

SMDL #18-012
RE: Ten Opportunities to Better Serve
Individuals Dually Eligible for Medicaid
and Medicare

December 19, 2018

Dear State Medicaid Director:

Over 12 million individuals are concurrently enrolled in Medicaid and Medicare. Such 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. Dually eligible individuals experience high rates of chronic illness, with many having multiple chronic conditions and/or social risk factors.ⁱ Forty-one percent of dually eligible beneficiaries have at least one mental health diagnosis, and about half use long term services and supports (LTSS).ⁱⁱ

Dually eligible individuals account for a disproportionately large share of expenditures in both the Medicare and Medicaid programs. Historically, dually eligible individuals have accounted for 20 percent of Medicare enrollees, yet 34 percent of Medicare spending. The same individuals have accounted for 15 percent of Medicaid enrollees and 33 percent of Medicaid spending.ⁱⁱⁱ Medicare and Medicaid 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 programs for their health care.

We often hear from states interested in how Medicare and Medicaid can work better together. A number of states have already launched ambitious initiatives to better serve dually eligible individuals, including those states that are testing demonstrations, such as the models under the Medicare-Medicaid Financial Alignment Initiative, in collaboration with Centers for Medicare & Medicaid Services (CMS). We will be outlining new demonstration-related opportunities for these and other states in the coming months.

This letter describes ten opportunities – none of which require complex demonstrations or Medicare waivers – to better serve individuals dually eligible for Medicare and Medicaid, including through new developments in managed care, using Medicare data to inform care coordination and program integrity initiatives, and reducing administrative burden for dually eligible individuals and the providers who serve them. A number of these opportunities are newly available to states through Medicare rulemaking or other CMS burden reduction efforts. We are happy to engage with you and your staff on one, many, or all of the items described in this letter. The CMS Medicare-Medicaid Coordination Office (MMCO) works across CMS and with states to better serve dually eligible individuals, including through efforts to better align the Medicare and Medicaid programs and demonstrations to test new approaches to integrated

service delivery and financing. Throughout this letter, we have included points of contact in CMS and its resource centers.

1. Medicare-Medicaid integrated care

One promising path to better serving dually eligible individuals is through creating more seamless experiences for beneficiaries across Medicare and Medicaid and aligning incentives and administrative processes across the two programs. Generally, we refer to these approaches as “integrated care.” Below, we describe opportunities to support integration through capitated managed care.

a. Integrating care through dual eligible special needs plans

Dual eligible special needs plans (D-SNPs) are specialized Medicare Advantage plans that exclusively serve dually eligible individuals. Over two million individuals are enrolled among almost 400 D-SNPs across the country. Several states have built integrated care programs by contracting with Medicaid managed care organizations that also offer D-SNPs. However, states still face challenges in creating seamless beneficiary experiences across programs, building sufficient enrollment volume, and supporting continuity of integrated care through state managed care procurement and contracting processes.

Through Medicare rulemaking finalized earlier this year (the “Final Parts C & D Rule for 2019”), we have created new opportunities for states to increase and maintain enrollment in these managed care options for dually eligible individuals by permitting use of default enrollment of newly Medicare-eligible dually eligible individuals into integrated D-SNPs and passive enrollment to maintain enrollment in integrated D-SNPs.^{iv} In addition, CMS has been partnering with states to improve member materials used by integrated D-SNPs and assist state oversight of their contracted D-SNPs.

During the 2019 rulemaking process, Congress passed and the President signed the Bipartisan Budget Act (BBA) of 2018, making D-SNPs a permanent feature of the Medicare program and creating new possibilities to improve experiences for dually eligible individuals. CMS is seeking public comment on new proposed regulations (See CMS-2018-0110-0001)^v to implement provisions to:

- Better unify appeals and grievance processes across Medicaid and Medicare for D-SNP members, so that beneficiary issues with Medicare and Medicaid services no longer follow completely separate tracks, and
- Establish new minimum standards of Medicaid integration for D-SNPs.

Additionally, Section 50311(b) of the BBA of 2018 established MMCO as a “dedicated point of contact” for states to address misalignments between the two programs and promote integration of D-SNPs and Medicaid managed care.

We appreciate the input we have already received from states, the National Association of Medicaid Directors, and other stakeholders on the BBA of 2018, and we look forward to continued collaboration.

i. OPPORTUNITY #1 – State contracting with D-SNPs

States have a powerful tool to promote integrated care through contracts with D-SNPs. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amended section 1859(f)(3)(D) of the Social Security Act to require D-SNPs to maintain a contract with each state in which they operate. These contracts are commonly called “MIPPA contracts” or “State Medicaid Agency Contracts (SMACs).”

Minimum requirements for MIPPA contracts are described at 42 CFR §422.107. States have the flexibility to determine the scope of Medicaid services and financial responsibility that D-SNPs must assume. States also have the flexibility to add additional state-specific requirements – or decide it is not in their best interest to execute the contract at all.^{vi} **We encourage states to use these MIPPA contracts to support and shape local integrated care approaches.** For example:

- Some states, including Idaho, Minnesota, New Jersey and Massachusetts, require that D-SNPs only enroll those individuals who are also in an affiliated Medicaid managed care product, thus ensuring that D-SNP enrollees are receiving Medicare and Medicaid services through the same parent organization.
- Arizona requires D-SNPs and affiliated Medicaid plans to coordinate all aspects of enrollees’ health, including use of Medicare and Medicaid data to coordinate services. The state requires that there be a contact person at each plan responsible for sharing the information needed to coordinate care when the benefit coverage switches from Medicare to Medicaid, and a point of contact for coordinating care related to cost-sharing protections and balance billing.
- Florida requires D-SNPs to facilitate Medicaid eligibility redeterminations for enrollees, including helping with applications for medical assistance and conducting enrollee education regarding maintenance of Medicaid eligibility.
- Tennessee requires D-SNPs to notify the enrollee’s Medicaid managed care plan of inpatient admissions and coordinate with the Medicaid plan regarding discharge planning. The requirements also include following up with enrollees and their Medicaid

plans to provide needs assessments or develop person-centered plans of care for enrollees using managed long-term services and supports (MLTSS).

Additional information on these and other examples of how states have used the MIPPA contracts to integrate care are available through the Integrated Care Resource Center.^{vii} State staff interested in learning more can contact Paul Precht in the CMS Medicare-Medicaid Coordination Office at Paul.Precht@cms.hhs.gov.

ii. OPPORTUNITY #2 – Default enrollment into a D-SNP

Default enrollment is a mechanism for facilitating enrollment in integrated care, while maintaining continuity of Medicaid managed care services, when Medicaid beneficiaries become eligible for Medicare. We established new Medicare regulations on default enrollment in April 2018 through the Final Parts C & D Rule for 2019. States can find the new regulation governing – and outlining the federal minimum requirements – for default enrollment at 42 CFR §422.66(c).^{viii} Through default enrollment, Medicaid beneficiaries in capitated managed care – and who remain in Medicaid managed care upon newly gaining Medicare eligibility – may be automatically enrolled into a D-SNP^{ix} affiliated with the individuals' Medicaid managed care organization (MCO). Individuals retain the ability to opt out of default enrollment to instead receive their Medicare services through Medicare Fee-For-Service (FFS), Programs of All-inclusive Care for the Elderly (PACE), or another Medicare Advantage plan.

States can use default enrollment to facilitate enrollment into managed care arrangements in which dually eligible individuals receive all of their Medicaid and Medicare services through the same organization.^x We structured the new regulations to empower state Medicaid agencies in this process, so a D-SNP can only utilize default enrollment where the state approves. States interested in supporting default enrollment will need to (a) indicate approval in the MIPPA contracts, and (b) provide data to the participating health plans to identify those individuals who are becoming newly Medicare-eligible in advance of their Medicare initial coverage election period. We encourage interested states and D-SNPs to contact us early in the process of considering options related to default enrollment.

We recently hosted and recorded a webinar for states on default enrollment.^{xi} State staff interested in learning more can contact Sharon Donovan in the CMS Medicare-Medicaid Coordination Office at Sharon.Donovan1@cms.hhs.gov.

iii. OPPORTUNITY #3 – Passive enrollment to preserve continuity of integrated care

While enrollment in a Medicare Advantage or standalone Part D plan is generally initiated by beneficiaries, in certain limited instances CMS may passively enroll individuals into Medicare health or drug plans.^{xiii} In these instances beneficiaries receive notification that they can choose another plan.

In an effort to promote integrated care, continuity of care, and partnership with states, CMS recently codified a new, limited expansion of its regulatory authority to conduct passive enrollment in the Final Parts C and D Rule for 2019. States can find the regulatory language for this limited D-SNP passive enrollment authority at 42 CFR §422.60(g). **This change authorizes CMS to passively enroll full-benefit dually eligible individuals from an integrated D-SNP that is no longer available to the individual into another comparable D-SNP in instances where integrated care coverage would otherwise be disrupted.** CMS will conduct such enrollments after consulting with a state Medicaid agency and where other conditions are met^{xiii} to ensure continuity and quality of care. Plans receiving passive enrollment are required to provide notices to enrollees that explain their ability to decline the enrollment, return to Original Medicare, or choose another plan.

Both the default enrollment and passive enrollment provisions are intended to help promote integrated care. Default enrollment is authorized only for people who are already enrolled in Medicaid managed care and become eligible for Medicare, among other requirements, while passive enrollment by CMS under the new provision is authorized only for beneficiaries who are already enrolled in an integrated D-SNP. State staff interested in learning more can contact Sharon Donovan in the CMS Medicare-Medicaid Coordination Office at Sharon.Donovan1@cms.hhs.gov.

b. OPPORTUNITY #4 – Integrating care through PACE

The Programs of All-Inclusive Care for the Elderly (PACE) provide comprehensive medical and social services to certain adults age 55 and older who meet a state’s nursing facility level of care criteria. Most PACE enrollees are dually eligible individuals.

In PACE, interdisciplinary teams of health professionals work with PACE participants to coordinate care. PACE is now active in 31 states, serving over 40,000 participants. For many states, PACE is an important way of offering innovative integrated care for dually eligible individuals. The comprehensive service package enables most participants to remain in the community rather than a nursing facility. **For most of its history, only not-for-profit organizations were permitted to sponsor PACE programs, but CMS now permits for-profit organizations to participate.**^{xiv}

States make a prospective monthly capitation payment to a PACE organization for a Medicaid participant enrolled in PACE which:

- Is less than what would otherwise have been paid under the state plan if not enrolled in PACE;
- Takes into account comparative frailty of participants; and

- Is a fixed amount regardless of changes in a participant’s health status.

Earlier research suggests there may be opportunities to improve the cost-efficiency of PACE capitation rates in certain states, and we encourage states with PACE sites to periodically re-examine their rate-setting methods to ensure they are appropriate.^{xv}

By incorporating PACE into a state’s integrated care strategy, a state may ensure continuing access to a proven community option. Interested state staff can find information on PACE through the Integrated Care Resource Center.^{xvi} States can also contact their CMS regional office for more information.

2. Medicare data

State efforts to better serve dually eligible individuals require access to both Medicare and Medicaid data. Lack of access to Medicare data or the internal capacity to link Medicare and Medicaid data for individual beneficiaries can make it difficult to coordinate all Medicare and Medicaid services. We are taking steps to unlock these important data and reduce the administrative burdens associated with obtaining them from CMS. Medicare data available to states include:

- Medicare claim and summary data for use of Medicare Part A, B, and D services
- Functional assessment data gathered as part of home health and skilled nursing services
- Integrated Medicare-Medicaid data sets (MMLEADS)

Twenty-nine Medicaid agencies currently receive Medicare data for the purposes of coordinating care for dually eligible individuals. Resources, including help with the data request process, use cases, ongoing shared learning calls, in-depth webinars, and recordings of past webinars for states on data-related issues, are available through our State Data Resource Center (SDRC).^{xvii}

We note, as detailed in a recent SMDL on Mechanized Claims Processing and Information Retrieval Systems (90/10), CMS provides, under 42 CFR §433.112(a), 90 percent enhanced federal financial participation (FFP) for Medicaid technology investments funded through an approved APD.^{xviii}

a. OPPORTUNITY #5 – Reducing the administrative burden in accessing Medicare data for use in care coordination

CMS is empowering individuals by ensuring they can access their health care data, and – through Blue Button 2.0 – providing a developer-friendly, standards-based data Application Programming Interface (API) to enable individuals to connect their Medicare claims data to the

applications, services, and research programs they trust. This same drive to streamline access to data has led us to re-examine the ways we share Medicare data with states.

CMS requires agreements to ensure that data requestors adhere to privacy and security requirements and data release policies. For states, we are significantly reducing the burdens associated with the process of obtaining and maintaining these agreements with CMS to access and use Medicare data, while ensuring the privacy and security requirements are maintained. **States may now execute “data request attestations” (DRAs) through a streamlined process, replacing the previous Data Use Agreement (DUA) process.** As of October 2018, twenty-three states have transitioned from DUAs to DRAs, and we look forward to working with additional states.

States with DUAs will hear from SDRC about transitioning to the DRA. If you have questions in the meantime, contact SDRC at sdrc@econometricainc.com. The SDRC will help complete all required forms, answer questions, and facilitate the submission process.

b. OPPORTUNITY #6 – Program integrity opportunities

When CMS originally began sharing Medicare claims and assessment data for dually eligible individuals with states, we restricted use to activities related to coordination of care. **State Medicaid agencies can now utilize Medicare data for program integrity purposes** (although it requires separate approval even if your state already has access to data for care coordination). Currently, there are seven states using these Medicare data for program integrity purposes. Program integrity uses include investigating improper provider billing and coding.

If you are interested in learning more about ways to use Medicare data for program integrity and how to gain approval to use data for program integrity purposes, contact SDRC at sdrc@econometricainc.com. The SDRC can help complete required forms, answer questions, and facilitate the submission process.

3. Improving beneficiary experiences and reducing administrative burden

We have identified numerous other opportunities for the federal government and states to improve beneficiary experiences and reduce overall administrative burden for states and providers serving dually eligible individuals, three of which are summarized below. States may pursue any of these opportunities as stand-alone updates or together with broader integrated care approaches.

a. Frequency of data exchange

i. OPPORTUNITY #7 -- MMA file timing

Since 2005, states have been submitting files at least monthly to CMS to identify all dually eligible individuals, including full-benefit dually eligible beneficiaries (i.e., those who qualify for full Medicaid benefits) and partial-benefit dually eligible beneficiaries (i.e., those who only get Medicaid help with Medicare premiums, and often for cost-sharing, but not full Medicaid benefits). The file is called the “MMA file” (after the Medicare Prescription Drug, Improvement and Modernization Act of 2003), but occasionally referred to as the “State Phasedown file.” CMS uses the MMA files for a variety of functions, including auto-enrolling full-benefit dually eligible beneficiaries into Medicare prescription drug plans and deeming full- and partial-benefit dually eligible beneficiaries automatically eligible for the Medicare Part D Low Income Subsidy (LIS, sometimes called Extra Help).

States must submit at least one file each month. However, states have the option to submit multiple MMA files throughout the month (up to one per day). Most states submit at least weekly.

We strongly encourage states to submit as frequently as possible. **More frequent submission achieves state efficiencies, improves beneficiary experiences, and reduces burden for providers.**^{xix}

State staff interested in learning about more frequent MMA file submission can contact Sharon Donovan in the CMS Medicare-Medicaid Coordination Office at Sharon.Donovan1@cms.hhs.gov. For technical system support, contact the MAPD Help Desk at mapdhelp@cms.hhs.gov or 1-800-927-8069. Or visit the MAPD Help Desk Web site at <http://go.cms.gov/mapdhelpdesk>.

ii. OPPORTUNITY #8 – State buy-in file data exchange

Under sections 1818(g) and 1843 of the Social Security Act, states and territories pay Medicare Part A and/or Part B premiums for certain residents dually eligible for Medicare and Medicaid. Under the state buy-in program, states can enter into Medicare Part A and B buy-in agreements to make it easier to enroll Medicaid recipients in Medicare and pay premiums on their behalf. Enrolling more individuals in Medicare can help limit state costs because Medicare is the primary payer for most medical care for dually eligible individuals. All states, three U.S. territories, and the District of Columbia have signed a Part B buy-in agreement; thirty-six states and the District of Columbia have also adopted a Part A buy-in agreement.

States, the Social Security Administration (SSA), and CMS share data to facilitate buy-in processes for Medicare Parts A and B. As with the MMA files, greater frequency of buy-in data exchange between the states and CMS supports more timely access to coverage and reduces

burdens for states, beneficiaries, and providers.^{xx} States have the option to submit buy-in files to CMS daily or monthly. Likewise, states can choose to receive CMS response files daily or monthly. Over half of the states are now exchanging buy-in files with CMS daily. **Daily submissions, and the ability to for states to receive daily response files from CMS, spread state staff workload more evenly across the month, permit errors to be corrected more quickly, and connect new beneficiaries more quickly to Medicare benefits.**

State staff interested in learning more about the frequency of state buy-in file submissions can contact Sharon Donovan in the CMS Medicare-Medicaid Coordination Office at Sharon.Donovan1@cms.hhs.gov. For technical support, state staff should contact Phyllis Martin in the CMS Office of Information Technology at Phyllis.Martin@cms.hhs.gov (and copy DPBCStateBuy-In@cms.hhs.gov).

b. OPPORTUNITY #9 – Improving Medicare Part A buy-in

Part A buy-in agreement permits a state to directly enroll eligible individuals in Part A at any time of the year, without late enrollment penalties assessed to a beneficiary’s premium liability. States without Part A buy-in agreements cannot enroll persons in Medicare Part A until the individual first goes to that individual’s local SSA office to complete a “conditional enrollment” application for Part A. Further, states without Part A buy-in agreements may only enroll persons in Part A during Medicare’s annual General Enrollment Period (January through March, with Medicare coverage beginning on July 1). States without a Part A buy-in agreement must pay any late enrollment penalties due to late Medicare Part A enrollment. Easing the administrative burden of Part A buy-in enrollments can produce state savings by increasing the number of Medicaid recipients who are enrolled in Medicare Part A. When that happens, Medicare becomes the primary payer for inpatient hospital and skilled nursing facility services.

For supplemental security income (SSI) recipients in particular, Auto Accrete states (also called “1634” states) already facilitate enrollments in Medicare Part B. Under a signed agreement between a state and SSA, when SSA finds someone eligible for SSI in an Auto Accrete state, he/she automatically receives Medicaid and is enrolled in Medicare Part B. Entering into a Part A buy-in agreement allows Auto Accrete states to ensure SSI recipients who are eligible for Medicare to be enrolled in Medicare Part A, in addition to Part B, without added costs for states (due to late enrollment penalties), delays, and the need for persons to complete the “conditional enrollment” for Part A application at their local SSA office.^{xxi} Without a Part A buy-in agreement, applying for Part A buy-in requires an application and eligibility determination by both SSA and Medicaid, requiring beneficiaries and eligibility workers to complete a multi-step application process which is complex and administratively burdensome.

We encourage interested state staff to contact Sharon.Donovan1@cms.hhs.gov in the CMS Medicare-Medicaid Coordination Office to discuss executing a Part A buy-in agreement.

c. OPPORTUNITY #10 – Opportunities to simplify eligibility and enrollment

Low-income Medicare beneficiaries who meet certain income and asset limits qualify for the Part D Low-Income Subsidy (LIS), which provides assistance with Medicare Part D premiums and cost-sharing. Many of these beneficiaries also qualify for Medicaid coverage of their Medicare Parts A and B premiums and cost-sharing through the Medicare Savings Programs (MSPs). The Social Security Administration (SSA) assesses LIS eligibility for many applicants, and section 1144(c)(3) of the Social Security Act requires that SSA send LIS application information to states for the purposes of initiating an MSP application.

Many states have maintained definitions and verification rules for income and assets that differ from those used by SSA.^{xxii} As a result, a determination of eligibility for the LIS by SSA does not necessarily provide enough information to allow a state to determine a beneficiary is automatically eligible for MSP, even though many of those currently enrolled in LIS also meet their states' eligibility standards for MSP.

A number of states have used the authority described in section 1902(r)(2)(A) of the Social Security Act to better align the LIS and MSP income and/or asset criteria.^{xxiii} Doing so can help achieve substantial efficiencies in the enrollment process, both for applicants and government eligibility workers, and simplify outreach to potential beneficiaries.^{xxiv} Prior studies of state experiences with MSPs have found significant administrative savings from reduced verification burdens, although each state should consider potential impacts based on local circumstances.^{xxv}

We remind states of the existing opportunities to simplify the eligibility and enrollment processes for applicants and eligibility workers, especially for the Medicare Savings Programs.

State staff interested in further exploring these opportunities can contact their CMS regional office or Gene Coffey in the CMS Children and Adults Health Programs Group at gene.coffey@cms.hhs.gov.

4. We are here to help!

The challenges of running a Medicaid agency are immense, and the opportunities described in this letter can get confusing. We are happy to talk with you or your staff to help assess the opportunities that work best for your state. We also provide resources for states, described below.

a. Technical support and peer-to-peer learning

CMS sponsors the Integrated Care Resource Center (ICRC) to provide state-specific assistance to better understand the state's dually eligible population, assess options for improving integration of care, and navigate aspects of the Medicare program that states can leverage to

benefit Medicaid. To learn more and to contact ICRC, please visit <http://www.integratedcareresourcecenter.com>.

CMS sponsors the State Data Resource Center (SDRC) to facilitate state access to, and use of, Medicare data on dually eligible individuals to support care coordination and program integrity. SDRC's technical advisors can help states determine how to use available data, assist with the process of obtaining Medicare data from CMS, and advise on methods for linking databases and creating analytic files. To learn more and to contact SDRC, please visit <http://www.statedataresourcecenter.com>.

b. Resources to help keep up with new policies and opportunities related to serving dually eligible beneficiaries

MMCO will provide information to state Medicaid agencies on contracting with D-SNPs and other resources for states interested in exploring such plans as a platform for integration. We frequently send such information through email listservs. We encourage interested states to sign up to receive listserv updates through MMCO^{xxvi} and the Integrated Care Resource Center.^{xxvii} For any other comments or questions, or to explore other potential opportunities, please contact Tim Engelhardt, Director of the CMS Medicare-Medicaid Coordination Office, at Tim.Engelhardt@cms.hhs.gov.

cc:

/s/
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Administrator

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

Academy Health

Endnotes

- i For discussion of social risk factors, see <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>.
- ii Medicare-Medicaid Coordination Office, National Profile 2012. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NationalProfile_2012.pdf.
- iii Ibid.
- iv The Medicare Advantage and Part D final rule is available at <https://www.gpo.gov/fdsys/pkg/FR-2018-04-16/pdf/2018-07179.pdf>.
- v See at <https://www.regulations.gov/document?D=CMS-2018-0110-0001>
- vi Per MIPPA section 163(d)(3)
- vii See “State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options” at: https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues__Options.pdf.
- viii HPMS Memo. August 31, 2018. Default Enrollment Option for Newly Medicare Advantage Eligible Medicaid Managed Care Plan Enrollees (formerly known as “Seamless Conversion Enrollment”).
- ix A D-SNP must receive CMS approval of a default enrollment program prior to implementation.
- x States like Arizona and Tennessee have partnered with health plans and used seamless conversion (the predecessor to default enrollment) to increase the number of individuals who receive all of their Medicaid and Medicare services through the same organization.
- xi The webinar on default enrollment is available at <https://www.integratedcareresourcecenter.com/webinar/aligning-coverage-dually-eligible-beneficiaries-using-default-and-passive-enrollment>.
- xii For example, CMS may initiate Medicare enrollment actions when low income beneficiaries are enrolled in a plan whose premium increased, or when a plan is not renewing or leaves the market.
- xiii See https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disenrollment_Guidance.pdf.
- xiv See <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACE/PACE-Demonstration.html>.
- xv Effect of PACE on costs, nursing home admissions, and mortality: 2006-2011, at https://aspe.hhs.gov/system/files/pdf/76971/PACEeffect_0.pdf.
- xvi https://www.integratedcareresourcecenter.com/resource-library?&field_resource_category%5B0%5D=271.
- xvii <http://www.statedataresourcecenter.com/>.
- xviii <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18005.pdf>.
- xix For more information on the benefits of, and process for, increasing the frequency of MMA file exchange, please visit http://www.statedataresourcecenter.com/assets/files/MMA_QA.pdf. OMB control number for this reporting requirement: 0938-0958.
- xx To effectuate the state payment of Medicare Part A or Part B premiums, a state submits data on a buy-in file to CMS. The state’s input file includes a record for each Medicare beneficiary for whom the state is adding, deleting coverage, or changing buy-in status. In response, CMS returns an updated transaction record that provides data identifying, for each transaction on the state file, whether CMS accepted, modified, or rejected it, as well as a Part A or Part B billing record showing the state’s premium responsibility. In addition, the CMS file may “push” new updates obtained from SSA to the state, for example, changes in the Medicare Beneficiary Identifier number or change of address. Daily exchanges reduce burden by spreading state workload throughout the months as well as significantly reduce lags in resubmitting an improperly processed transaction and recouping and redistributing premiums.
- xxi See 42 C.F.R. 406.26.
- xxii The primary points of misalignment between LIS and MSPs are the value of life insurance policies, burial funds, and in-kind support. xxiii General Accountability Office, “Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment,” September 2012, available at <http://www.gao.gov/products/GAO-12-871>.
- xxii Amy Tiedemann and Kimberly Fox, “Promising Strategies for Medicare Savings Program Enrollment: Modifying Eligibility Criteria and Documentation Requirements,” Rutgers Center for State Health Policy, May 2005, available at <http://www.cshp.rutgers.edu/Downloads/5300.pdf>; Kim Glaun, “Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Program Case Study Findings,” Kaiser Commission on Medicaid and the Uninsured, December 2002, available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-programs-to-assist-low-income-medicare-beneficiaries-medicare-savings-programs-case-study-findings-background-paper.pdf>.



xxiv General Accountability Office, “Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment,” September 2012, available at <http://www.gao.gov/products/GAO-12-871>.

xxv Amy Tiedemann and Kimberly Fox, “Promising Strategies for Medicare Savings Program Enrollment: Modifying Eligibility Criteria and Documentation Requirements,” Rutgers Center for State Health Policy, May 2005, available at <http://www.cshp.rutgers.edu/Downloads/5300.pdf>; Kim Glaun, “Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Program Case Study Findings,” Kaiser Commission on Medicaid and the Uninsured, December 2002, available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-programs-to-assist-low-income-medicare-beneficiaries-medicare-savings-programs-case-study-findings-background-paper.pdf>.

xxvi Sign up for the MMCO listserv at https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_7840.

xxvii Sign up for the ICRC listserv at <https://www.integratedcareresourcecenter.com/about-us/e-alerts>.