

# Medicare Basics: An Overview for States Seeking to Integrate Care for Medicare-Medicaid Enrollees

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**IN BRIEF:** States seeking to better integrate care for Medicare-Medicaid enrollees need to understand Medicare benefits and enrollee cost-sharing provisions in order to better structure and coordinate the Medicaid benefits they will be offering to these enrollees. This technical assistance brief provides an overview of these Medicare issues and, where relevant, highlights important areas of overlap with Medicaid, including coverage of nursing facility services, home health, durable medical equipment, hospice, transportation, and prescription drugs. It also provides a brief summary of how rates are set in Medicare Advantage managed care programs.

The Centers for Medicare & Medicaid Services (CMS) is implementing a Financial Alignment Initiative that is providing states with the opportunity to better integrate services for Medicare-Medicaid enrollees (sometimes referred to as “dually eligible beneficiaries”) through the use of two models:

- A **capitated model** in which the state, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment from CMS and the state to provide comprehensive, coordinated care; and
- A **managed fee-for-service (FFS) model** in which the state and CMS enter into an agreement under which the state would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

In these models and in other state initiatives to integrate care, it is important for states to have a good understanding of the Medicare program and the way it interacts with Medicaid for Medicare-Medicaid enrollees. This technical assistance brief from the *Integrated Care Resource Center* (ICRC) provides basic information on the Medicare program, the services it covers, and the process used to set rates. Where relevant, it highlights important areas of overlap with Medicaid, including coverage of nursing facility services, home health, durable medical equipment (DME), hospice, transportation, and prescription drugs. The worksheet in Appendix A provides a template for states to develop a side-by-side comparison of the Medicare and Medicaid benefits that will be available to Medicare-Medicaid enrollees in integrated care programs in their state.

## I. Program Basics

### Who is Eligible for Medicare?

Medicare provides health insurance for eligible individuals who are: (1) age 65 and over; (2) under age 65 and have received Social Security disability insurance (SSDI) for two years; or (3) have end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease) and are of any age.

### What Services Does Medicare Cover?

Medicare has four program components, or parts, each of which provides different benefits and services:

- **Medicare Part A** pays for hospital expenses, including hospitalizations in specialty psychiatric hospitals. Medicare Part A also pays for up to 100 days in a skilled nursing facility and for skilled home health services; for persons with a life expectancy of six months or less, it pays for hospice services. For those with sufficient work history, enrollment in Part A does not require a premium.

- **Medicare Part B** provides medical insurance that pays for physician visits/services, skilled home health services, DME, outpatient hospital services, ambulance services, and lab tests. The Part B program also covers certain preventive health care services. Enrollment in Part B is voluntary, and beneficiaries must pay a monthly premium to participate.
- **Medicare Part C or Medicare Advantage (MA)** is a voluntary program that allows participants to receive their Part A, B, and sometimes Part D benefits through private managed care organizations.
- **Medicare Part D** provides prescription drugs through private health plans, either stand-alone Prescription Drug Plans (PDPs), or MA plans (MA-PDs). MA-PDs cover prescription drugs and all other Part A and B services.

Though Original Medicare is a major payer for health care services, there are some important services that it does not generally cover. MA plans may offer some of these services as supplemental benefits. The services not generally covered by Medicare include:

- Routine eye care and eyeglasses;
- Routine dental care and dentures;
- Hearing aids and exams for fitting hearing aids;
- Routine foot care, except for individuals with diabetes-related conditions;
- Long-term institutional services;
- Personal assistance services;
- Cosmetic surgery; and
- Bathroom grab bars and similar equipment.

As discussed below, Medicaid may pay for many of these services, but the extent of coverage will vary by state. Exhibit 1 briefly describes the major services covered by the two programs for Medicare-Medicaid enrollees.

### How and When Do Beneficiaries Choose Their Medicare Coverage?

Beneficiaries have two main options for Medicare coverage: FFS Medicare (referred to as “Original Medicare”) and Medicare Advantage managed care plans (MA plans). There are also different types of managed care plans, including Medicare cost plans, Health Care Prepayment Plans, Programs of All-Inclusive Care for the Elderly (PACE), and demonstrations and pilot programs, which also provide Medicare coverage but are not addressed in this document. Medicare Part D is discussed in more detail in a separate document.<sup>1</sup>

- **Original Medicare** is FFS coverage under which the federal government directly pays health care providers the Medicare-approved amount for services covered by Parts A and B. Beneficiaries who have Original Medicare can join a Part D plan to add drug coverage. They may also purchase private insurance, or Medigap policies, that supplement coverage under Parts A and B.
- **Medicare Advantage** provides coverage for Part A and B services through private managed care plans and their defined network of providers. Medicare pays for those services through a capitated monthly payment to the plan for each enrolled member. Benefits and cost-sharing requirements may differ between plans and may be different than those in Original Medicare. All MA plans cover Part A and B benefits, and most also cover the Part D benefit (MA-PD plans). Some cover only Parts A and B benefits (MA-only plans). Some MA plans also offer additional benefits not covered by Original Medicare, like vision or dental care.

When individuals enroll in Medicare, they receive services in the Original Medicare program. If they want to have their Medicare coverage provided by an MA plan or they want Part D coverage, they must actively enroll in it during a valid enrollment period.

## Exhibit 1. Major Services Covered by Medicare and Medicaid for Medicare-Medicaid Enrollees

Medicare Coverage	Medicaid Coverage
Ambulance services	Transportation to medical appointments
Dialysis	Medicare cost sharing**
Durable medical equipment	Medicare cost sharing,** and DME not covered by Medicare
Home health care	Home health care not covered by Medicare when the individual qualifies as needing nursing facility services or otherwise at the state's option
Hospice	Hospice services not covered by Medicare
Inpatient hospital services	Medicare cost sharing** and inpatient services if Medicare Part A benefits are exhausted
Outpatient hospital services	Medicare cost sharing**
Physician services	Medicare cost sharing**
Prescription drugs*	Prescription drugs excluded from Part D coverage, if covered by Medicaid for other Medicaid beneficiaries; Medicaid does not cover Medicare Part D copayments
Skilled nursing facility services after a three-day hospital stay, up to 100 days per benefit period	Long-term nursing facility services, Medicare cost sharing,** and skilled nursing facility services if Medicare Part A benefits are exhausted
Original Medicare does not offer coverage for dental, vision, or hearing services, home and community-based services (HCBS), and personal care***	Optional services: dental, vision, hearing, home and community-based services, and personal care assistance

SOURCE: Table 5-1. MedPAC. Report to the Congress: Aligning Incentives in Medicare, June 2010 and authors' analysis. Available at: [http://www.medpac.gov/docs/default-source/reports/Jun10\\_EntireReport.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/Jun10_EntireReport.pdf?sfvrsn=0).

\* Prescription drugs are covered primarily through Part D plans. Original Medicare provides very limited prescription drug coverage under Medicare Part B. Medicare Advantage plans may also provide Part D prescription drug coverage.

\*\* The amount of Medicare beneficiary cost sharing (deductibles, coinsurance, and copayments) paid for Medicare-Medicaid enrollees by Medicaid in a specific state depends on the Medicaid state plan in that state. States are required to pay Medicare beneficiary cost sharing only up to the amount that Medicaid would pay for a specific service in that state. For details on how each state handles this, see MACPAC, "State Medicaid Payment Policies for Medicare Cost Sharing," January 2017. Available at: <https://www.macpac.gov/publication/state-medicare-payment-policies-for-medicare-cost-sharing-2016/>.

\*\*\* Medicare Advantage plans may cover some of these services as supplemental benefits.

Compared to the enrollment periods available to beneficiaries with Medicare only (described in Exhibit 2 below), some notable exceptions apply to Medicare-Medicaid enrollees. First, Medicare-Medicaid enrollees are allowed to enroll in or disenroll from MA plans each month, whereas other Medicare beneficiaries can enroll in or change their enrollment in MA or Part D plans only during the annual open enrollment periods for MA and Part D and during defined special election periods. Second, while Part D is a voluntary program, almost all Medicare-Medicaid enrollees are automatically enrolled in stand-alone PDPs if they do not voluntarily enroll, or unless they voluntarily enroll in MA-PDs, as about 20 percent of Medicare-Medicaid enrollees have done.

## II. Services Covered by Both Medicare and Medicaid for Medicare-Medicaid Enrollees

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### What Medicare Services Are Also Covered by Medicaid?

Medicare is considered the primary payer for most acute care services for Medicare-Medicaid enrollees, including hospital, physician, and short-term skilled nursing facility services. For about three-fourths of Medicare-Medicaid enrollees (“full benefit” dually eligible beneficiaries), Medicaid pays for Medicare Parts A and B premiums and enrollee cost-sharing, long-term nursing facility and other institutional services, community-based long-term services and supports, and many non-Medicare-covered services like dental, vision, and transportation. Medicaid coverage of behavioral health services is also generally more extensive than Medicare coverage of these services. There are often complex overlaps between Medicare and Medicaid coverage of nursing facility, home health, DME, hospice, and transportation services.

Appendix A provides a worksheet with detailed descriptions of Medicare benefits and cost sharing requirements and a blank column that states can use to describe the corresponding Medicaid benefits for Medicare-Medicaid enrollees. Appendix B provides a detailed comparison of Medicare and Medicaid coverage of home health, DME, and hospice benefits where the overlaps between Medicare and Medicaid coverage are especially complex.

## III. Medicare Rate Setting

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### How Are Rates Set for Medicare-Covered Services?

Rate setting in Original Medicare is a complicated process performed using different methods for different service types. MA managed care rate setting is also quite complex. Since rate setting in both Original Medicare and MA may differ significantly from how rates are set in Medicaid, it is important for states operating integrated programs to be aware of the differences.

#### *Original Medicare*

- **Hospital acute inpatient services:** Medicare’s Inpatient Prospective Payment System pays per-discharge rates that are based on national payment amounts for operating and capital expenses. These base rates are adjusted to account for two broad factors that affect hospitals’ costs of providing services: (1) the patient’s diagnosis and related treatment needs and (2) market conditions in the facility’s location. In addition to adjusting for these two factors, the operating and capital payments are increased for facilities that operate physician training programs or that treat a disproportionate share of low-income patients, and outlier payments are added for patients who are extraordinarily costly.<sup>2</sup>
- **Outpatient hospital services:** Medicare’s outpatient prospective payment system sets payments for individual services by classifying services according to their resource requirements and median costs, converting this into dollar payment rates, and applying adjustments for geographic differences in input prices. Hospitals also can receive additional payments in the form of outlier adjustments for extraordinarily high-cost services and pass-through payments for some new technologies.<sup>3</sup> Facilities that provide outpatient dialysis services for individuals with ESRD are paid using a separate method.<sup>4</sup>

## Exhibit 2. Medicare Enrollment Periods

Enrollment Period	Original Medicare (Parts A and B)	Medicare Advantage	Medicare Part D
Initial Enrollment	7-month period that begins 3 months before a person turns 65 or before the 25th month of receiving disability benefits.*	7-month period that begins 3 months before month of Medicare eligibility. Beneficiaries must have both Part A and Part B to enroll in MA.	7-month period that begins 3 months before month of Part D eligibility. Medicare-Medicaid enrollees are deemed to have enrolled in Part D and will be facilitated into a Part D plan.
Annual Enrollment Period or General Enrollment Period	General Enrollment Period to enroll in Part B and premium-free Part A (for people who did not sign up for Part B when they first became eligible): January 1-March 31 each year (coverage begins July 1). Individuals who meet the criteria for premium-free Part A can enroll in Part A at any time.	Annual Enrollment Period (AEP) to enroll in, disenroll from, or change plans: October 15-December 7 (coverage begins January 1).	Annual Enrollment Period** to enroll in, disenroll from, or change plans: October 15-December 7 (coverage begins January 1).
Special Enrollment	Available: (1) any time that a person or spouse (or family member for those with disabilities) is working and is covered by an employer-based group health plan based on current employment; or (2) during the 8-month period beginning the month after a person stops working or loses employer-based group health plan coverage based on current employment, whichever comes first.	Available if: (1) a person moves out of the plan's service area; (2) the plan leaves the Medicare program or reduces its service area; (3) a person leaves or loses employer or union coverage; (4) a person enters, lives at, or leaves a long term care facility; (5) a person is dually eligible or qualifies for a low-income subsidy (LIS), or loses dual-eligibility/LIS status; (6) a person joins or switches to a plan that has a 5-star rating; or (7) other special situations. Medicare-Medicaid enrollees may enroll in MA plans at any time.	Available if a person: (1) permanently moves out of the plan's service area; (2) loses other creditable prescription drug coverage; (3) was not adequately informed the other coverage was not creditable,** (4) enters, lives in, or leaves a long-term care facility; (5) is dually eligible or qualifies for LIS, or loses dual-eligibility/LIS status; (6) belongs to a State Pharmaceutical Assistance Program; (7) joins or switches to a plan that has a 5-star rating; or (8) other special situations. Medicare-Medicaid enrollees may enroll in Medicare Part D plans at any time.
Disenrollment	Voluntary termination is available for Part B at any time. Termination is processed through the Social Security Administration and becomes effective the first day of the month after the voluntary termination request is filed.	Disenrollment Period is January 1-February 14. During this period, enrollees in MA can shift to Original Medicare. (Coverage in Original Medicare begins the first of the month after a person leaves the MA plan.) People who disenroll may also join a stand-alone Part D plan but cannot join another MA plan during this period. Switching from one MA plan to another is permitted only during the AEP or a Special Enrollment Period (SEP). Medicare-Medicaid enrollees may disenroll at any time.	Switching from one PDP to another, or dropping prescription drug coverage completely, is only permitted during the AEP or an SEP. Medicare-Medicaid enrollees may disenroll from Medicare Part D plans at any time.

Sources: National Medicare Training Program. Department of Health and Human Services; Centers for Medicare and Medicaid Services. Understanding Medicare. February 2017. Available at: <https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1190652.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending>; Medicare.gov. Signing up for Part A & Part B. Accessed March 29, 2017 from <https://www.medicare.gov/sign-up-change-plans/get-parts-a-and-b/when-how-to-sign-up-for-part-a-and-part-b.html>.

\* Disability benefits include those received from the Social Security Administration or the Railroad Retirement Board.

\*\* Creditable coverage means that the payer is expected to pay on average as much as the standard Medicare prescription drug coverage.

- **Physician services:** Medicare pays for physician services based on a list of services and their payment rates, called the physician fee schedule. In determining payment rates for each service on the fee schedule, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to these three inputs, called relative value units (RVUs), are adjusted for geographic market variation, and then multiplied by a specified factor that converts the adjusted RVUs into dollar values and adjusts for spending growth. The resulting amount may be modified based on provider characteristics, additional geographic designations, and other factors before the final payment is made to the physician. Annual updates to the physician fee schedule were governed in the past by a sustainable growth rate limit that Congress frequently modified, and that has now been replaced by a payment system established by the Medicare Access and Chip Reauthorization Act of 2015 (MACRA).<sup>5</sup>

MACRA limits annual updates to 0.5 percent per year for 2016 through 2018, and zero for 2019 through 2025. Beginning in 2019, CMS will provide an incentive payment to clinicians who participate in qualifying alternative payment models if the level of revenue they receive through such models meets a certain threshold. Clinicians who do not participate in alternative payment models will receive either a bonus or penalty, based on their relative quality, resource use, meaningful use of certified electronic health records, and clinical practice improvement activities, as measured through the Merit-based Incentive Payment System.<sup>6</sup>

- **Skilled nursing facility (SNF) services:** The payment rates, computed separately for urban and rural areas, reflect a projection of the amount that SNFs received in 1995. These rates are updated each year based on the projected increase in the SNF market basket index, a measure of the cost of all goods and services needed to provide SNF care, which can change over time. Daily payments to SNFs are based on three components: (1) the intensity of nursing care patients are expected to require; (2) the amount of therapy services provided or expected to be provided; (3) the expected costs of room and board, linens, and administrative services.<sup>7</sup>
- **Durable medical equipment:** Medicare uses a competitive bidding process to set prices for DME in competitive bid areas. In this process, suppliers in a defined area submit bids for selected products, and CMS awards contracts to the suppliers who offer the best price and meet applicable quality and financial standards. Contractors are paid an amount for each product equal to the median of all winning bids for the item.<sup>8</sup> For non-competitive bid areas, most payment rate adjustments for DME are made regionally based on average competitive rates; the amount of variation in regionally adjusted rates is limited by a national ceiling and floor of 110 and 90 percent, respectively, of average regional rates.<sup>9</sup>
- **Home Health:** CMS uses a prospective payment system that pays home health agencies a predetermined rate for each 60-day episode of home health care. The payment rates are based on patients' conditions and service use, and they are adjusted to reflect the level of market input prices in the geographical area where services are delivered.<sup>10</sup>
- **Hospice:** Medicare pays hospice agencies a daily rate for each day an individual is enrolled in the hospice benefit. Payments are made according to a fee schedule that has four base payment amounts for the four different categories of care, distinguished by the location and intensity of services provided: (1) routine home care; (2) continuous home care; (3) inpatient respite care; and (4) general inpatient care. The base rates are updated annually according to the hospital market basket index, which measures the cost of all goods and services needed to provide hospital care at a given point in time.<sup>11</sup> Beneficiaries in MA plans that elect hospice receive coverage through a FFS basis.

### **Medicare Advantage**

Medicare capitated payments for services provided through MA managed care plans are set through a separate process that starts with county-level benchmarks that are based on per capita Medicare FFS expenditures in each county. MA plans bid to offer Parts A and B coverage to an average, or standard, enrollee and include plan administrative costs and profit in their bids.<sup>12</sup> CMS bases the Medicare payment for a private plan on the relationship between its bid and a benchmark, or bidding target. If a plan's standard bid is above the benchmark, then the plan receives a base rate equal to the benchmark, and the enrollees have to pay a basic premium that equals

the difference between the bid and the benchmark. If a plan's bid falls below the benchmark, the plan receives a base rate equal to its standard bid. Plans bidding below the benchmark also receive "rebate" payments from Medicare, which must be returned to enrollees in the form of lower Part B or Part D premiums, reduced cost sharing, or additional benefits.

Since Medicaid pays Part B premiums and cost sharing for Medicare-Medicaid enrollees, and Medicare-Medicaid enrollees are not required to pay Part D premiums, plans that specialize in serving Medicare-Medicaid enrollees, like Dual Eligible Special Needs Plans (D-SNPs), use most of their rebates for additional benefits.<sup>13</sup> Plans with higher quality rankings have bonus amounts added to the benchmark levels. The CMS star rating system is the mechanism for determining the bonus amount levels.

The benchmark is determined by a statutory formula that was modified in the Affordable Care Act of 2010. For local plans in 2012 and thereafter, the factors determining the benchmark levels include the relationship between per capita FFS expenditures in a county compared to the national average, as well as plan quality indicators. For regional plans, the benchmark is a weighted average of the average county rate and the average plan bid in the region. Regional plan benchmarks are calculated somewhat differently from those of local plans, using weighted averages of both county rates and plan bids in the region.

Payments to MA plans are also based on enrollees' demographic and health risk characteristics and adjusted based on the CMS Hierarchical Condition Categories (CMS-HCC) risk adjustment system. The CMS-HCC system uses regression techniques to estimate prospective costs based on demographic factors (i.e., age, sex, Medicaid status, institutional status, and eligibility) and current medical conditions, which are grouped into hierarchical condition categories. Payment for the Part D prescription drug portion of plan benefits is calculated separately, using a similar RxHCC model.

## **IV. Conclusion**

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There are a number of complex intersections between the Medicare and Medicaid programs, particularly in the area of nursing facility services, home health, DME, hospice, transportation, and prescription drugs. States that understand the key features of the Medicare program can work to align their Medicaid programs in order to improve both the delivery and experience of care for individuals enrolled in both programs.

## Appendix A. Worksheet on Medicare and Medicaid Benefits Available to Medicare-Medicaid Enrollees

States that are developing integrated programs for Medicare-Medicaid enrollees need basic information on Medicare services, especially those that overlap substantially with Medicaid services, including nursing facility services, DME, home health, hospice, and transportation. States can use this worksheet to lay out Medicaid benefits available to Medicare-Medicaid enrollees alongside the Medicare benefits they will also receive. In addition, states can highlight the services that Medicaid provides for Medicare-Medicaid enrollees and that Medicare does not, such as home- and community-based waiver and related services, and vision and dental benefits. Note that MA plans may offer some supplemental services that are not covered by Original Medicare.

Benefit	Medicare Coverage	Medicare Cost Sharing in 2017 <sup>a</sup>	State Medicaid Coverage
Adult Day Services	Generally not covered by Medicare.	Not applicable.	
Adult Day Service Transportation	Generally not covered by Medicare.	Not applicable.	
Ambulance Services (Medically Necessary Ambulance Service)	Medicare Part B will cover ambulance services to or from a hospital, critical access hospital, or a skilled nursing facility in cases of emergencies. <sup>b</sup>	Beneficiaries are responsible for 20% coinsurance. <sup>c</sup>	
Dental Benefits	May be covered by Medicare in certain circumstances (i.e., accident or injury).	Not applicable.	
Durable Medical Equipment	With prior authorization for certain DME types, such as powered wheelchairs, Medicare covers DME that: (1) can withstand repeated use; (2) serves primarily a medical purpose; (3) generally is not useful to a person without an illness or injury; and (4) is appropriate for use in a patient's home. <sup>d</sup> Examples include: <ul style="list-style-type: none"> <li>• Oxygen and oxygen equipment;</li> <li>• Wheelchairs;</li> <li>• Diabetic testing equipment and supplies;</li> <li>• Medication that is necessary to the function performed by durable equipment; and</li> <li>• Other equipment that generally has an expected life of at least 5 years.</li> </ul>	Beneficiaries are responsible for 20% coinsurance. <sup>e</sup>	
End-Stage Renal Disease (ESRD) Benefits	ESRD-related benefits include outpatient maintenance dialysis services, after completion of a 33-month waiting period. <sup>f</sup>	Beneficiaries are responsible for 20% coinsurance.	

<sup>a</sup> For more information on Medicare cost sharing, see: <https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>.

<sup>b</sup> Centers for Medicare & Medicaid Services. *Medicare Coverage of Ambulance Services*. January 2017. Available at: <https://www.medicare.gov/Pubs/pdf/11021-Medicare-Coverage-of-Ambulance-Services.pdf>.

<sup>c</sup> Centers for Medicare & Medicaid Services. *Medicare Coverage of Ambulance Services*. January 2017. Available at: <https://www.medicare.gov/Pubs/pdf/11021-Medicare-Coverage-of-Ambulance-Services.pdf>.

<sup>d</sup> Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services. Rev. 228, 10-13-16 Available at: <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>.

<sup>e</sup> MedPAC. *Durable Medical Equipment Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_dme\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_dme_final.pdf?sfvrsn=0).

<sup>f</sup> Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual, Chapter 11 – End Stage Renal Disease. Rev. 224, 06-03-16. Available at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c11.pdf>.

Benefit	Medicare Coverage	Medicare Cost Sharing in 2017 <sup>a</sup>	State Medicaid Coverage
Home Health Benefits	<p>Beneficiaries who are homebound and need skilled care (i.e., from a nurse, physical, occupational, or speech therapist) on a part-time or intermittent basis are eligible for Medicare home health.</p> <p>Care provided for each 60-day episode(s) may include:</p> <ul style="list-style-type: none"> <li>• Skilled nursing services;</li> <li>• Home health aide services;</li> <li>• Physical therapy;</li> <li>• Speech-language pathology services;</li> <li>• Occupational therapy services; and</li> <li>• Medical social services.<sup>g</sup></li> </ul>	Beneficiaries are not required to make any copayments or other cost sharing for these services (with the exception of DME received through this benefit, which still carries a 20% coinsurance).	
Home- and Community-Based Waiver and Related Services	Not covered by Medicare.	Not applicable.	
Hospice	Beneficiaries who are entitled to Medicare Part A and be certified as being terminally ill may elect hospice care under Medicare. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course. <sup>h</sup>	The beneficiary is responsible for 5% of the Medicare-approved amount for inpatient respite care and a copayment of up to \$5 per prescription for outpatient prescription drugs for pain and symptom management for the terminal illness and related conditions. Medicare does not cover room and board when a beneficiary receives a home level of hospice care while residing in a nursing home or other facility.	
Inpatient Psychiatric Facility Services	This benefit is available for individuals with both a psychiatric and co-morbid diagnosis; beneficiary lifetime limit of 190 days in an inpatient psychiatric hospital. <sup>i</sup>	<ul style="list-style-type: none"> <li>• \$1,316 deductible per benefit period.</li> <li>• \$0 for the first 60 days of each benefit period.</li> <li>• \$329 per day for days 61-90 of each benefit period.</li> <li>• \$658 per day for up to 60 "lifetime reserve days"<sup>j</sup> that can be used after 90 days of hospitalization in a benefit period. There is a 190-day lifetime limit on Medicare coverage of this service.<sup>k</sup></li> </ul>	
Inpatient Hospital Services	<p>Inpatient hospital or inpatient Critical Access Hospital (CAH) services include the following services furnished to an inpatient of a participating hospital (acute care hospital, long-term care hospital, or inpatient rehabilitation facility) or of a participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:</p> <ul style="list-style-type: none"> <li>• Bed and board;</li> <li>• Nursing services and other related services;</li> <li>• Use of hospital or CAH facilities;</li> <li>• Medical social services;</li> <li>• Drugs, biologicals, supplies, appliances, and equipment;</li> <li>• Certain other diagnostic or therapeutic services;</li> <li>• Medical or surgical services provided by certain interns or residents-in-training; and</li> <li>• Transportation services, including transport by ambulance.</li> </ul>	<ul style="list-style-type: none"> <li>• \$1,316 deductible per benefit period.</li> <li>• \$0 for the first 60 days of each benefit period.</li> <li>• \$329 per day for days 61-90 of each benefit period.</li> <li>• \$658 per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over a beneficiary's lifetime).</li> </ul>	

<sup>g</sup> MedPAC. *Home Health Care Services Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_hha\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_hha_final.pdf?sfvrsn=0).

<sup>h</sup> Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual, Chapter 11 – Coverage of Hospice Services Under Hospital Insurance. Rev. 209, 05-08-15. Available at: <http://www.cms.gov/manuals/Downloads/bp102c09.pdf>.

<sup>i</sup> Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual, Chapter 2 – Inpatient Psychiatric Hospital Services. Rev. 223, 05-13-16. Available at: <http://www.cms.gov/manuals/Downloads/bp102c02.pdf>.

<sup>j</sup> Medicare will pay for up to 60 days in excess of a 90-day hospital stay over the course of a lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance (\$658 in 2017).

<sup>k</sup> Centers for Medicare & Medicaid Services. *Your Medicare Benefits*. January 2017. Available at: <https://www.medicare.gov/Pubs/pdf/10116-Your-Medicare-Benefits.pdf>.

Benefit	Medicare Coverage	Medicare Cost Sharing in 2017 <sup>a</sup>	State Medicaid Coverage
Outpatient Mental Health Services	Medicare covers the following services: <ul style="list-style-type: none"> <li>• Psychiatric diagnostic interviews;</li> <li>• Individual and group psychotherapy;</li> <li>• Family psychotherapy (of which the primary purpose is treatment of the individual's condition);</li> <li>• Psychoanalysis;</li> <li>• Pharmacologic management;</li> <li>• Electroconvulsive therapy;</li> <li>• Diagnostic psychological and neuropsychological tests;</li> <li>• Hypnotherapy;</li> <li>• Narcosynthesis; and</li> <li>• Partial hospitalization programs furnished by a hospital to its outpatients and by Community Mental Health Centers.<sup>l</sup></li> </ul>	20% of the Medicare-approved amount for most outpatient mental health care. For services performed in a hospital outpatient clinic, or hospital outpatient department, the beneficiary may have to pay an additional copayment or coinsurance amount to the hospital. This amount will vary depending on the service provided but will be between 20% and 40% of the Medicare-approved amount.	
Outpatient Physical Therapy and Speech Therapy	Medicare Part B 2017 limits: \$1,980 (combined maximum for physical and speech therapy). <sup>m</sup>	Beneficiaries are responsible for 20% coinsurance.	
Outpatient Occupational Therapy	Medicare Part B 2017 limits: \$1,980. <sup>n</sup>	Beneficiaries are responsible for 20% coinsurance.	
Personal Assistance Services	Not covered by Medicare.	Not applicable.	
Physician Services	Physician services include office visits, surgical procedures, anesthesia services, chronic care management services, and a broad range of other diagnostic and therapeutic services. <sup>o</sup>	Beneficiaries are responsible for 20% coinsurance.	
Prescription Drugs	Medicare Part D covers a wide range of generic and brand name drugs in the most commonly prescribed categories and classes. All PDP and MA plans must cover the same categories of drugs, but plans can choose which specific drugs are covered in each drug category.	Cost sharing varies by beneficiary type and living arrangement. <ul style="list-style-type: none"> <li>• Individuals with full Medicare and Medicaid benefits who live in an institution or who are receiving Medicaid home and community-based services (HCBS) do not pay any cost sharing (including premiums, deductibles, or copays).</li> <li>• Individuals with full Medicare and Medicaid benefits who reside in the community and are not receiving HCBS do not pay premiums or deductibles. Depending on income, their copay is \$1.20-3.30 per generic drug or \$3.70-\$8.25 per brand name drug. There are no copays after total drug spending reaches \$7,425.00. Medicare beneficiaries who are not receiving full Medicare and Medicaid benefits pay Part D premiums, deductibles, coinsurance, and higher copays.<sup>p</sup></li> </ul>	

<sup>l</sup> Centers for Medicare & Medicaid Services. *Medicare & Your Mental Health Benefits*. April 2016. Available at: <https://www.medicare.gov/Pubs/pdf/10184-Medicare-Mental-Health-Bene.pdf>.

<sup>m</sup> Centers for Medicare & Medicaid Services. *Medicare Limits on Therapy Services*. January 2017. Available at: <https://www.medicare.gov/Pubs/pdf/10988-Medicare-Limits-Therapy-Services.pdf>.

<sup>n</sup> Centers for Medicare & Medicaid Services. *Medicare Limits on Therapy Services*. January 2017. Available at: <https://www.medicare.gov/Pubs/pdf/10988-Medicare-Limits-Therapy-Services.pdf>.

<sup>o</sup> CMS established separate billing codes for chronic care management services starting in 2015. Centers for Medicare & Medicaid Services. *Chronic Care Management Services*. December 2016. Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>.

<sup>p</sup> Centers for Medicare & Medicaid Services. *Your Guide to Medicare Prescription Drug Coverage*. April 2016. Available at: <https://www.medicare.gov/Pubs/pdf/11109-Your-Guide-to-Medicare-Prescrip-Drug-Cov.pdf>.

Benefit	Medicare Coverage	Medicare Cost Sharing in 2017 <sup>a</sup>	State Medicaid Coverage
Preventive Services	<p>Medicare covers a variety of preventive services, including:<sup>q</sup></p> <ul style="list-style-type: none"> <li>• Initial preventive physical examination and annual wellness visits;</li> <li>• Cardiovascular screening blood tests;</li> <li>• Screening for breast, cervical and vaginal, colorectal, and prostate cancers;</li> <li>• Influenza, pneumococcal, and Hepatitis B vaccinations;</li> <li>• Bone mass measurements;</li> <li>• Diabetes screening and diabetes self-management training;</li> <li>• Medical nutrition therapy;</li> <li>• Glaucoma tests;</li> <li>• Tobacco use cessation counseling;</li> <li>• HIV screening; and</li> <li>• Ultrasound (for abdominal aortic aneurism).</li> </ul> <p>For a complete list of services, see the Medicare Quick Reference Information chart on Preventive Services.<sup>r</sup></p>	<p>Most preventive services are free to beneficiaries.</p> <p>For some services, beneficiary must pay 20% of the Medicare-approved amount for physician costs plus outpatient copays (Part B deductible does not apply). Applies to:</p> <ul style="list-style-type: none"> <li>• Barium enemas; and</li> <li>• HIV screening.</li> </ul> <p>For other services, beneficiaries pay 20% of Medicare-approved amount after yearly Part B deductible, including:</p> <ul style="list-style-type: none"> <li>• Digital rectal exam;</li> <li>• Continued diabetes screening and supplies; and</li> <li>• Glaucoma tests.</li> </ul>	
Skilled Nursing Facility Services	<p>Medicare covers up to 100 days of SNF care per episode of illness (must be preceded by a three-day inpatient hospital stay). Beginning on day 21 of a SNF stay, an enrollee is responsible for a daily copayment.<sup>s</sup></p>	<ul style="list-style-type: none"> <li>• \$0 for the first 20 days each benefit period.</li> <li>• \$164.50 per day for days 21-100 each benefit period.<sup>t</sup></li> <li>• All costs for each day after day 100 in a benefit period.</li> </ul>	
Vision Services and Hearing Aids	<p>Covered only for those at high risk of glaucoma.</p>	<p>Not applicable.</p>	

<sup>q</sup> Centers for Medicare & Medicaid Services. *Your Guide to Medicare's Preventive Services*. March 2015. Available at: <https://www.medicare.gov/Pubs/pdf/10110.pdf>.

<sup>r</sup> Centers for Medicare & Medicaid Services. Medicare Preventive Services. Available at: <https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html>.

<sup>s</sup> MedPAC. *Skilled Nursing Facility Services Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_snf\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_snf_final.pdf?sfvrsn=0).

<sup>t</sup> Medicare.gov. Medicare 2017 Costs at a Glance. Available at: <https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>

## Appendix B: Relationships between Medicare and Medicaid Coverage of Home Health, Durable Medical Equipment, and Hospice Benefits

The table below provides a detailed comparison of Medicare and Medicaid coverage of home health, DME, and hospice benefits, where the overlaps between Medicare and Medicaid coverage are especially complex.

Benefit	Medicare Coverage	Medicaid Coverage
Home Health	<p>Medicare covers medically-necessary part-time or intermittent skilled nursing care, select therapies, and social services delivered in the home. For services to be considered part-time or intermittent, they must be furnished or needed on fewer than seven days each week or less than eight hours of each day for periods of 21 days or less, with extensions in exceptional circumstances. The services covered under the home health benefit include:</p> <ul style="list-style-type: none"> <li>• Skilled nursing care provided on a part-time or intermittent basis, by either an RN or LPN with RN supervision;</li> <li>• Home health aide services provided on a part-time or intermittent basis, and ordered by a physician as part of a written plan of care;</li> <li>• Physical therapy, occupational therapy, and speech-language pathology services that are determined to be reasonable and necessary;</li> <li>• Medical social services that are provided under the direction of a doctor;</li> <li>• Medical supplies that are ordered by the home health agency as part of an episode of care; and</li> <li>• Covered osteoporosis drugs (excludes all other drugs and biologicals).</li> </ul> <p>To be eligible for the Medicare home health benefit, the enrollee must be confined to the home. In general, this means that leaving the home is medically contraindicated or that the enrollee has a condition due to an illness or injury that restricts the ability to leave the place of residence except with physical assistance. Trips outside the home must be infrequent, of short duration, or for the purpose of receiving health care treatment.</p>	<p>States must offer nursing services, home health aide services, and medical supplies, equipment, and appliances suitable for use in the home under their state plan. States also have the option of adding additional therapeutic services like physical therapy, occupational therapy, speech pathology, and audiology services. Medicaid requires that home health services be provided in the home by a Medicare-certified home health agency, but there is no requirement that beneficiaries be homebound.</p> <p>States must offer home health services to Medicaid beneficiaries age 21 and older who meet the states' criteria for nursing home coverage; they may offer home health to additional groups of beneficiaries if they choose. The home health services must be ordered by a physician as part of a written plan of care which must be reviewed every 60 days. States may not limit Medicaid home health services to individuals who require skilled nursing and therapy services.</p>

Benefit	Medicare Coverage	Medicaid Coverage
<p>Durable Medical Equipment</p>	<p>DME encompasses a wide range of supportive equipment and devices including wheelchairs, walkers, prosthetics, oxygen tanks, and associated supplies. For Medicare to consider an item to be DME, it must be: (1) able to withstand repeated use; (2) used primarily and customarily to serve a medical purpose; (3) not useful to a person in the absence of an illness or injury; and (4) appropriate for use in the home.</p> <p>Beneficiaries who rent or purchase DME may be reimbursed for their expenses by Medicare if the DME is considered necessary and reasonable for the treatment of the patient's illness or injury, or to improve the functioning of his or her malformed body member. The equipment must also be used in the patient's home. Medicare may reimburse beneficiaries for repairs, maintenance, and delivery of equipment and for expendable and non-reusable items essential to the effective use of the equipment. Medicare, however, will only authorize payments after a good or service has been delivered to the enrollee.<sup>u</sup></p> <p>Medicare previously set payment rates for each item on the basis of a FFS schedule, but it now uses a competitive process that awards contracts to enough qualified low bidders to meet enrollee demand in competitive bid areas. For non-competitive bid areas, it uses a payment schedule adjustment.<sup>v, w</sup></p> <p>Medicare is gradually implementing prior authorization rules for DME and will enforce these rules for power wheelchairs nationwide in 2017. The program also established a master list of DME identified as frequently subject to unnecessary utilization. The items on this list are potentially subject to prior authorization.<sup>x</sup></p>	<p>DME is covered as part of Medicaid's mandatory home health benefit.<sup>y</sup> Medicaid defines 'equipment and appliances' in a broader manner than Medicare and notes that states are not restricted to the DME items covered under Medicare.<sup>z</sup> Each state may set its own "reasonable standards" to determine whether an item is covered, based on criteria such as medical necessity or utilization control.<sup>aa</sup> Because states may not categorically exclude types of items without individually assessing whether a requested item has a medical purpose, quantity limits and categories of covered equipment may be more generous in some Medicaid programs than in Medicare. Medicaid may also be more generous than Medicare in that it covers items that can be used to help individuals function outside the home.<sup>bb</sup> Medicaid, for example, may cover heavy duty wheelchairs that could be used both at home and out of doors, while Medicare would cover only a wheelchair suitable for use within the home.</p> <p>For Medicare-Medicaid enrollees, since Medicaid is the payer of last resort, state Medicaid agencies generally require that a bill for DME be submitted first to Medicare. Only after Medicare has rejected the claim or paid its share will Medicaid process a payment. This may present complications for both beneficiaries and providers if the processes for the two systems are not well coordinated.<sup>cc</sup></p> <p>Starting on January 1, 2018, Medicaid will limit payments for DME to the rates established by the Medicare competitive bidding process.<sup>dd</sup></p>

<sup>u</sup> Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual, Chapter 15. Rev. 228, 10-13-16. Available at: <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>.

<sup>v</sup> Centers for Medicare & Medicaid Services. DMEPOS Competitive Bidding. March 10, 2017. Available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid>.

<sup>w</sup> MedPAC. *Durable Medical Equipment Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_dme\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_dme_final.pdf?sfvrsn=0)

<sup>x</sup> Centers for Medicare & Medicaid Services. Prior Authorization Process for Certain Durable Medical Equipment, Prosthetic, Orthotics, Supplies (DMEPOS) Items. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html>

<sup>y</sup> 42 C.F.R. sec. 440.70(b)(3).

<sup>z</sup> 42 CFR 440.70(b)(3)(ii)

<sup>aa</sup> Centers for Medicare & Medicaid Services. State Medicaid Director Letter, September 4, 1998. Available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD090498.pdf>.

<sup>bb</sup> Burke, Georgia and Kevin Prindiville. Medicare and Medicaid Alignment: Challenges and Opportunities for Serving Dual Eligibles. Washington, DC: National Senior Citizens Law Center, August 2011. Available at:

[http://www.justiceinaging.org/wp-content/uploads/2015/05/RE\\_DualsAlignmentBrief-NSCLC.pdf](http://www.justiceinaging.org/wp-content/uploads/2015/05/RE_DualsAlignmentBrief-NSCLC.pdf) .

<sup>cc</sup> Burke and Prindiville, pp. 5-9.

<sup>dd</sup> 42 U.S.C. 1396b(i)(27).

## ENDNOTES

- <sup>1</sup> J. Verdier. "Medicare Part D Prescription Drug Coverage for Medicare-Medicaid Enrollees in the Capitated Financial Alignment Demonstration." Integrated Care Resource Center, March 2013. Available at: [http://www.integratedcareresourcecenter.com/pdfs/ICRC%20-%20Part%20D%20Brief%20for%20States%20FINAL%20\(2-22-13\).pdf](http://www.integratedcareresourcecenter.com/pdfs/ICRC%20-%20Part%20D%20Brief%20for%20States%20FINAL%20(2-22-13).pdf).
- <sup>2</sup> MedPAC. *Hospital Acute Inpatient Services Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_hospital\\_finalecfc0fadfa9c665e80adff00009edf9c.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_hospital_finalecfc0fadfa9c665e80adff00009edf9c.pdf?sfvrsn=0).
- <sup>3</sup> MedPAC. *Outpatient Hospital Services Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_opd\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_opd_final.pdf?sfvrsn=0).
- <sup>4</sup> MedPAC. *Outpatient Dialysis Services Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_dialysis\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_dialysis_final.pdf?sfvrsn=0).
- <sup>5</sup> MedPAC. *Physician and Other Health Professionals Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_physician\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_physician_final.pdf?sfvrsn=0).
- <sup>6</sup> MedPAC. *Medicare's New Framework for Paying Clinicians*. June 2016. Available at: <http://www.medpac.gov/docs/default-source/reports/chapter-2-medicare-s-new-framework-for-paying-clinicians-june-2016-report-.pdf?sfvrsn=0>.
- <sup>7</sup> MedPAC. *Skilled Nursing Facility Services Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_snf\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_snf_final.pdf?sfvrsn=0).
- <sup>8</sup> MedPAC. *Durable Medical Equipment Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_dme\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_dme_final.pdf?sfvrsn=0).
- <sup>9</sup> 42 CFR 414.210(g)(1).
- <sup>10</sup> MedPAC. *Home Health Care Services Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_hha\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_hha_final.pdf?sfvrsn=0).
- <sup>11</sup> MedPAC. *Hospice Services Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_hospice\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_hospice_final.pdf?sfvrsn=0).
- <sup>12</sup> MedPAC. *Medicare Advantage Program Payment System*. October 2016. Available at: [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_16\\_ma\\_final.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_ma_final.pdf?sfvrsn=0).
- <sup>13</sup> In 2010, all Medicare Advantage plans combined devoted 54 percent of their rebate dollars to reducing beneficiary cost sharing, another 12 percent to reducing Part B and Part D premiums, and only 34 percent to adding and enhancing benefits. Plans that specialize in serving dually eligible beneficiaries presumably allocate most of their rebate dollars to adding and enhancing benefits. MedPAC, Report to the Congress, March 2010, Figure 4.2, p. 268. Available at: [http://www.medpac.gov/docs/default-source/reports/mar10\\_ch04.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/mar10_ch04.pdf?sfvrsn=0).