



March 23, 2023

The Honorable Kamala D. Harris
Vice President of the United States
President of the Senate
Washington, DC 20510

Dear Madam Vice President:

Pursuant to 42 USC §1315b(e), I have enclosed the fiscal year 2022 report of the Federal Coordinated Health Care Office.

The purpose of the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) is to better integrate Medicare and Medicaid benefits and to improve the coordination between the federal and state government for individuals eligible for both Medicare and Medicaid benefits (dually eligible beneficiaries). The enclosed report describes progress to date on implementing the goals and responsibilities of the Medicare-Medicaid Coordination Office.

We look forward to continuing to work with Congress to strengthen the Medicare and Medicaid programs and the care experience of dually eligible beneficiaries. I am also sending a copy of this report to the Speaker of the House of Representatives. Please do not hesitate to contact me at 202-690-7627 if you have questions or concerns.

Sincerely,

A handwritten signature in blue ink, appearing to read "MAE", is written over the typed name.

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Enclosure



March 23, 2023

The Honorable Kevin McCarthy
Speaker of the House of Representatives
Washington, DC 20510

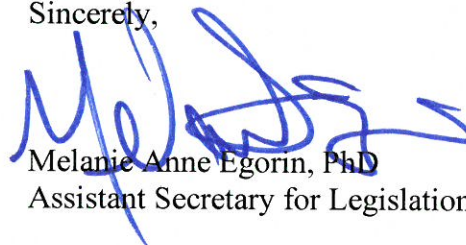
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Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Medicare-Medicaid Coordination Office

Fiscal Year 2022 Report to Congress



Introduction

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

Medicare and Medicaid are distinct programs with different rules for eligibility, covered benefits, and payment, and the programs have operated separately despite a growing number of people who depend on both Medicare and Medicaid for their health care. Better aligning these programs can improve outcomes and experiences for dually eligible individuals, while reducing administrative burden for individuals, providers, health plans, and states.

In this report, we discuss our activities to better serve dually eligible individuals in 2022.

This report also contains three legislative recommendations, which were proposed in the President’s Fiscal Year (FY) 2024 Budget.

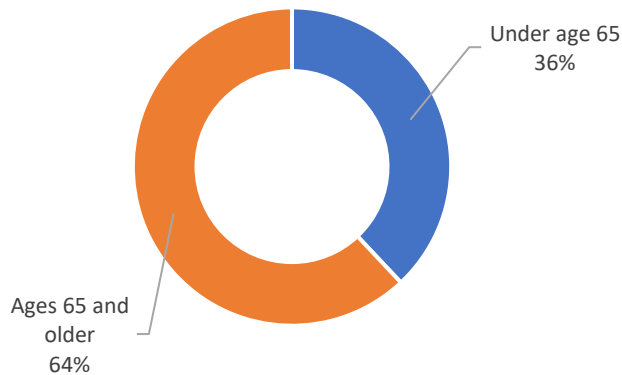
About Dually Eligible Individuals

During 2022, more than 13 million individuals were concurrently enrolled in both Medicare and Medicaid. These individuals navigate two separate programs: Medicare for the coverage of most preventive, primary, and acute health care services and drugs, and Medicaid for coverage of long-term services and supports, certain behavioral health services, and for help with Medicare premiums and cost-sharing.

Dually eligible individuals may either be enrolled first in Medicare by virtue of age or disability and then qualify for Medicaid on the basis of income and other eligibility factors, or vice versa.

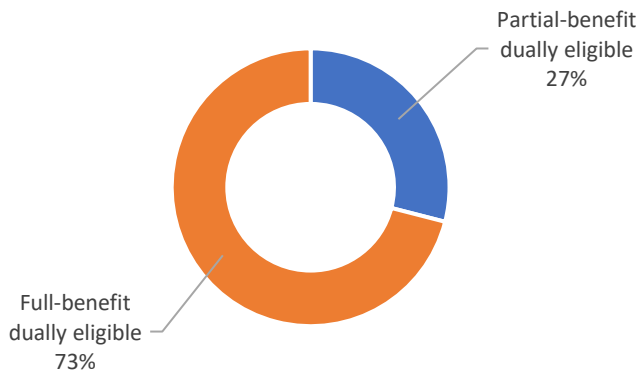
They may also be *full-benefit* dually eligible individuals, who qualify for the full range of Medicaid services, or *partial-benefit* dually eligible individuals, who receive assistance only with Medicare premiums and, in most cases, assistance with Medicare cost-sharing. Full-benefit dually eligible individuals often separately qualify for assistance with Medicare premiums and cost-sharing through the Medicare Savings Programs (MSPs).

Most dually eligible individuals are 65+, but a significant portion are under 65



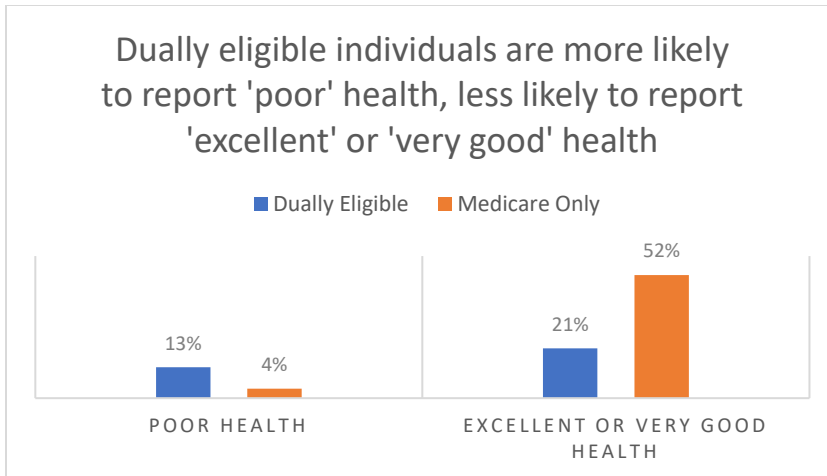
Source: CMS Analysis of 2021 data

Most dually eligible individuals qualify for the full range of Medicaid services, but 27% qualify only for assistance with Medicare costs

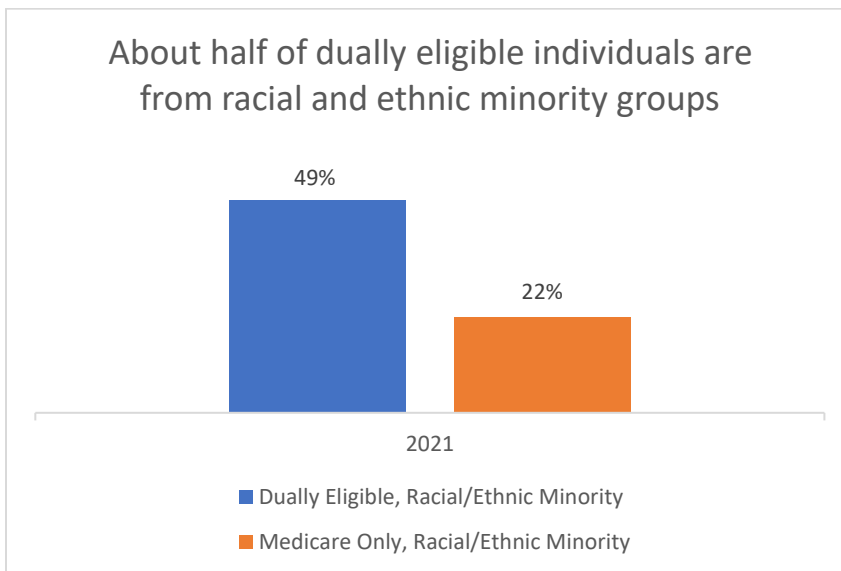


Source: CMS Analysis of 2021 data

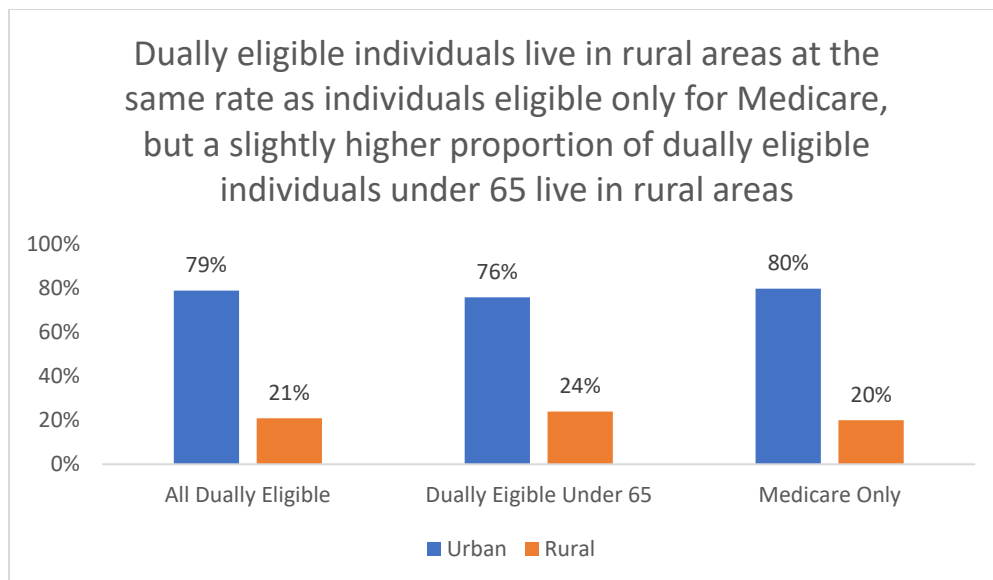
Overall, dually eligible individuals have a higher prevalence of many health conditions than their Medicare-onlyⁱ and Medicaid-onlyⁱⁱ peers. They often have unmet social needs—such as food insecurity and lack of transportation access—that can lead to poor health outcomes. Relative to Medicare-only beneficiaries, dually eligible individuals are more likely to report being in poor healthⁱⁱⁱ and experienced worse outcomes from COVID-19, such as higher hospitalization rates.^{iv} Dually eligible individuals are more likely to be from racial and ethnic minority groups. Racial and ethnic minorities are more likely to have worse health outcomes, limited access to care, and lower quality of care than non-minorities.^v



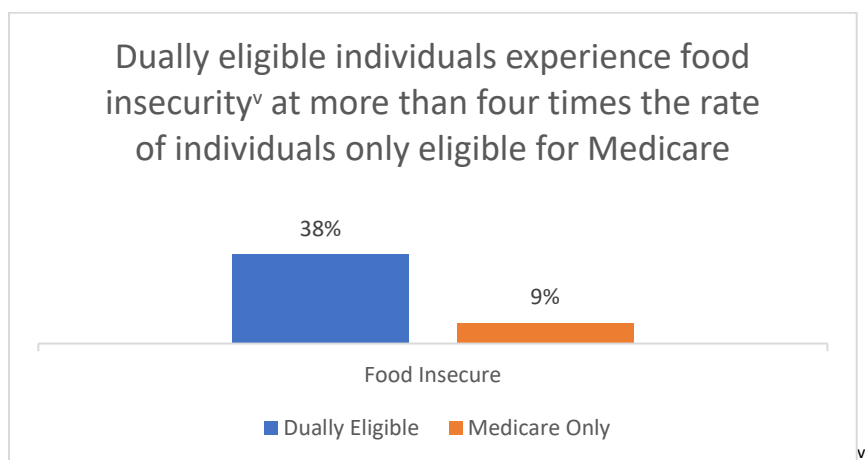
Source: [MedPAC/MACPAC Analysis](#) of 2020 Medicare Current Beneficiary Survey



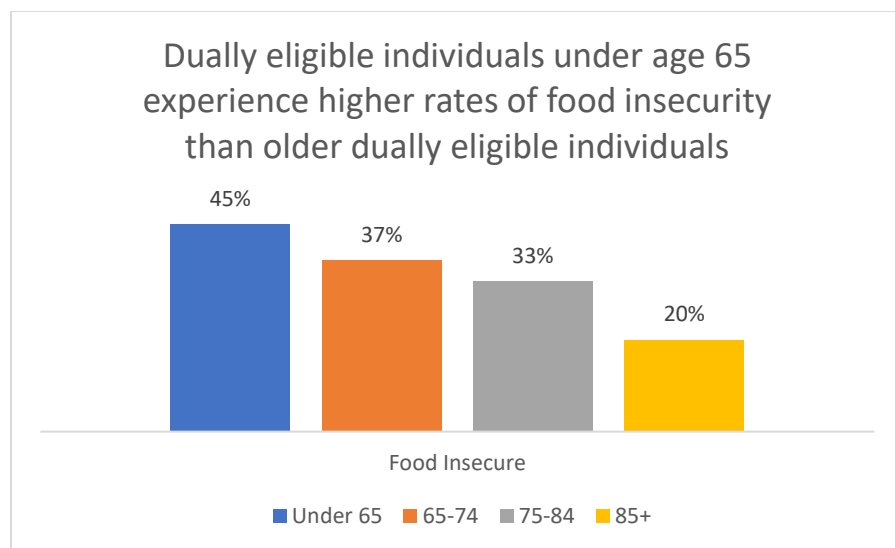
Source: CMS Analysis



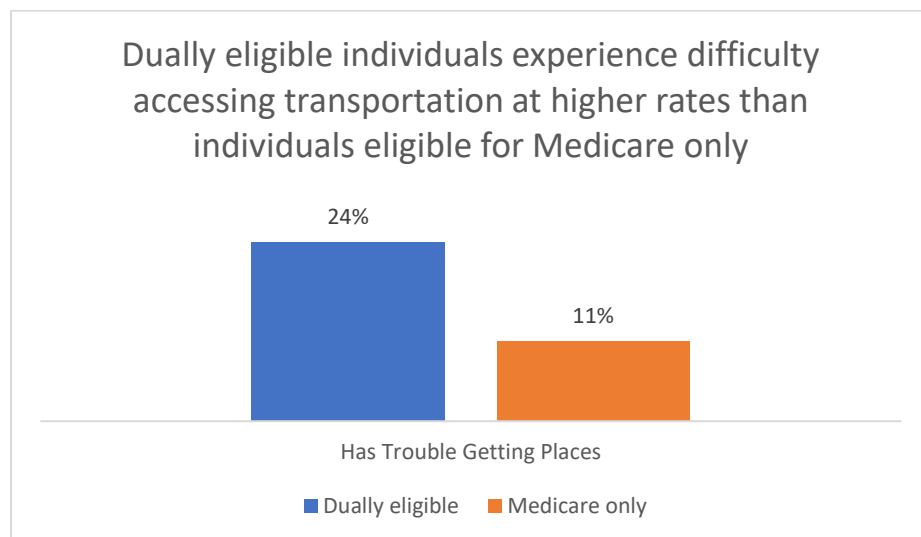
Source: [MedPAC/MACPAC Analysis](#) of 2020 Medicare Current Beneficiary Survey



Source: 2020 Medicare Current Beneficiary Survey



Source: 2020 Medicare Current Beneficiary Survey



Source: 2020 Medicare Current Beneficiary Survey

Recommendations for Legislative Action

We recommend the following items for legislative actions that were proposed in the President's FY 2024 Budget:^{vii}

- **Align Medicare Savings Programs and Part D Low-income Subsidy Eligibility Methodologies**
This legislative proposal would simplify the eligibility processes for the Medicare Savings Programs and Part D Low-Income Subsidy by removing elements of the income and asset determination process that apply to one program and not the other. Aligning the eligibility methodologies for these programs reduces administrative barriers to enrollment and eliminates the need for the federal government and states to perform nearly identical eligibility determinations for the same over-burdened individuals.
- **Align Qualified Medicare Beneficiary Renewal Period with Other Medicaid Groups**
This legislative proposal would establish a 12-month renewal period for Medicare Savings Programs in statute, which would allow CMS to establish a renewal period for Qualified Medicare Beneficiaries no more restrictive than the renewal period for people eligible for Medicaid based on Modified Adjusted Gross Income. By streamlining and simplifying the renewal process, this proposal reduces the risk of additional churn off Medicaid and improves maintenance of eligibility for these beneficiaries.
- **Improve Medicaid Home and Community-Based Services**
This legislative proposal would invest in Medicaid home and community-based services, enabling seniors and people with disabilities – the majority of whom are dually eligible for Medicare and Medicaid – to remain in their homes and stay active in their communities. At the same time, the proposal promotes better quality jobs for home care workers and enhances supports for family caregivers, many of whom are too often forced out of the workforce due to the demands of caring for a loved one.

What We Are Doing

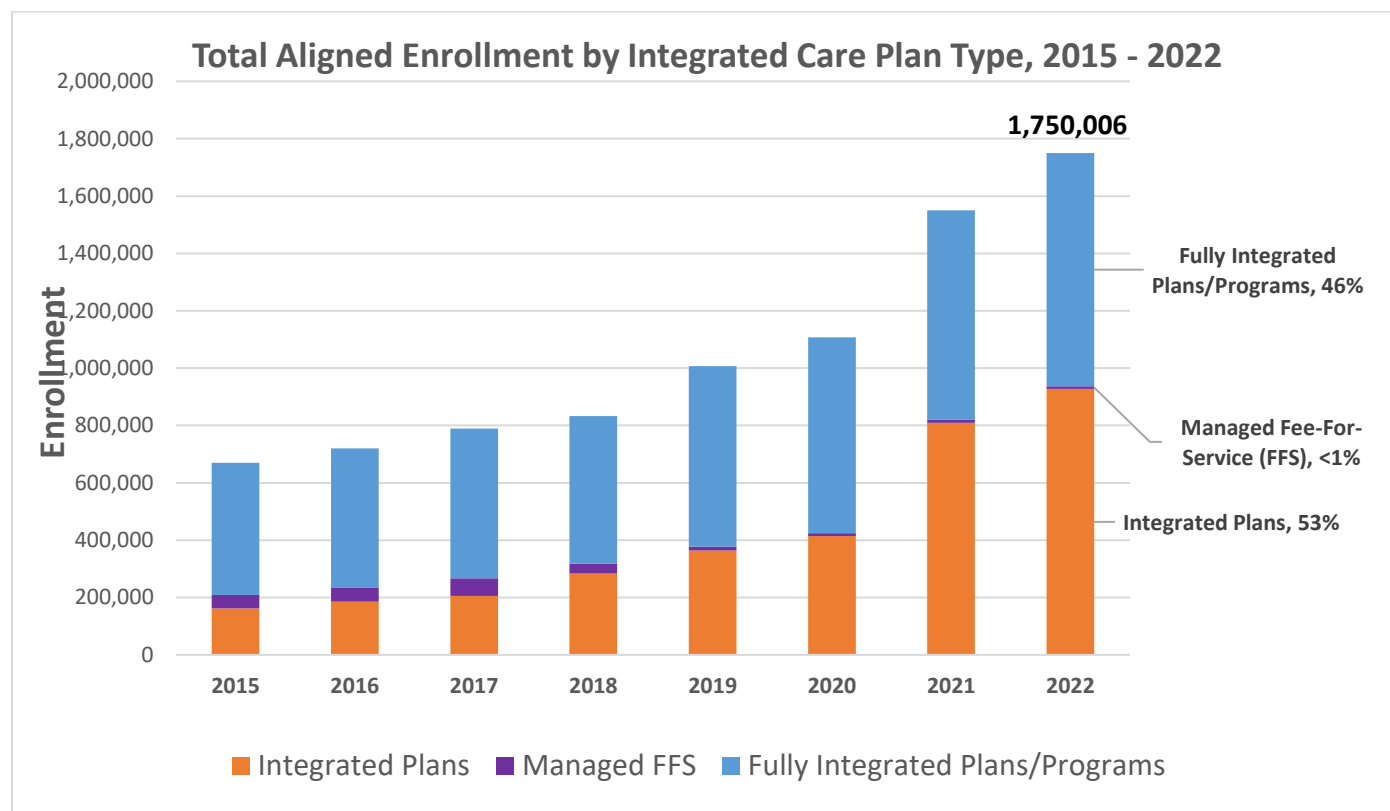
Advancing Integrated Care

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 refers 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 individuals.

Integrated care includes Programs of All-Inclusive Care for the Elderly (PACE); Financial Alignment Initiative demonstrations; and managed care arrangements where the same organization covers both Medicare and Medicaid services.

In 2022, about 21 percent of full-benefit dually eligible individuals were enrolled in integrated care. We are working to increase this percentage in a variety of ways, including through existing and new platforms for integration. Overall, the number of dually eligible individuals in integrated care and/or financing models has increased over time. In 2011, just 161,777 individuals were enrolled in integrated care, compared to 1.75 million in 2022. The chart below summarizes the increase by integrated health plan type between 2015 and 2022,^{viii} and the paragraphs that follow provide more detail on enrollment in PACE, the Financial Alignment Initiative demonstrations, and integrated Medicare Advantage dual eligible special needs plans (D-SNPs).



PACE

The vast majority of [PACE](#) participants are dually eligible individuals. As of June 2022, more than 60,000 older adults were enrolled in 146 PACE organizations in 31 states.^{ix}

Financial Alignment Initiative Demonstrations

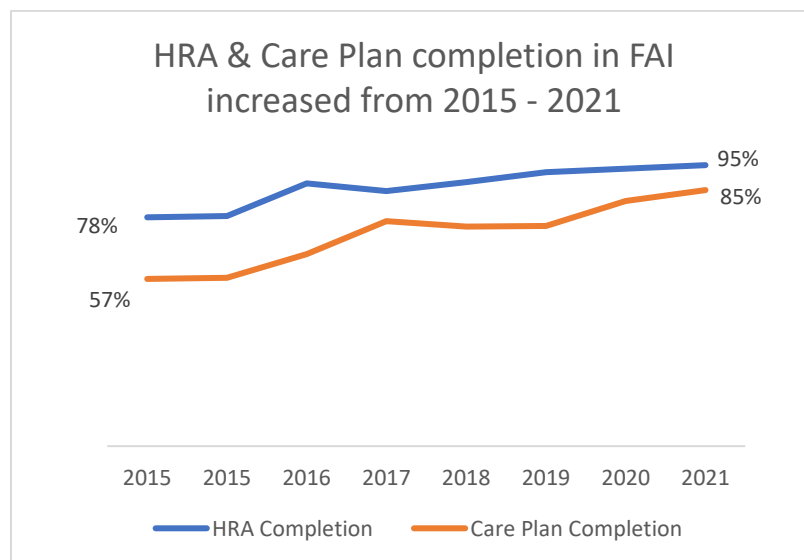
As of September 2022, about 428,000 dually eligible individuals in nine states^x were enrolled in Medicare-Medicaid Plans (MMPs), fully integrated health plans that are part of the capitated model of the Financial Alignment Initiative. About 9,000 dually eligible individuals were enrolled in Washington's managed fee-for-service Financial Alignment Initiative demonstration.

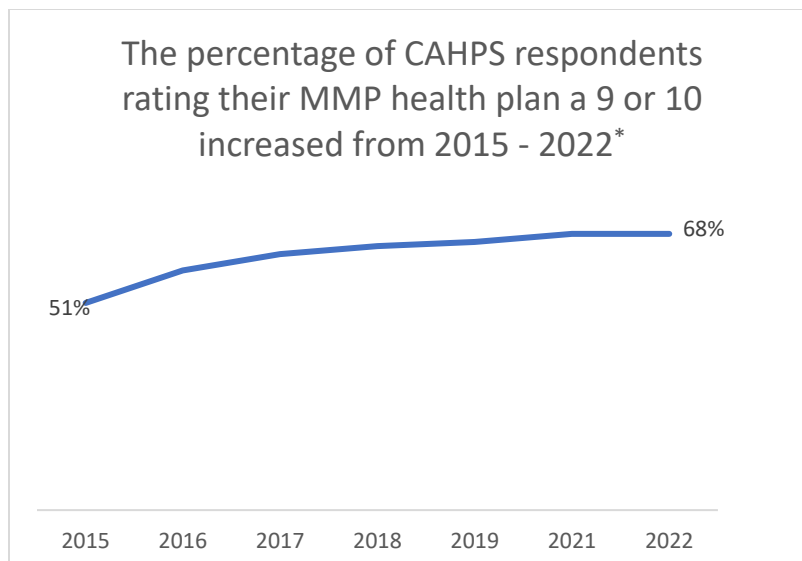
Dual Eligible Special Needs Plans (D-SNPs) paired with Medicaid Managed Care

Over the past several years, CMS has strengthened integration standards for D-SNPs to ensure that the growing number of dually eligible individuals enrolled in these health plans receive quality, coordinated care. We are working with our state partners to promote greater alignment between Medicare and Medicaid health plans. The number of D-SNPs with exclusively aligned enrollment—in which all D-SNP members are in an affiliated Medicaid managed care organization—increased from 104 to 123 between the 2022 and 2023 plan years.

Improving beneficiary experience in integrated managed care

Over time, an increasing proportion of enrollees in health plans in the capitated model demonstrations under the Financial Alignment Initiative have rated their health plans a 9 or 10 (with 10 being the best) in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. In 2022, 68 percent of all demonstration survey respondents rated their health plan a 9 or 10, compared to 51 percent in 2015—a 33 percent increase. We have also seen increasing access to care coordination within the capitated model demonstrations, including a 20 percent increase in health risk assessment (HRA) completion and a 48 percent increase in care plan completion from 2015 to 2021.





Source: CMS analysis of CAHPS results.

*There were no CAHPS surveys held in 2020.

CY 2023 Medicare Advantage & Part D Final Rule

In April 2022, CMS released the contract year (CY) [2023 Medicare Advantage and Part D Final Rule](#) to advance CMS' strategic vision of expanding access to affordable health care and improving health equity in MA and Part D.

A number of provisions in the rule affect dually eligible individuals and aim to improve integration of Medicare and Medicaid. Many of these provisions build on lessons learned from the Financial Alignment Initiative.

- **Enrollee input on D-SNP operations.** CMS finalized a requirement that all D-SNPs establish and maintain one or more enrollee advisory committees for each state in which the D-SNP is offered and that D-SNPs consult with advisory committees on various issues, including ways to improve health equity for underserved populations.
- **Social determinants of health and special needs plan health risk assessments.** Beginning in CY 2024, all SNP health risk assessments must include questions on housing stability, food security, and access to transportation. This requirement will help better identify the risk factors that may inhibit enrollees from accessing care and achieving optimal health outcomes.
- **Simplified appeals and grievance process.** New appeals and grievance requirements took effect in 2021 for certain D-SNPs in which all enrollees also receive their Medicaid coverage through an affiliated Medicaid managed care organization. Individuals in these plans go through one Medicare-Medicaid appeals process at the plan level. The final rule expanded the universe of D-SNPs for which the unified appeals and grievance processes apply, making appeals and

grievance processes more accessible and extending the protection of continuation of benefits pending appeal to additional dually eligible enrollees.

- **New pathways to have star ratings specific to the performance of the local D-SNP.** CMS created a pathway to allow certain states with integrated care programs to require that MA organizations establish a contract that only includes one or more D-SNPs, which will allow for star ratings for that contract to reflect the D-SNPs' local performance.
- **New pathways to simplify D-SNP enrollee materials.** CMS codified a mechanism through which states can require the D-SNPs in D-SNP-only contracts to use integrated materials to make it easier to understand the full scope of Medicare and Medicaid benefits available through the D-SNPs.
- **Maximum out-of-pocket (MOOP) policy for dually eligible enrollees.** The final rule specified that the MOOP limit in an MA plan (after which the plan pays 100 percent of MA costs) is calculated based on the accrual of all Medicare cost-sharing in the plan benefit, whether that Medicare cost-sharing is paid by the enrollee, Medicaid, or other secondary insurance, or remains unpaid. Prior to the implementation of the final rule, guidance allowed MA plans, including D-SNPs, to not count Medicaid-paid amounts or unpaid amounts toward this MOOP limit, which resulted in increased State payments of Medicare cost-sharing and disadvantaged providers serving dually eligible individuals in Medicare Advantage plans. We project that the change will save state Medicaid agencies \$2 billion over ten years while increasing payment to providers serving dually eligible enrollees by \$8 billion over ten years.
- **Technical and definitional updates for FIDE SNPs and HIDE SNPs.** The final rule requires, beginning in 2025, that all fully integrated dual eligible special needs plans (FIDE SNPs) have exclusively aligned enrollment (i.e., limit enrollment to individuals in the affiliated Medicaid managed care organization) and cover Medicaid home health, durable medical equipment, and behavioral health services through a capitated contract with the state Medicaid agency. It also requires that each highly integrated dual eligible special needs plan's (HIDE SNP's) capitated contract with the state apply to the entire service area for the D-SNP for plan year 2025 and subsequent years.
- **Transitioning Financial Alignment Initiative demonstrations to permanent integrated care programs.** CMS will work with states with capitated model Financial Alignment Initiative demonstrations to convert MMPs into integrated D-SNPs. After receiving feedback on our initial notice of proposed rulemaking, we are allowing states additional time—through 2025—for this transition to ensure it is as seamless as possible for enrollees.

We are working closely with states, plans, and other partners to implement these rule provisions, which will significantly raise the bar for integrated care.

Expanding Access to the Medicare Savings Programs (MSPs)

In addition to the Medicare Advantage final rule, during FY 2022 CMS released two significant pieces of rulemaking to improve access to the MSPs for dually eligible individuals.

Revisions to Medicare Enrollment and Eligibility Rules

In October 2022, CMS finalized updates to the various regulations that affect a state Medicaid agency's payment of the Medicare Part A and B premiums on behalf of 10 million low-income individuals (often known as "state buy-in").

The rule extends the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual MSPs to new immunosuppressant coverage in Medicare. Additional changes also better align the MSP regulations with federal statute, policy, and operations that have evolved over time.

By clarifying and streamlining existing requirements, these policies will promote access to affordable health coverage and essential medical treatment and improve health equity for underserved populations. They will help us better hold states—and ourselves—accountable for effective implementation of the MSPs.

Streamlining Medicaid Eligibility & Enrollment Notice of Proposed Rulemaking (NPRM)

In August 2022, CMS released an [NPRM](#) that would make it easier for millions of eligible people to enroll in and retain their Medicaid coverage.

The MSPs are essential to the health and economic well-being of those enrolled, promoting access to care and helping free up individuals' limited income for food, housing, and other of life's necessities. Yet a 2017 study conducted for Medicaid and CHIP Payment and Access Commission^{xi} estimated that only about half of eligible Medicare beneficiaries were enrolled in MSPs. Currently, there are no regulations that ensure consumers have access to an efficient and streamlined enrollment process for the MSPs for Medicare enrollees highly likely or certain to be eligible for the MSPs based on receipt of other program benefits (e.g., Extra Help for Medicare Part D). As a result, millions of eligible individuals are not enrolled.

A number of provisions in the NPRM would affect dually eligible individuals. For example, the NPRM would, if finalized as proposed:

- Provide automatic enrollment, with limited exceptions, of Supplemental Security Income (SSI) recipients into the Qualified Medicare Beneficiary (QMB) group.
- Clarify the effective date of QMB coverage for an individual who enrolls in conditional Part A during the General Enrollment Period (GEP); such coverage may begin as early as the month Part A entitlement begins.
- Require use of low-income subsidy (LIS) "leads" from Medicare Part D to:
 - Initiate applications for the MSP eligibility groups; and
 - Facilitate the enrollment of LIS recipients into MSP coverage to the maximum extent possible.

In addition to issuing this proposed rulemaking, we also:

- Conducted focus groups to gather feedback on MSP messaging, and are piloting different messaging to determine the best way to reach individuals eligible for the MSPs and ensure they gain access to these important programs.
- Continued to improve data exchange between states and CMS to reduce delays in enrollment or disenrollment.

ⁱ The term “Medicare-only” beneficiaries refers to beneficiaries who are eligible for Medicare and not Medicaid. “Medicare-only” beneficiaries may have supplemental (Medigap) coverage.

ⁱⁱ The term “Medicaid-only” beneficiaries refers to beneficiaries who are only eligible for Medicaid services, and not for Medicare services.

ⁱⁱⁱ https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_Sec4_SEC.pdf

^{iv} <https://www.cms.gov/research-statistics-data-systems/preliminary-medicare-covid-19-data-snapshot>

^v <https://www.cms.gov/files/document/paving-way-equity-cms-omh-progress-report.pdf>

^{vi} Food insecure is defined as the self-report of any of the following: could not buy food because of cost; could not afford balanced meals; cut size of meals or skipped meals due to cost; ate less because of cost; or hungry because there was not enough food.

^{vii} <https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf>

^{viii} **Note:** Integrated care enrollment includes only aligned Medicare and Medicaid enrollment for full benefit dually eligible individuals, not total enrollment in state programs that may include both aligned and unaligned enrollees. Aligned enrollment refers to situations in which full benefit dually eligible individuals receive both Medicare and full Medicaid services from affiliated or aligned Medicare D-SNPs and Medicaid managed care plans. Data includes only Full Benefit Dually Eligible Individuals (FBDEs).

Consolidations and Recategorization: From 2015-2018, we categorized plans/programs into five categories, which included a ‘partially integrated’ category and a “Legacy Medi-Medi Demo” category (not shown in the graph above). Beginning in 2019, we made the following changes: (1) Consolidated the “Legacy Medi-Medi Demonstration Programs” category into the “fully integrated” category; (2) Consolidated the ‘partially integrated’ category into the ‘integrated category;’ and (3) Recategorized FIDE SNPs that were not part of the Legacy Medi-Medi Demonstrations from the ‘integrated’ category to the ‘fully integrated’ category based on ICRC and MMCO analysis of their operational characteristics. In 2022, we have made the first two changes (consolidations) across all years (2015-2022), but we are not able to make the third change (a recategorization) across all years. Therefore, the ‘integrated’ category from 2015-2018 contains FIDE SNPs that were included in the ‘fully integrated’ category in subsequent years.

Analysis performed by the Integrated Care Resource Center, under contract with CMS. “Fully Integrated Plans” includes enrollment in Programs of All-Inclusive Care for the Elderly (PACE); capitated Financial Alignment Initiative demonstrations; and all Fully Integrated Dual-Eligible Special Needs Plans (FIDE SNPs), including both Applicable Integrated Plan (AIP) FIDE SNPs and non-AIP FIDE SNPs. “Managed FFS” includes enrollment in the Washington managed fee-for-service Financial Alignment Initiative demonstration through July 2022, as well as enrollment in Colorado’s managed fee-for-service Financial Alignment Initiative demonstration through 2017 (the Colorado demonstration ended 12/31/17). “Integrated Plans” includes CO D-SNP and HIDE D-SNP enrollees who were also

enrolled in affiliated Medicaid managed care plans that cover at least some Medicaid benefits, generally including coverage of substantial behavioral health services or long-term services and supports or both. In 2022, this category included AIP HIDE SNP enrollment, other aligned HIDE SNP enrollment (in non-AIP HIDE SNPs), and aligned enrollment in select Coordination-Only (CO) D-SNPs that are aligned with affiliated Medicaid managed care plans in certain states.

^{ix} https://www.npaonline.org/sites/default/files/PDFs/infographic/infographic_update_june2022_combined.pdf

^x https://www.integratedcareresourcecenter.com/sites/default/files/MMP_Enroll_by_State_September_2022.pdf

^{xi} <https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf>.