Working with Medicare

Medicare 101 and 201: Key Issues for States

February 20, 2019
1:00-2:00 pm Eastern Time
The “Working with Medicare” Webinar Series

• Designed for all states interested in Medicare-Medicaid integration

• Webinars are repeated annually:
  • Medicare 101 and 201
  • Update on State Contracting with D-SNPs
  • Medicare and Medicaid Nursing Facility Benefits
  • Coordination of Medicare & Medicaid Behavioral Health Benefits

• Supplemented by:
  • ICRC updates/e-alerts on important new Medicare information
  • ICRC technical assistance briefs on Medicare issues of importance to states

• Slides and recordings available: https://www.integratedcareresourcecenter.com/resource-library?&field_resource_type%5B0%5D=306&field_resource_type%5B1%5D=307

• Sign up and view past e-alerts: https://www.integratedcareresourcecenter.com/about-us/e-alerts
Agenda

• Dually Eligible Beneficiaries: Characteristics, Service Use, and Spending
• Challenges Resulting from Medicaid Payment of Medicare Premiums and Cost Sharing
• Challenges Resulting from Overlapping Medicare and Medicaid Benefits
• Overview of Integrated Care Models
• State Opportunities to Better Serve Dually Eligible Individuals
• Appendix: Additional Slides and Resources
• Questions and Answers
Presenters

• Danielle Chelminsky
  • Mathematica Policy Research (MPR)

• Alena Tourtellotte
  • MPR

• Lauren Rava
  • Center for Health Care Strategies (CHCS)

• Nancy Archibald
  • CHCS
Dually Eligible Beneficiaries: Spending, Service Use, and Characteristics
Dually Eligible Beneficiaries: Eligible for both Medicare AND Medicaid

- **Medicare**:
  - Proportion of Medicare Enrollees: 20%
  - Proportion of Medicare Spending: 34%

- **Medicaid**:
  - Proportion of Medicaid Enrollees: 15%
  - Proportion of Medicaid Spending: 32%

Dually Eligible Beneficiaries: Service Use and Chronic Conditions, CY 2013

- **High Service Use:**
  - 26% used Medicare inpatient hospital services
  - 20% used Medicaid institutional LTSS
  - 14% used Medicaid HCBS waivers
  - 12% used Medicaid HCBS state plan services

- **High Chronic Condition Prevalence:**
  - Age 65 and older: 23% had Alzheimer’s or related conditions, 65% had hypertension, 33% had heart disease
  - Under Age 65: 33% had at least one behavioral health condition (anxiety, bipolar, depression, schizophrenia and other)

- For more details, see Appendix, Slides 50 and 51

---

1. Among Full Benefit Dual Eligible Enrollees in fee-for-service
2. Among All Dually Eligible Beneficiary Enrollees in fee-for-service

**Source:** MedPAC-MACPAC. Duals Data Book, January 2018, Exhibits 8, 14 and 15.
Who is Eligible for Medicare?

*Must have at least 10 years of employment for premium-free Part A. Medicare-covered employment requirement met by either the individual or the spouse or ex-spouse.

**Received SSDI benefits for at least two years. Those under 65 with end stage renal disease (ESRD) or Lou Gehrig’s disease (ALS) also qualify for Medicare.

Who is Eligible for both Medicare and Medicaid (dually eligible beneficiaries)?

**Medicare eligible**

- **DO NOT meet state Medicaid eligibility requirements***
  - DO NOT meet state income/asset requirement for full Medicaid benefits

- **Low Income/Assets**
  - Meets Medicare Savings Program requirements

  **PARTIAL BENEFIT DUAL ELIGIBLES**

- **Meet state Medicaid eligibility requirements**
  - Meet state income/asset requirement

  **FULL BENEFIT DUAL ELIGIBLES**

* Resource/asset limits are determined by the state. In most cases, these limits are linked to the SSI program. For more detailed information about the Medicare Savings Program income and asset limits, see pages 4-5 of the January 2018 MedPAC-MACPAC Duals Data Book, pages 4-5.
Dually Eligible Beneficiaries: Eligibility and Age Categories

Enrollees in both Medicare and Medicaid in 2017: 12.0 million

60% are age 65+
40% are under age 65

# Medicare Savings Program Eligibility and Medicaid Payment Responsibility (Partial Benefit Dual Eligibles)

<table>
<thead>
<tr>
<th>Partial Benefit Dual Eligibles</th>
<th>Eligibility As of 2019</th>
<th>Medicaid Payment Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monthly Income</td>
<td>Assets</td>
</tr>
<tr>
<td>Qualified Medicare Beneficiary (QMB-Only)</td>
<td>Indiv: $1,061</td>
<td>Indiv: $7,730</td>
</tr>
<tr>
<td></td>
<td>Married: $1,430</td>
<td>Married: $11,600</td>
</tr>
<tr>
<td>Specified Low-Income Medicare Beneficiary (SLMB-Only)</td>
<td>Indiv: $1,269</td>
<td>Indiv: $7,730</td>
</tr>
<tr>
<td></td>
<td>Married: $1,711</td>
<td>Married: $11,600</td>
</tr>
<tr>
<td>Qualifying Individual (QI)</td>
<td>Indiv: $1,426</td>
<td>Indiv: $7,730</td>
</tr>
<tr>
<td></td>
<td>Married: $1,923</td>
<td>Married: $11,600</td>
</tr>
<tr>
<td>Qualifying Disabled and Working Individual (QDWI)</td>
<td>Indiv: $4,249</td>
<td>Indiv: $4,000</td>
</tr>
<tr>
<td></td>
<td>Married: $5,722</td>
<td>Married: $6,000</td>
</tr>
</tbody>
</table>

---

**Partial Benefit Dual Eligibles by Type**

3.4 million enrollees, CY 2017

- **QMB-Only**, 50%
- **SLMB-Only**, 32%
- **QI**, 18%
- **QDWI**, >1%

---

# Medicare Savings Program Eligibility and Medicaid Payment Responsibility (Full Benefit Dual Eligibles)

<table>
<thead>
<tr>
<th>Full Benefit Dual Eligibles</th>
<th>Eligibility As of 2018</th>
<th>Medicaid Payment Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary Plus (QMB+)</td>
<td>Same as QMB-only, plus meet requirements for full Medicaid benefits</td>
<td>Medicare Part A and B premiums and cost sharing*; all Medicaid benefits</td>
</tr>
<tr>
<td>Specified Low-Income Medicare Beneficiary Plus (SLMB+)</td>
<td>Same as SLMB-only, plus meet requirements for full Medicaid benefits</td>
<td>Medicare Part B premiums; Medicare cost sharing depends on state plan; all Medicaid benefits</td>
</tr>
<tr>
<td>Other Full Benefit Dual Eligibles (FBDEs)</td>
<td>Meet requirements for full Medicaid benefits; MSP income and asset limits determined by state</td>
<td>All Medicaid benefits; Medicare Part B premium and cost sharing payments depend on state plan</td>
</tr>
</tbody>
</table>

### Full Benefit Dual Eligibles by Type

- **QMB+, 70%**
- **SLMB+, 4%**
- **Other FBDEs, 26%**

*May have a small Medicaid copay for certain Medicaid-covered services.

## Medicare Coverage

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Part A</th>
<th>Part B</th>
<th>Part C</th>
<th>Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital stays, care in a skilled nursing facility, hospice care, some home health</td>
<td>Physician and outpatient services, medical supplies, preventive services</td>
<td>Medicare Advantage (Medicare managed care): includes Parts A, B, and D</td>
<td>Prescription Drugs</td>
<td></td>
</tr>
</tbody>
</table>

### Costs

<table>
<thead>
<tr>
<th>Part</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A</strong></td>
<td>Free, with 40 credits of Medicare-covered employment, deductable ($1,364 in 2019, a $24 increase from 2018) and coinsurance for inpatient stays</td>
</tr>
<tr>
<td><strong>Part B</strong></td>
<td>$135.50 premium (new enrollees in 2019), deductible ($185 in 2019, a $2 increase from 2018) and coinsurance of 20% of Medicare-approved amount for most services</td>
</tr>
<tr>
<td><strong>Part C</strong></td>
<td>Part B premium, plan premium, cost sharing, note: coinsurance and copayments differ by service types</td>
</tr>
<tr>
<td><strong>Part D</strong></td>
<td>Premium, deductible, cost sharing, coverage gap, low-income subsidy (LIS) covers premiums and most cost-sharing for dually eligible beneficiaries</td>
</tr>
</tbody>
</table>

**Note:** For more details, refer to slides 48 and 49 for links to these resources:
- June 2017 ICRC “Medicare Basics” TA brief, Appendix A
- January 2018 MedPAC-MACPAC. Duals Data Book, January 2018, Tables 3 and 4
Using Data to Profile Medicare-Medicaid Enrollees

**Example:** State and County Monthly Enrollment Snapshots

Challenges Resulting from Medicaid Payment of Medicare Premiums and Cost Sharing
Medicaid Payment of Medicare Beneficiary Premiums and Cost Sharing

• Medicare is similar to private insurance with premiums, deductibles, coinsurance, and copayments
  • Please see slide 14 in previous section for 2019 FFS amounts
  • Medicare Advantage plans may charge different amounts

• Through Medicare Savings Programs (MSPs), Medicaid may pay for some or all Medicare premiums and cost sharing for low-income Medicare beneficiaries
  • Medicaid paid $13.8 billion for Medicare premiums in 2013
  • Dually eligible beneficiaries also incurred $16.8 billion in Medicare Part A and B FFS cost sharing in 2013, although Medicaid does not always pay the full incurred amounts
  • Premium and cost sharing coverage varies by full or partial benefit category, as discussed earlier in the presentation

• Only about half of those who are eligible are enrolled in MSPs, and partial benefit dual eligibles are substantially less likely to enroll

Sources: https://www.cms.gov/newsroom/fact-sheets/2019-medicare-parts-b-premiums-and-deductibles; MedPAC-MACPAC January 2018 Data Book, Table 4, pp.9-10 and Table 5, p. 15
State Use of Lesser-of Policy

- Crossover claims for deductibles and coinsurance
  - Medicare is primary payer, so providers must bill Medicare first
  - Claims then “cross over” to Medicaid for payment of beneficiary cost sharing and for services Medicare does not cover but Medicaid may
  - For more information on cost sharing, see MACPAC March 2013 Report to Congress, Chapter 4 (“Medicaid Coverage of Premiums and Cost Sharing for Low-Income Medicare Beneficiaries”) at: https://www.macpac.gov/publication/ch-4-medicaid-coverage-of-premiums-and-cost-sharing-for-low-income-medicare-beneficiaries/
  - Appendix slides 52 and 53 provide more detail on crossover claims and how they are paid

- States may choose to cover:
  - The full amount of Medicare deductibles and co-insurance; or
  - The difference between the Medicaid rate and the amount already paid by Medicare (i.e., “lesser-of” payment policies)
Improper Billing and Access to Care

• When Medicaid does not cover cost sharing up to full Medicare-approved amount, QMBs cannot be billed for the balance, so the difference must be absorbed by providers
  • For more information on improper billing, see ICRC February 2018 issue brief at: http://www.integratedcareresourcecenter.com/PDFs/ICRC_Prevent_Improper_Billing.pdf

• May lead to access to care issues for dually eligible beneficiaries if providers are reluctant to see them
  • For more information on these access to care issues, see July 2015 CMS Medicare-Medicaid Coordination Office report (“Access to Care Issues Among Qualified Medicare Beneficiaries”) at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.
Challenges Resulting from Overlapping Medicare and Medicaid Benefits
Medicare and Medicaid Overlapping Benefits

• Both Medicare and Medicaid provide coverage for a number of services, including: (1) home health; (2) DME; (3) behavioral health; (4) nursing facility; and (5) transportation.

• Which program covers what, when, and under what circumstances is complicated and confusing for providers, beneficiaries, and payers.

• Can lead to higher costs for states if Medicaid pays for services that Medicare could/should have covered, or if inadequate coordination results in higher use of Medicaid LTSS.

• As will be discussed in last section of the presentation, making one managed care plan responsible for both Medicare and Medicaid services provides an opportunity for greater coordination, simplicity, and efficiency.
# 1. Home Health Benefits

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
</table>
| • Requires need for “skilled” care services  
  • Physical therapy, speech therapy, skilled nursing  
  • Must be “part-time” and “intermittent”*  
  • Does not require “improvement”**  
  • Requires beneficiaries to be homebound  
  • Consolidates provider payment into 60-day episodes of care  
  • No equivalent coverage of LTSS | • Does not require beneficiaries to be homebound  
  • Most programs pay by service or by visit  
  • Covers non-medical home care provided through LTSS |

• For more information on how to improve coordination of home health services, see April 2014 TA brief: [https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_-Improving_Coordination_of_HH_and_DME_-4-29-14_%282%29.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_-Improving_Coordination_of_HH_and_DME_-4-29-14_%282%29.pdf)

**Notes:** *Medically necessary care for up to 35 hours/week may be considered on a case-by-case basis.  
2. DME Benefits

- Medicare and Medicaid combined accounted for about 30 percent of total national spending on DME in 2017, with each accounting for about 15 percent

- Medicare limits DME coverage to items used primarily in the home; Medicaid coverage is broader than Medicare’s, as detailed in 42 CFR §440.70(b)(3)

- Medicare competitive bidding for DME has reduced Medicare payments in recent years
  - For details on the competitive bidding system, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html

- Medicaid uses a variety of payment methods for DME, with Medicare payment often used as a ceiling
  - Federal law now limits federal Medicaid reimbursement to states for jointly covered DME to what Medicare would have paid, in the aggregate, for such items
    - For details, see this January 2018 CMS State Medicaid Director Letter: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18001.pdf

- Most states require DME suppliers to submit claims to Medicare first and to obtain a final payment denial
  - Due to this payment uncertainty, providers may be reluctant to supply DME items to dually eligible beneficiaries

- Slide 46 includes additional information on opportunities to better coordinate DME benefits

3. Behavioral Health Benefits

**Medicare**

- Outpatient services must generally be provided by an eligible professional*
- Inpatient psychiatric care in a free-standing psychiatric hospital (limited to 190 days in a lifetime)
- Medically necessary substance use treatment**

**Medicaid**

- **Mandatory** services include inpatient/outpatient hospital services & physician services
- Most states cover several optional services, including non-medical support services***
- Rx drugs and substance use treatment services not covered by Medicare

- ICRC October 2018 WWM webinar provides more in-depth information on coordination of Medicare and Medicaid BH benefits:

- For a list of behavioral health services covered by Medicare, please see the Appendix, Slide 54.

**Notes:**


** For a list of professionals covered as suppliers of Substance Use Treatment Services see: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1604.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1604.pdf)

4. Nursing Facility Benefits

<table>
<thead>
<tr>
<th>Type of Nursing Facility Stay</th>
<th>3 day inpatient hospital stay first?</th>
<th>Medicare Coverage?</th>
<th>Medicaid Coverage?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-term, skilled care</strong> (physical, occupational, speech therapy, or skilled nursing services)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Short-term, skilled care</strong> (physical, occupational, speech therapy, or skilled nursing services)</td>
<td>No</td>
<td>No</td>
<td>Yes*</td>
</tr>
<tr>
<td><strong>Long-term custodial care</strong> (assistance with activities of daily living – eating, bathing, dressing, etc.)</td>
<td>N/A</td>
<td>No</td>
<td>Yes*</td>
</tr>
</tbody>
</table>

*In these two scenarios, Medicaid would be the primary payer for nursing facility services (presuming the beneficiary does not have other third party coverage in addition to Medicare and Medicaid).

- Slide 45 includes additional information on coordinating nursing facility benefits

**Note:** ICRC May 2018 WWM webinar provides more in-depth information on coordination opportunities between Medicare and Medicaid for nursing facility services:  
## 5. NEMT Benefits

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
</table>
| • Generally covers only **emergency** ambulance transportation to a hospital or skilled nursing facility if it is medically necessary | • Much broader – **non-emergency**  
| • In limited circumstances, Medicare will cover non-emergency ambulance transportation if a doctor states in writing that is it medically necessary | • Travel expenses for medical exams and treatment by any medical provider – travel may be provided by ambulance, taxi, common carrier, “or other appropriate means” (42 CFR § 440.170) |
Overview of Integrated Care Models for Dually Eligible Beneficiaries
Integrated Care Models

• Managed care options
  • Programs of All-Inclusive Care for the Elderly (PACE)
  • Medicare-Medicaid Plans (MMPs) through Financial Alignment Initiative demonstrations
  • Fully-Integrated Dual-Eligible Special Needs Plans (FIDE-SNPs)
  • Dual-Eligible Special Needs Plans (D-SNP) / Managed Long-Term Supports and Services (MLTSS) plans

• Fee-for-service options
  • Primary Care Case Management (PCCM)
  • Medicaid Health Homes
Managed Care-Based Integration Models

**Key:**
- BH = Behavioral Health
- C-SNPs = Chronic Conditions Special Needs Plans
- D-SNPs = Dual Eligible Special Needs Plans
- FFS = Fee-for-service
- FIDE SNPs = Fully Integrated Dual Eligible Special Needs Plans
- I-SNPs = Institutional Special Needs Plans
- MA-PDs = Medicare Advantage Prescription Drug Plans
- MLTSS = Managed Long-Term Services and Supports
- MMPs = Medicare-Medicaid Plans
- PACE = Program of All-Inclusive Care for the Elderly

**Note:** Shaded boxes represent models that integrate all or some Medicare and Medicaid benefits for dually eligible beneficiaries.

**Medicare Benefits**
- Original Medicare
- Medicare Advantage
  - MA-PDs
  - SNPs
  - D-SNPs
  - I-SNPs
  - C-SNPs

**Medicaid Benefits**
- FFS
- Managed Acute Care
- MLTSS
- BH Managed Care
# Key Differences Between Managed Care Options

<table>
<thead>
<tr>
<th></th>
<th>PACE</th>
<th>MMP</th>
<th>D-SNP</th>
<th>FIDE SNP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authorization</strong></td>
<td>Permanent</td>
<td>Demonstration</td>
<td>Permanent</td>
<td>Permanent</td>
</tr>
<tr>
<td><strong>States, where plan is available</strong></td>
<td>31</td>
<td>9</td>
<td>41</td>
<td>9</td>
</tr>
<tr>
<td><strong>Number of plans (1/2018)</strong></td>
<td>124</td>
<td>50</td>
<td>348</td>
<td>45</td>
</tr>
<tr>
<td><strong>Enrollment (1/2018)</strong></td>
<td>41,079</td>
<td>383,047</td>
<td>1,695,074</td>
<td>159,158</td>
</tr>
<tr>
<td><strong>Contracting structure</strong></td>
<td>3-way contract*</td>
<td>3-way contract</td>
<td>Separate Medicare and Medicaid contracts</td>
<td>Separate Medicare and Medicaid contracts</td>
</tr>
<tr>
<td><strong>Level of integration</strong></td>
<td>High</td>
<td>High</td>
<td>Varies widely by state</td>
<td>High</td>
</tr>
<tr>
<td><strong>Passive enrollment</strong></td>
<td>Not allowed</td>
<td>Allowed</td>
<td>Allowed to maintain enrollment in integrated care</td>
<td>Allowed to maintain enrollment in integrated care</td>
</tr>
<tr>
<td><strong>States can share Medicare savings</strong></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*Some states use an additional 2-way contract to issue state-specific requirements, in addition to the standard 3-way contract. 
Comparison of Managed Care Enrollment in Medicare and Medicaid, CY 2010 and CY 2016

<table>
<thead>
<tr>
<th></th>
<th>Medicare Managed Care</th>
<th>Medicaid Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2010</strong></td>
<td><strong>2016</strong></td>
<td><strong>2016</strong></td>
</tr>
<tr>
<td><strong>Dually Eligible Beneficiaries</strong></td>
<td>18%</td>
<td>33%</td>
</tr>
<tr>
<td><strong>All Medicare Beneficiaries</strong></td>
<td>24%</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Dually Eligible Beneficiaries</strong></td>
<td>11%</td>
<td>24%</td>
</tr>
</tbody>
</table>

**Note:** “Duals” includes both full and partial dual eligibles. All Medicaid enrollees include both duals and non-duals. Medicare managed care includes all forms of Medicare Advantage. Medicaid managed care includes only comprehensive managed care organizations (MCOs).

**Sources:** See slide 55 in the Appendix for details on the sources used and links to them.
Percentage of Dually Eligible Beneficiaries Served by D-SNPs, by State

Notes: 5 plans spanned multiple states. For this map, the enrollment of these plans was divided equally between states. Some states allow partial benefit duals in their D-SNPs, which are also captured in this map. Total D-SNP enrollment reflects January 2019 data, while the total number of dually eligible beneficiaries reflects December 2017 data per the sources below. PR data are not included in Monthly Enrollment Snapshot.


State Medicaid Agency Contracts with D-SNPs

- States have different approaches to D-SNP contracting with varying levels of alignment and integration, from standalone, unaligned D-SNPs to highly integrated D-SNP/MLTSS programs.
- D-SNPs are required by federal law (MIPPA) to have contracts with states:
  - Contracts must contain some specific features, but states can add others (42 CFR §422.107)
  - Minimum requirements include D-SNP responsibility to provide or arrange for Medicaid benefits, beneficiary cost sharing protections, information sharing, eligibility verification, service area covered, and contract period
  - For contract year 2019, there are 481 D-SNPs with total national enrollment in January 2019 of 2.4 million

Key 2019 Medicare Advantage Dates

- **January 30**: Release of Advance Notice of MA payment policies and Draft Call Letter
- **February 13**: Initial and service area expansion MA applications due to CMS (for CY 2020)
- **April 1**: Release of Final Call Letter and MA capitation rates
- **June 3**: Bid submission deadline; MA organizations not renewing MA contracts must notify CMS in writing
- **Early July**: MA organizations must submit MIPPA D-SNP contracts to CMS
- **October 9**: Medicare Stars ratings for upcoming year go live on Medicare.gov
- **October 15**: Start of Medicare Annual Election Period Final
- **November 12**: Notice of intent to apply (NOIA) from D-SNP and MMP applicants due to CMS (e.g., due in Nov 2019 for CY 2021)
- **December 7**: End of Medicare Annual Election Period

For more information on key MA Dates what activities state Medicaid agencies may want to undertake to prepare for or respond to a particular Medicare Advantage event, see the September 2017 ICRC “Key Medicare Advantage Dates and Action Items for States Contracting with Dual Eligible Special Needs Plans.” Available at: [https://www.integratedcareresourcecenter.com/PDFs/Key_MA_Dates_for_States_Contracting_with_D-SNPs.pdf](https://www.integratedcareresourcecenter.com/PDFs/Key_MA_Dates_for_States_Contracting_with_D-SNPs.pdf)
Fee-for-Service Options

• Primary Care Case Management (PCCM)
  • State plan option
  • Enroll Medicaid beneficiaries who select or are assigned into the program by the state
  • PCCM entity provides care management, administrative oversight, performance measurement, and reporting, as well as bringing the pieces of the fee-for-service system together to meet the complex needs of dually eligible beneficiaries.

• Medicaid Health Homes
  • State plan option
  • Enroll Medicaid beneficiaries with chronic physical or behavioral health conditions; cannot exclude dually eligible beneficiaries
  • Health home must provide: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care/follow-up; (5) individual and family support; and (6) referral to community and social support services
  • States receive a 90% enhanced Federal Medical Assistance Percentage for health home services for the first eight quarters after the program’s effective date

State Opportunities to Better Serve Dually Eligible Individuals
What Can States Do Right Now?

- December 19, 2018 State Medicaid Director Letter: 

- 10 opportunities that do not need demonstration authority or Medicare waivers
  - Managed care-related
  - Data-related
  - Burden and access-related
Managed Care-Based Integration Models

Medicare Benefits

- Original Medicare
- Medicare Advantage
  - MA-PDs
  - SNPs
  - MA-PDs
  - SNPs

Medicaid Benefits

- MMPs
- FIDE SNPs
- PACE
- FFS
- Managed Acute Care
- MLTSS
- BH Managed Care

Note: Shaded boxes represent models that integrate all or some Medicare and Medicaid benefits for dually eligible beneficiaries.

Key: BH = Behavioral Health; C-SNPs = Chronic Conditions Special Needs Plans; D-SNPs = Dual Eligible Special Needs Plans; FFS = Fee-for-service; FIDE SNPs = Fully Integrated Dual Eligible Special Needs Plans; I-SNPs = Institutional Special Needs Plans; MA-PDs = Medicare Advantage Prescription Drug Plans; MLTSS = Managed Long-Term Services and Supports; MMPs = Medicare-Medicaid Plans; PACE = Program of All-Inclusive Care for the Elderly
Managed Care-Related Opportunities

- **Contracting with D-SNPs (Opportunity #1)**
  - A state’s contracts with D-SNPs (i.e., “MIPPA” contracts) can be used to shape an approach to integrated care
  - D-SNPs operating with companion Medicaid managed long-term services and supports (MLTSS) plans have greater potential for integration
  - Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) provide an even higher level of integration and coordination

**Potential for integration improves when enrollment is ALIGNED**

Managed Care-Related Opportunities

• **Aligned enrollment**: Enrollment in a D-SNP and Medicaid managed care plan offered by the same parent company in the same geographic area.

• Aligned enrollment creates opportunities for integrated delivery of Medicare and Medicaid by:
  • Aligning incentives and coordinating benefits administration
  • Streamlining payment of Medicare cost sharing
  • Facilitating care coordination
  • Allowing integration of beneficiary materials

• State policymaking can be used to maximize aligned D-SNP/Medicaid managed care enrollment

Managed Care-Related Opportunities

• Using D-SNP default enrollment to promote alignment (Opportunity #2)
  • Automatic enrollment of newly Medicare-eligible individuals who are already enrolled in a Medicaid managed care plan owned by the same parent organization and operated in the same geographic area
  • Can be used to align Medicare and Medicaid service coverage and promote care coordination
  • States must: (1) design with the D-SNP a data sharing and implementation plan; and (2) provide timely, prospective Medicare eligibility information on Medicaid managed care beneficiaries

• Preserving continuity of integrated care through passive enrollment (Opportunity #3)
  • Limited to situations where integrated care will be disrupted
  • Cannot be used to move people into managed care from fee-for-service

Managed Care-Related Opportunities

- Integrating care through Programs of All-Inclusive Care for the Elderly (PACE) (Opportunity #4)
  - PACE is in 31 states
  - Serve 44,000 mainly dually eligible individuals
  - Both non-profit and for-profit providers

For more information, see: “Programs of All-Inclusive Care for the Elderly for States.” Available at: https://www.medicaid.gov/medicaid/ltss/pace/pace-for-states/index.html
Data-Related Opportunities

• Using Medicare data for care coordination (Opportunity #5)
  • States can access Medicare data through a streamlined process for executing “data request attestations” (DRAs) that replaces the previous data use agreement (DUA) process
  • Data can be used to: (1) create predictive modeling tools; (2) inform care planning and care coordination; and (3) support beneficiary outreach and engagement

• Using Medicare data for program integrity (Opportunity #6)
  • Medicare data can now be used for program integrity purposes (e.g., investigating provider billing and coding issues) as well as care coordination activities
  • Requires a separate approval

For more information, contact the State Data Resource Center (SDRC) sdrc@econometricainc.com and see: “Using and Requesting Medicare Data for Medicare–Medicaid Care Coordination and Program Integrity Frequently Asked Questions.” State Data Resource Center, January 2018. Available at: http://www.statedataresourcecenter.com/assets/files/SDRC_FAQ.pdf
Burden and Access-Related Opportunities

• **Exchanging MMA files with CMS more frequently (Opportunity #7)**
  - States must submit MMA files to CMS at least monthly to identify all dually eligible individuals
  - More frequent file submission: (1) enables quicker access to drug coverage under Medicare Part D and reduces out-of-pocket costs; (2) permits clearer communication with beneficiaries about cost-sharing liability; (3) streamlines Medicaid administrative processes; and (4) reduces provider burden

• **Increasing frequency of buy-in file data exchange (Opportunity #8)**
  - More frequent exchange of Medicare Part A and B premium buy-in files supports timely beneficiary access to Medicare benefits, reduces burden for state staff, and allows more rapid correction of data errors
  - Enrolling more individuals in Medicare can help limit state costs because Medicare is the primary payer for most medical care for dually eligible individuals

• **Executing Part A buy-in agreements (Opportunity #9)**
  - Allows enrollment in Medicare Part A at any time; eliminates penalties for late enrollment
  - Enables beneficiaries to receive integrated care from Medicare Advantage plans or Medicare-Medicaid Plans
  - Potentially reduces Medicaid costs because Medicare becomes the primary payer

• **Simplifying eligibility and enrollment (Opportunity #10)**
  - Aligning state Medicare Savings Program (MSP) eligibility criteria with Social Security Administration’s Part D LIS eligibility criteria can streamline beneficiary access to services and also result in significant administrative savings for states

• **CMS February 11, 2019 proposed rule on interoperability applies to Opportunities #7 and #8**

Nursing Facility-Related Opportunities

• In FFS, states can modify bed hold policies to reduce incentives for avoidable hospitalizations and use a reimbursement system that makes it financially feasible to treat higher-acuity residents in the facility rather than admitting them to a hospital.

• In managed care systems, states can promote efforts to reduce hospitalizations through contract requirements, performance incentives, and performance improvement projects.
  • When one entity (e.g., FIDE SNP) is at risk for hospitalizations, SNF/NF stays, and other Medicare and Medicaid benefits, states can work with the health plan to:
    • Reduce avoidable hospitalizations and emergency room use for SNF/NF residents
    • Operate SNF and NF benefits more seamlessly
    • Improve care transitions between SNFs/NFs, hospitals, and the community
    • Increase use of home-and community-based services as alternatives to SNF/NF services
    • Improve monitoring and utilization of Part D prescription drugs, especially in NFs

DME-Related Opportunities

• Most states have required a Medicare denial before the state Medicaid agency will pay for DME for dually eligible beneficiaries

• A January 4, 2019 CMS Informational Bulletin (https://www.medicaid.gov/federal-policy-guidance/downloads/cib010419.pdf) provides the guidance that states do not need to require a Medicare denial for DMEPOS that Medicare routinely denies as non-covered under the Medicare DME benefit.

• Other strategies states can use to support dually eligible beneficiaries’ access to DME in FFS include:
  • Developing a list of Medicare non-covered DME items allowing providers to submit claims for these items to the state without a Medicare denial.
  • Offering a process for FFS suppliers to request preliminary or provisional Medicaid prior authorization of DME for dually eligible beneficiaries.
  • Requiring a Medicare non-affirmed prior authorization decision only for the specific items for which Medicare offers prior authorization. If a supplier requests Medicare prior authorization, a non-affirmed prior authorization decision is sufficient for meeting states’ obligation to pursue other coverage before considering Medicaid coverage.
  • Assessing claims for medical supplies, equipment, and appliances for dual eligible beneficiaries against Medicaid’s broader coverage criteria.
  • For details, see: https://www.medicaid.gov/federal-policy-guidance/downloads/cib011317.pdf

Advancing Medicare-Medicaid Integration

- **Bipartisan Budget Act of 2018**
  - Permanently authorized D-SNPs, C-SNPs, and I-SNPs
  - Raised the bar for integration
  - Called for development of a unified grievance and appeals process

- **Notice of Proposed New Rulemaking** issued on November 1, 2018
  - Would establish minimum integration standards for D-SNPs starting in 2021
    - Cover Medicaid LTSS and/or behavioral health services; and/or
    - Share information with the state on care transitions by high-risk individuals
  - Proposes new definitions of FIDE SNP, highly integrated D-SNP (HIDE SNP), and aligned enrollment
  - Would create unified grievance and appeals process, but only for D-SNPs and Medicaid managed care plans with exclusively aligned enrollment

For more information, see: “CMS Proposes New Requirements for D-SNP Medicaid Integration and Unified Grievance and Appeals Procedures.” ICRC, November 2, 2018. Available at: https://www.integratedcareresourcecenter.com/e_alert/spotlight-cms-proposes-new-requirements-d-snp-medicaid-integration-and-unified-grievance-and
Looking Ahead

- **Spring 2019**
  - Final Rule published
  - ICRC Spotlight e-alert will summarize the Final Rule
  - ICRC *Working with Medicare* webinar “Update on D-SNP Contracting”

- **Email [ICRC@chcs.org](mailto:ICRC@chcs.org)**
Appendix:
Additional Slides and Resources
### Percent Using Service and Per-User Spending, CY 2013

**FBDE Enrollees in FFS**

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare % Using Service</th>
<th>Medicare $ Per User</th>
<th>Medicaid % Using Service</th>
<th>Medicaid $ Per User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>26%</td>
<td>$19,580</td>
<td>13%</td>
<td>$2,033</td>
</tr>
<tr>
<td>Other Outpatient</td>
<td>95%</td>
<td>$5,962</td>
<td>86%</td>
<td>$2,325</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>10%</td>
<td>$18,141</td>
<td>20%</td>
<td>$41,903</td>
</tr>
<tr>
<td>Home Health</td>
<td>14%</td>
<td>$5,655</td>
<td>14%</td>
<td>$29,144</td>
</tr>
<tr>
<td>Part D Drugs</td>
<td>93%</td>
<td>$5,120</td>
<td>35%</td>
<td>$272</td>
</tr>
<tr>
<td>Managed Care Capitation*</td>
<td>-</td>
<td>-</td>
<td>35%</td>
<td>$3,781</td>
</tr>
</tbody>
</table>

*Payments to limited-benefit managed care plans for behavioral health, transportation, and/or dental services.

### FFS Dually Eligible Beneficiaries With Selected Conditions, CY 2013

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent of FFS Dually Eligible Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under age 65</td>
</tr>
<tr>
<td><strong>COGNITIVE IMPAIRMENT</strong></td>
<td></td>
</tr>
<tr>
<td>Alzheimer’s disease or related dementia</td>
<td>4</td>
</tr>
<tr>
<td>Intellectual disabilities and related conditions</td>
<td>8</td>
</tr>
<tr>
<td><strong>MEDICAL CONDITIONS</strong></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>23</td>
</tr>
<tr>
<td>Heart failure</td>
<td>8</td>
</tr>
<tr>
<td>Hypertension</td>
<td>39</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>14</td>
</tr>
<tr>
<td><strong>BEHAVIORAL HEALTH CONDITIONS</strong></td>
<td></td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td><strong>24</strong></td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>15</td>
</tr>
<tr>
<td>Depression</td>
<td><strong>33</strong></td>
</tr>
<tr>
<td>Schizophrenia and other psychotic disorders</td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

## Crossover Claims Examples (Lesser-of-Policy)

<table>
<thead>
<tr>
<th>Physician Visit*</th>
<th>FFS Full Payment Policy</th>
<th>FFS Lesser-of Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider charge</td>
<td>$125</td>
<td>$125</td>
</tr>
<tr>
<td>Medicare-approved amount</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Medicaid payment rate</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td>Medicare payment (e.g., 80% Medicare approved amount less deductible)</td>
<td>(80% of $100)-$0 = $80</td>
<td>(80% of $100)-$0 = $80</td>
</tr>
<tr>
<td>Medicare cost sharing (billed to Medicaid as a crossover claim)</td>
<td>$20</td>
<td>$20</td>
</tr>
</tbody>
</table>
| Medicaid payment to provider | $20 | • Lesser of Medicare cost sharing, ($20) OR
                • Medicaid rate minus Medicare payment ($75-$80 = $0) |
| Total provider payment | $100                  | $80                  |

*Example assumes full Medicare deductible has been met.

Simplified Crossover Claims in Managed Care

If one managed care plan covers both Medicare and Medicaid services, all payments may be handled within the plan:

- May reduce burden on providers, beneficiaries, and Medicaid agency
- Amounts payable for crossover claims may be outlined in state contract with plans and/or plan contracts with providers
- If plans are responsible for paying Medicaid cost sharing payments to providers, state makes capitated payments to plans to cover projected amounts

How Providers Bill Services for Dually Eligible Beneficiaries

<table>
<thead>
<tr>
<th>Beneficiary Medicare &amp; Medicaid Status</th>
<th>Medicare Physician Service Claim</th>
<th>Crossover Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage (MA) &amp; FFS Medicaid</td>
<td>Bill MA Organization</td>
<td>Bill State directly</td>
</tr>
<tr>
<td>MA and Managed Medicaid</td>
<td>Bill MA Organization</td>
<td>Bill Medicaid MCO</td>
</tr>
<tr>
<td>FFS Medicare and Medicaid</td>
<td>Bill CMS directly</td>
<td>Typically an automatic crossover to state</td>
</tr>
<tr>
<td>FFS Medicare and Managed Medicaid</td>
<td>Bill CMS directly</td>
<td>Typically an automatic crossover to MCO</td>
</tr>
<tr>
<td>D-SNPs receiving payment for Medicaid cost sharing</td>
<td>Bill D-SNP regardless of services Providers submit one claim</td>
<td></td>
</tr>
</tbody>
</table>
## Behavioral Health Benefits Covered by Medicare

<table>
<thead>
<tr>
<th>Covered Medicare Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric diagnostic interviews and diagnostic psychological/neuropsychological tests</td>
</tr>
<tr>
<td>Psychotherapy (individual, interactive, family, group)</td>
</tr>
<tr>
<td>Psychoanalysis</td>
</tr>
<tr>
<td>Medication management</td>
</tr>
<tr>
<td>Electroconvulsive therapy (ECT)</td>
</tr>
<tr>
<td>Hypnotherapy and Narcosynthesis</td>
</tr>
<tr>
<td>Biofeedback therapy</td>
</tr>
<tr>
<td>Individualized activity therapy (if part of a partial hospitalization program and not primarily recreational/diversionary)</td>
</tr>
<tr>
<td>Screening, Brief Intervention, and Referral to Treatment (SBIRT)</td>
</tr>
<tr>
<td>Annual screenings for depression and alcohol misuse</td>
</tr>
</tbody>
</table>

For more information, the ICRC October 2018 WWM webinar provides more in-depth information on Medicare and Medicaid coverage of BH benefits: [https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_WWM_BH_Benefits_10-09-18_FINAL_FOR%20508.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_WWM_BH_Benefits_10-09-18_FINAL_FOR%20508.pdf)
Sources for Slide 31

Medicare Managed Care

• **Duals 2010 data:** CMS Medicare-Medicaid Coordination Office. Data Analysis Brief: Managed Care Enrollment Trends among Medicare-Medicaid Beneficiaries and Medicare-only Beneficiaries, 2006 through 2016. Table 1, Attachment B. Available at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ManagedCareEnrollmentTrends2006-2016Data.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ManagedCareEnrollmentTrends2006-2016Data.pdf)


Medicaid Managed Care


Key Medicare Terms

• **Call Letter** – Medicare Advantage guidance document that accompanies advance notice and announcement of Medicare Advantage capitated rates; issued each year by CMS in draft form in February and final form in April.

• **Cost-sharing** – Costs incurred by the enrollee that may include deductibles, coinsurance, and copayments.

• **Crossover Claim** – A claim submitted for payment first to Medicare that is then submitted for Medicaid payment. The crossover is the transfer of processed claim data from Medicare operations to Medicaid (or state) agencies. Medicaid agencies can delegate responsibility for processing of crossover claims to contracted health plans.

• **Dual Eligible Special Needs Plan (D-SNP)** – Dual Eligible Special Needs Plans (D-SNPs) are SNPs that enroll beneficiaries who are entitled to both Title XVIII (Medicare) and Medical Assistance from a State/Territorial plan under Title XIX (Medicaid) of the Social Security Act (the Act).

• **Low Income Subsidy (LIS) Medicare Part D Reassignment** – Annual movement of Medicare beneficiaries from their current Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Prescription Drug Plan (MA-PD) to another PDP if necessary to maintain the option of minimum beneficiary cost sharing.
Key Medicare Terms (Cont.)

- **Medicare Advantage (MA) Plan** – Health benefits coverage offered under a policy or contract by a MA organization that includes a specific package of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area (or segment of the service area) of the MA plan.

- **Medicare Advantage-Prescription Drug Plan (MA-PD Plan)** – A MA plan that provides qualified prescription drug coverage, as defined at 42 CFR 423.100 and in section 20.1 of Chapter 5 of the Prescription Drug Benefit Manual, under Part D of the Social Security Act.

- **Medicare-Medicaid Plan (MMP)** – A MA plan that has entered into a three-way contract with CMS and a state participating in the CMS Financial Alignment Initiative capitated model to provide comprehensive Medicare and Medicaid benefits to individuals dually eligible for Medicare and Medicaid ("dually eligible beneficiaries").

- **Notice of Intent to Apply (NOIA)** – CMS requires notification from all interested plans in November of each year for all new contracts, contract extensions, or service area expansions planned for the next full MA plan cycle (e.g., Nov 2017 NOIAs are for the CY 2019 plan cycle).

- **State Medicaid Agency Contract (SMAC) or MIPPA Contract** – Interchangeable terms for required state contracts that D-SNP applicants must submit to CMS by July 1st of each year to receive approval from CMS to operate a D-SNP product in a state in the upcoming year.
ICRC Resources


ICRC Resources (Cont.)


• “Working with Medicare Webinar: Update on State Contracting with D-SNPs.” December 2017: http://www.integratedcareresourcecenter.com/PDFs/ICRC_WWM_D-SNP_Contracting%20DRAFT%202012-12-17%20for%20508%20review.pdf


ICRC Resources (Cont.)

- “Medicare Basics: An Overview for States Seeking to Integrate Care for Medicare-Medicaid Enrollees.” June 2017: 

- “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

- “Preventing Improper Billing of Medicare-Medicaid Enrollees in Managed Care: Strategies for States and Dual Eligible Special Needs Plans.” July 2017: 

- “Facilitating Access to Medicaid Durable Medical Equipment for Dually Eligible Beneficiaries in the Fee-for-Service System: Three State Approaches.” June 2018. Available at: 
Links to Additional Sources Cited


• CMS SNP Comprehensive Reports