Integrated Care Resource Center

Spotlight: Recent Federal Reports and the President's Proposed 2017 Budget

Medicare-Medicaid Coordination Office FY 2015 Report to Congress

On March 2, 2016, the Medicare-Medicaid Coordination Office's FY 2015 Report to Congress was delivered to Congressional leadership. The report includes a review of Fiscal Year 2015 activities, as well as four legislative recommendations that were included in the President's FY 2017 budget proposal (described below): (1) ensure retroactive Part D coverage of newly-eligible low-income beneficiaries; (2) establish an integrated appeals process for Medicare-Medicaid enrollees; (3) allow for federal/state coordinated review of D-SNP marketing materials; and (4) improve alignment of Medicare Savings Program and Part D LIS income and asset definitions. The report also describes areas of interest that could improve the experience of Medicare-Medicaid enrollees, including coverage standards for overlapping benefits, cost-sharing rules for qualified Medicare beneficiaries, quality measures, and payment accuracy.

Measurement, Monitoring, and Evaluation of the Financial Alignment Initiative for Medicare-Medicaid Enrollees: Preliminary Findings from the Washington MFFS Demonstration

The Centers for Medicare & Medicaid Services (CMS) released an evaluation report with preliminary findings from the first 18 months (July 1, 2013 to December 31, 2014) of the Washington State managed fee-for-service (MFFS) demonstration under the Medicare-Medicaid Financial Alignment Initiative. The Washington demonstration is built on the state's Medicaid health home program, which integrates primary and acute care, behavioral health services, and long-term services and supports for full-benefit Medicare-Medicaid enrollees. Estimates in this report show a reduction of $21.6 million in Medicare spending relative to a comparison group, representing more than 6 percent savings. The report also includes early quality and utilization results, eligibility and enrollment data, characteristics of the population eligible for the demonstration, beneficiary focus group findings, and a discussion of the initial implementation experience.

Report on Early Implementation of Demonstrations under the Financial Alignment Initiative

CMS released a report on the early implementation activities, successes, and challenges experienced in the seven demonstrations launched as of May 1, 2014, as part of the Medicare-Medicaid Financial Alignment Initiative. Those seven demonstrations include five capitated model demonstrations in California, Illinois, Massachusetts, Ohio, and Virginia; one MFFS model demonstration in Washington; and one alternative model in Minnesota focused on administrative changes to better align Medicare and Medicaid operational components of the existing Minnesota Senior Health Options program. Highlights of early findings focus on integrated delivery systems, enrollment, care coordination models, beneficiary safeguards, and stakeholder engagement. The report also identifies issues on which the evaluation team will focus in the future.

2016 MedPAC/MACPAC Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid

An updated *MedPAC/MACPAC 2016 Data Book* was released in January 2016, and provides a current snapshot of demographic, health care utilization, and health care spending information for individuals dually eligible for Medicare and Medicaid. The Data Book gives an overview of the full dually eligible population and also compares sub-groups, including fully-eligible and partially-eligible individuals, individuals over 65 and under 65, non-dual Medicaid beneficiaries, and non-dual Medicare beneficiaries (as comparison groups).

President's FY2017 Budget Proposal

The President's FY2017 budget describes proposed federal fiscal policy and priorities for federal programs, including proposed changes to Medicaid and Medicare. Following are proposals that could impact states or programs serving dually eligible beneficiaries:

- **Improve Alignment of Medicare Savings Program and Part D Low-Income Subsidy (LIS) Income and Asset Definitions.** Many individuals qualify for both the Medicare Savings Program and Part D LIS. This proposal would better align the definitions of 'countable income' and 'assets' for both programs to simplify and more closely align the eligibility processes to increase access to both programs. *This proposal is estimated to cost $394 million over 10 years.* (p. 99)

- **Ensuring Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries** would make permanent a current demonstration that allows CMS to contract with a single Part D plan to provide coverage to low-income beneficiaries while their eligibility is being processed. According to the budget summary, the demonstration has shown that enrolling newly eligible beneficiaries into a single plan as opposed to the current approach of randomly assigning individuals to a qualifying Part D plan during this time period is less disruptive to beneficiaries. In addition, under the demonstration the plan is reimbursed retroactively, instead of prospectively as under current law. This allows CMS to reimburse at rates closer to actual beneficiary costs. *This proposal is estimated to cost $100 million over 10 years.* (p. 99)

- **Allow for Federal/State Coordinated Review of Dual Eligible Special Need Plan (D-SNP) Marketing Materials.** Under current law, CMS must review all D-SNP marketing materials, while many states require a separate review for compliance with state Medicaid rules. This proposal would streamline the review process by allowing CMS to coordinate its review of D-SNP marketing materials with states and establish a unified set of standards for compliance. *This proposal is estimated to have no budget impact.* (p. 99)

- **Integrate the Appeals Process for Medicare-Medicaid Enrollees.** Medicare and Medicaid appeals processes have different requirements related to timeframes, amounts in controversy, and levels of appeals, which can be confusing for dually eligible individuals. This proposal would provide the Secretary of Health and Human Services with authority to implement a streamlined appeals process to more efficiently integrate requirements and maintain beneficiary protections in both programs. *This proposal is estimated to have no budget impact.* (p. 100)

- **Eliminate the 190-Day Lifetime Limit on Inpatient Psychiatric Facility Services**. The current Medicare limit on mental health benefits does not achieve parity with the corresponding physical health benefit. This proposal would lift the 190-day limit, potentially having a significant impact on Medicare-Medicaid enrollees—particularly those under age 65 who qualify on the basis of a disability—who have a higher prevalence of serious mental illness. This proposal is estimated to cost $2.4 billion over 10 years). (p. 70)

- **Provide Authority to Expand Competitive Bidding for Certain Durable Medical Equipment (DME)**. Medicare's competitive bidding process for DME has saved the program and beneficiaries billions of dollars by matching payments more closely to market-based prices. This proposal

would expand Medicare's competitive bidding process to additional categories of DME including inhalation drugs, prosthetics and orthotics, ostomy, tracheostomy, and urological supplies. A new federal law passed in late 2015 will limit Medicaid reimbursement rates for DME to the Medicare rates established by competitive bidding, beginning January 1, 2019. This proposal is estimated to save $3.8 billion over 10 years. (p. 72)

Government Accountability Office Report on Care Coordination in Demonstrations under the Medicare-Medicaid Financial Alignment Initiative

The Government Accountability Office (GAO) interviewed states, health plans, and other demonstration stakeholders in five of the 12 states with live demonstrations. The report found that the demonstrations in the study implemented care coordination in a variety of ways, and that care coordinators used a range of interactions with beneficiaries to coordinate care. The report discusses challenges faced by demonstration states, health plans, and other entities that affected their ability to coordinate care, such as difficulty locating beneficiaries. GAO noted the importance of measuring the extent to which care coordination is occurring, and recommended that CMS develop or standardize certain measures across the capitated and MFFS financial alignment models to assess care coordination across the demonstrations under the Financial Alignment Initiative. The CMS response to the report, included as an appendix, describes current efforts to measure care coordination and notes that CMS balances the need to measure care coordination against the need to measure in ways that reflect different model environments.