



MEDICARE- MEDICAID COORDINATION OFFICE



FY 2019 Report to Congress

Introduction

The Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office,” hereinafter “MMCO”) was established by statute to improve the coordination between the federal government and states to enhance access to quality services for individuals dually eligible for both Medicare and Medicaid benefits (“dually eligible individuals”). MMCO is submitting its annual report to Congress.

The Medicare and Medicaid programs were originally created as distinct programs with different purposes. Not surprisingly, the programs have different rules for eligibility, covered benefits, and payment, and the programs have operated as separate and distinct systems despite a growing number of people who depend on both 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 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 60 million individuals estimated to be covered by Medicare and more than 75 million individuals covered by Medicaid in 2019, we are focused on integrated service delivery as a means toward improving quality, beneficiary-centered care, bending the health care cost curve, and using data to inform the design and continuous improvement of new initiatives.¹

In this report, we discuss some of the ways in which we have carried out activities to better serve dually eligible individuals in 2019, including modernizing the Medicare Savings Programs (MSPs); creating new opportunities for innovative, integrated care; and improving beneficiary outcomes, including reductions in hospital readmissions for dually eligible individuals.

This report contains four legislative proposals, which are also included in the President’s Fiscal Year (FY) 2021 Budget. As we continue our work in collaboration with state and federal partners, and with beneficiaries and their caregivers, advocates, providers, and other stakeholders, we will continue to identify areas where regulatory or legislative changes are needed to improve care coordination and benefits.



About Dually Eligible Individuals



During 2019, 12.2 million Americans² were concurrently enrolled in both the Medicare and Medicaid programs. These individuals must navigate two separate programs: Medicare for the coverage of most preventive, primary, and acute health care services and drugs, and Medicaid for coverage of long-term services and supports, certain behavioral health services, and for help with Medicare premiums and cost sharing.

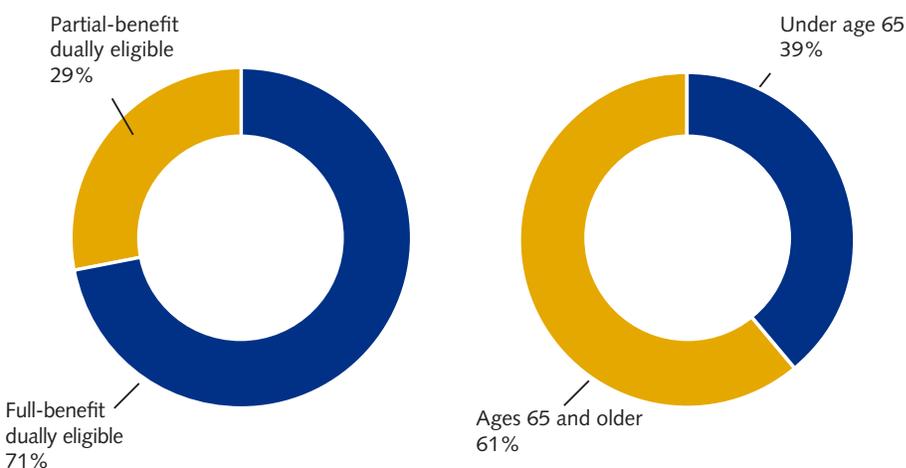
Dually eligible individuals may either be enrolled first in Medicare by virtue of age or disability and then qualify for Medicaid on the basis of income, or vice versa. They may also be full-benefit dually eligible individuals, who qualify for the full range of Medicaid services, or partial-benefit dually eligible individuals, who receive assistance only with Medicare premiums and, in most cases, assistance with 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. In December 2016, the HHS Office of the Assistant Secretary for Planning and Evaluation published a report that found Medicare beneficiaries with social risk factors had worse health outcomes on many quality measures, regardless of the providers they saw,

and that dual eligible status was the most powerful predictor of poor outcomes.³ Historically, dually eligible individuals accounted for 20 percent of all Medicare enrollees, but 34 percent of the costs; similarly, they accounted for 15 percent of all Medicaid enrollees, but 33 percent of the costs.⁴

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

Dually Eligible Individuals by Age and Type of Benefit



shoulder the burden of such investments without sharing in the acute care savings. Dually eligible individuals could benefit from more integrated systems of care that meet all of their needs — primary, acute, long-term, behavioral, and social — in a high quality, cost-effective manner. Better alignment of the administrative, regulatory, statutory, and financial aspects of these two programs holds promise for improving the quality and cost of care for this complex population.

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

- **70% of dually eligible individuals have three or more chronic conditions (vs. 52% of Medicare-only beneficiaries)⁴**
- **41% have at least one mental health diagnosis (vs. 16% of Medicare-only beneficiaries)⁴**
- **38.6% are eligible for Medicare due to disability (vs. 8.4% of Medicare-only beneficiaries)⁵**



Recommendations for Legislative Action



We recommend the following items for legislative actions that are proposed in the President's FY 2021 Budget:

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

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

Clarify PACE organizations' coverage of inpatient hospital stays.

Under this legislative proposal, CMS would require PACE organizations to cover PACE participants' entire hospital stay, even for beneficiaries who change coverage during the hospital stay. This would help ensure a more seamless transition from PACE into other types of Medicare and Medicaid coverage. Additionally, this change would eliminate payment disputes, provide beneficiary protections, and reduce the administrative burden associated with appealing unpaid claims in an effort to resolve those disputes.

Clarify the Part D Special Enrollment Period for dually eligible individuals.

Under current law,⁶ CMS is required to maintain a Special Enrollment Period (SEP) for full-benefit dually eligible beneficiaries. This recommendation would narrow, beginning in plan year 2021, the applicability of the SEP by specifying that the intent is to promote integration of Medicare and Medicaid coverage and to allow individuals to make alternative choices following auto-assignment into a Part D plan. The SEP would be limited to either a change of plan following auto-assignment into a Part D plan or enrollment into a health plan or other program (such as PACE) that integrates Medicare and Medicaid coverage. This recommendation is intended to allow CMS to apply the same annual election process for both dually eligible and non-dually eligible beneficiaries, but preserve the ability for dually eligible beneficiaries to use an SEP to opt into integrated care programs or to change plans following auto-assignment. Efficient use of the Part D SEP for full-benefit dual eligible beneficiaries reduces aggressive marketing targeted to low-income beneficiaries, improves incentives to make investments in and provide care coordination for high-cost, often vulnerable beneficiaries, and reduces the administrative burden on health plans from beneficiary fluctuations between plans numerous times throughout the year.

Allow for federal/state coordinated review of Dual Eligible Special Needs Plan marketing materials.

Under current law,⁷ marketing materials provided by Dual Eligible Special Needs Plans (D-SNPs) to beneficiaries have to go through separate state and CMS review processes. This recommendation would allow for joint state and CMS review, building on CMS' experience with joint review

conducted under current demonstration authority under the Medicare-Medicaid Financial Alignment Initiative and the Minnesota demonstration testing Medicare and Medicaid administrative alignment activities. The recommendation is intended to lower administrative burden on participating plans and enhance plans' ability to provide a uniform message to beneficiaries.



What We Are Doing



In 2019, CMS Administrator Seema Verma made “Better Care for Dually Eligible Individuals” one of the Agency’s strategic initiatives. Under this initiative, CMS is redoubling efforts to improve quality, reduce costs, and improve the customer experience for people eligible for both Medicare and Medicaid.

Our work focuses 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 fall into two primary areas:

1. Modernizing Medicare Savings Programs (MSPs) and state data exchange, and
2. Promoting integrated care

In addition, we are working with states and Medicare Advantage plans to ensure continuity of care for dually eligible individuals using Opioid Treatment Program (OTP) services. On January 1, 2020, with the implementation of a new Medicare OTP benefit, Medicare became the primary payer for OTP services for dually eligible individuals who, in most states, may previously have obtained OTP services through Medicaid. CMS issued an Informational Bulletin to state Medicaid agencies providing background information on the Medicare enrollment of providers for this benefit and clarifying options available for coordination of benefits/third party liability under Medicaid. We also issued guidance to Medicare Advantage plans on promoting access to OTP services, including preserving continuity for dually eligible individuals already in treatment with an OTP provider on January 1, 2020.

MODERNIZING THE MEDICARE SAVINGS PROGRAMS (MSPs)

Millions of Americans rely on the Medicare Savings Programs 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.⁸ 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 only exacerbate coordination challenges and contribute to beneficiary access problems.

In December 2018, we released a State Medicaid Director letter highlighting opportunities for states to simplify MSP eligibility and enrollment processes, and other opportunities for states to better serve dually eligible individuals, none of which require complex demonstrations or Medicare waivers.⁹

We are also taking action to address these challenges by:

Reducing Improper Billing of Qualified Medicare Beneficiaries (QMBs)

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

By law, Medicare providers may not bill QMBs for Medicare Parts A and B cost sharing amounts. Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state’s Medicare cost sharing payments. Nonetheless, improper billing and confusion about the QMB billing requirements among providers and beneficiaries persists. Feedback from Medicare providers and associations indicates that providers face barriers in identifying the QMB status of their patients.

Internal CMS analysis found that our Medicare eligibility information sent to providers and notices issued to beneficiaries and providers after fee-for-service claims could be enhanced to indicate when an individual is a QMB and cannot be billed for Medicare cost sharing.

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

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

In FY 2019, we educated providers and beneficiaries about these changes and about QMB billing requirements more broadly. Feedback from providers and beneficiaries has been positive, and indicates the changes may be helping to reduce billing issues. We are currently building the capacity to more systematically track incidences of inappropriate billing reported to CMS to assess the impact of our efforts and guide future work in this area.

Interoperability Rule

In FY 2019, CMS proposed the Interoperability and Patient Access Rule to mandate 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 these individuals in Medicare drug plans; deem them automatically eligible for the low income subsidy for Part D premiums, deductibles, and copayments; and terminate or activate state payment of Medicare premiums.

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

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. Fewer than 10% of dually eligible individuals are in integrated care. We are working to increase this percentage in a variety of ways, including through new and existing 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 in 2011 and 2019.

Figure 1. Total Integrated Care Enrollment by Program Type: 2011 and 2019¹⁰

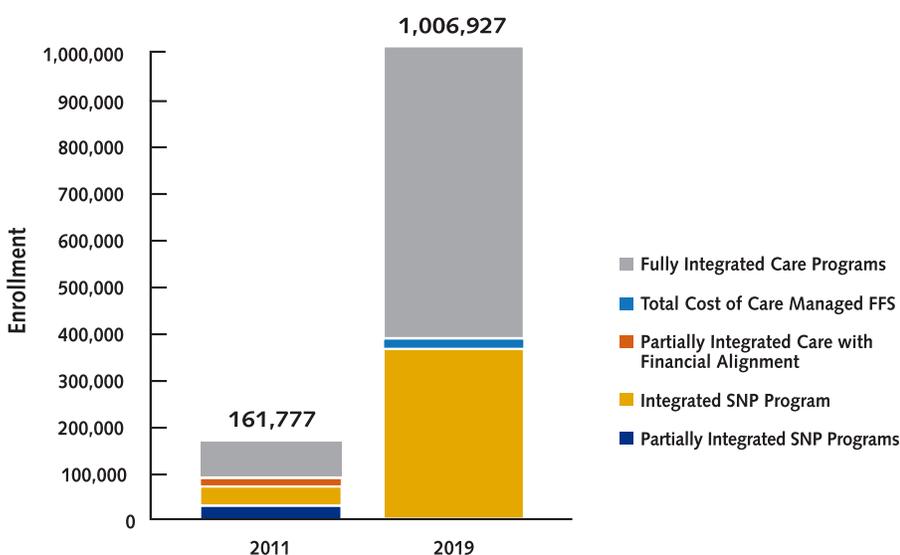
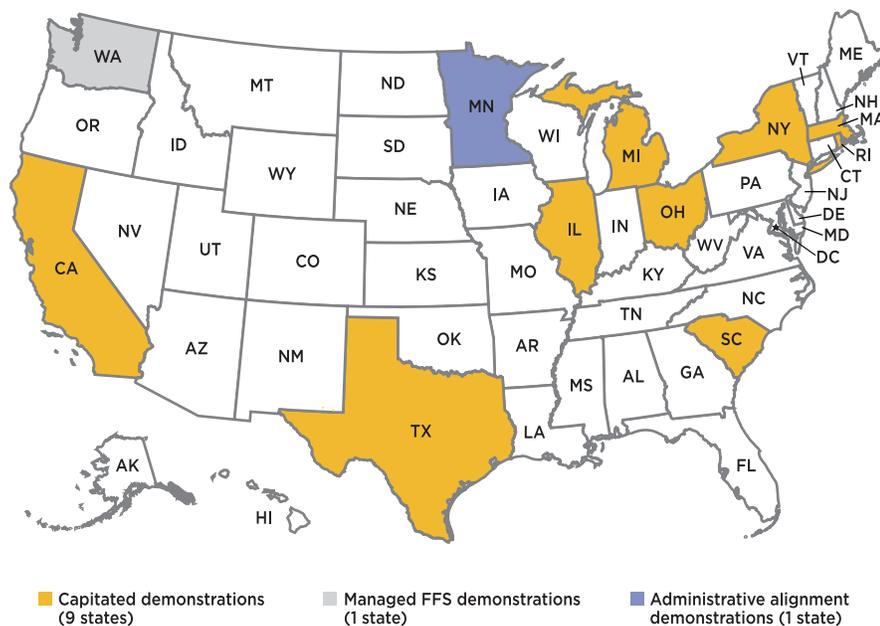


Figure 2. Demonstrations Under the Financial Alignment Initiative, 2019



Medicare-Medicaid Financial Alignment Initiative¹¹

In 2019, the demonstrations under the Medicare-Medicaid Financial Alignment Initiative (the Financial Alignment Initiative) accounted for more than 40% of integrated care enrollment nationally. Through the Financial Alignment Initiative and related work, we are partnering with states to test demonstrations that integrate primary, acute, and behavioral health care, and long-term services and supports for dually eligible individuals. As of September 1, 2019, there were 11 demonstrations in 10 states, serving over 400,000 dually eligible individuals.¹² 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 September 1, 2019.¹³

Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (NFI)¹⁴

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

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

On May 28, 2019, CMS finalized a rule¹⁵ to update and modernize the PACE program by strengthening protections and improving care for PACE participants, and providing

administrative flexibility and regulatory relief for PACE organizations. The rule reflects updates based upon best practices in caring for frail and elderly individuals, including implementing a more flexible approach to the composition of the interdisciplinary team that is central to the coordinated care participants receive from PACE organizations in order to allow the team to better meet beneficiaries' needs. In addition, we finalized a number of other flexibilities, including allowing non-physician primary care practitioners to provide some services in the place of primary care physicians. This gives PACE organizations flexibility to improve efficiency, while ensuring they continue to meet the needs and preferences of beneficiaries. The majority of participants

PACE serves are dually eligible individuals. More than 45,000 older adults are currently enrolled in more than 100 PACE organizations in 31 states, and enrollment in PACE has increased by over 120 percent since 2011.¹⁶

Dual Eligible Special Needs Plans (D-SNPs)

Section 50311(b) of the Bipartisan Budget Act of 2018 (Public Law No. 115-123) created a new Section 1859(f)(8) of the Social Security Act in order to increase integration of D-SNPs. With this expanded authority, we finalized in the 2020 Medicare Advantage and Part D final rule¹⁷ policies that create standards to better integrate Medicare Advantage D-SNPs, as well as new Medicare-Medicaid unified appeals and grievance processes for beneficiaries in certain integrated plans.

Direct Contracting (DC) Model¹⁸

The DC Model is a voluntary payment model that creates an opportunity for a broad range of organizations to partner with CMS in testing risk-sharing arrangements that promote high quality health care and create value for beneficiaries in Medicare fee-for-service, including dually eligible individuals. The DC Model will test novel methods for participating organizations to manage Medicare fee-for-service expenditures and better integrate care for dually eligible individuals, including through organizations serving high needs populations through a PACE-like care model.

Opportunities to Test Innovative Models of Integrated Care

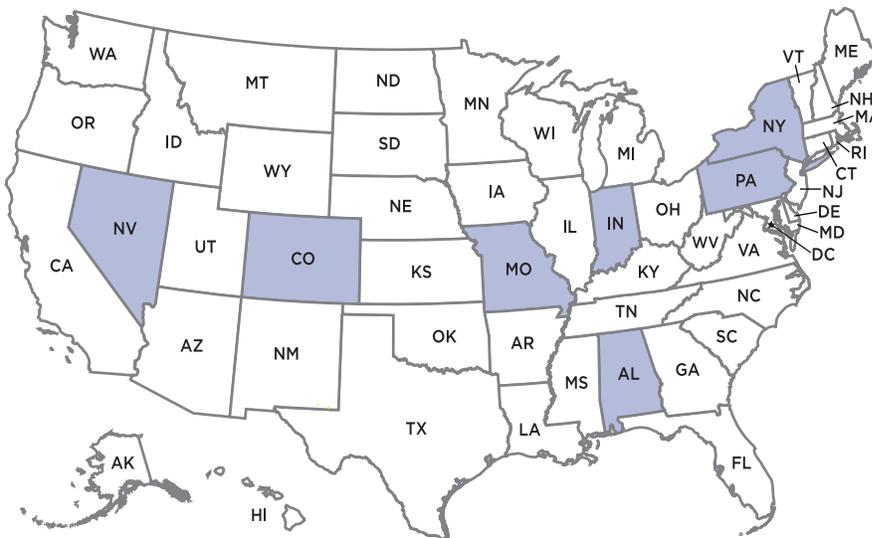
We have continued to hear from states that they want opportunities to develop, revise, or continue the approaches to serving dually eligible individuals that work best for their populations. In response, we are driving innovation in integrated care through new and existing CMS models and demonstrations. On April 24, 2019, we released a State Medicaid Director letter inviting states to partner with CMS to test innovative approaches to better serve individuals dually eligible for Medicare and Medicaid.¹⁹ Approaches discussed in the State Medicaid Director letter include: integrating care through two options under the current Financial Alignment Initiative — the capitated financial alignment model and the managed fee-for-service model — and state-specific models that would give states additional flexibility. In 2019, we effectuated extensions in the capitated model demonstrations under the Financial Alignment Initiative operating in California, Illinois, Massachusetts, and Ohio. We look forward to working with states on any or all of these opportunities.

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 Original Medicare as an outcome of better coordinated care and quality of care. Fee-for-service hospital readmissions for dually eligible individuals have declined by nearly nine percent from 2012 to 2017.²⁰
- **Lower hospitalization rate among long-stay nursing facility residents.** From 2013-2016, all seven sites in the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents reduced hospitalizations, with six of the seven achieving statistically significant improvement in all-cause

Figure 3. Initiative to Reduce Avoidable Hospitalizations for Nursing Facility Residents, Participating Facility Locations, 2019



hospitalizations, potentially avoidable hospitalizations, or both. Please see the full evaluation report for additional analysis, including other quality and expenditure results.²¹

- **Lower hospitalization and skilled nursing facility (SNF) rates in integrated managed care.** A rigorous external evaluation is underway for the demonstrations under the Financial Alignment Initiative. Where data are available, the evaluation includes regression-based analysis of service utilization. Based on results to date, four of five capitated model demonstrations with reports released through 2019 showed significant declines in inpatient utilization.²² Three of four demonstrations showed significant declines in SNF utilization.²³
- **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).²⁴ We have also seen increasing access to care coordination within the capitated model demonstrations, including a 30 percent increase in health risk assessment completion and a 60 percent increase in care plan completion from 2014 to 2018.²⁵
- **Medicare savings in Washington Health Home demonstration.** An independent evaluation of the Washington state demonstration under the Financial Alignment Initiative found that the initiative has achieved \$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.²⁶

Conclusion



Through collaborative efforts with state and federal partners, and with beneficiaries and their caregivers, advocates, providers, and other stakeholders, we made great strides in 2019 to improve dually eligible beneficiaries' experiences with the Medicare and Medicaid programs. We will continue the "Better Care for Dually Eligible Individuals" strategic initiative to implement and improve approaches to integrate Medicare and Medicaid service delivery and financing. We are committed to examining policy areas that have the potential to improve the experience of dually eligible individuals.

The legislative recommendations, if implemented, would help further our work as we look to 2020 and beyond. We will continue to work with the Congress and commit to keeping all of our partners apprised of our work and broader agency efforts to improve quality, reduce costs, and improve the customer experience for people eligible for both Medicare and Medicaid.



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

² <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2018.pdf>

³ <https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf>

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

⁵ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2018.pdf>

⁶ Social Security Act §1860D-1(b)(3)(D)

⁷ Social Security Act §1851(h), § 1860D-1(b)(1)(B)(vi)

⁸ “Better Care For People Dually Eligible For Medicare And Medicaid,” Health Affairs Blog, April 24, 2019. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20190423.701475/full/>

⁹ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf>

¹⁰ 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 2019. This category also includes the FIDE SNPs previously noted as “Legacy Medi-Medi Demo Programs” and categorized separately in previous reports. “Total Cost of Care Managed FFS” includes enrollment in the Washington Managed Fee-For-Service demonstration under the Medicare-Medicaid Financial Alignment Initiative. “Integrated SNP Program” enrollment includes programs in which a dually eligible individual receives both Medicare and Medicaid services from companion or aligned Medicare D-SNPs and Medicaid managed care plans; several state programs were reclassified from partially integrated to integrated to align with the integration standards for D-SNPs finalized in the 2020 Medicare Advantage and Part D final rule. “Partially Integrated Care with Financial Alignment” refers to the North Carolina Medicare Health Care Quality Demonstration, for which no 2019 information is included because the initiative had ended. No state data was available in July 2019 for “Partially Integrated SNP Program” enrollment. The 2019 analysis newly includes data from existing integrated care options in Oregon, select D-SNPs in California, and FIDE-SNPs and certain types of D-SNPs in Florida.

¹¹ For additional information about the Medicare-Medicaid Financial Alignment Initiative, see <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>

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

¹³ CMS is also continuing to work with some states to pursue demonstrations designed to improve care for dually eligible individuals 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. For more information, see <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Minnesota.html>

¹⁴ 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>

¹⁵ <https://www.cms.gov/newsroom/fact-sheets/programs-all-inclusive-care-elderly-pace-final-rule-cms-4168-f>

¹⁶ <https://www.cms.gov/newsroom/fact-sheets/programs-all-inclusive-care-elderly-pace-final-rule-cms-4168-f>

¹⁷ <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>

¹⁸ <https://innovation.cms.gov/initiatives/direct-contracting-model-options/>

¹⁹ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd19002.pdf>

²⁰ CMS analysis using data from the CMS Geographic Variation Database (Foundation of the Chronic Conditions Warehouse)

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

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

²³ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>

²⁴ CMS analysis

²⁵ CMS analysis

²⁶ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalReport3.pdf>