Working with Medicare

Medicare 101 and 201: Key Issues for States

February 10, 2020
1:00-2:00 pm Eastern Time
The “Working with Medicare” Webinar Series

• Designed for all states interested in improving coordination of Medicare and Medicaid benefits for dually eligible (Medicare-Medicaid) beneficiaries

• 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

• 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 Pathways for States Serving Dually Eligible Beneficiaries
• Appendix: Additional Slides and Resources
• Questions and Answers
Presenters

• Danielle Perra
  • Center for Health Care Strategies (CHCS)

• Alena Tourtellotte
  • Mathematica

• Danielle Chelminsky
  • Mathematica
Dually Eligible Beneficiaries: Spending, Service Use, and Characteristics
Dually Eligible Individuals Are a High-Need Population

- 12.2 million individuals enrolled in both Medicare and Medicaid
- High prevalence of health conditions, functional limitations, and social risk factors
  - 70% have been diagnosed with three or more chronic conditions
  - 41% have a behavioral health disorder
  - Over 40% use long-term services and supports (LTSS)
- The most prevalent chronic conditions among dually eligible individuals vary by age group (see slide 44)

**Dually Eligible Beneficiaries as a Share of Medicare and Medicaid Spending and Enrollment, 2013**

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

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

**Sources:** Center for Medicare & Medicaid Services. Medicare-Medicaid Coordination Office Fiscal Year 2018 Report to Congress; Medicare Payment Advisory Commission and Medicaid and CHIP Payment Advisory Commission. Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid, January 2018.
Who is Eligible for Medicare?

**Age** 65 or older*

Under age 65

Permament Disability**

Eligible for Medicare

All Medicare Beneficiaries
62.8 million enrollees, CY 2018

Age, 77%

Disability, 23%

ESRD, > 1%

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*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 a Dually Eligible Beneficiary?

Medicare eligible

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

Meet state Medicaid eligibility requirements
Meet state income/asset requirement

Low Income/Assets
Meets Medicare Savings Program requirements

PARTIAL BENEFIT DUAL ELIGIBLES

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

Of the 12.2 million dually eligible beneficiaries in 2018...

# Medicare Savings Program Eligibility and Medicaid Payment Responsibility

<table>
<thead>
<tr>
<th>Categories of Dual Eligibles</th>
<th>Full or Partial?</th>
<th>Medicaid Payment Responsibilities</th>
<th>Percent of All Duals Enrolled in Category (CY 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB- only)</td>
<td>Partial</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Qualified Medicare Beneficiary Plus (QMB+)</td>
<td>Full</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Specified Low-Income Medicare Beneficiary (SLMB-Only)</td>
<td>Partial</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Specified Low-Income Medicare Beneficiary Plus (SLMB+)</td>
<td>Full</td>
<td>X</td>
<td>Depends on State Plan*</td>
</tr>
<tr>
<td>Qualifying Individual (QI)</td>
<td>Partial</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Qualifying Disabled and Working Individual (QDWI)</td>
<td>Partial</td>
<td>X</td>
<td>Depends on State Plan*</td>
</tr>
<tr>
<td>Full Medicaid (only)</td>
<td>Full</td>
<td></td>
<td>Depends on State Plan*</td>
</tr>
</tbody>
</table>

*States can opt to cover Medicare Parts A&B cost-sharing in their state plan for SLMB+ and/or “Other” FBDE categories. If states do not do that, these individuals will have Medicaid coverage as secondary to Medicare for services (and providers) covered by Medicaid.

**Source:** CMS Dually Eligible Individuals – Categories, Table 1. 2019. Available at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-CoordinationOffice/Downloads/MedicareMedicaidEnrolleeCategories.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-CoordinationOffice/Downloads/MedicareMedicaidEnrolleeCategories.pdf)

Using Data to Profile Dually Eligible Beneficiaries

Example: State and County Monthly Enrollment Snapshots

Dually Eligible Beneficiaries by Enrollment Type
National Average, December 2018
Total: 10,868,567

- QMB: 14%
- SLMB: 9%
- SLMB+: 3%
- QI: 5%
- Other FBDEs: 17%
- Other: 7%

Dually Eligible Beneficiaries by Enrollment Type
Alabama, December 2018
Total: 211,451

- QMB+: 52%
- QMB: 33%
- SLMB: 17%
- SLMB+: 2%
- QI: 10%
- Other FBDEs: 7%
- Other: 3%

Challenges Resulting from Medicaid Payment of Medicare Premiums and Cost Sharing
Medicare Coverage (Costs to Beneficiaries)

Medicare is similar to private insurance with premiums, deductibles, coinsurance, and copayments.

<table>
<thead>
<tr>
<th>Part A</th>
<th>Part B</th>
<th>Part C</th>
<th>Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient coverage</td>
<td>Outpatient coverage</td>
<td>Private Medicare Advantage (MA) plans that cover Medicare benefits (A, B, and often D)</td>
<td>Private plans that offer prescription drug benefits</td>
</tr>
<tr>
<td>Costs</td>
<td>Costs</td>
<td>Costs</td>
<td>Costs</td>
</tr>
<tr>
<td>• Free, with 40 credits of Medicare-covered employment</td>
<td>• $144.60 premium (new enrollees in 2020)</td>
<td>• Part B premium</td>
<td>• Plan Premium</td>
</tr>
<tr>
<td>• Deductible ($1,408 in 2020, a $44 increase from 2019)</td>
<td>• Deductible ($198 in 2020, a $13 increase from 2019)</td>
<td>• Plan premium</td>
<td>• Plan Cost-sharing</td>
</tr>
<tr>
<td>• Coinsurance for inpatient stays</td>
<td>• Coinsurance of 20% of Medicare-approved amount for most services</td>
<td>• Plan Cost-sharing</td>
<td>• 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 55 and 56 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
- See also: [www.medicare.gov/your-Medicare-costs](http://www.medicare.gov/your-Medicare-costs)
Medicaid Payment of Medicare Beneficiary Premiums and Cost Sharing

• 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 (~10% of Medicaid spending on dually eligible beneficiaries that year)
  • 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

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

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/
    - For more information on state payment of Medicare premiums, see the State Payment of Medicare Premiums Draft Manual available at: https://www.cms.gov/medicare-medicaid-coordination/medicare-medicaid-coordination-office/state-payment-medicare-premiums
  - Appendix slides 45 and 46 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.

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

• 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. Durable Medical Equipment (DME) Benefits

- Medicare and Medicaid combined accounted for about 31 percent of total national spending on DME in 2018
  - Medicare was 16 percent and Medicare 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 and Medicaid Payment for DME

• 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
  • 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.
  • Slide 49 includes additional information on opportunities to better coordinate DME benefits

*This competitive bidding process is in a “temporary gap period” until December 31, 2020.
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)
- FDA-approved, medically necessary substance use treatments**
- **Opioid use disorder treatment services (new in 2020)**

### Medicaid

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

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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)

New Medicare Opioid Treatment Benefit

• Beginning January 1, 2020, CMS will pay bundled payments for opioid use disorder (OUD) treatment services provided by Opioid Treatment Programs (OTP) to people with Part B coverage

• Under the new benefit, Medicare covers:
  • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications
  • Dispensing and administration of MAT medications (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**
  - Medicare will become the primary payer beginning in 2020 for dually eligible beneficiaries who receive OUD services from OTPs in states that provide this benefit under Medicaid

- **Cost sharing for dually eligible beneficiaries**
  - The Part B copayment for OTP services will be zero in 2020, but the Part B deductible will apply
    - For dually eligible beneficiaries 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 will 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 beneficiaries, 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 beneficiaries.
  - See guidance available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Medicaid](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 beneficiaries to align Medicaid OUD benefits with the new Medicare benefit.
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>&lt;br&gt;(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>&lt;br&gt;(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>&lt;br&gt;(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).

Note: ICRC May 2018 WWM webinar provides more in-depth information on coordination opportunities between Medicare and Medicaid for nursing facility services: [https://www.integratedcareresourcecenter.com/PDFs/ICRC_WWM_NF_Benefits_05-03-18_FINAL_for_508_review_rev.pdf](https://www.integratedcareresourcecenter.com/PDFs/ICRC_WWM_NF_Benefits_05-03-18_FINAL_for_508_review_rev.pdf)
5. NEMT Benefits

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Generally covers only emergency ambulance transportation to a hospital or skilled nursing facility if it is medically necessary*</td>
<td>• Much broader – non-emergency</td>
</tr>
<tr>
<td>• In limited circumstances, Medicare will cover non-emergency ambulance transportation if a doctor states in writing that it is medically necessary</td>
<td>• 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)</td>
</tr>
</tbody>
</table>

Overview of Integrated Care Pathways for States Serving Dually Eligible Beneficiaries
State Pathways to Integrated Care

Integrated Care Paths

- Capitated Managed Care
  - D-SNP/MLTSS
  - FIDE SNPs
  - Medicare-Medicaid Plans (MMPs)
  - PACE
  - Other Custom Models
  - State-Specific Models

- Managed Fee-For-Service (MFFS)
  - Medicaid Health Homes
  - MFFS Financial Alignment Initiative Demonstrations
  - Primary Care Case Management (PCCM)
Capitated Managed Care: Program Overviews

- **Program of All-Inclusive Care for the Elderly (PACE):** Organizations that provide integrated Medicare- and Medicaid-covered services, including primary, acute, specialty, and long-term services and supports for those **55 and older who are nursing-home eligible.** PACE organizations receive capitated rates to provide comprehensive and coordinated Medicare and Medicaid benefits.

- **Capitated Model Demonstrations under the Financial Alignment Initiative (Medicare-Medicaid Plans):** Three-way contracts between the state, CMS, and health plans enable delivery of integrated primary, acute, behavioral health and long-term services and supports for dually eligible enrollees. Plans receive **capitated blend payments** to provide comprehensive, coordinated care.

- **Dual Eligible Special Needs Plans (D-SNPs):** Medicare Advantage plans for dually eligible beneficiaries that must at least coordinate Medicare and Medicaid benefits. **D-SNPs must hold a contract** (called a State Medicaid Agency Contract or “SMAC”) with the state Medicaid agency, **with at least certain minimum required elements**, which determine the level of administrative, clinical, and financial integration that may be achieved.
  - D-SNPs may be paired with affiliated Medicaid managed care or Managed Long Term Services and Supports (MLTSS) plans.

- **Fully Integrated Dual Eligible Special Needs Plan (FIDE SNPs):** Medicare Advantage plans that provide dually eligible beneficiaries access to Medicare and Medicaid benefits under a single legal entity that holds both a **D-SNP contract with CMS** and a Medicaid managed care contract with the state Medicaid agency to cover Medicaid long-term services and supports.
## Capitated Managed Care: Key Differences

<table>
<thead>
<tr>
<th>Authorization</th>
<th>PACE</th>
<th>MMP</th>
<th>D-SNP</th>
<th>D-SNP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
<td>Demonstration</td>
<td>Permanent</td>
<td>Permanent</td>
</tr>
<tr>
<td>States, where plan is available</td>
<td>31</td>
<td>9</td>
<td>41</td>
<td>10</td>
</tr>
<tr>
<td>Number of plans (1/2020)</td>
<td>132</td>
<td>40</td>
<td>503</td>
<td>48</td>
</tr>
<tr>
<td>Enrollment (1/2020)</td>
<td>48,581</td>
<td>385,959</td>
<td>2,554,208</td>
<td>279,124</td>
</tr>
<tr>
<td>Contracting structure</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>Level of integration</td>
<td>High</td>
<td>High</td>
<td>Varies widely by state</td>
<td>High</td>
</tr>
<tr>
<td>Passive enrollment</td>
<td>Not allowed</td>
<td>Allowed</td>
<td>Limited. Allowed to maintain enrollment in integrated care</td>
<td>Limited. Allowed to maintain enrollment in integrated care</td>
</tr>
<tr>
<td>States can share Medicare savings</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.

**Sources**:

Capitated Managed Care: Integration Models

Note: Shaded boxes in the figure below represent models that coordinate and/or 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; HIDE SNPs = Highly Integrated 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

*HIDE SNPs must cover Medicaid LTSS and/or BH services through the HIDE SNP or an affiliated Medicaid managed care plan. FIDE SNPs must cover Medicaid LTSS through the same legal entity as the FIDE SNP, and may cover Medicaid BH. Regular D-SNPs must at least coordinate Medicaid benefits, and may cover some or all Medicaid benefits through the D-SNP or an affiliated Medicaid managed care plan.
Capitated Managed Care: Spectrum of Integration

<table>
<thead>
<tr>
<th>Medicare Inpatient (Part A)</th>
<th>Medicare Inpatient</th>
<th>Medicare Inpatient</th>
<th>Medicare Inpatient</th>
<th>Medicare Inpatient</th>
<th>Medicare Inpatient</th>
<th>Medicare Inpatient</th>
<th>Medicare Prescription (Part D)</th>
<th>Medicaid FFS or managed care</th>
<th>Medicaid FFS or managed care</th>
<th>Medicaid FFS or managed care</th>
<th>Medicaid FFS or managed care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Outpatient (Part B)</td>
<td>Medicare Outpatient</td>
<td>Medicare Outpatient</td>
<td>Medicare Outpatient</td>
<td>Medicare Outpatient</td>
<td>Medicare Outpatient</td>
<td>Medicare Outpatient</td>
<td>Medicare Prescriptions</td>
<td>Medicaid FFS or managed care</td>
<td>Medicaid FFS or managed care</td>
<td>Medicaid FFS or managed care</td>
<td>Medicaid FFS or managed care</td>
</tr>
<tr>
<td>Medicare Prescriptions</td>
<td>Medicare Prescriptions</td>
<td>Medicare Prescriptions</td>
<td>Medicare Prescriptions</td>
<td>Medicare Prescriptions</td>
<td>Medicaid Prescriptions</td>
<td>Medicaid Prescriptions</td>
<td>Medicaid Prescriptions</td>
<td>Medicaid FFS or managed care</td>
<td>Medicaid FFS or managed care</td>
<td>Medicaid FFS or managed care</td>
<td>Medicaid FFS or managed care</td>
</tr>
</tbody>
</table>

**Notes:** Medicaid services vary by state. Medicare plans can offer additional services. 
*D-SNPs vary greatly by state, and can also be aligned with MLTSS. Enrollment may be aligned.** FIDE and HIDE SNPs may have aligned enrollment.
D-SNP Contracts: Aligned Enrollment

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

- **Exclusively aligned enrollment**: 100% of D-SNP enrollees receive their Medicaid benefits from the Medicaid managed care plan offered by the same parent company as the D-SNP.

- Exclusively 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.

D-SNP Contracts: New Integration Requirements for 2021

D-SNPs must meet at least one of the following criteria effective CY 2021:

1) Further coordination/alignment: Cover Medicaid behavioral health services and/or LTSS to be either:
   - A Fully Integrated Dual Eligible (FIDE) SNP, or
   - A Highly Integrated Dual Eligible (HIDE) SNP

2) Information Sharing: Notify state and/or its designee(s) of Medicare hospital and skilled nursing facility (SNF) admissions for group of high-risk enrollees to improve coordination during transitions of care

CMS also issued new requirements for certain D-SNPs to implement integrated grievance and appeals: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib111419-2.pdf

**States will need to work with D-SNPs on new contract provisions ahead of the July 6, 2020 submission deadline.**

See slide 53 in the Appendix for ICRC Resources

Capitated Managed Care: Medicare Enrollment Among Full Benefit Dually Eligible Beneficiaries, January 2020

Note: PACE programs may enroll non-dually eligible individuals in some states. The chart excludes partial benefit dually eligibles in the denominator, although D-SNP enrollment includes partial benefit dually eligibles. The total number of FBDEs is from Dec 2018. D-SNP total does not include FIDE SNP enrollment and does not include D-SNPs in Puerto Rico.

Capitated Managed Care: What States Are Doing in 2020

* These states have affiliated D-SNP/MLTSS plans and/or FIDE SNPs as of 2020.
Integrated Care Paths: Managed Fee-for-Service (MFFS)

• **Managed Fee-for-Service Model Demonstration under the Financial Alignment Initiative:** A state and federal option to enroll dually eligible beneficiaries into integrated Medicare and Medicaid programs that cover primary, acute, behavioral health, and long term services and supports services.

• **Primary Care Case Management (PCCM):** A state plan option to enroll Medicaid beneficiaries who select or are assigned into the program by the state. The 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:** A state plan option to enroll Medicaid beneficiaries with chronic physical or behavioral health conditions and cannot exclude dually eligible beneficiaries. The 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.
Integrated Care Paths: State-Specific Models

  - 10 opportunities that do not need demonstration authority or Medicare waivers
    - Managed care-related
    - Data-related
    - Burden and access-related
  
- CMS letter with three **new opportunities** for states to test innovative models of integrated care:
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:
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</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Using Service</td>
<td>$ Per User</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>26%</td>
<td>$19,580</td>
</tr>
<tr>
<td>Other Outpatient</td>
<td>95%</td>
<td>$5,962</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>10%</td>
<td>$18,141</td>
</tr>
<tr>
<td>Home Health</td>
<td>14%</td>
<td>$5,655</td>
</tr>
<tr>
<td>Part D Drugs</td>
<td>93%</td>
<td>$5,120</td>
</tr>
<tr>
<td>Managed Care Capitation*</td>
<td>-</td>
<td>-</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>24</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>15</td>
</tr>
<tr>
<td>Depression</td>
<td>33</td>
</tr>
<tr>
<td>Schizophrenia and other psychotic disorders</td>
<td>13</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>
<tr>
<td>Medicaid payment to provider</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Total provider payment</td>
<td>$100</td>
<td>$80</td>
</tr>
</tbody>
</table>

*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

## Covered Medicare Mental Health Services

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

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)
Percentage of Dually Eligible Beneficiaries Served by D-SNPs, January 2019

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.


Comparison of Managed Care Enrollment in Medicare and Medicaid, CY 2010 and CY 2017

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

Sources: See slide 55 for details on the sources used and links to them.
**DME-Related Opportunities**

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


- 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.

Key 2020 Medicare Advantage Dates

- **June 1:** Bid submission deadline; MA organizations not renewing MA contracts must notify CMS in writing
- **July 6:** MA organizations must submit D-SNP contracts for CY 2021 to CMS
  - D-SNP contracts must either document Medicaid benefit integration that meets HIDE or FIDE bar, or a hospital and SNF admission notification process for a group of high-risk D-SNP enrollees that will be in place for CY 2021
- **October:** Medicare Stars ratings for upcoming year go live on Medicare.gov
- **October 15:** Start of Medicare Annual Election Period Final
- **November:** Notice of intent to apply (NOIA) from D-SNP and MMP applicants due to CMS (e.g., due in Nov 2020 for CY 2022)
- **December 7:** End of Medicare Annual Election Period
- **January 1, 2021:** New D-SNP integration standards must be in place

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
Key Medicare Terms

- **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).

- **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.
Key Medicare Terms (Cont.)

• **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 2019 NOIAs are for the CY 2020 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

Integration Related

• **State Pathways to Integrated Care: Exploring Options for Medicare-Medicaid Integration.** Available at: [https://www.integratedcareresourcecenter.com/sites/default/files/pdfs/ICRC_Pathways_to_Integration_04.15.19.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/pdfs/ICRC_Pathways_to_Integration_04.15.19.pdf)


D-SNP Contracting Related


• **Working with Medicare Webinar: Update on State Contracting with D-SNPs** (December 2017): [http://www.integratedcareresourcecenter.com/PDFs/ICRC_WWM_D-SNP_Contracting%20DRAFT%2012-17%20for%20508%20review.pdf](http://www.integratedcareresourcecenter.com/PDFs/ICRC_WWM_D-SNP_Contracting%20DRAFT%2012-17%20for%20508%20review.pdf)

ICRC Resources

D-SNP Information Sharing:


ICRC Resources

Benefits:


• **Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans** (November 2017): http://www.integratedcareresourcecenter.com/PDFs/ICRC_VBP_in_Nursing_Facilities_November_2017.pdf


CMS Resources on D-SNP Integration


• Bipartisan Budget Act of 2018: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf