

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**MEDICARE-MEDICAID COORDINATION OFFICE**

**FISCAL YEAR 2017 REPORT TO CONGRESS**



## INTRODUCTION

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The Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office,” hereinafter “MMCO”) is submitting its annual report to Congress. 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 (“Medicare-Medicaid enrollees,” sometimes referred to as “dual eligible individuals”).

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 Medicare-Medicaid enrollees, 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 58 million individuals covered by Medicare and more than 72 million individuals covered by Medicaid in 2017, CMS is 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.

In this report, CMS discusses some of the ways in which CMS has carried out activities to better serve Medicare-Medicaid enrollees in alignment with the CMS strategic goals to:

1. improve the CMS customer experience;
2. support innovative approaches to improving quality, accessibility, and affordability;
3. usher in a new era of state flexibility and local leadership; and
4. empower beneficiaries to make decisions about their health care.

As MMCO continues this work in collaboration with state and federal partners, and with beneficiaries and their caregivers, advocates, providers, and other stakeholders, MMCO will continue to identify areas where regulatory or legislative changes are needed to improve care coordination and benefits. This report contains four such legislative recommendations, which were also proposed in the President’s Fiscal Year (FY) 2019 Budget.

## ABOUT MEDICARE-MEDICAID ENROLLEES

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During 2016, 11.7 million Americans<sup>1</sup> were concurrently enrolled in both the Medicare and Medicaid programs. These 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. In the same year, individuals enrolled in both programs were more likely to have qualified based on a disability than Medicare-only beneficiaries (52.3 percent of Medicare-Medicaid enrollees versus 16.4 percent of Medicare only enrollees), as illustrated in Table 1.

**Table 1. Original Basis for Medicare Entitlement among Medicare-Only Enrollees versus Medicare-Medicaid Enrollees\*<sup>2</sup>**

	<b>Medicare-Only Enrollees</b>	<b>Medicare-Medicaid Enrollees<sup>3</sup></b>
Age	83.2%	46.4%
Disability	16.4%	52.3%
ESRD	0.2%	0.7%
Disability with Current ESRD	0.2%	0.7%

Note: Due to rounding, numbers may not add to 100%

\* Data Source: Common Medicare Environment (CME) data from the CMS Chronic Condition Warehouse (CCW)

Overall, Medicare-Medicaid enrollees have a higher prevalence of many conditions, including, but not limited to, diabetes, pulmonary disease, stroke, Alzheimer’s disease, and mental illness, than their Medicare-only and Medicaid-only peers. In December 2016, the Department of Health & Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) published a report on social risk factors and performance under Medicare value-based purchasing programs that found 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.<sup>4</sup> In 2012, Medicare-Medicaid enrollees accounted for only 20 percent of all Medicare enrollees, but 34 percent of the costs; similarly, they accounted for only 15 percent of all Medicaid enrollees, but 33 percent of the costs.<sup>5</sup>

**During 2016, 11.7 million Americans were concurrently enrolled in both the Medicare and Medicaid programs.**

For Medicare-Medicaid enrollees, Medicare coverage includes primary and acute health care services and prescription drugs. Medicaid covers a comprehensive range of services, but since other payers (including Medicare) are required to pay for medical costs incurred by a beneficiary before the Medicaid program, Medicaid is considered the payer of last resort. For Medicare-Medicaid enrollees, Medicaid covers:

- supplemental benefits and services such as medical supplies, equipment, and appliances,
- home health (for people who would not qualify for the Medicare home health benefit),
- services not covered by Medicare, such as long-term care services and supports, and
- help to qualifying individuals with low incomes to pay their Medicare premiums and cost-sharing.

A lack of alignment and cohesiveness between the programs can lead to fragmented or episodic care for Medicare-Medicaid enrollees and misaligned incentives for both payers and providers, resulting in reduced quality and increased costs to both programs and to enrollees. Medicare-Medicaid enrollees 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.

## RECOMMENDATIONS FOR LEGISLATIVE ACTION

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CMS recommends the following items for legislative actions that were proposed in the President's FY 2019 budget:<sup>6</sup>

- Permanently Authorize a Successful Pilot on Retroactive Medicare Part D Coverage for Low-Income Beneficiaries;
- Allow for Federal/State Coordinated Review of Dual Eligible Special Needs Plan (D-SNP) Marketing Materials;
- Improve Appeals Notifications for Dually Eligible Individuals in Integrated Health Plans; and
- Clarify the Part D Special Enrollment Period for Dually Eligible Beneficiaries.

Each recommendation is discussed in greater detail below.

### ***Permanently Authorize a Successful Pilot on Retroactive Medicare Part D Coverage for Low-Income Beneficiaries***

Under current law,<sup>7</sup> 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 for Federal/State Coordinated Review of Dual Eligible Special Needs Plan (D-SNP) Marketing Materials***

Under current law,<sup>8</sup> marketing materials provided by Dual Eligible Special Needs Plans 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's experience with joint review conducted under current demonstration authority under the Medicare-Medicaid Financial Alignment Initiative and Minnesota's 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.

### ***Improve Appeals Notifications for Dually Eligible Individuals in Integrated Health Plans***

This recommendation would provide HHS with the authority to streamline the appeals communication requirements imposed on private and non-profit health plans that integrate payment and services for Medicare-Medicaid enrollees. This recommendation is intended to

enhance beneficiary communications so they do not receive conflicting instructions based on differing Medicare and Medicaid requirements, and would improve care coordination for a population with complex and high-cost medical needs.

This recommendation was addressed by Section 50311 of the Bipartisan Budget Act of 2018, signed into law on February 9, 2018, which requires the Secretary to unify grievances and appeals procedures under Sections 1852(f), 1852(g), 1902(a), and 1932(b) of the Social Security Act, to the extent feasible. The unified procedure is to include single written notification of all applicable appeal rights under Medicare and Medicaid. CMS has begun preliminary work to develop a strategy for implementing these statutory changes and soliciting stakeholder input as necessary.

### ***Clarify the Part D Special Enrollment Period for Dually Eligible Beneficiaries***

Under current law,<sup>9</sup> CMS is required to maintain a Special Enrollment Period (SEP) for full-benefit dually eligible beneficiaries. This recommendation would narrow, beginning in plan year 2019, 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. 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.

## **REVIEW OF 2017**

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In support of the following CMS strategic goals and priorities, CMS activities have encouraged individuals, states, providers, and health plans to develop innovative approaches to improving access to high quality integrated care for their populations.

### **1. CMS is improving the customer experience for Qualified Medicare Beneficiaries.**

#### ***Preventing Improper Billing of Medicare Cost Sharing to Qualified Medicare Beneficiaries.***

In 2017, MMCO improved beneficiary experience with the provider billing process through activities designed to reduce 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 by adopting policies that limit payment to the lesser of (a) the Medicare cost sharing amount, or (b) the difference between the Medicare payment and the Medicaid rate for the service. A 2017 publication by the Medicaid and CHIP Payment and Access Commission (MACPAC) showed that most states have adopted such policies.<sup>10</sup>

Part A providers, such as hospitals, can collect bad debt payments to make up part of this difference in payment from Medicare; Part B providers and suppliers, however, including primary care physicians and specialists, are typically not eligible for bad debt payments.

In March 2015, MACPAC summarized its analysis showing that Medicare-Medicaid enrollees (including QMBs, as well as other full-benefit, dually eligible individuals for whom states opt to cover Medicare cost-sharing) have greater access to certain primary care and behavioral health in states that pay a higher percentage of Medicare cost-sharing.<sup>11</sup> In July 2015, CMS published a study quantifying the impact on QMBs' utilization of outpatient services in states that pay less than full Medicare cost sharing. Based on interviews with beneficiaries, the study also found that improper billing and confusion about the QMB billing rules persists, and that these factors, which sometimes lead to referrals to collection agencies, take a negative toll on beneficiaries and their caregivers.<sup>12</sup> Some Medicare providers have also reported that it is difficult for them to identify the QMB status of their patients, including whether they are exempt from any cost sharing obligations.

In Fall 2017, CMS began implementing key changes aimed at empowering beneficiaries as well as providers and suppliers with information that will better facilitate provider and supplier adherence to QMB billing requirements and better inform beneficiaries of their obligations. More specifically, in November 2017, Medicare providers and suppliers could begin to use Medicare eligibility data shared with Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS' HIPAA Eligibility Transaction System (HETS) to verify a beneficiary's QMB status and exemption from cost sharing charges. HETS is widely used by providers, suppliers, and their authorized billing agents to check the Medicare eligibility of their patients prior to submitting claims to Medicare.

Starting July 2018, the Medicare Summary Notice, the document sent to beneficiaries detailing their claims from the past quarter, will identify when a beneficiary is enrolled in the QMB program and will accurately reflect that the beneficiary's cost sharing is \$0 for the period he or she is enrolled in the QMB program. Starting July 2018, providers and suppliers who serve beneficiaries enrolled in Original Medicare will be able to readily identify beneficiaries' QMB status and billing prohibitions from the Medicare Provider Remittance Advice, the statement the Medicare Administrative Contractors (MACs) send to providers after processing their claims. To raise provider and beneficiary awareness of these changes, CMS highlighted them through a new QMB billing webpage, Medicare Learning Network (MLN)<sup>®</sup> email newsletters, publications and trainings for providers, and presentations for State Health Insurance Assistance Programs (SHIPs) and beneficiary advocates.<sup>13</sup>

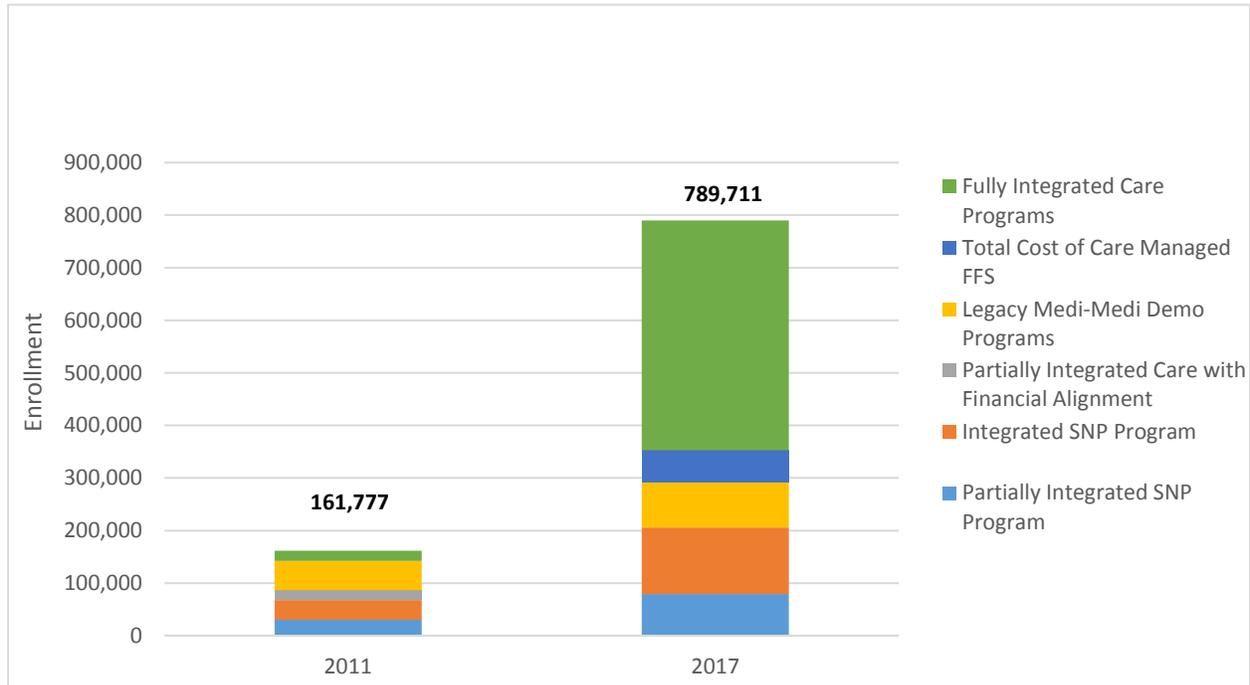
In addition, CMS has taken a number of other steps to improve CMS customer service for beneficiaries, providers, and plans and to alleviate confusion about QMB billing requirements. For example, in September 2016, 1-800-MEDICARE implemented new protocols to advise and assist QMB callers, and in December 2016 began escalating beneficiary reports of persistent billing to the MACs to issue letters to the beneficiary's provider requesting resolution of any billing problems. Further, to enhance beneficiary education and supports, CMS held internal QMB trainings in 2016 and 2017 for CMS staff, and partnered with the HHS Administration on Community Living and beneficiary organizations to hold webinars and release new materials to educate beneficiaries, SHIPs, and other intermediaries about QMB protections.

CMS reiterated the QMB billing requirements and ways to promote provider compliance in the calendar year (CY) 2017 Physician Fee Schedule Rule and in updated MLN articles. In 2016 and 2017, CMS also reiterated Medicare Advantage plan requirements in various guidance materials, including the CY 2017 Call Letter and other written guidance and presentations.<sup>14</sup> In June 2017, CMS issued guidance to Medicare Advantage plans regarding how to identify the QMB status of enrollees through existing CMS sources and recommending concrete steps to promote compliance with QMB billing rules.<sup>15</sup> In 2018, CMS included additional suggestions for Medicare Advantage plans in the CY 2019 Draft Call Letter about resources and specific strategies for promoting compliance. During Summer 2016, CMS engaged in strategic conversations with Medicare Advantage organizations to discover their technical assistance needs and learn about concrete strategies to promote compliance.

## **2. CMS is supporting innovative approaches to improving quality, accessibility, and affordability.**

One vehicle for innovation is through integrated care and financing models. MMCO has focused on initiatives to better integrate and strengthen access to care for Medicare-Medicaid enrollees and to eliminate unnecessary cost shifting between the two programs. There are a range of approaches to integrating Medicare and Medicaid benefits and/or financing, and the number of Medicare-Medicaid enrollees in integrated care and/or financing models has increased over time. Figure 1 summarizes enrollment by program type in 2011 and 2017.

**Figure 1. Total Integrated Care Enrollment by Program Type: 2011 and 2017<sup>16</sup>**



MMCO has been also measuring the 30-day all-cause hospital readmissions rate for Medicare-Medicaid enrollees in Original Medicare as an outcome of better coordinated care and quality of care. Since 2012, the measure's baseline year, MMCO has seen an overall reduction in fee-for-service hospital readmissions for Medicare-Medicaid enrollees of 8.7%, from 92.7 readmissions per 1,000 beneficiaries in 2012 to 84.0 per 1,000 beneficiaries in 2015.<sup>17</sup>

***Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.***

Phase I: Unnecessary hospitalizations can be disruptive and dangerous for nursing facility residents and costly for Medicare. Through the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents (the Initiative),<sup>18</sup> CMS funded seven organizations, known as Enhanced Care and Coordination Providers (ECCPs), to test strategies to reduce avoidable hospitalizations for Medicare and Medicaid enrollees who are long-stay residents of nursing facilities. These organizations provided clinical staff and/or staff training in partnership with 143 nursing facilities to test evidence-based interventions over a four-year period. The first phase of the initiative ran from 2013 – 2016.<sup>19</sup>

CMS has contracted with an independent evaluator to measure and evaluate the overall impact of each phase of the Initiative. This effort includes looking at the quantitative impacts on quality,

utilization, and Medicare and Medicaid expenditures, as well as qualitative observations on implementation and performance.

The final independent evaluation report of the first phase of the Initiative was published in October 2017.<sup>20</sup> The report found that all seven sites reduced hospitalizations, with six of the seven achieving statistically significant improvement in all-cause hospitalizations, potentially avoidable hospitalizations, or both. Total Medicare expenditures were reduced in six of the seven sites, with statistical significance in four sites. If the intervention cost is taken into account, four of the seven sites achieved Medicare expenditure reductions in excess of costs, though overall the difference was not statistically significant.

The report found the strongest improvements in both cost and quality at the intervention sites with a full-time nurse at each facility providing direct care to residents. These models demonstrated greater changes in facility culture, greater support for the need to reduce avoidable hospitalizations, and greater overall buy-in to the Initiative from facility staff, resulting in stronger intervention effects. Intervention sites where nurses did not provide direct care, or where nurses rotated across multiple facilities, showed less consistent effects.

According to the report, "Overall, these findings provide persuasive evidence of the Initiative's effectiveness in reducing hospital inpatient admissions, ED visits, and hospitalization-related Medicare expenditures."<sup>21</sup>

Phase II: CMS is newly implementing a second phase of the Initiative<sup>22</sup> to test whether three new fee-for-service payments for nursing facilities and practitioners will further reduce avoidable hospitalizations, lower combined Medicare and Medicaid spending, and improve the quality of care received by nursing facility residents.

The new payment reforms aim to reduce avoidable hospitalizations by funding higher-intensity interventions in nursing facilities for residents who may otherwise be hospitalized upon an acute change in condition (examples include intravenous treatment, respiratory therapy, and cardiac monitoring). The Initiative includes fee-for-service billing codes for practitioners to diagnose and treat acute changes in condition in the nursing facility setting at the same payment rate as for a comparable visit in a hospital setting. Practitioners can also bill Medicare for increased provider engagement in multidisciplinary care planning activities.

***Programs of All-Inclusive Care for the Elderly (PACE).***

Programs of All-Inclusive Care for the Elderly (PACE) provide comprehensive medical and social services to certain frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals works with PACE participants to coordinate care. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home.

In August 2016, CMS issued a proposed rule to update the PACE program.<sup>23</sup> The proposal is intended to help the program reflect the latest advances in caring for frail elders and changes in the use of technology. The proposal also aims to strengthen protections for PACE participants and

**In Phase One of the NFI, all seven participants reduced both potentially avoidable and all-cause hospitalizations. For six of the participants, those reductions were statistically significant for either or both measures.**

provide PACE organizations with more administrative and operational flexibilities so they can do what they do best – care for our nation’s most vulnerable individuals.

The PACE Innovation Act of 2015 (PIA) provides authority to waive certain provisions of Section 1934 of the Social Security Act in order to test applications of PACE-like models for additional populations, including populations under the age of 55, and those who do not qualify for a nursing home level of care. In December 2016, CMS released a Request for Information (RFI) describing potential adaptations to the PACE model of care for a potential model test serving younger dually eligible individuals with mobility-related impairments, and in July 2017 published cost and payment related data for this model. The December RFI also sought feedback on additional populations who might experience improved care under potential model tests under the PIA. CMS received a wide array of comments from states, PACE organizations, and other providers and beneficiary advocates in response to the RFI.<sup>24</sup> Many commenters were supportive of adapting the PACE model of care to improve community integration for younger individuals with physical disabilities. Commenters also advocated using the authority provided by the PIA to conduct model tests that leveraged PACE organizations’ experience providing coordinated care for the frail elderly. CMS has reviewed responses to the RFI and is incorporating this feedback as it considers options for how to proceed with a potential model test under the PIA.

### 3. CMS is ushering in a new era of state flexibility and local leadership.

***Medicare-Medicaid Financial Alignment Initiative.*** Through the Medicare-Medicaid Financial Alignment Initiative (the Financial Alignment Initiative) and related work, CMS is partnering with states to test state-specific demonstrations that integrate primary, acute, and behavioral health care, and long-term services and supports for Medicare-Medicaid enrollees. The Financial Alignment Initiative includes a capitated model and a managed fee-for-service model. Under the capitated model, a state, CMS, and a health plan enter into a three-way contract, and the health plan receives a prospective blended payment to provide comprehensive, coordinated Medicare and Medicaid services. Under the managed fee-for-service model, a state and CMS enter into an agreement by which the state is eligible to benefit from a portion of the savings from initiatives that improve quality and reduce costs of Medicare and Medicaid services. Although the approaches differ in each demonstration to best serve the needs of the local population, beneficiaries in every version of the model receive their full array of Medicare and Medicaid benefits, with added care coordination, beneficiary protections, and access to additional or enhanced services.<sup>25</sup>

In 2017, CMS continued to partner with states and health plans under the Financial Alignment Initiative. As of September 1, 2017, there were 14 demonstrations in 13 states.<sup>26</sup> Eleven of these demonstrations, including two in New York, are testing the capitated model, serving nearly 408,000 beneficiaries as of September 1, 2017.<sup>27</sup> Two demonstrations, in Colorado and Washington, are testing the managed fee-for-service model, serving approximately 62,180 beneficiaries as of September 1, 2017. CMS is partnering with Minnesota to implement an alternative model testing Medicare and Medicaid administrative alignment activities, building on the longstanding Minnesota

**Health plans in ten states are serving nearly 408,000 beneficiaries in capitated model demonstrations as of September 1, 2017.**

Senior Health Options program, and serving 38,570 Medicare-Medicaid enrollees as of September 1, 2017.<sup>28</sup>

Approved demonstrations are at different stages of implementation. Start dates range from July 2013 for the Washington managed fee-for-service demonstration to July 2016 for the Rhode Island capitated demonstration. The Virginia and Colorado demonstrations concluded as scheduled at the beginning of CY 2018. In both states, enrollees will continue to have access to care coordination and support services through integrated care initiatives that build upon demonstration experiences.

**Table 2. Medicare-Medicaid Financial Alignment Initiative Enrollment by State**

State	Geographic Area	Enrollment (As of 9/1/2017)
California	7 of 58 counties	118,264
Colorado	Statewide	28,699
Illinois	21 of 102 counties	51,981
Massachusetts	9 of 14 counties	17,544
Michigan	25 of 83 counties	39,891
Minnesota	Statewide	38,570
New York FIDA	6 of 62 counties	4,600
New York FIDA I/DD	9 of 62 counties	617
Ohio	29 of 88 counties	77,824
Rhode Island	Statewide	13,605
South Carolina	38 of 46 counties	12,049
Texas	6 of 254 counties	46,109
Virginia	66 of 95 counties*	25,277
Washington	Statewide	33,481
<b>Total Enrollment</b>		<b>508,511</b>

\*The Virginia demonstration service area also includes 32 of 38 independent cities.

CMS has contracted with an independent evaluator to measure and evaluate the overall impact of the demonstrations under the Financial Alignment Initiative. This effort looks at the beneficiary experience of care, impacts on quality and beneficiary-level outcomes, and Medicare and Medicaid costs. State-specific evaluation plans are available on the Financial Alignment Initiative website.<sup>29</sup> To date, CMS has released the first annual evaluation reports for the Washington, Massachusetts, and Minnesota demonstrations.<sup>30</sup>

In 2016 and 2017, CMS also released four multi-demonstration evaluation reports covering various aspects of early implementation across demonstration states.<sup>31</sup> CMS also makes performance data from demonstration reporting and other sources available on the MMCO website.<sup>32</sup>

**Resources for States.** In 2017, CMS continued to make the following resources available to states to support their ability to use data-driven insights to ensure cost effective care and outcome improvements:

- **Integrated Care Resource Center (ICRC).** The ICRC serves as a technical resource center for states that are interested in integrating services and financing for Medicare-Medicaid enrollees. The ICRC assists states with program design, stakeholder engagement, data analysis,

and other functions. The ICRC also facilitates the sharing of best practices across states. This resource is available to all states. In FY 2017, the ICRC worked directly with 41 states, and provided small group learning events and hosted webinars on topics of interest to others.

- **State Data Resource Center (SDRC).** The SDRC provides assistance to states on using and accessing Medicare data, along with hosting webinars and bi-monthly Medicare Data Workgroup calls. To date, 48 states have contacted CMS to about obtaining Medicare Parts A, B, and D data to support care coordination, program integrity, and quality measures for Medicare-Medicaid enrollees. In FY 2017, 47 states participated in SDRC programs and 29 states are actively receiving data.
- **Medicare-Medicaid Data Integration (MMDI) Team.** CMS created the Medicare-Medicaid Data Integration Team to provide technical assistance to states on the successful integration of Medicare and Medicaid data to improve care coordination and address program integrity for the Medicare-Medicaid enrollee population. In FY 2017, the MMDI Team assisted Colorado, Minnesota, Ohio, Rhode Island, and Virginia. In this same year, with funding from the Medicaid Innovation Accelerator Program, the MMDI Team provided technical support to Alabama, District of Columbia, New Hampshire, New Jersey, and Pennsylvania to support the integration of Medicare and Medicaid data. The team also developed tools to support states in meeting their care coordination goals for Medicare-Medicaid enrollees and use cases that provide states with detailed examples of analyses that utilize integrated data and also support care coordination and program integrity.

#### 4. CMS is empowering Medicare-Medicaid enrollees to make decisions about their health care.

***Funding to Support Medicare-Medicaid Enrollee Choices and Protections.*** Since the start of the Financial Alignment Initiative, CMS has provided support through two separate-but-related programs for states to assist beneficiaries with making enrollment decisions and with resolving care delivery or other concerns that may arise:

- **Funding for Ombudsman Services.** CMS requires 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.
- **Funding 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, CMS provides additional funds 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 2017, CMS had awarded funds to 11 states, in support of more than 340,000 demonstration enrollees plus additional demonstration-eligible beneficiaries since the beginning of the Financial Alignment Initiative.<sup>33</sup>

## CONCLUSION

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In 2017, MMCO worked to improve 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. MMCO contends that the legislative recommendations, if implemented, would help further these goals. MMCO continues to examine other policy areas that have the potential to improve the experience of Medicare-Medicaid enrollees.

Through continuous collaboration with state and federal partners, and with beneficiaries and their caregivers, advocates, providers, and other stakeholders, MMCO will continue to explore, implement, and improve approaches to integrate Medicare and Medicaid service delivery and financing. MMCO looks forward to continuing to work with the Congress and is committed to keeping the Congress and other stakeholders apprised of its work, and broader agency efforts, to promote quality, coordinated care for all Medicare-Medicaid enrollees.

## NOTES

<sup>1</sup> [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/Eleven-YearEver-EnrolledTrendsReport\\_2006-2016.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/Eleven-YearEver-EnrolledTrendsReport_2006-2016.pdf).

<sup>2</sup> [“Eleven-year Ever-enrolled Trends Report - Accompanying Data Tables \(2006-2016 Data\)” available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html.](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html)

<sup>3</sup> This column includes full benefit and partial benefit Medicare-Medicaid enrollees. “Partial benefit” Medicare-Medicaid enrollees refers to individuals who receive assistance from Medicaid with payment of Medicare cost sharing but are not otherwise eligible for Medicaid benefits. “Full benefit” Medicare-Medicaid enrollees are eligible for full Medicaid benefits in addition to assistance with Medicare cost sharing.

<sup>4</sup> <https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf>.

<sup>5</sup> [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NationalProfile\\_2012.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NationalProfile_2012.pdf).

<sup>6</sup> <https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf>.

<sup>7</sup> Social Security Act §1860D-1(b)(1)(C), §1860D-15.

<sup>8</sup> Social Security Act §1851(h), § 1860D-1(b)(1)(B)(vi).

<sup>9</sup> Social Security Act §1860D-1(b)(3)(D).

<sup>10</sup> <https://www.macpac.gov/publication/state-medicaid-payment-policies-for-medicare-cost-sharing-2016/#>.

<sup>11</sup> <https://www.macpac.gov/wp-content/uploads/2015/03/Effects-of-Medicaid-Coverage-of-Medicare-Cost-Sharing-on-Access-to-Care.pdf>.

<sup>12</sup> [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](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).

<sup>13</sup> The MLN® article describing the July 2018 changes is at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10433.pdf>. Materials for providers and beneficiary advocates are posted on the MMCO QMB website at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html>.

<sup>14</sup> For CY 2017 plan instructions, see e.g., Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Announcement2017.pdf>. See also, HPMS memo, “2017 Readiness Checklist for Medicare Advantage Organizations, Prescription Drug Plans, and Cost Plans” October 26, 2017.

<sup>15</sup> See HPMS memo, “Qualified Medicare Beneficiary Program Enrollee Status Resources” June 21, 2017.

<sup>16</sup> Source: analysis performed by the Integrated Care Resource Center, under contract with CMS. “Fully Integrated Programs/Models” include MMP and PACE enrollment through July 2017. “Total Cost of Care Managed FFS” includes enrollment in the Colorado and Washington Managed Fee-For-Service demonstrations under the Medicare-Medicaid Financial Alignment Initiative. “Legacy Medi-Medi Demo Programs” includes enrollment in FIDE SNP programs in Massachusetts, Minnesota, and Wisconsin that began as demonstrations. “Partially Integrated Care with Financial Alignment” refers to the North Carolina Medicare Health Care Quality Demonstration; no 2015, 2016, or 2017 information is included because the initiative had ended. “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.

<sup>17</sup> 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.

<sup>18</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/AvoidableHospitalizationsamongNursingFacilityResidents.html>.

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- <sup>19</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NFPAHFinalReport092017.pdf>.
- <sup>20</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NFPAHFinalReport092017.pdf>.
- <sup>21</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NFPAHFinalReport092017.pdf>.
- <sup>22</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/PhaseTwoPaymentReform.html>.
- <sup>23</sup> <https://www.federalregister.gov/documents/2016/08/16/2016-19153/medicare-and-medicaid-programs-programs-of-all-inclusive-care-for-the-elderly-pace>.
- <sup>24</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACE/PACE-Innovation-Act.html>.
- <sup>25</sup> For example, in Massachusetts beneficiaries have access to new services such as diversionary behavioral health services and expanded dental benefits. <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MassMOU.pdf>.
- <sup>26</sup> CA, CO, IL, MA, MI, MN, NY, OH, RI, SC, TX, VA, WA.
- <sup>27</sup> CA, IL, MA, MI, NY, OH, RI, SC, TX, VA.
- <sup>28</sup> 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. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Minnesota.html>.
- <sup>29</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.
- <sup>30</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.
- <sup>31</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.
- <sup>32</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html>.
- <sup>33</sup> CA, CO, IL, MA, MI, NY, OH, RI, SC, VA, WA.