

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MEDICARE-MEDICAID COORDINATION OFFICE

FISCAL YEAR 2016 REPORT TO CONGRESS



INTRODUCTION

The Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office” hereinafter “MMCO”) is submitting its annual report to Congress. The purpose of MMCO includes helping to improve the coordination between the federal government and the 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”).

During 2015, 11.4 million Americans¹ 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. Individuals enrolled in both programs are more likely to have qualified based on a disability than Medicare-only beneficiaries (52 percent of enrollees versus 17 percent), as illustrated in Table 1.

Table 1. Basis for Medicare-Only versus Medicare-Medicaid Enrollee Eligibility²

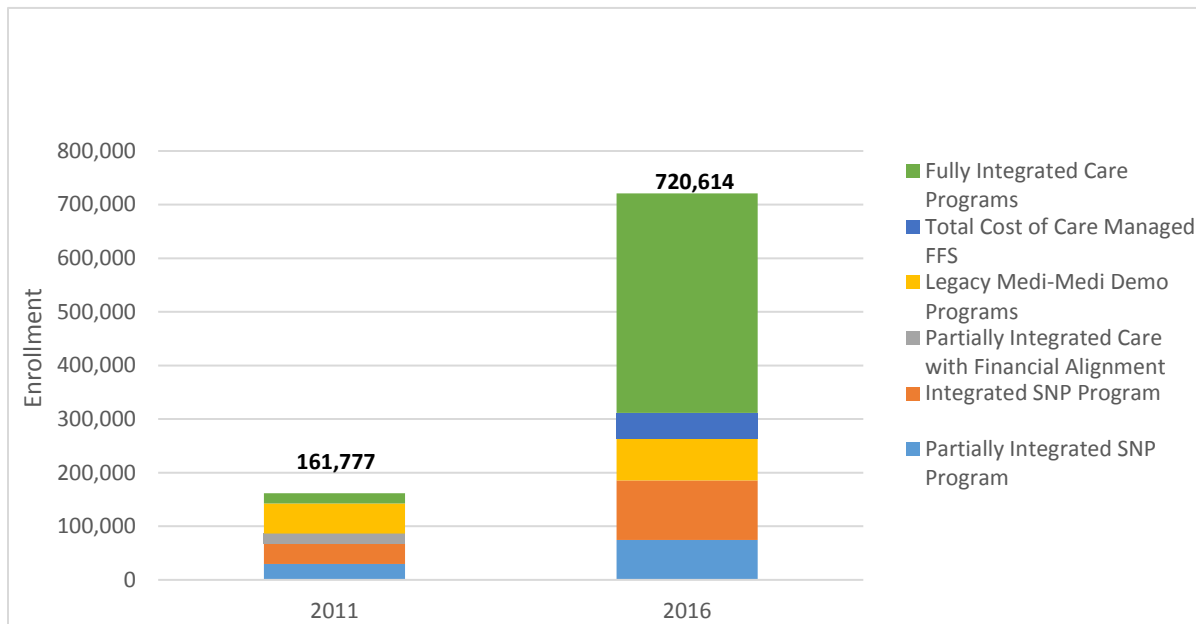
Original Reason For Medicare Entitlement	Medicare-Only Enrollees	Medicare-Medicaid Enrollees³
Age	82.9%	46.3%
Disability	16.7%	52.4%
ESRD	0.2%	0.6%
Disability and Current ESRD	0.2%	0.7%

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 2011, Medicare-Medicaid enrollees’ health costs were four times greater than those of all other people with Medicare.⁴

REVIEW OF 2016

MMCO has focused on initiatives to better integrate and strengthen access to care for beneficiaries dually eligible for Medicare and Medicaid 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 people in integrated care has increased over time. Figure 1 summarizes enrollment by program type in 2011 and 2016.

Figure 1. Total Integrated Care Enrollment by Program Type: 2011 and 2016⁵



Medicare-Medicaid Financial Alignment Initiative. Through the Medicare-Medicaid Financial Alignment Initiative and related work, CMS is partnering with states to test models of integrating 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 would be 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, beneficiaries in every version of the model will receive their full array of Medicare and Medicaid benefits, with added care coordination, beneficiary protections, and access to additional or enhanced services.⁶

In 2016, CMS continued to partner with states and health plans under the Financial Alignment Initiative. At the end of 2016, there were 14 demonstrations in 13 states testing new models.⁷ Eleven of these demonstrations, including two in New York, are testing the capitated model, serving approximately 393,000 beneficiaries as of January 1, 2017.⁸ Two demonstrations, in Colorado and Washington, are testing the managed fee-for-service model, serving approximately 45,000 beneficiaries as of January 1, 2017. CMS is partnering with Minnesota to implement an alternative model testing Medicare and Medicaid administrative alignment activities, building on the longstanding Minnesota Senior Health Options program, and serving 37,050 Medicare-Medicaid enrollees as of January 1, 2017.⁹

Health plans in ten states are serving 393,000 beneficiaries in capitated model demonstrations as of January 1, 2017.

Approved demonstrations are at different stages of implementation. For the capitated model, start dates range from October 1, 2013 for the Massachusetts demonstration to July 1, 2016 for the Rhode Island demonstration. The Washington managed fee-for-service demonstration began in July 2013, the Minnesota administrative alignment demonstration began in September 2013, and the Colorado managed fee-for-service demonstration began in September 2014.

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

State	Geographic Area	Enrollment (As of 1/1/2017)
California	7 of 58 counties	115,125
Colorado	Statewide	25,147
Illinois	21 of 102 counties	46,299
Massachusetts	9 of 14 counties	16,188
Michigan	25 of 83 counties	38,455
Minnesota	Statewide	37,050
New York FIDA	6 of 62 counties	4,834
New York FIDA I/DD	9 of 62 counties	435
Ohio	29 of 88 counties	70,716
Rhode Island	Statewide	10,092
South Carolina	38 of 46 counties	9,178
Texas	6 of 254 counties	52,119
Virginia	66 of 95 counties	29,667
Washington	37 of 39 counties	20,229
Total Enrollment		475,534

In late fiscal year (FY) 2016, CMS released the first annual evaluation reports for the Washington and Massachusetts demonstrations.¹⁰ The first annual report for the Minnesota demonstration was released in December 2016,¹¹ and the first annual reports for the demonstrations that began in calendar year (CY) 2014 are expected in FY 2017.

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.

Through the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents,¹² 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. In FY 2016, these organizations continued to provide clinical staff and/or staff training in partnership with 143 nursing facilities to test evidence-based interventions over a four-year period. The Initiative serves about 16,000 beneficiaries each month.

In FY 2016, CMS also released the third annual evaluation report¹³ for the first phase of the Initiative, which includes the estimated effect of each of the seven ECCP interventions during CY 2014. CMS released the fourth annual report in early 2017, including results through CY 2015.¹⁴

In March 2016, CMS announced six new cooperative agreements for a second phase of the Initiative¹⁵ to test whether three new fee-for-service payments for nursing facilities and practitioners, beginning in October 2016, will further reduce avoidable hospitalizations, lower combined Medicare and Medicaid spending, and improve the quality of care received by nursing facility residents.

The Programs of All-Inclusive Care for the Elderly (PACE). In 2016, CMS proposed a major regulatory update to the PACE program.¹⁶ CMS is reviewing comments received on the proposed rule.

On December 23, 2016 CMS released a Request for Information (RFI) on potential PACE-like models for testing under the PACE Innovation Act.¹⁷ CMS is currently reviewing responses to the RFI.

Medicare-Medicaid Accountable Care Organization (ACO) Model. In late 2016, CMS announced the Medicare-Medicaid ACO Model, a new initiative designed to improve the quality of care and lower costs for Medicare-Medicaid enrollees.¹⁸ The model will build on the current Medicare Shared Savings Program, allowing Shared Savings Program ACOs and states to take on accountability for the quality of care and both Medicare and Medicaid costs for Medicare-Medicaid enrollees. CMS has released a Request for Letters of Intent from states that wish to work with CMS to design certain state-specific elements of the model. The deadline for letters of intent from states that wish to start the model in 2019 is August 2017.

Preventing Illegal Billing of Medicare Cost Sharing to Qualified Medicare Beneficiaries. State Medicaid programs pay Medicare Parts A and B premiums and cost-sharing (coinsurance and deductibles) for enrollees in the Qualified Medicare Beneficiary (QMB) program. By law, Medicare providers may not bill QMBs for any Medicare cost sharing balances that are not paid by the state. However, inappropriate billing of QMBs persists.

In 2016, CMS launched a concerted campaign to reduce inappropriate billing of QMBs and took steps to clarify QMB billing rules for plans and providers.

Resources for States. In 2016, CMS made the following resources available to states:

- **Funding for Ombudsman Services.** CMS requires states participating in the Medicare-Medicaid Financial Alignment Initiative to have dedicated ombudsman support. As of October 2016, CMS had awarded funds to 10 states to support ombudsman activities.¹⁹ In September 2016, CMS released a new funding opportunity announcement to further support the ombudsman activities.
- **Funding for State Health Insurance Counseling and Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs).** In states with demonstrations under the Medicare-Medicaid 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 October 2016, CMS had awarded funds to eight states for options counseling activities.²⁰ In September 2016, CMS released a new funding opportunity announcement to further support the SHIP and ADRC activities.
- **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 2016, the ICRC worked directly with 19 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. In FY 2016, 41 states received or were working with CMS to receive Medicare Parts A, B, and D data to support care coordination for Medicare-Medicaid enrollees.

- **Medicare-Medicaid Data Integration (MMDI) Team.** CMS created the Medicare-Medicaid Data Integration Team to provide technical assistance to states on the integration of Medicare and Medicaid data. In FY 2016, the MMDI Team assisted Colorado, Minnesota, Ohio, and Virginia. In this same year, with funding from CMS' Innovation Accelerator Program, the MMDI Team provided technical support to Medicaid agencies in six additional states to support the integration of Medicare and Medicaid data and define uses cases for the integrated data.

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 care coordination and benefits for Medicare-Medicaid enrollees.

NOTES

¹ https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DualEnrollment_2006-2015.pdf.

² https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DualEnrollment_2006-2015.pdf.

³ 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.

⁴ 2011 Medicare-Medicaid enrollee national profile, viewable at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>.

⁵ Source: analysis performed by the Integrated Care Resource Center, under contract with CMS. “Fully Integrated Programs/Models” include MMP and PACE enrollment through July 2016. “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 or 2016 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.

⁶ For example, in Massachusetts beneficiaries receive new services such as diversionary behavioral health services and expanded dental benefits. Memorandum of Understanding (MOU) between the Commonwealth of Massachusetts and CMS, Massachusetts MOU, pages 69-81, available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MassMOU.pdf>.

⁷ CA, CO, IL, MA, MI, MN, NY, OH, RI, SC, TX, VA, WA.

⁸ CA, IL, MA, MI, NY, OH, RI, SC, TX, and VA.

⁹ 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. More information on the Minnesota demonstration is available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Minnesota.html>.

¹⁰ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.

¹¹ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.

¹² <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/AvoidableHospitalizationsamongNursingFacilityResidents.html>.

¹³ Ingber, M. J. et al, *Evaluation of the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: Final Annual Report Project Year 3*, January 2016, available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NFPAH2015AnnualReport.pdf>.

¹⁴ Ingber, M. J. et al, *Evaluation of the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: Annual Report Project Year 4*, March 2017, available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NFPAH2017AnnualReport.pdf>.

Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NFPAH2016AnnualReport.pdf.

¹⁵ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/PhaseTwoPaymentReform.html>.

¹⁶ Centers for Medicare & Medicaid Services, available at: <https://www.federalregister.gov/documents/2016/08/16/2016-19153/medicare-and-medicicaid-programs-programs-of-all-inclusive-care-for-the-elderly-pace>.

¹⁷ Centers for Medicare & Medicaid Services, available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACEInnovationAct.html>.

¹⁸ CMS press release, “Medicare-Medicaid ACO Model joins growing number of state-based efforts to improve quality of care, lower costs,” December 15, 2016, available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-12-15-2.html>

¹⁹ CA, CO, IL, MA, MI, OH, RI, SC, VA, and WA. Additional information is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html>

²⁰ CA, IL, MA, MI, NY, RI, VA, and WA. Additional information is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOptionsCounselingforMedicare-MedicaidEnrollees-.html>