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Working with Medicare

Coordination of Medicare and Medicaid Behavioral Health Benefits

April 15, 2020

12:30-1:30 pm Eastern Time

The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services' Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica and the Center for Health Care Strategies.

The "Working with Medicare" Webinar Series

- Designed for all states interested in improving coordination of Medicare and Medicaid benefits for dually eligible (Medicare-Medicaid) individuals
- Webinars are repeated annually:
  - Medicare 101 and 201
  - Coordination of Medicare and Medicaid Behavioral Health Benefits
  - Medicare and Medicaid Nursing Facility Benefits
  - Update on State Contracting with D-SNPs
- Supplemented by:
  - ICRC updates/e-alerts on important new Medicare information
  - ICRC technical assistance briefs and other written tools on Medicare issues of importance to states
- Sign up and view past e-alerts: https://www.integratedcareresourcecenter.com/about-us/e-alerts

Agenda

- Clinical Profiles and Behavioral Health Expenditures for Dually Eligible Individuals
- Medicare and Medicaid Behavioral Health Benefits
- Integrating Medicare and Medicaid Behavioral Health Benefits: State Approaches and Options
- Questions and Answers

Presenters

- Zaire Graves
  - Integrated Care Resource Center (ICRC)
- Danielle Chelminsky
  - ICRC
- Caitlin Murray
  - ICRC

Clinical Profiles and Behavioral Health Expenditures for Dually Eligible Individuals

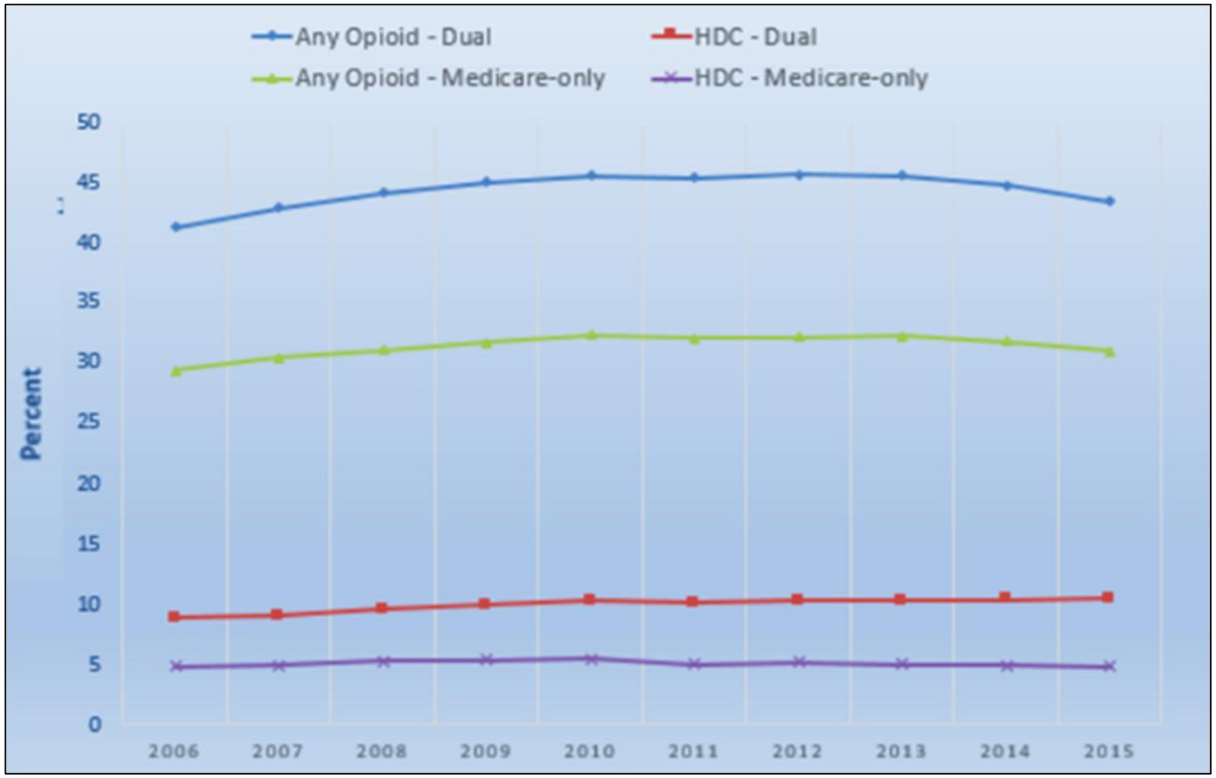
Behavioral Health Conditions Are Highly Prevalent Among Dually Eligible Individuals

Behavioral health conditions are more prevalent among dually eligible individuals under age 65 than among those age 65 and older.

Behavioral Health Condition (CY 2013)	% Under 65	% 65 and Older
Anxiety Disorders	**24%**	15%
Bipolar Disorder	**15%**	3%
Depressive Disorder	**33%**	22%
Schizophrenia and Other Psychotic Disorders	**13%**	7%

Source: MedPAC-MACPAC. "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." January 2018. Exhibit 8. Available at: http://medpac.gov/docs/default-source/data-book/jan18_medpac_macpac_dualsdatabook_sec.pdf?sfvrsn=0

Prevalence of Any and High Dose Chronic (HDC) Opioid Use among Dually Eligible and Medicare-Only Beneficiaries, 2006-2015



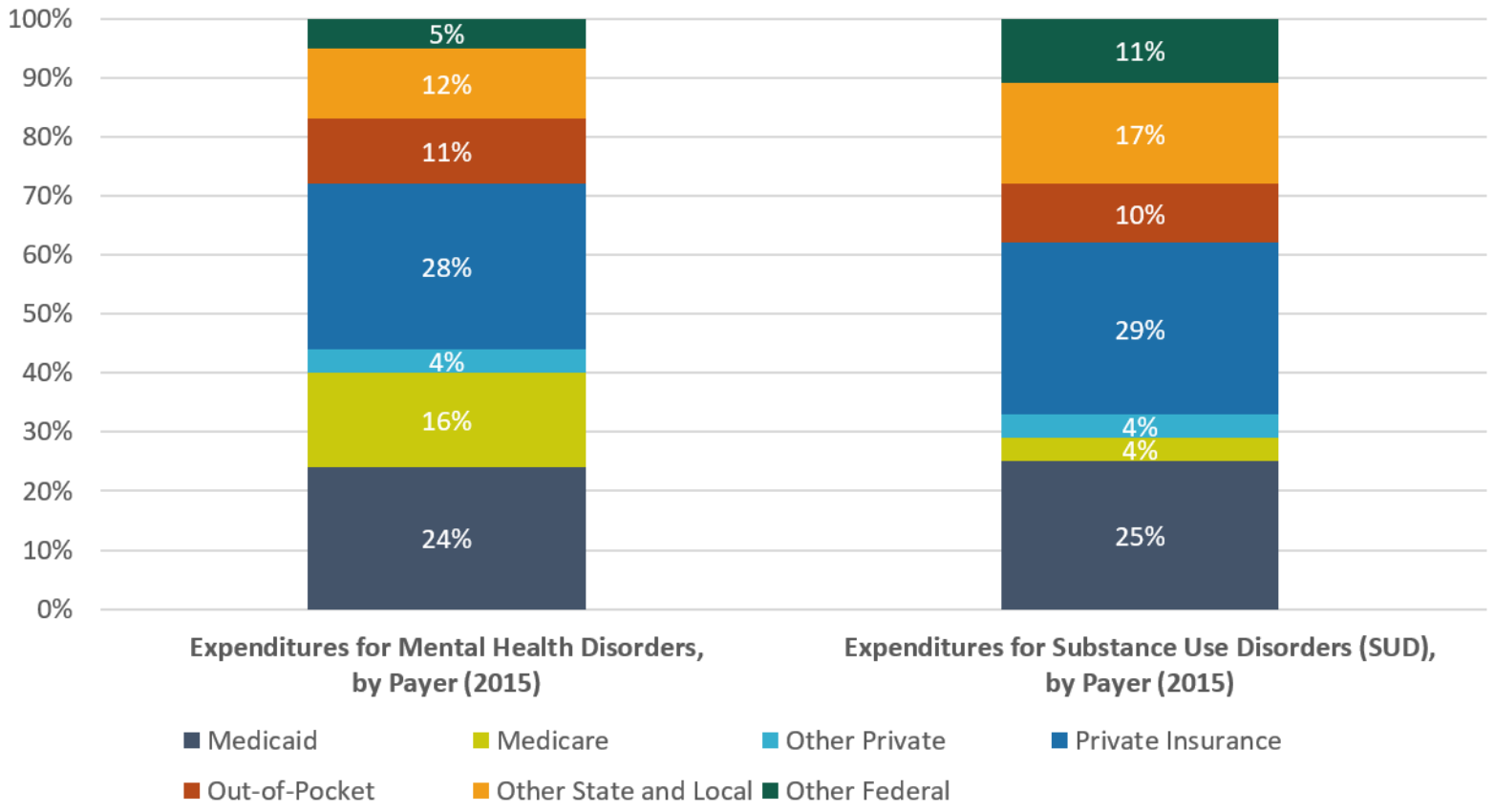
Source: CMS. "National Trends in High-dose Chronic Opioid Utilization among Dually Eligible and Medicare-only Beneficiaries (2006-2015). "October 2018. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/OpioidsDataBrief_2006-2015_10242018.pdf

Dually Eligible Individuals with Mental Health Conditions Have High Rates of Some Comorbid Physical Health Conditions

Chronic Physical Health Comorbidity (CY 2008)	Prevalence
Heart Condition	75%
Musculoskeletal Disorder	42%
Anemia	36%
Diabetes	36%
Lung Disease	30%

Source: CMS. "Physical and Mental Health Condition Prevalence and Comorbidity among FFS Medicare-Medicaid Enrollees." 2014. Table 25. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidity_2014.pdf

Expenditures for Mental Health Disorders and Substance Used Disorders (SUD), by Payer (2015)



Source: U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). "Behavioral Health Spending & Use Accounts, 2006-2015," February 2019. Available at: https://store.samhsa.gov/product/Behavioral-Health-Spending-and-Use-Accounts-2006-2015/SMA19-5095?referer=from_search_result

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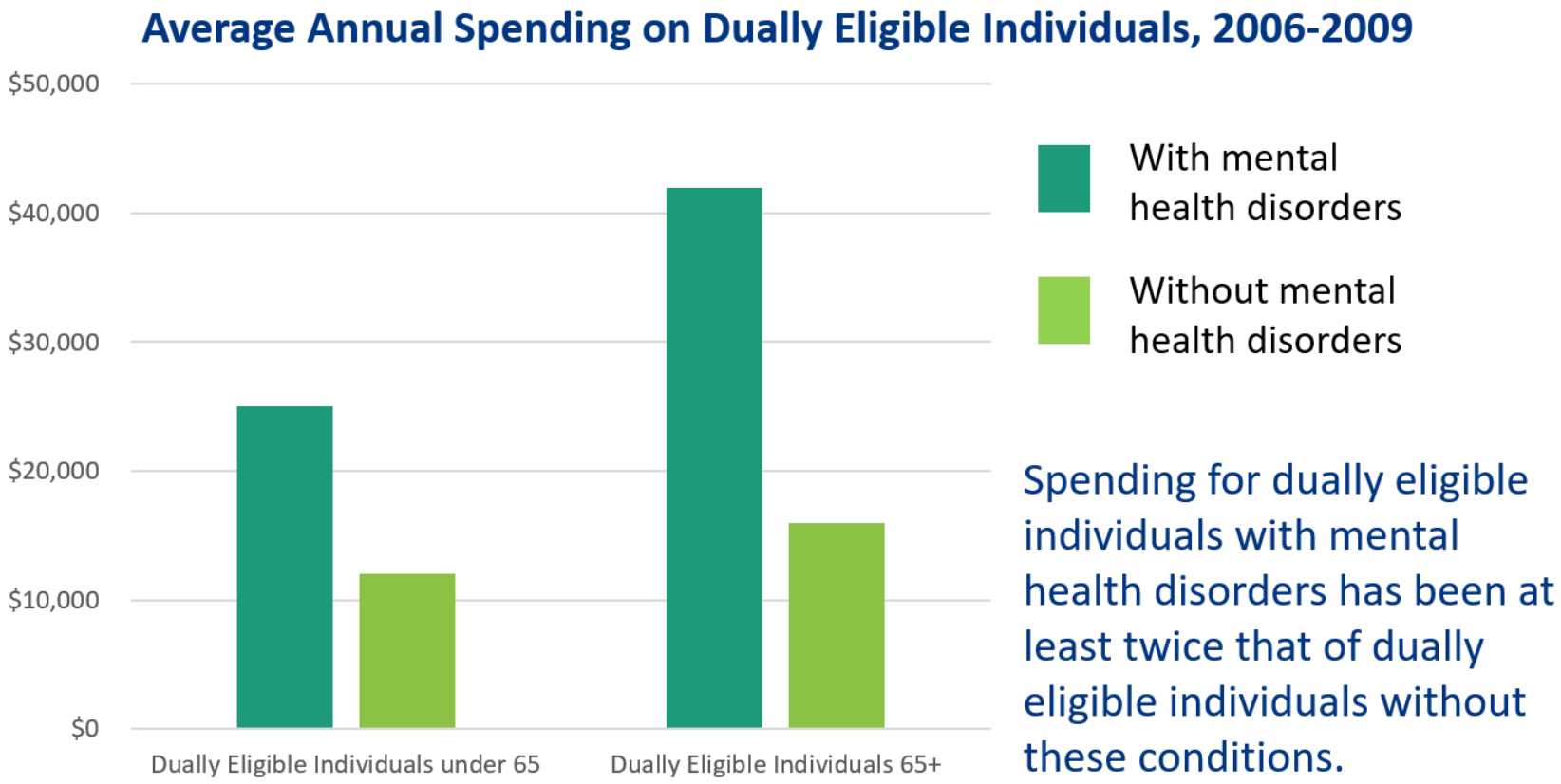
Comparison of Spending for Dually Eligible Individuals With and Without Mental Health Disorders



Spending for dually eligible individuals with mental health disorders has been at least twice that of dually eligible individuals without these conditions.

Source: R. Frank. "Mental Illness and a Duals Dilemma." *Journal of the American Society on Aging*, 37, no. 2 (2013): 47-53.

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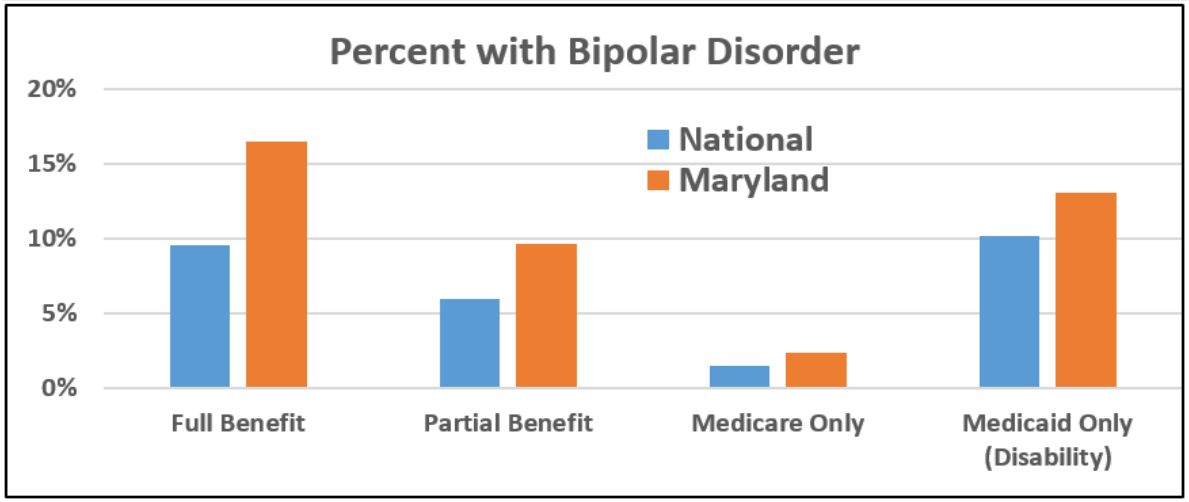
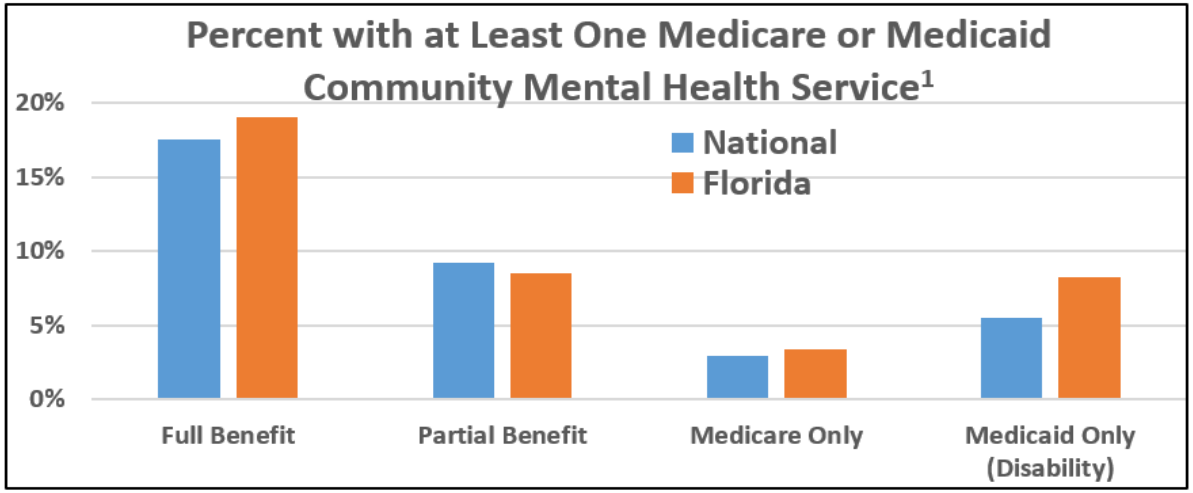
Characteristics of Dually Eligible Individuals in Each State

- The Medicare-Medicaid Linked Enrollee Analytics Data Source (MMLEADS) file has detailed **state** and **national** level data on the characteristics of dually eligible individuals. *Note: Data is from 2012 and is fee-for-service only.*
- Example Variables (see first tab in MMLEADS link for list of all variables):
  - **Chronic conditions:** Percent with Alzheimer's disease, bipolar disorder, depression, drug use
  - **Utilization:** Percent with at least one Medicare or Medicaid community or residential mental health service
  - **Payment:** Medicaid mental health FFS payments
- Why It's Useful to States:
  - **Compare types of beneficiaries** by demographics, enrollment categories, chronic conditions, utilization and spending
  - **Compare states** to other states and to the national average
  - Help develop **tailored integrated care programs**
  - See the ICRC TA brief: How States Can Better Understand their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources for more information

State vs. National Examples from MMLEADS, 2012





[1] Percent with at least one Medicare or Medicaid Community Mental Health service includes anyone with a Medicare claim for a community mental health center, a Medicare psychiatry physician visit, or a Medicaid claim with a place of service code.

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Medicare and Medicaid Behavioral Health Benefits

Medicare Mental Health and Substance Use Disorder (SUD) Services Coverage

Mental Health and SUD Services	Medicare Coverage
Inpatient care mental health and SUD services in general and psychiatric hospitals	Part A
Outpatient mental health and SUD services provided by approved health care professionals[1] • May include individual and group psychotherapy, psychiatric diagnostic interviews, medication management, and other services and therapies including Screening, Brief Intervention, and Referral to Treatment (SBIRT).	Part B
Prescription drugs, including drugs to treat mental health and SUD conditions[2]	Part D

Note: Medicare Advantage plans may offer supplemental benefits to meet social needs.

[1] Includes psychiatrists and other physicians, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, and physician assistants); includes depression and alcohol misuse screenings. Part B may cover partial hospitalization, a structured program of psychiatric services provided in community mental health centers, or hospital outpatient settings. Standard copay amounts apply for both Part A and Part B coverage, which Medicaid covers for dually eligible individuals.

[2] Medicare covers Medication-Assisted Treatment (MAT) through a combination of Part A, B and/or D, depending on the setting in which the MAT was administered.

Sources: CMS. "Medicare & Your Mental Health Benefits." 2019. Available at: https://www.medicare.gov/Pubs/pdf/11358-Medicare-Mental-Health-Getting-Started.pdf. CMS Medicare Learning Network. "Medicare Mental Health" 2020. Available at: https://www.cms.gov/files/document/medicare-mental-health.pdf; and SAMHSA. "Medication-Assisted Treatment." Available at: https://www.samhsa.gov/medication-assisted-treatment.

New Medicare Opioid Treatment Benefit

- As of January 1, 2020, CMS began making bundled payments for opioid use disorder (OUD) treatment services provided by Opioid Treatment Programs (OTP) to people with Part B coverage
  - For details, see this December 2019 CMCS Informational Bulletin: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib121719.pdf
- Under the new benefit, Medicare covers:
  - U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT)
  - Dispensing and administration of MAT (if applicable)
  - Substance use counseling
  - Individual and group therapy
  - Toxicology testing
  - Intake activities
  - Periodic assessments

New Medicare Opioid Treatment Benefit: Implications for States

- **Impact of the OTP benefit on Medicaid OUD payments and the OUD service market**
  - In 2020, Medicare became the primary payer for dually eligible individuals who receive OUD services from OTPs in states that provide this benefit under Medicaid.
- **Cost sharing for dually eligible individuals**
  - The Part B copayment for OTP services will be zero in 2020, but the Part B deductible will apply.
    - For dually eligible individuals in FFS Medicare who are in the Part B deductible phase, CMS will crossover the claim to Medicaid for adjudication.
- **Continuity of care**
  - OTP providers need to enroll as Medicare providers to receive Medicare payment.
  - To prevent payment disruptions during the transition from Medicaid to Medicare as the primary payer for OTP services for dually eligible individuals, CMS has issued guidance to states and OTPs regarding coordination of benefits and third party liability options.
  - CMS has also released guidance to Medicare Advantage plans on strategies to promote continuity of care for dually eligible individuals.
  - See guidance available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Medicaid
- **Alignment with Medicare**
  - States with more limited OTP benefits may want to consider expanding Medicaid OUD treatment options for dually eligible individuals to align Medicaid OUD benefits with the new Medicare benefit.

Medicare Plan Flexibilities from Comprehensive Addiction and Recovery Act of 2016 (CARA)[1]

- CARA included provisions that give Medicare Part D and Medicare Advantage plans **flexibilities to address opioid overutilization through Drug Management Programs.**
- CMS designates specific opioids and benzodiazepines as "**frequently abused drugs**" and plans use clinical guidelines and consult with prescribers to determine if a beneficiary is "**at-risk**" for addiction.
  - Plans can take specific actions to prevent and address potential addition (see next slide for details).

[1]Public Law 114-198, 114th Congress. §704(a)(5). July 22, 2016. Available at: https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf.

Medicare Plan Flexibilities from CARA *(Continued)*

If a beneficiary is determined to be "at-risk" for addiction, plans can:

1. Prevent beneficiaries from making enrollment changes outside of standard Medicare enrollment periods.
   - Most dually eligible individuals qualify for a Special Enrollment Period (SEP) to make changes to their Medicare Advantage plans once per quarter for the first three quarters of the year.[1] However, "at-risk" beneficiaries are unable to use this SEP.
2. Limit the beneficiary's access to frequently abused drugs to *select* providers and/or pharmacies ("lock-in").
3. Use beneficiary-specific point-of-sale claim edits to alert the pharmacist and/or prompt pharmacist action.

- These flexibilities are optional for 2020 and 2021 but will be mandatory beginning in 2022 as a result of the SUPPORT Act.[2]

[1]All states currently allow dually eligible individuals in Medicare-Medicaid Plans to change, switch, or disenroll every month. For more information on Medicare SEPs, see "Medicare-Medicaid Plan Enrollment and Disenrollment Guidance." 2019. Available at: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disenrollment_Guidance.pdf.

[2]Section 2004 of the SUPPORT Act (P.L. 115-271) requires mandatory implementation of the Medicare Part D Drug Management Programs created by CARA.

Medicaid Mental Health Services Coverage

- States are required to cover medically necessary mental health services, including services delivered in inpatient hospital, outpatient hospital, rural health clinic, nursing facility, home health, and physician office settings (e.g., psychiatrist services).
- States can elect to cover additional services through state plans or waivers (i.e., home and community based services).
- As of 2015, all states covered prescription drugs for mental health treatment.
  - Medicare provides those drugs for dually eligible individuals.

States Covering Mental Health Services, 2018	
Individual Therapy	45
Inpatient Psychiatric Hospital	43
Crisis Intervention	43
Telemedicine[1]	39
Day Treatment	34
Partial Hospitalization	33
Peer Support	32
Case Management	29
Psychosocial Rehabilitation	29
Psychiatric Residential Treatment	23

Sources: Kaiser Family Foundation. "Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals." 2017. Available at: https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/ and KFF State Health Facts. "Medicaid Behavioral Health Services Database." 2018. Available at: https://www.kff.org/data-collection/medicaid-behavioral-health-services-database/

[1] Data as of 2015 from MACPAC "State Policies for Behavioral Health Services Covered under the State Plan." 2016. Available at: https://www.macpac.gov/subtopic/behavioral-health-services-covered-under-state-plan-authority/.

Medicaid Substance Use Disorder Services Coverage

- All states cover Buprenorphine and Naltrexone for Medication-Assisted-Treatment (MAT), and most states also cover Suboxone and Methadone.
  - Medicare provides those drugs for dually eligible individuals.
- Many states provide SUD services, such as detoxification, psychotherapy, peer support, and crisis intervention through Medicaid state plan services.

States Covering Continuum of SUD Services, 2018	
Early Intervention	42
Outpatient Services	49
Intensive Outpatient	38
Medically Managed Intensive Inpatient Services	43
Residential Rehabilitation	33

Sources: MACPAC. "State Policies for Behavioral Health Services Covered under the State Plan." 2016. Available at: https://www.macpac.gov/subtopic/behavioral-health-services-covered-under-state-plan-authority/; KFF State Health Facts. "Medicaid Behavioral Health Services Database." 2018. Available at: https://www.kff.org/data-collection/medicaid-behavioral-health-services-database/; and MACPAC. "Substance Use Disorder Continuum of Care and the IMD Exclusion." 2018. Available at: https://www.macpac.gov/publication/substance-use-disorder-continuum-of-care-and-the-imd-exclusion/.

Coverage of Institutions for Mental Diseases (IMD) Services for Dually Eligible Individuals

- **IMDs:** Inpatient facilities of more than 16 beds in which 51 percent or more of patients are being treated for mental diseases.
- Medicare covers medically necessary **inpatient psychiatric facility** services through Part A (up to 90 days and a total of 190 days in a lifetime), but does not cover SUD treatment services in non-hospital-based residential facilities.
  - 44% of patients at inpatient psychiatric facilities are dually eligible individuals.[1]
  - Not all IMDs necessarily qualify as inpatient psychiatric hospitals.
- **IMD Exclusion:** Historically, federal law has prohibited the use of federal Medicaid matching payments for IMD services used by Medicaid beneficiaries between the ages of 22 and 64. States therefore had to fund these services with state-only dollars, limiting their availability.[2]

[1]MedPAC. "Assessing Medicare's payments for services provided in inpatient psychiatric facilities." Oct 4, 2018. Available at: http://www.medpac.gov/docs/default-source/default-document-library/psych-pps-october-2018-public-final.pdf?sfvrsn=0

[2] MACPAC. "Report to Congress on Oversight of Institutions for Mental Diseases." Dec 19, 2019. Available at: https://www.macpac.gov/wp-content/uploads/2020/01/Report-to-Congress-on-Oversight-of-Institutions-for-Mental-Diseases-December-2019.pdf

New Medicaid Coverage Options for IMD

States have new options to use federal Medicaid funds to cover IMD services for non-elderly adults under the IMD exclusion, including:

- **Section 1115 demonstration waivers:** Allows states to test short-term inpatient and residential SUD treatment services in IMDs using Medicaid funds. States must meet certain milestones around care coordination, quality of care, and early detection for treatment.
- **Medicaid managed care "in lieu of" authority:** Allows states to use Medicaid funds for capitated payments to managed care plans to cover IMD SUD and mental health services for up to 15 days a month *instead of* providing other services under the state plan benefit package, such as non-IMD inpatient or outpatient services.
- **Disproportionate share hospital (DSH) payments**: Allows states to use Medicaid DSH funding for IMD services.
- **The SUPPORT Act state plan option**: Temporarily allows states to use Medicaid funds on non-elderly adults receiving IMD SUD services for up to 30 days a year, lifting the IMD exclusion until 2023 if states meet certain criteria, use evidence-based treatment practices, and have at least two forms of medication-assisted-treatment on site.

Sources: KFF. "State Options for Medicaid Coverage of Inpatient Behavioral Health Services." Nov 2019. Available at: http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services; and State Medicaid Director Letter, 2019. Available at: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd19003.pdf

States Using IMD Coverage Options

Nearly every state is using some form of federal flexibility to use Medicaid funds to cover IMD services for non-elderly adults.

Number of states using the various IMD coverage options for non-elderly adults in FY 2020	
1115 Waivers	26[1]
Managed Care "in-lieu of" Authority	35
DSH Payments	33[2]
SUPPORT Act (State Plan Option)	5

[1]As of Nov 2019. Includes two states with approved and pending waivers.
Source: Kaiser Family Foundation. "State Options for Medicaid Coverage of Inpatient Behavioral Health Services." Nov 2019. Available at: http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services
[2]As of 2018.

Integrating Medicare and Medicaid Behavioral Health Benefits: State Approaches and Options

Multiple Layers of Fragmentation for Dually Eligible Individuals

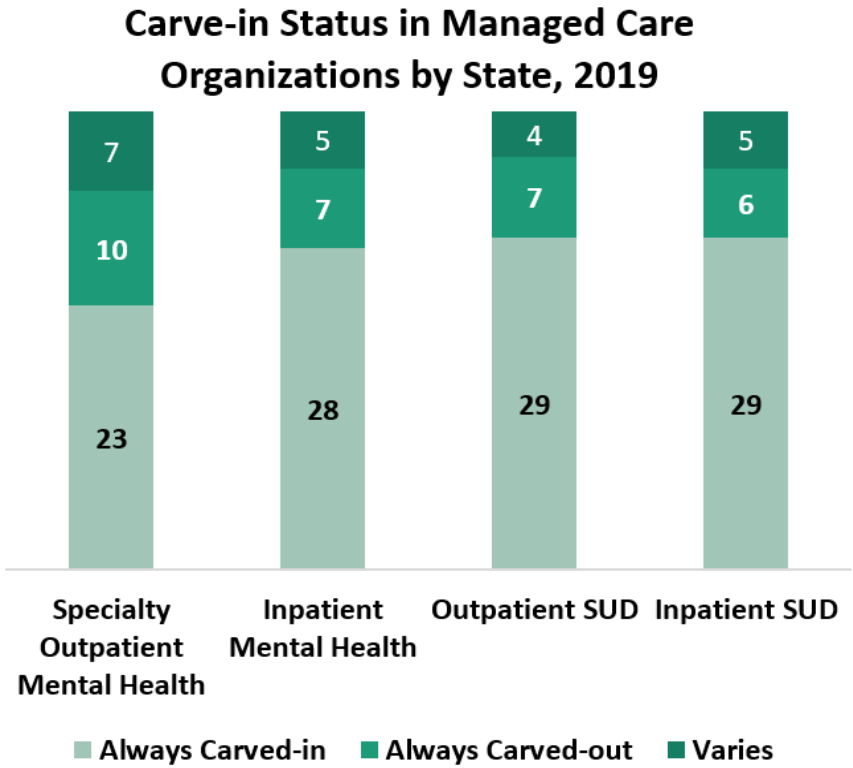
- Dually eligible individuals with behavioral health issues often must navigate across several different delivery systems:
  - Physical health and behavioral health services/related supports may be provided by separate systems
    - Some BH services may be covered through federal, state, or local grant programs that are separate from Medicare and Medicaid
  - Medicare and Medicaid covered services and program rules are different
  - Mental health and SUD services are often provided by different systems and provider types

Implications of Medicare and Medicaid Behavioral Health Coverage Differences and Payer Disconnects

- **Challenges in coordinating prescription drug utilization**
  - Major form of treatment for behavioral health conditions
  - Covered by Medicare for dually eligible individuals
  - Significant coordination/clinical issues in Medicaid nursing facilities and in HCBS waiver programs
    - Providers may not know about or be able to coordinate prescription drug use
- **Coverage limitations in each program; gap-filling coverage from each program is often not coordinated**
  - **Medicare**
    - Limited SUD services and limited longer-term and/or rehabilitative mental health service coverage
    - Few "step-down" options in lieu of costly inpatient psychiatric services
  - **Medicaid**
    - IMD exclusion; coverage for optional benefits varies by state
    - BH benefits may be carved in or out of managed care programs
- **Limits on certain types of behavioral health providers under Medicare**
- **Administrative and operational challenges due to gaps in data (e.g., for care coordination)**

Medicaid System-Level Landscape

- General trend away from fee-for-service, toward managed systems for behavioral health care, but managed care purchasing models in many states still separate behavioral health services from other Medicaid-covered health services.
- Behavioral health services are often administered and regulated by multiple state agencies and levels of government, even if a single health plan is responsible for both physical and behavioral health.
- Growing movement towards physical and behavioral health integration in managed care models.



Source: Kaiser Family Foundation. "A View from the States: Key Medicaid Policy Changes." October 2019. Available at: https://www.kff.org/medicaid/report/a-view-from-the-states-key-medicaid-policy-changes-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2019-and-2020/

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State Approaches to Coordinating/Integrating Physical and BH Benefits for Dually Eligible Individuals

- **Comprehensive carve-in models**
  - MA, TN, and TX use comprehensive carve-in models, which incorporate all physical and behavioral health services, including those for mild-to-moderate and serious behavioral health conditions, under the management of one managed care organization (MCO). While the health plan bears the responsibility for managing all services, it may rely on a subcontracted Behavioral Health Organization (BHO) to manage all or a subset of behavioral health services.
- **Specialty plans for beneficiaries with serious mental illness (SMI)**
  - AZ's use of three Regional Behavioral Health Authorities (RBHAs) is an example of this approach, which integrates physical and behavioral health services under one plan, but only for a specific high-need population that is carved out of general Medicaid.
- **Hybrid models**
  - AZ's model is also an example of a hybrid model, which carves into the standard managed care benefit package mild-to-moderate behavioral health services for most beneficiaries, but carves out services for people with SMI to be separately managed by an RBHA.
- **Coordinated carve-out models**
  - MI and PA utilize coordinated carve-out models, which retain separate plan management of physical and behavioral health services but rely on contract partnerships and incentives to encourage collaboration between plans and systems.

Source: Integrated Care Resource Center. "Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working With Managed Care Delivery Systems." 2017. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf

State Example: Arizona

- Arizona went from carving-out behavioral health services to carving-in, except for continued carve-outs for serious and persistent mental illness (SPMI)
  - Behavioral health services were previously carved out of managed care and managed by RBHAs
  - Two factors that led to those services being carved-in:
    - A 2014 pilot of a specialty plan for beneficiaries with SMI that integrated physical and behavioral health services, which ultimately informed the statewide implementation in 2015;
    - The administration of behavioral health services was consolidated under Arizona's Medicaid agency in 2016, which brought together the contract oversight and the regulatory levers needed to encourage change at the plan level.
- Arizona currently has a hybrid model
  - Medicaid MCOs, in conjunction with a D-SNP, managing mild-to-moderate behavioral health services for dually eligible individuals
  - The state's Regional Behavioral Health Authorities (RBHAs) managing behavioral health services for people with serious mental illness (SMI)

Source: Integrated Care Resource Center. "Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working With Managed Care Delivery Systems." 2017. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf

State Example: Michigan

- Michigan has a coordinated carve-out model
  - Some of MI's Integrated Medicare-Medicaid Plans (MMPs) subcontract with Medicaid BHOs to provide Medicare behavioral health services for dually eligible individuals and assist with overall care coordination
- Developing the "backbone" for information sharing
  - The state contractually obligates all MMPs to share data with BHOs
    - MI developed standard forms and processes to simplify data sharing
    - Ongoing development of CareBridge to facilitate information sharing between MMPs and behavioral health PIHPs
  - MI requires MMPs and partnering BHOs to establish care team meetings to discuss shared enrollees

Source: Integrated Care Resource Center. "Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working With Managed Care Delivery Systems." 2017. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf

Using Dual Eligible Special Needs Plans (D-SNPs) to Integrate Physical and Behavioral Health Benefits

- Dual Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage (MA) plan designed for dually eligible individuals
  - Must at least coordinate Medicare and Medicaid benefits
    - Some D-SNPs cover Medicaid benefits, when contracted by the state to do so
  - Must have a Model of Care that describes how the plan will assess enrollee needs, develop individualized care plans, and coordinate care
- D-SNPs must have a contract with the state Medicaid agency in every state where they operate.
  - States are not required to contract with D-SNPs
  - State contracts with D-SNPs must include certain required elements
    - Many states choose to include additional requirements in their contracts with D-SNPs to improve coordination of benefits for dually eligible individuals.

For more information about D-SNP contracting, see ICRC's July 2019 Working with Medicare webinar on State Contracting with D-SNPs: https://www.integratedcareresourcecenter.com/webinar/update-state-contracting-d-snps-basics-and-meeting-new-federal-requirements-2021

New Integration Requirements for D-SNPs and Implications of Behavioral Health Carve-ins/Carve-outs

- As a result of the Bipartisan Budget Act of 2018, effective January 1, 2021, all D-SNPs must meet at least one of the following criteria:
  1) Cover Medicaid behavioral health services and/or LTSS to be designated as either:
     - A Fully Integrated Dual Eligible SNP (FIDE SNP), or
     - A Highly Integrated Dual Eligible SNP (HIDE SNP)
  2) Notify state and/or its designee(s) of Medicare hospital and skilled nursing facility (SNF) admissions for at least one group of high-risk enrollees
     - Goal: improve coordination during care transitions
- Two key factors in determining whether D-SNPs qualify as FIDE SNPs or HIDE SNPs:
  - Whether the state includes substantial[1] coverage of behavioral health services (and/or long-term services and supports) in its capitated contract with the D-SNP, the D-SNP's parent organization, or another entity owned and controlled by the D-SNP's parent organization; and
  - What entity holds the capitated contract with the state

See Resources in Appendix for more information about FIDE SNP, HIDE SNP, and information sharing requirements.

[1] To qualify as a HIDE SNP or FIDE SNP, a D-SNP must cover behavioral health services, LTSS or both. For more information about allowable carve-outs, see the January 17, 2020 CMS Informational Bulletin here: https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf

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Challenges to Physical and Behavioral Health Integration

- **Data sharing challenges**
  - Privacy considerations, such as federal regulations around sharing substance-use data
  - Limited financial and staff resources to enhance capacity
  - Limited adoption of electronic health records by mental health and SUD providers
- **Quality measures** and **payment incentives** are needed to promote provider accountability
- **Administrative barriers** to program monitoring and quality improvement
  - Separate Medicare and Medicaid payers and separate state-level mental health and substance use disorder systems
- Different **cultures of care delivery**, such as the medical model vs. recovery-focused model
- Separate **professional training** of physical and behavioral health providers

Essential Components for Integrating Physical and Behavioral Health Benefits

- When implementing any type of integrated care model, there are 5 crucial components to consider:
    1. Understanding and building on the different cultures of behavioral and physical health care and services
    2. Information sharing
    3. Designing care management and coordination
    4. Provider training
    5. Program monitoring and quality improvement

Source: Integrated Care Resource Center. "Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working With Managed Care Delivery Systems." 2017. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf

Opportunities for States to Drive Integration

- Administrative and payment changes
- Develop "backbone" for information sharing
- Use contract requirements to encourage and enhance connections for care coordination
- Develop strategies for program monitoring and quality improvement

For more information, see ICRC's TA brief, "Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working with Managed Care Delivery Systems," (August 2017): http://www.integratedcareresourcecenter.com/PDFs/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf

- Interviewed state administrators and health plans in six states (AZ, MA, MI, PA, TN, TX) in 2016 about their experiences with integrating physical and behavioral health benefits for dually eligible individuals

Questions?

ICRC is Here to Help

Interested in further integration?

ICRC is available to provide one-on-one technical assistance to states seeking to further integrate care for their dually eligible populations.

Email ICRC@chcs.org

Appendix

Attributes of FIDE SNPs and HIDE SNPs

	FIDE SNP	HIDE SNP
Must have a contract with the state Medicaid agency that meets the requirements of a managed care organization as defined in section 1903(m) of the Act.	Yes	No
May provide coverage of Medicaid services to full-benefit dually eligible enrollees via a Prepaid Inpatient Health Plan (PIHP) or a prepaid ambulatory health plan (PAHP).	No	Yes
Must provide coverage of applicable Medicaid benefits to full-benefit dually eligible enrollees through the same entity that contracts with CMS to operate as an MA plan.	Yes	No[1]
Must have a capitated contract with the state Medicaid agency to provide coverage of LTSS to full-benefit dually eligible enrollees, consistent with state policy.	Yes	No, if the capitated contract otherwise covers behavioral health services.
Must have a capitated contract with the state Medicaid agency to provide coverage of behavioral health services to full-benefit dually eligible enrollees, consistent with state policy.	No. Complete carve-out of behavioral health coverage by the state Medicaid agency is permitted.	No, if the capitated contract otherwise covers LTSS.
Must have a capitated contract with the state Medicaid agency to provide coverage of a minimum of 180 days of nursing facility services to full-benefit dually eligible enrollees during the plan year.	Yes	No

[1] The state Medicaid contract may be with: (1) the MA organization offering the D-SNP; (2) the MA organization's parent organization; or (3) another entity owned and controlled by the MA organization's parent organization.

Source: Medicare-Medicaid Coordination Office. "Additional Guidance on CY 2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs)." 2020. Available at: https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf

Resources

Resources on New D-SNP Integration Requirements for 2021

- **CMS Resources on D-SNP Integration Requirements:** https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs
- **Working with Medicare Webinar on State Contracting with D-SNPs**: https://www.integratedcareresourcecenter.com/webinar/update-state-contracting-d-snps-basics-and-meeting-new-federal-requirements-2021
- **Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans.** ICRC TA Tool, November 2019: https://www.integratedcareresourcecenter.com/resource/sample-language-state-medicaid-agency-contracts-dual-eligible-special-needs-plans
- **Appeals and Grievances: Comparisons of Existing and New Processes for Individuals Enrolled in Applicable Integrated Plans.** ICRC TA Tool, January 2020: https://www.integratedcareresourcecenter.com/resource/appeals-and-grievances-comparisons-existing-and-new-integrated-processes-individuals
- **State Options and Considerations for Sharing Medicaid Enrollment and Service Use Information with D-SNPs.** ICRC TA Tool, December 2019: https://www.integratedcareresourcecenter.com/resource/state-options-and-considerations-sharing-medicaid-enrollment-and-service-use-information-d
- **Key Questions and Considerations for States Implementing New D-SNP Information-Sharing Requirements.** ICRC Study Hall Call, December 2019: https://www.integratedcareresourcecenter.com/webinar/key-questions-and-considerations-states-implementing-new-d-snp-information-sharing
- **Information Sharing to Improve Care Coordination for High-Risk Dual Eligible Special Needs Plan Enrollees: Key Questions for State Implementation.** ICRC TA Tool, September 2019: https://www.integratedcareresourcecenter.com/resource/information-sharing-improve-care-coordination-high-risk-dual-eligible-special-needs-plan
- **Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations.** ICRC Brief, August 2019: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_InfoSharing_HospitalSNF.pdf

Resources Continued

Resources on New Medicare Opioid Treatment Benefit

- **December 2019 CMCS Informational Bulletin:** https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib121719.pdf
- **Information about the Medicare Part B Opioid Treatment Program:** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Medicaid

Resources on Medicaid Coverage of IMD Services

- **November 2019 State Medicaid Director letter regarding implementation of SUPPORT Act and Medicaid Coverage of Care Provided in IMDs:** https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd19003.pdf
- **MACPAC Releases Report to Congress on Oversight of Institutions for Mental Diseases:** https://www.macpac.gov/news/macpac-releases-report-to-congress-on-oversight-of-institutions-for-mental-diseases
- **State Options for Medicaid Coverage of Inpatient Behavioral Health Services:** https://www.kff.org/medicaid/report/state-options-for-medicaid-coverage-of-inpatient-behavioral-health-services/

Resources for Integrated Physical and Behavioral Health Benefits

- **Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working with Managed Care Delivery Systems:** http://www.integratedcareresourcecenter.com/PDFs/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf

Resources Continued

Resources for Learning More about Dually Eligible Individuals in Your State

- **The Medicare-Medicaid Linked Enrollee Analytics Data Source (MMLEADS)**: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMLEADS_PUF_EXCELTABLES_2006-2012.xlsx

- **How States Can Better Understand their Dually Eligible Individuals: A Guide to Using CMS Data Resources**: https://www.integratedcareresourcecenter.com/sites/default/files/CMS%20Data%20Resources%20Guide%20May%20Update.pdf

Resources Continued

COVID- 19 Related Resources

- **Centers for Medicare and Medicaid Services (CMS) COVID-19 Partner Toolkit**: https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit
- **CMS Interim Final Rule on COVID-19:** https://www.cms.gov/files/document/covid-final-ifc.pdf
- **CMS Waivers**: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
- **Medicare COVID-19 Information Page**: https://www.medicare.gov/medicare-coronavirus
- **Substance Abuse and Mental Health Services Administration (SAMHSA) COVID-19 Website**: https://www.samhsa.gov/coronavirus
- **Drug Enforcement Administration (DEA) COVID-19 Information Page:** https://www.deadiversion.usdoj.gov/coronavirus.html
- **White House, CDC, and FEMA Website**: https://www.coronavirus.gov/
- **Medicaid Coronavirus Resources for States**: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html

About ICRC

- Established by CMS to advance integrated care models for dually eligible individuals
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica and the Center for Health Care Strategies
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send other ICRC questions to: integratedcareresourcecenter@chcs.org