



Medicare-Medicaid Coordination Office

FISCAL YEAR 2023 REPORT TO CONGRESS



April 2024



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 2023.

This report also contains four legislative recommendations proposed in the President’s Fiscal Year (FY) 2025 Budget.

About Dually Eligible Individuals

During 2023, more than 13 million individuals were concurrently enrolled in Medicare and Medicaid.ⁱ 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 full coverage 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 through the Medicare Savings Programs (MSPs). Full-benefit dually eligible individuals often also qualify for assistance with Medicare premiums and cost-sharing through the MSPs.

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

73%

Full-benefit dually eligible

27%

Partial-benefit dually eligible

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

65%

65+

35%

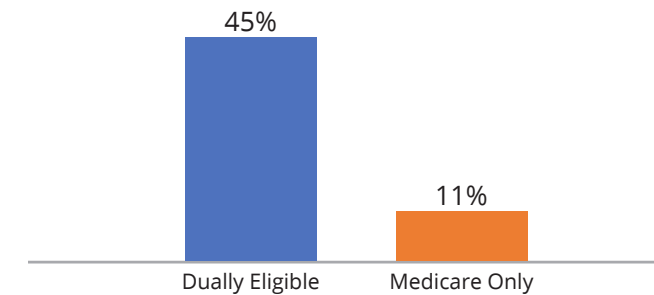
Under 65

Source: CMS Analysis of 2022 data

Overall, dually eligible individuals have a higher prevalence of many health conditions than their Medicare-only and Medicaid-onlyⁱⁱⁱ peers. They often have unmet social needs—such as food insecurity and lack of transportation access—that can lead to poor health outcomes, and they are more likely than non-dually-eligible Medicare beneficiaries

to report being in poor health.^{iv} Dually eligible individuals are more likely than Medicare-only individuals to identify as Black/African American, Hispanic/Latino, Asian and Pacific Islander, or American Indian/Alaskan Native. People from these racial and ethnic groups are more likely to have worse health outcomes, limited access to care, and lower quality of care.^{v,vi}

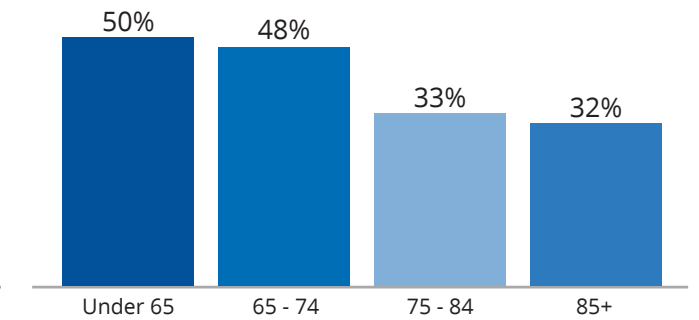
Dually eligible individuals are **food insecure**¹ at more than four times the rate of Medicare-only individuals



Source: 2021 Medicare Current Beneficiary Survey.

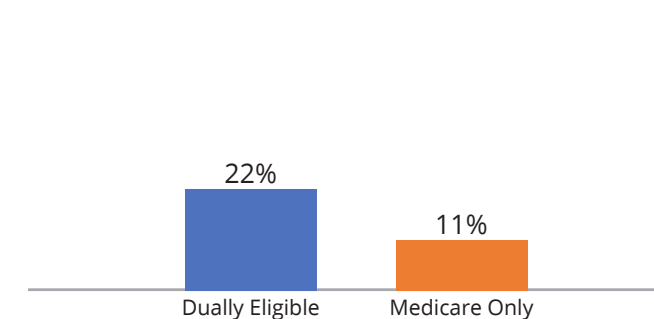
¹ Food insecure is defined as the self-report of any of the following: could not buy food because of cost; could not afford balanced meals; cut size of meals or skipped meals due to cost; ate less because of cost; or hungry because there was not enough food.

Half of dually eligible individuals under 65 are **food insecure**



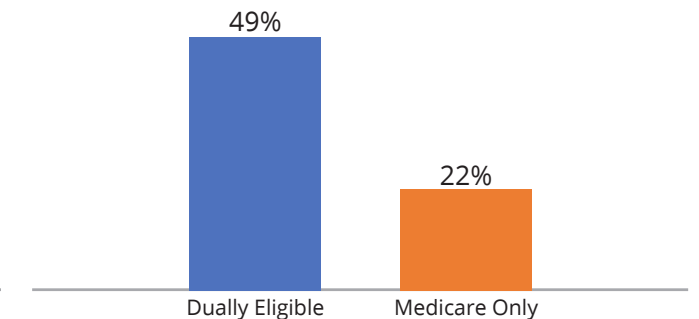
Source: 2021 Medicare Current Beneficiary Survey

Dually eligible individuals have **“trouble getting places”** at twice the rate of Medicare-only individuals



Source: 2021 Medicare Current Beneficiary Survey

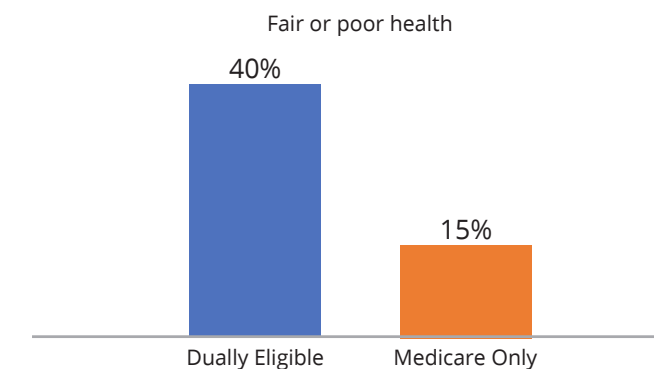
About **half** of dually eligible individuals are from **non-white racial and ethnic groups**



Source: CMS Analysis of 2022 data.

ⁱⁱⁱ “Non-white” includes Black/African American, Hispanic/Latino, Asian and Pacific Islander, American Indian/Alaskan Native, Other Race, and Unknown Race.

Dually eligible individuals are more likely to **self-report poor health**



Source: 2021 Medicare Current Beneficiary Survey



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 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 individuals.

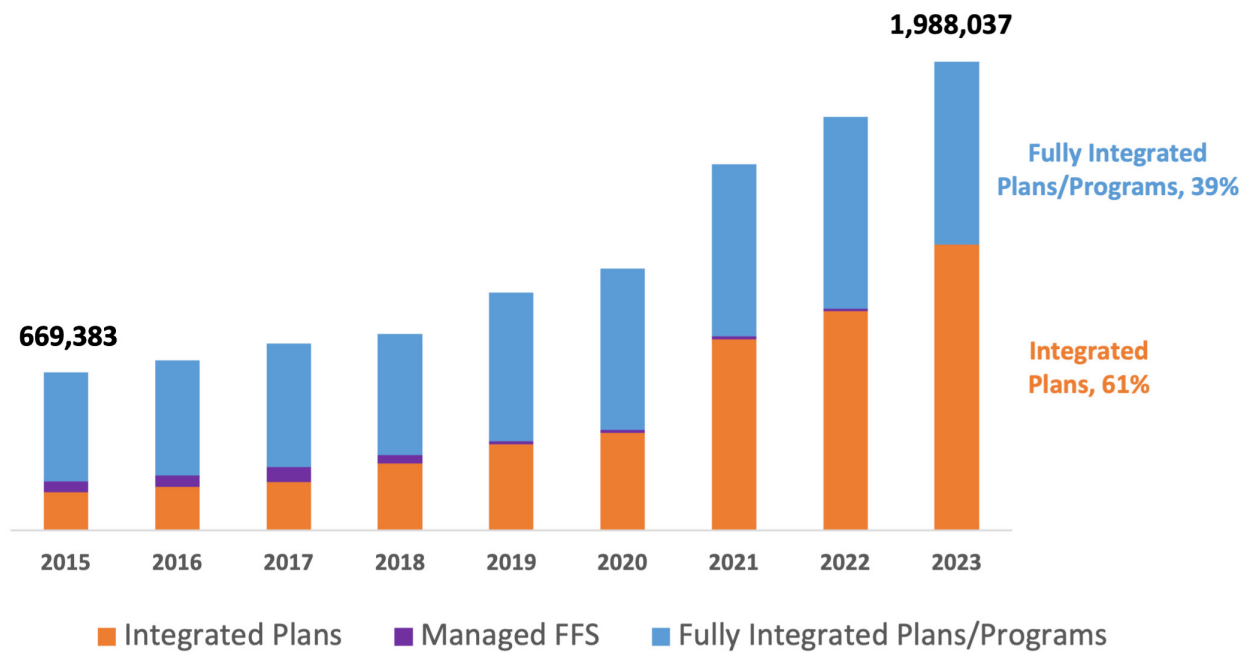


Integrated Care

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 2023, about 22 percent of full-benefit dually eligible individuals were enrolled in integrated care. We are working to increase this percentage 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 2015, 669,383 individuals were enrolled in integrated care, compared to 1.98 million in 2023. Of those, 1.26 million were in programs where all enrollees receive Medicare and Medicaid services through the same organization. The chart below summarizes the increase by integrated health plan or program type between 2015 and 2023,^{vii} 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).

Total Integrated care enrollment increased significantly since 2015



PACE

The vast majority of **PACE** participants are dually eligible individuals. PACE organizations deliver the full range of Medicare and Medicaid services for participants aged 55 and older who live in an area served by a PACE program and who are certified as eligible for a nursing facility level of care by a state Medicaid agency. As of September 2023, more than 70,000 older adults were enrolled in 155 PACE organizations in 32 states and the District of Columbia.^{viii}

Financial Alignment Initiative Demonstrations

As of September 2023, about 314,000 dually eligible individuals in eight states^{ix} were enrolled in Medicare-Medicaid Plans (MMPs), fully integrated health plans that are part of the capitated model of the Financial Alignment Initiative. As of September 2023, about 6,107 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

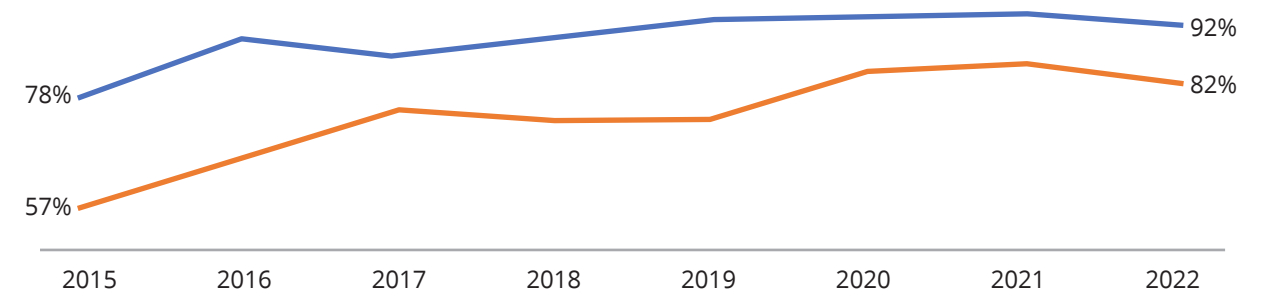
Over the past several years, CMS has strengthened integration standards for D-SNPs to ensure that the growing number of dually eligible individuals enrolled in these health plans receive quality, coordinated care. We are working with our state partners to promote greater alignment between Medicare and Medicaid health plans. As of September 2023, more than 895,000 individuals were enrolled in D-SNPs with exclusively aligned enrollment—in which all D-SNP enrollees are in an affiliated Medicaid managed care organization—compared to about 627,000 a year earlier.^x

This exclusively aligned enrollment included individuals who transitioned from Medicare-Medicaid plans as part of the California Financial Alignment Initiative demonstration to integrated D-SNPs offered by the same health plan organizations. Ninety-six percent of demonstration enrollees enrolled into the matching D-SNP effective on January 1, 2023. Three months later, more than 96 percent of the January 1st enrollment remained enrolled in the affiliated D-SNP. CMS worked closely with the CA Department of Health Care Services, health plans, advocates, and other stakeholders to plan for and implement this transition. The state has expanded the integrated D-SNP program beyond the ten plans that participated in the demonstration to 14 plans and is expanding the integrated D-SNP program statewide by 2026.

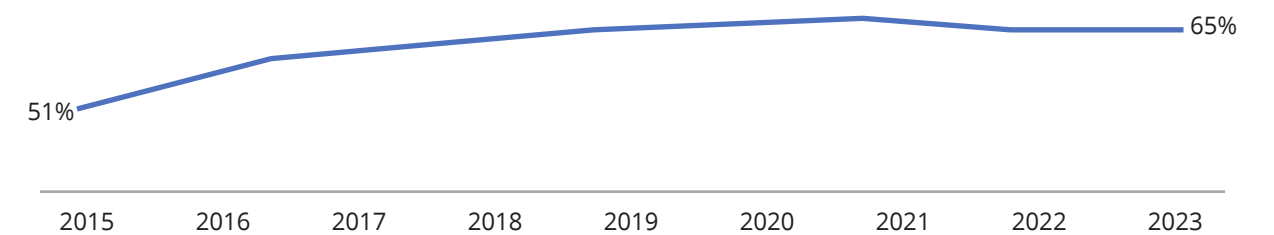
Improving beneficiary experience in integrated managed care

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 2023, 65 percent of all demonstration survey respondents rated their health plan a 9 or 10, compared to 51 percent in 2015—a 27 percent increase. We have also seen increasing access to care coordination within the capitated model demonstrations, including an 18 percent increase in health risk assessment completion and a 44 percent increase in care plan completion from 2015 to 2022.

Health Risk Assessment and Care Plan completion increased from 2015 - 2022



The percentage of CAHPS* respondents rating their MMP health plan a **9 or 10** increased from 2015 - 2023⁺



Source: CMS analysis of CAHPS results.

*Consumer Assessment of Healthcare Providers and Systems (CAHPS), a set of surveys designed to improve understanding of patient experience.

+There were no CAHPS surveys held in 2020.

Recent Medicare Advantage & Part D Rulemaking

In 2023, CMS began implementing 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.** Beginning in January 2023, all D-SNPs are required to 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. In 2023, CMS released guidance outlining what screening instruments SNPs can use to meet the new requirement.
- **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. For 2023 CMS 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 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. Four states are utilizing this new pathway for 2024 materials, and we anticipate additional states will do so for 2025.
- **Transitioning Financial Alignment Initiative demonstrations to permanent integrated care programs.** CMS is working with states with capitated model Financial Alignment Initiative demonstrations to convert MMPs into integrated D-SNPs no later than January 1, 2026.

In 2023, CMS also released the [2024 Medicare Advantage & Part D Final Rule](#). Two provisions in the rule are specific to dually eligible individuals:

- **Language access.** Beginning with 2024 materials, CMS will require that fully integrated dual eligible (FIDE) SNPs, highly integrated dual eligible (HIDE) SNPs, and applicable integrated plans translate required materials into any languages required by the Medicare translation standard plus any additional languages required by their state's Medicaid translation standard. This will ensure that dually eligible individuals enrolled in these plans receive all the materials necessary for accessing all their benefits (both Medicare and Medicaid) in a language they understand.
- **D-SNP look-alikes.** CMS finalized amendments to close unforeseen loopholes in the scope of the regulation adopted to prohibit D-SNP look-alikes. CMS will apply existing restrictions to individual segments of an MA plan and apply restrictions to both new and existing MA plans. CMS regulations on D-SNP lookalike plans help ensure we can meaningfully implement the minimum integration requirements of the Bipartisan Budget Act of 2018.

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)

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 life necessities. Yet MSP enrollment processes can be burdensome, and many dually eligible individuals may not be aware they qualify for the programs.

Historically, federal funding through the Medicare Improvements for Patients and Providers Act (MIPPA) has allowed organizations such as State Health Insurance Assistance Programs, area agencies on aging, and Aging and Disability Resource Centers to educate low-income older adults and individuals with disabilities about the MSPs and assist them with the application process. This education and support is key to ensuring access to the MSPs for those who qualify.

Expanding access to the MSPs has also been the focus of recent CMS rulemaking. In addition to the Medicare Advantage rulemaking described in the previous section, during FY 2023 CMS finalized two significant pieces of rulemaking (described below) to improve access to the MSPs for dually eligible individuals.



Revisions to Medicare Enrollment and Eligibility Rules

In October 2022, CMS **finalized updates**^{xi} 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 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.

Simplifying MSP Enrollment

In September 2023, CMS released a **final rule**^{xii} to streamline enrollment in the MSPs, making coverage more affordable for an estimated 860,000 older adults and people with disabilities.

Despite the importance of these programs, a 2017 study conducted for the Medicaid and CHIP Payment and Access Commission^{xiii} estimated that only about half of eligible Medicare beneficiaries were enrolled in MSPs, in part due to cumbersome application and verification processes now simplified by this final rule.

Under the final rule:

- Many **Supplemental Security Income** (SSI) recipients will now be enrolled *automatically* into the most comprehensive form of MSP coverage: the **QMB** eligibility group, which covers Medicare premiums and cost sharing. All Medicare-eligible individuals who receive SSI are financially eligible for MSPs, but many are not enrolled because of burdensome and duplicative paperwork.
- States will also make better use of data from the Medicare Part D Low Income Subsidy (LIS, also known as "Extra Help") that helps many older adults and people with disabilities pay for prescription drugs and prescription drug coverage when they live on a limited income. Concurrently, CMS and the Social Security Administration are preparing to implement provisions of the President's prescription drug law that expands eligibility for the full LIS benefit, allowing an estimated **300,000 people** to have lower drug costs starting January 1, 2024.
- We estimate that older adults and people with disabilities will save **nearly 19 million** hours of paperwork each year, with administrative burden on state government declining by over 2 million hours each year.

Recommendations for Legislative Action

We recommend the following items for legislative actions that were proposed in the President’s FY 2025 Budget:^{xiv}

- **Align Medicare Savings Programs and Part D Low-income Subsidy Eligibility Methodologies**

The Part D Low-Income Subsidy and Medicare Savings Program methodologies for counting income and assets are similar but not identical, causing eligibility process inefficiencies. This proposal would simplify the eligibility processes for programs 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 would reduce administrative barriers to enrollment and eliminate 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**

Currently, there is a standard renewal period of one year for many Medicaid eligibility groups, but statute allows states to use shorter renewal periods for individuals in the Qualified Medicare Beneficiary Program. Shorter renewal periods burden beneficiaries and risk improper ineligibility determinations. This proposal would establish a 12-month renewal period for Medicare Savings Programs in statute, which would allow CMS to establish a renewal period for individuals in the Qualified Medicare Beneficiary Program 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 would reduce the risk of disruption and improve maintenance of eligibility for these beneficiaries.

- **Allow Retroactive Coverage of Medicare Part B Premiums for Qualified Medicare Beneficiary Applicants**

While many Medicaid eligibility groups allow for retroactive eligibility, the Qualified Medicare Beneficiary Program, by statute, does not. Many applicants at or below 100 percent of the federal poverty level pay Medicare Part B premiums before enrollment in the program takes effect, which poses a significant financial burden. This proposal would allow for retroactive coverage of Medicare Part B premiums for Qualified Medicare Beneficiary applicants.

- **Unify Medicare and Medicaid Appeals Procedures**

Individuals enrolled in both Medicare and Medicaid face a complex process to appeal service denials. Although CMS has already taken action to unify Medicare and Medicaid appeal processes at the plan level, a statutory change is required to protect beneficiary access to care and the right to a Departmental hearing when enrollees appeal any plan decision to a higher level. Building on results from the **Financial Alignment Initiative demonstrations**, this proposal would give the Secretary the authority to unify the procedures for Medicare and Medicaid review for individuals enrolled in integrated managed care plans by waiving amount-in-controversy minimums and allowing benefits to continue while an appeal is pending. Unifying these external review procedures would simplify a technical and arduous process for enrollees and codify key beneficiary protections.

ⁱ This captures the total number of individuals with dual eligibility at any point during 2023.
ⁱⁱ The term “Medicare-only” beneficiaries refers to beneficiaries who are eligible for Medicare and not Medicaid. “Medicare-only” beneficiaries may have supplemental (Medigap) coverage.
ⁱⁱⁱ The term “Medicaid-only” beneficiaries refers to beneficiaries who are only eligible for Medicaid services, and not for Medicare services.
^{iv} https://www.medpac.gov/wp-content/uploads/2024/01/Jan24_MedPAC_MACPAC_DualsDataBook-508_SEC.pdf
^v <https://www.cms.gov/files/document/paving-way-equity-cms-omh-progress-report.pdf>
^{vi} <https://www.cms.gov/files/document/2020-national-level-results-race-ethnicity-and-gender-pdf.pdf>
^{vii} **Note:** Integrated care enrollment includes only aligned Medicare and Medicaid enrollment for full-benefit dually eligible (FBDE) individuals, not total enrollment in state programs that may include both aligned and unaligned enrollees. Aligned enrollment refers to situations in which FBDE individuals receive both Medicare and full Medicaid benefits from: (1) a single legal entity, or (2) affiliated or aligned Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) and Medicaid managed care plans that are owned or operated by the same parent company. Aligned enrollment data were collected as of July of each year unless otherwise specified. (Data from June in 2015.)

Category	Category Definitions in 2023
Fully Integrated Plans/Programs	Plans or programs in which a full-benefit dually eligible individual receives substantially all Medicare and Medicaid benefits, including LTSS, from either: (1) a single health plan that covers Medicare and Medicaid benefits, or (2) a fully integrated D-SNP (FIDE SNP) and an affiliated Medicaid managed care plan owned and operated by the same parent company as the FIDE SNP. This category includes capitated model Financial Alignment Initiative demonstration Medicare-Medicaid Plans (MMPs), Programs of All-Inclusive Care for the Elderly (PACE), Legacy Medi-Medi Demonstration Programs, and all other FIDE SNPs, including FIDE SNPs that may not cover Medicaid behavioral health services. Most plans in this category have exclusively aligned enrollment, but a few FIDE SNPs do not.
Managed FFS	A model in the CMS Financial Alignment Initiative in which states can enter into an agreement with CMS through which the state may benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicare and Medicaid.
Integrated Plans	Plans in which a full-benefit dually eligible individual receives care via a Medicaid health plan that covers (generally) LTSS and/or behavioral health services and may elect to enroll in an affiliated D-SNP for coverage of Medicare benefits. This category includes Highly Integrated D-SNPs (HIDE SNPs) beginning in 2021, as well as select Coordination Only (CO) D-SNPs that are aligned with affiliated Medicaid managed care plans. Some HIDE SNPs have exclusively aligned enrollment, although most plans in this category do not have exclusively aligned enrollment. In 2023, we included AIP CO D-SNPs in this category.

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) between 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.

^{viii} https://www.npaonline.org/docs/default-source/uploadedfiles/pdfs/pace-in-the-states/pace_in_the_states_9.23.pdf?sfvrsn=69e7ce13_1.
^{ix} <https://www.integratedcareresourcecenter.com/resource/monthly-integrated-care-exclusively-aligned-enrollment-report-dually-eligible-individuals>, as of Sept 2023.
^x Reflects enrollment in D-SNPs with exclusively aligned enrollment (EAE) in 50 states, D.C., and Puerto Rico in September 2023 compared to September 2022.
^{xi} Implementing Certain Provisions of the Consolidated Appropriations Act (CAA), 2021 and other Revisions to Medicare Enrollment and Eligibility Rules, 87 FR 66454 (Nov 3, 2022). <https://www.federalregister.gov/documents/2022/11/03/2022-23407/medicare-program-implementing-certain-provisions-of-the-consolidated-appropriations-act-2021-and>.
^{xii} Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment, 88 FR 65230 (Sept 21, 2023). <https://www.federalregister.gov/documents/2023/09/21/2023-20382/streamlining-medicare-medicare-savings-program-eligibility-determination-and-enrollment>.
^{xiii} <https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf>.
^{xiv} <https://www.hhs.gov/sites/default/files/fy-2025-budget-in-brief.pdf>.



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