Dual Eligible (FIDE) SNP, and PACE enrollment through July 2020. “Managed FFS” includes enrollment in the Washington Managed Fee-For-Service demonstration under the Medicare-Medicaid Financial Alignment Initiative with data through June 2020. “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. “Partially Integrated Care with Financial Alignment” refers to the North Carolina Medicare Health Care Quality Demonstration, for which no 2020 information is included because the initiative ended in 2015.
- ¹⁷ 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>.
- ¹⁸ CA, IL, MA, MI, NY (FIDA-IDD), OH, RI, SC, TX, WA.

- ¹⁹ 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-Office/FinancialAlignmentInitiative/Minnesota.html>.
- ²⁰ 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>.
- ²¹ <https://www.cms.gov/newsroom/fact-sheets/contract-year-2021-and-2022-medicare-advantage-and-part-d-proposed-rule-cms-4190-p>.
- ²² <https://www.cms.gov/newsroom/fact-sheets/programs-all-inclusive-care-elderly-pace-final-rule-cms-4168-f>.
- ²³ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrollData/Monthly-Contract-and-Enrollment-Summary-Report>.
- ²⁴ https://www.integratedcareresourcecenter.com/sites/default/files/PACE_Enroll_by_State_October_2020.pdf
- ²⁵ <https://www.cms.gov/newsroom/fact-sheets/programs-all-inclusive-care-elderly-pace-final-rule-cms-4168-f>.
- ²⁶ <https://www.cms.gov/files/document/covid-pace-faqs.pdf>.
- ²⁷ 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>.
- ²⁸ See integration status for 2021 at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs>.
- ²⁹ <https://www.cms.gov/newsroom/fact-sheets/contract-year-2021-medicare-advantage-and-part-d-final-rule-cms-4190-f1-fact-sheet>.
- ³⁰ CMS analysis using data from the CMS Geographic Variation Database (Foundation of the Chronic Conditions Warehouse).
- ³¹ <https://www.cms.gov/files/document/faicahpsresults.pdf>.
- ³² CMS analysis.
- ³³ <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 reflect updates in the beneficiaries that the evaluation considers to be eligible for the demonstration, and adjustments to the evaluation methodology.