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Working with Medicare

Medicare 101 and 201: Key Issues for States

February 10, 2020

1:00-2:00 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) 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

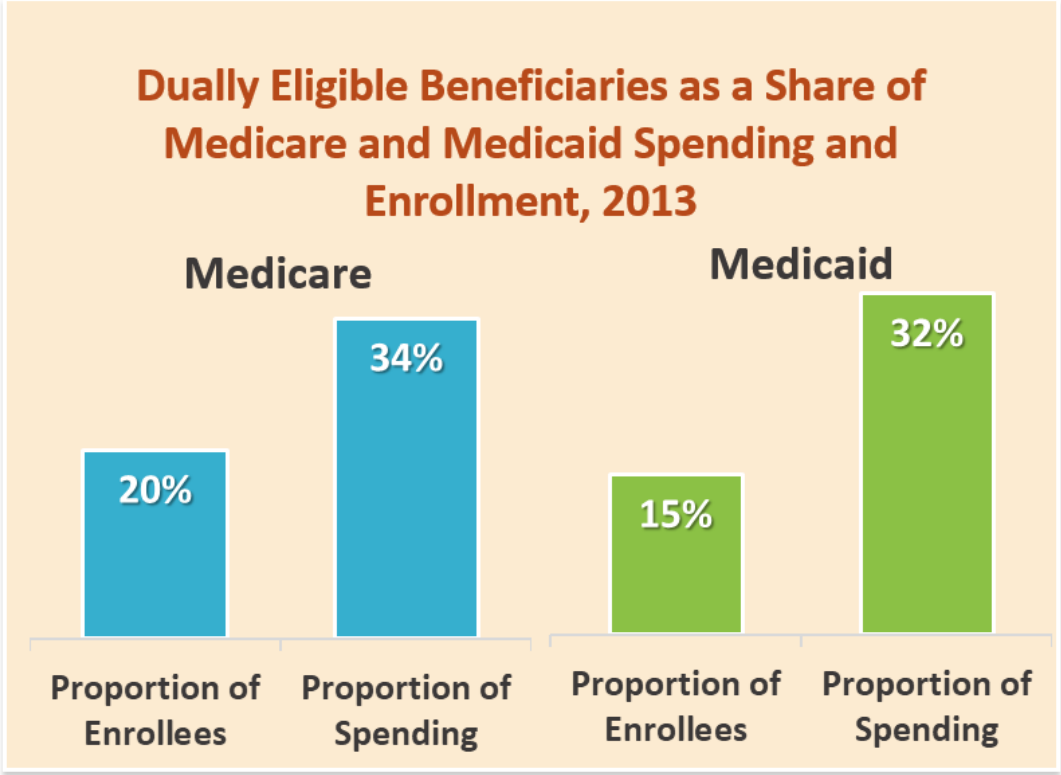
Presenters

- 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)



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.

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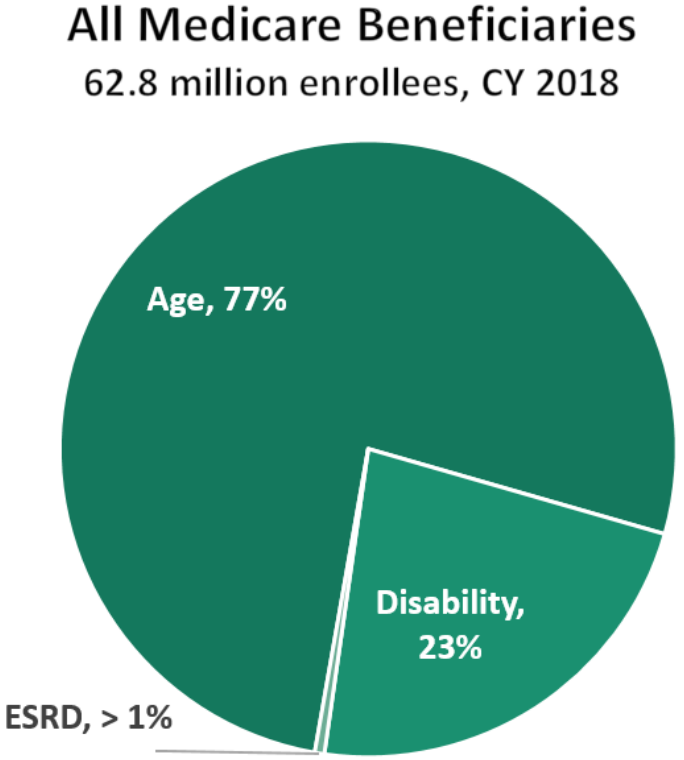
Who is Eligible for Medicare?

Age 65 or older*

Under age 65

Permanent
Disability**

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.

Source: Centers for Medicare & Medicaid Services. Medicare-Medicaid Coordination Office. "Twelve-Year Trends Report – Accompanying Data Tables (2006-2018). January 2020. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources

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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

Low Income/Assets

Meets Medicare Savings Program requirements

PARTIAL BENEFIT DUAL ELIGIBLES

Meet state Medicaid eligibility requirements

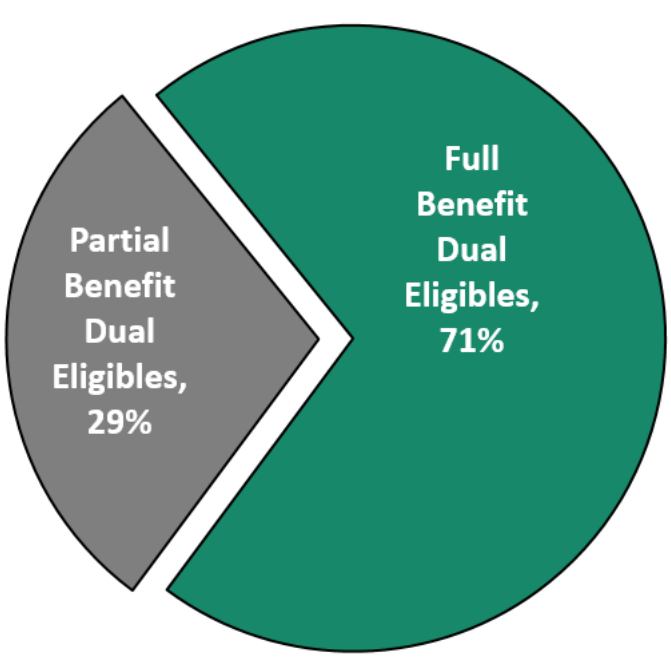
Meet state income/asset requirement

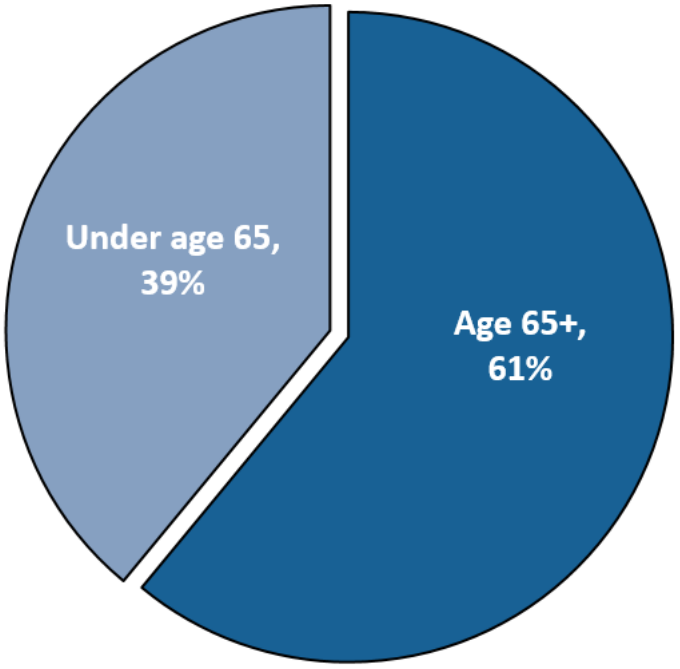
FULL BENEFIT DUAL ELIGIBLES

* 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

Of the 12.2 million dually eligible beneficiaries in 2018…





Source: Centers for Medicare & Medicaid Services. Medicare-Medicaid Coordination Office. "Twelve-Year Trends Report – Accompanying Data Tables (2006-2018). January 2020. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources

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Medicare Savings Program Eligibility and Medicaid Payment Responsibility

Categories of Dual Eligibles	Full or Partial?	Medicaid Payment Responsibilities				Percent of All Duals Enrolled in Category (CY 2018)
		Part A premium (when applicable)	Part B premium	Parts A &B cost sharing	Full Medicaid coverage	
Qualified Medicare Beneficiary **(QMB- only)**	Partial	X	X	X		14.1%
Qualified Medicare Beneficiary Plus **(QMB+)**	Full	X	X	X	X	49.9%
Specified Low-Income Medicare Beneficiary **(SLMB-Only)**	Partial		X			9.3%
Specified Low-Income Medicare Beneficiary Plus **(SLMB+)**	Full		X	Depends on State Plan*	X	2.7%
Qualifying Individual **(QI)**	Partial		X			5.4%
Qualifying Disabled and Working Individual **(QDWI)**	Partial	X				<1%
Full Medicaid (only)	Full		Depends on State Plan*	Depends on State Plan*	X	18.5%

*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-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf

Centers for Medicare & Medicaid Services. Medicare-Medicaid Coordination Office. "Twelve-Year Ever-Enrolled Trends Report – Accompanying Data Tables (2006-2018)". January 2020. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources

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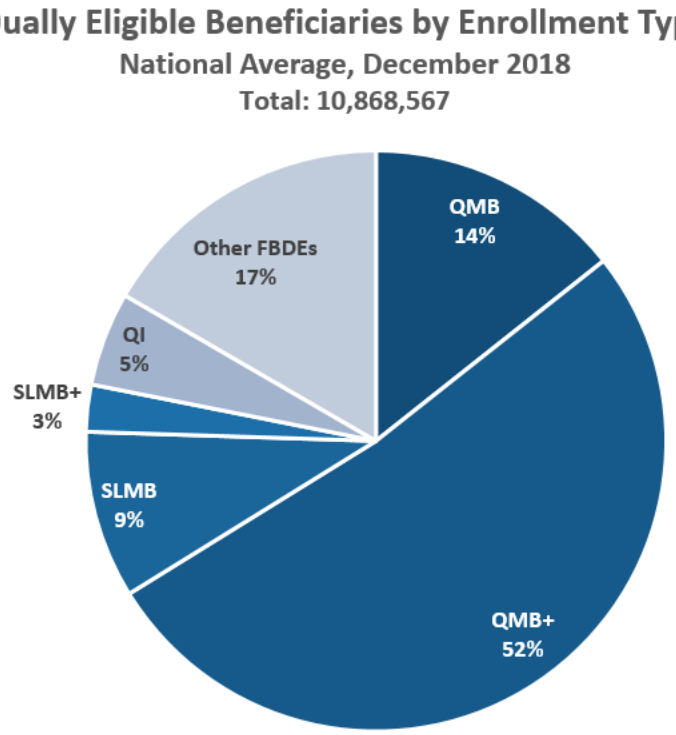
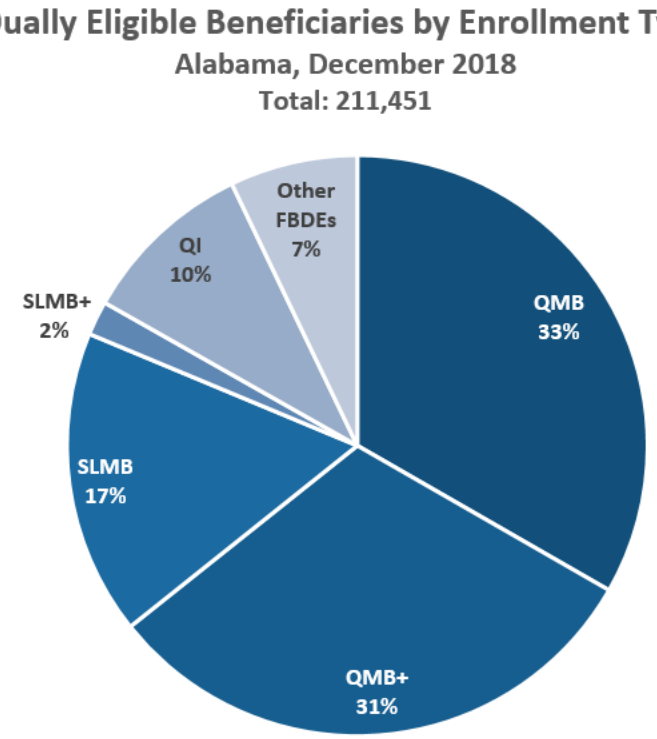
10

Using Data to Profile Dually Eligible Beneficiaries

Example: State and County Monthly Enrollment Snapshots





Sources: D. Chelminsky. "How States Can Better Understand their Medicare-Medicaid Enrollees: A Guide to Using CMS Data Resources." Integrated Care Resource Center, November 2018. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/CMS_Data_Resources_Nov_2018.pdf; & CMS Monthly Enrollment Snapshots, January 2020. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources.html

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11

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.

	Part A *Inpatient coverage*	Part B *Outpatient coverage*	Part C *Private Medicare Advantage (MA) plans that cover Medicare benefits (A, B, and often D)*	Part D *Private plans that offer prescription drug benefits*
Costs	• Free, with 40 credits of Medicare-covered employment • Deductible ($1,408 in 2020, a $44 increase from 2019) • Coinsurance for inpatient stays	• $144.60 premium (new enrollees in 2020) • Deductible ($198 in 2020, a $13 increase from 2019) • Coinsurance of 20% of Medicare-approved amount for most services	• Part B premium • Plan premium • Plan Cost-sharing • Note: Coinsurance/ copayments differ by service types, and different Medicare Advantage plans may charge different amounts	• Plan Premium • Plan Cost-sharing • Low-Income Subsidy (LIS) covers premiums and most cost-sharing for dually eligible beneficiaries

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

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
  - See MACPAC August 2017 issue brief: https://www.macpac.gov/wp-content/uploads/2017/08/Medicare-Savings-Programs-New-Estimates-Continue-to-Show-Many-Eligible-Individuals-Not-Enrolled.pdf

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. 14-15

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/
    - 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)
  - For more information on "lesser-of" payment policies and impacts on access to care, see MACPAC March 2015 Report to Congress, Chapter 6 ("Effects of Medicaid Coverage of Medicare Cost Sharing on Access to Care") at: https://www.macpac.gov/wp-content/uploads/2015/03/Effects-of-Medicaid-Coverage-of-Medicare-Cost-Sharing-on-Access-to-Care.pdf

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

Medicare

- 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

Medicaid

- 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

Notes: *Medically necessary care for up to 35 hours/week may be considered on a case-by-case basis.
**For information/guidance on this, see MLN Matters: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf
Source: Medicare Benefit Policy Manual, Chapter 7: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

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)

Source: National Health Expenditures, Table 17 at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html

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

- ICRC October 2018 WWM webinar provides more in-depth information on coordination of Medicare and Medicaid BH benefits: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_WWM_BH_Benefits_10-09-18_FINAL_FOR%20508.pdf
- For a list of behavioral health services covered by Medicare, please see the Appendix, Slide 46.

Notes: * MLN booklet on Medicare and Mental Health Services, January 2015: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mental-Health-Services-Booklet-ICN903195.pdf
** 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
*** 2016 MACPAC comparison of behavioral health services included in states Medicaid state plan benefits: https://www.macpac.gov/publication/behavioral-health-state-plan-services/

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
  - 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) 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
- **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

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

*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

5. NEMT Benefits

Medicare

- Generally covers only emergency ambulance transportation to a hospital or skilled nursing facility if it is medically necessary*
- In limited circumstances, Medicare will cover non-emergency ambulance transportation if a doctor states in writing that is it medically necessary

Medicaid

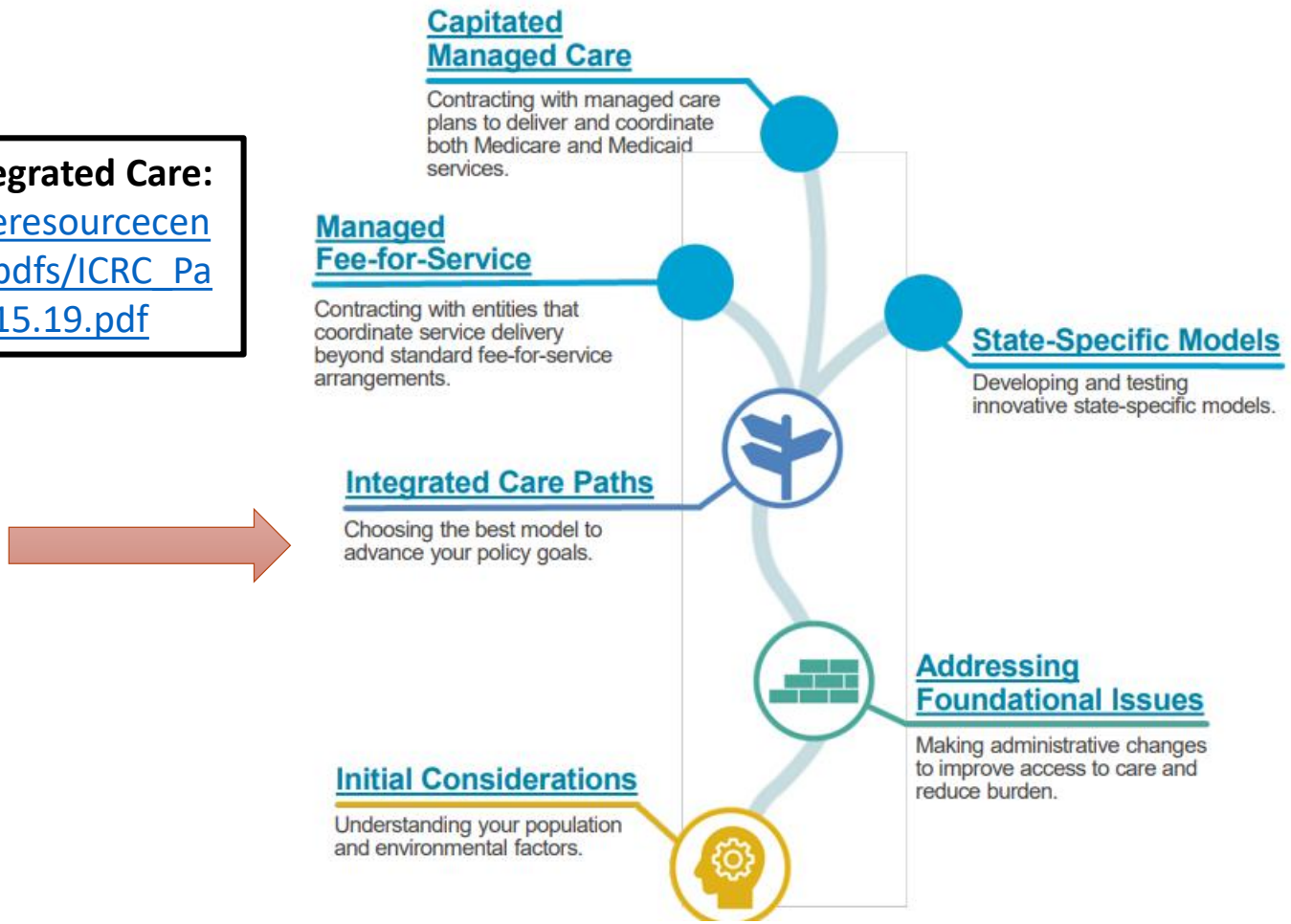
- Much broader – non-emergency
- Travel expenses for medical exams and treatment by any medical provider – travel may be provided by ambulance, taxi, common carrier, "or other appropriate means" (42 CFR § 440.170)

*Medicare Advantage plans have flexibility in offering supplemental benefits, which may include transportation services. For more information, see this April 2018 Final Rule: https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare.

Overview of Integrated Care Pathways for States Serving Dually Eligible Beneficiaries

State Pathways to Integrated Care

ICRC State Pathways to Integrated Care: https://www.integratedcareresourcecenter.com/sites/default/files/pdfs/ICRC_Pathways_to_Integration_04.15.19.pdf



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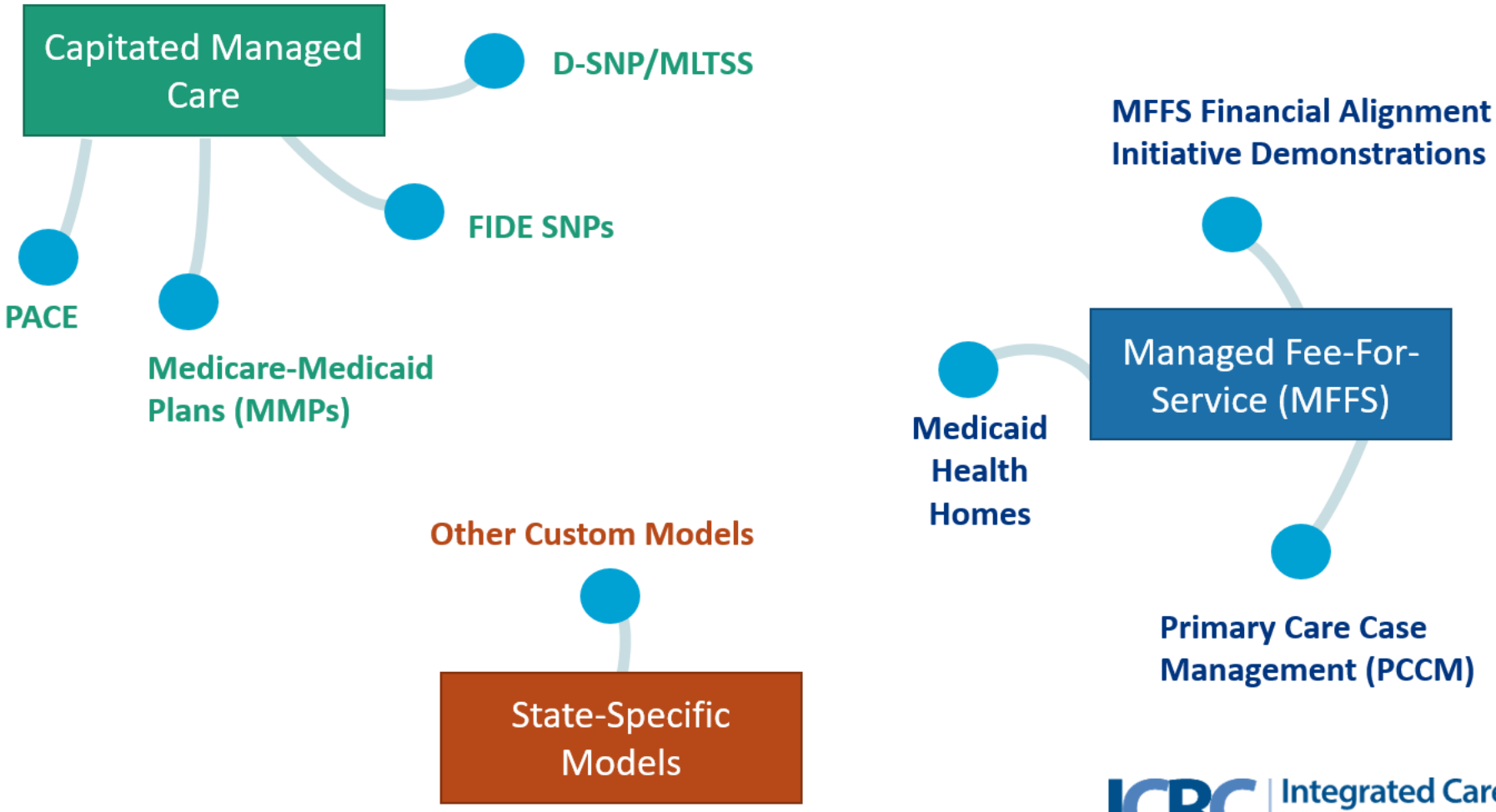
Integrated Care Paths



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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

	PACE	MMP	D-SNP	
			Regular	FIDE SNP
Authorization	Permanent	Demonstration	Permanent	Permanent
States, where plan is available	31	9	41	10
Number of plans (1/2020)	132	40	503	48
Enrollment (1/2020)	48,581	385,959	2,554,208	279,124
Contracting structure	3-way contract*	3-way contract	Separate Medicare and Medicaid contracts	Separate Medicare and Medicaid contracts
Level of integration	High	High	Varies widely by state	High
Passive enrollment	Not allowed	Allowed	Limited. Allowed to maintain enrollment in integrated care	Limited. Allowed to maintain enrollment in integrated care
States can share Medicare savings	No	Yes	No	No

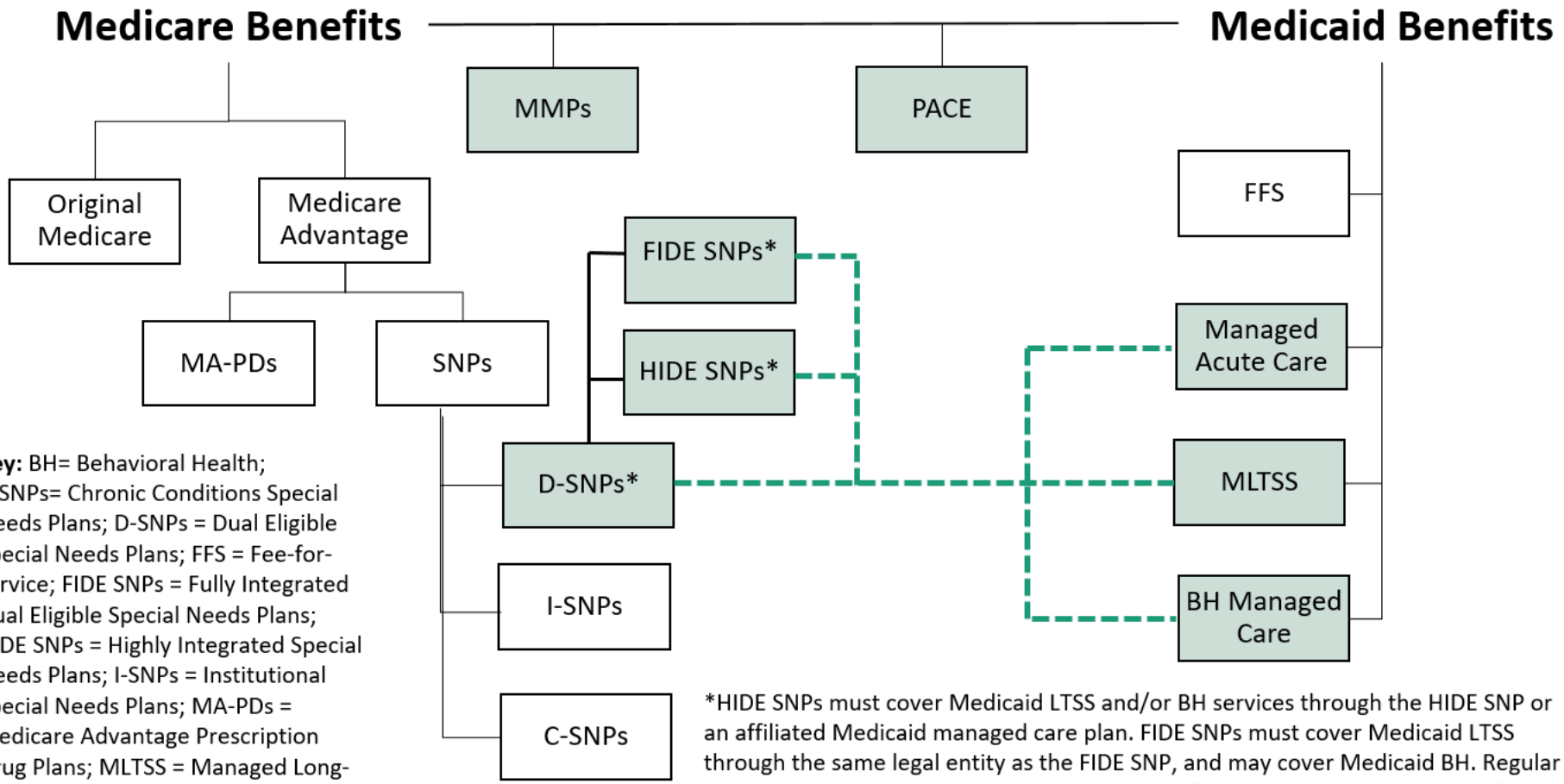
*Some states use an additional 2-way contract to issue state-specific requirements, in addition to the standard 3-way contract.

Sources: MedPAC. "Report to the Congress: Medicare and the Health Care System." June 2018, Table 9-9, p.267. Available at: http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf?sfvrsn=0

Plan numbers and enrollment data from the CMS Monthly Reports for Jan 2020: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData

Capitated Managed Care: Integration Models

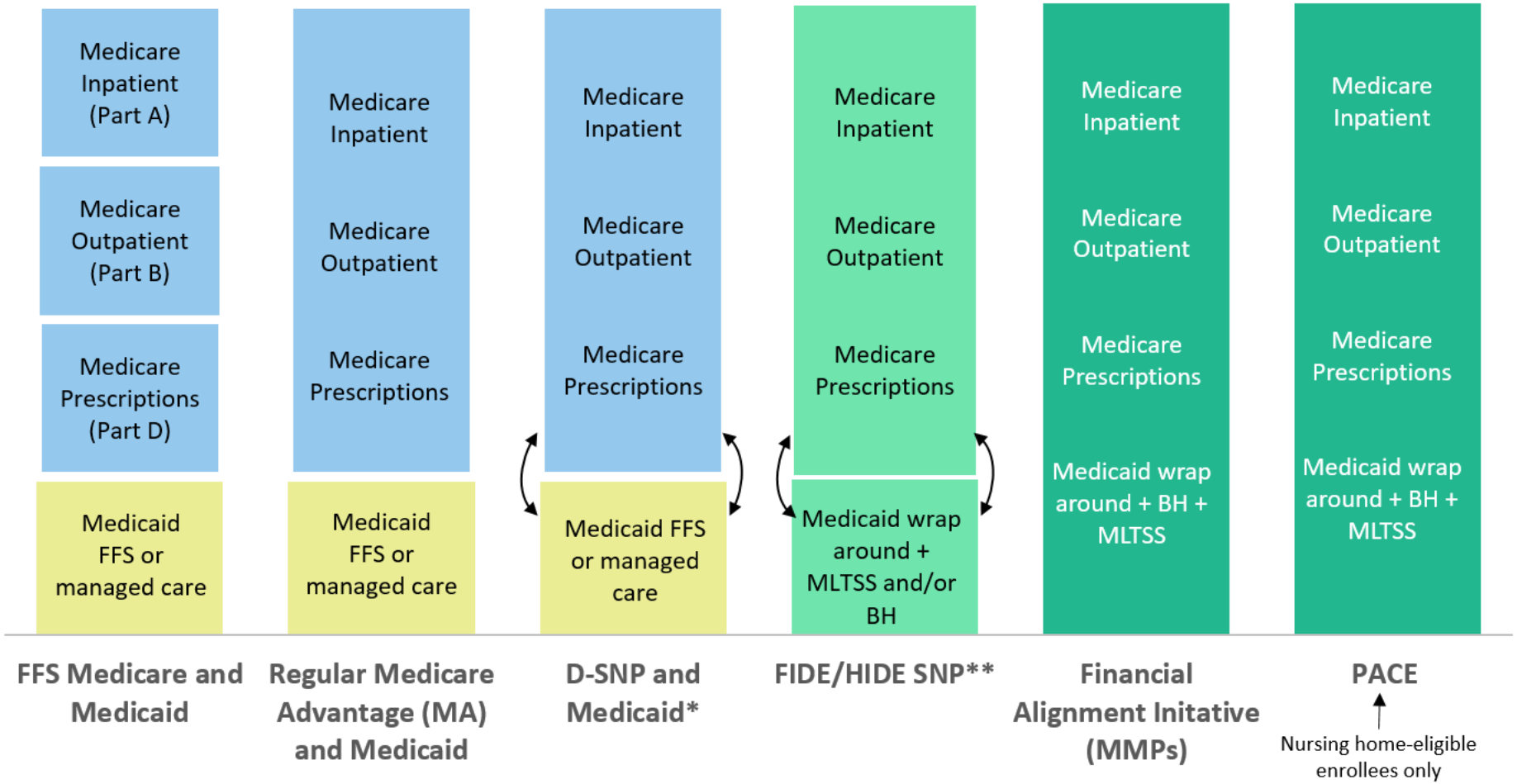
Note: Shaded boxes in the figure below represent models that coordinate and/or integrate all or some Medicare and Medicaid benefits for dually eligible beneficiaries.



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.

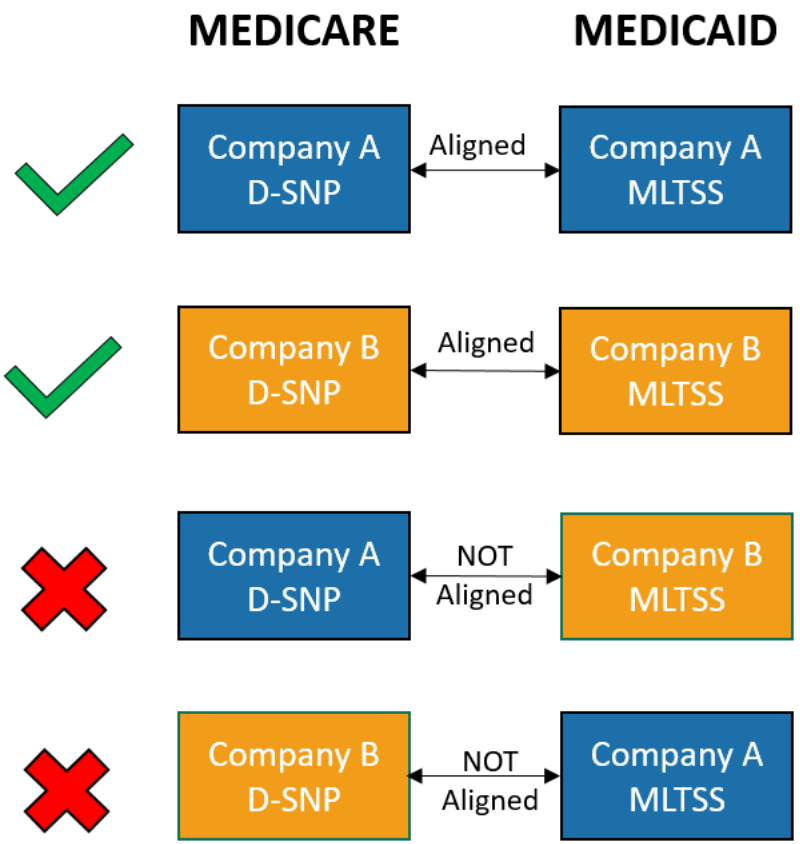
Capitated Managed Care: Spectrum of Integration



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.



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34

For more information, see: E. Weir Lakhmani and A. Kruse. "Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment." ICRC, April 2018. Available at: https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Aligning_Enrollment.pdf

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

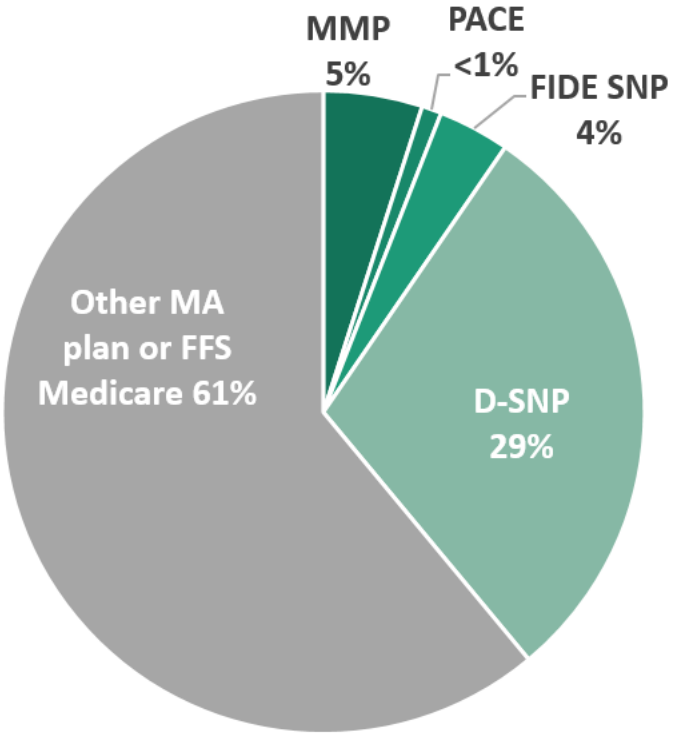
CMS also issued new requirements for certain D-SNPs to implement **integrated grievance and appeals**: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib111419-2.pdf

*****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

Source: CMS. "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021." *Federal Register*, April 16, 2019, pp.15710-15718 and *42 CFR 422.107(d))* p. 15828. Available at: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

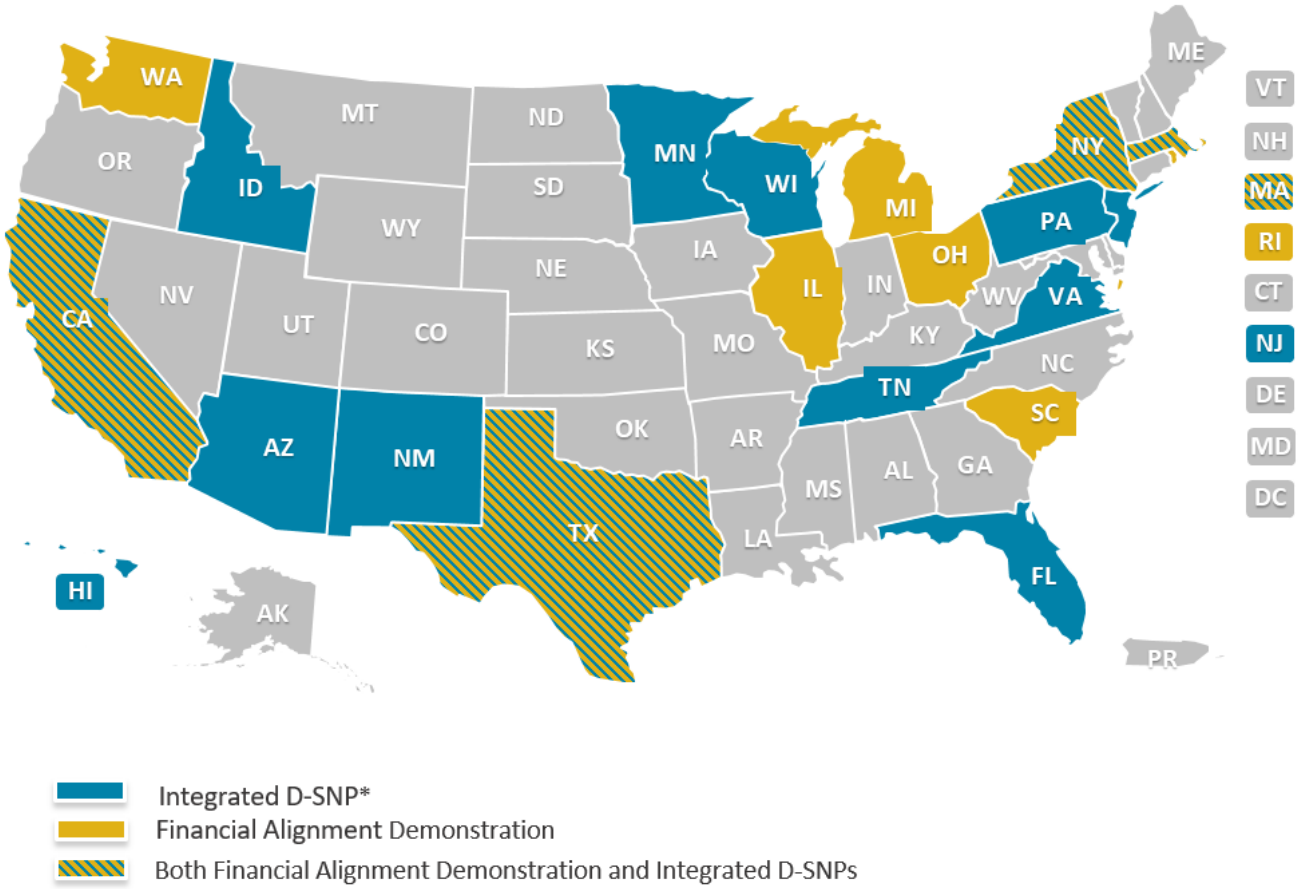
Capitated Managed Care: Medicare Enrollment Among Full Benefit Dually Eligible Beneficiaries, January 2020



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.

Sources: CMS Quarterly Enrollment Snapshot, December 2018. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html; CMS Monthly Enrollment by Contract Report, Jan 2020. Available at: https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/enrollment-contract-2020-01; and CMS Special Needs Plan Comprehensive Report, Jan 2020. Available at: https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldataspecial-needs/snp-comprehensive-report-2020-01

Capitated Managed Care: What States Are Doing in 2020



* These states have affiliated D-SNP/MLTSS plans and/or FIDE SNPs as of 2020.

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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

- **State Medicaid Director Letter**: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf
  - 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:
  - https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd19002.pdf

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:
Additional Slides and Resources

Percent Using Service and Per-User Spending, CY 2013

FBDE Enrollees in FFS

Medicare			Medicaid		
Service	**% Using Service**	**$ Per User**	**Service**	**% Using Service**	**$ Per User**
Inpatient Hospital	**26%**	**$19,580**	Inpatient Hospital	13%	$2,033
Other Outpatient	95%	$5,962	Outpatient	86%	$2,325
Skilled Nursing Facility	10%	$18,141	Institutional LTSS	**20%**	**$41,903**
Home Health	14%	$5,655	HCBS Waiver	**14%**	**$29,144**
			HCBS State Plan	**12%**	**$8,662**
Part D Drugs	93%	$5,120	Drugs	35%	$272
-	-	-	Managed Care Capitation*	35%	$3,781

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

Source: MedPAC and MACPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid: Data Book." January 2018, Exhibits 14 and 15. Available at: https://www.macpac.gov/wp-content/uploads/2017/01/Jan18_MedPAC_MACPAC_DualsDataBook.pdf.

42

FFS Dually Eligible Beneficiaries With Selected Conditions, CY 2013

Condition	Percent of FFS Dually Eligible Beneficiaries	
	Under age 65	Age 65 and older
COGNITIVE IMPAIRMENT		
Alzheimer's disease or related dementia	4	**23**
Intellectual disabilities and related conditions	8	1
MEDICAL CONDITIONS		
Diabetes	23	35
Heart failure	8	23
Hypertension	39	**65**
Ischemic heart disease	14	**33**
BEHAVIORAL HEALTH CONDITIONS		
Anxiety disorders	**24**	15
Bipolar disorder	**15**	3
Depression	**33**	22
Schizophrenia and other psychotic disorders	**13**	7

Source: MedPAC and MACPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid: Data Book." January 2018, Exhibit 8. Available at: https://www.macpac.gov/wp-content/uploads/2017/01/Jan18_MedPAC_MACPAC_DualsDataBook.pdf.

Crossover Claims Examples (Lesser-of Policy)

Physician Visit*	FFS Full Payment Policy	FFS Lesser-of Policy
Provider charge	$125	$125
Medicare-approved amount	$100	$100
Medicaid payment rate	$75	$75
Medicare payment (*e.g., 80% Medicare approved amount less deductible*)	(80% of $100)-$0 = $80	(80% of $100)-$0 = $80
Medicare cost sharing (*billed to Medicaid as a crossover claim*)	$20	$20
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.

Source: Medicaid and CHIP Payment and Access Commission. "Report to the Congress on Medicaid and CHIP. Chapter 5. Issues in Setting Capitation Rates for Integrated Care Plans." March 2013. Available at: https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-313/

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

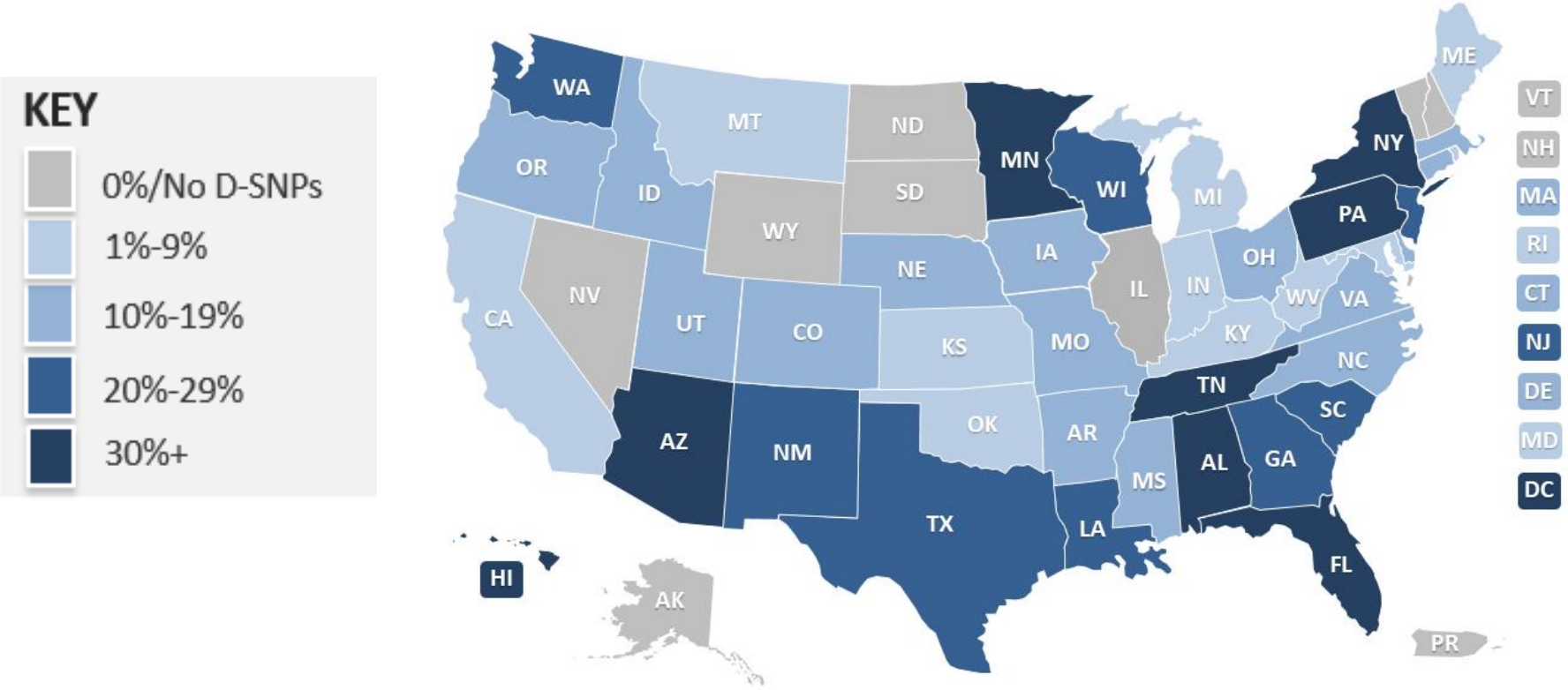
Beneficiary Medicare & Medicaid Status	Medicare Physician Service Claim	Crossover Claim
Medicare Advantage (MA) & FFS Medicaid	Bill MA Organization	Bill State directly
MA and Managed Medicaid	Bill MA Organization	Bill Medicaid MCO
FFS Medicare and Medicaid	Bill CMS directly	Typically an automatic crossover to state
FFS Medicare and Managed Medicaid	Bill CMS directly	Typically an automatic crossover to MCO
D-SNPs receiving payment for Medicaid cost sharing	Bill D-SNP regardless of services Providers submit one claim	

Behavioral Health Benefits Covered by Medicare

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

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

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.

Sources: Centers for Medicare & Medicaid Services. *SNP Comprehensive Report.* January 2019. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2019-1.html?DLPage=2&DLEntries=10&DLSort=1&DLSortDir=descending
Center for Medicare & Medicaid Services. *CMS Monthly Enrollment Snapshots*, December 2017. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources.html.

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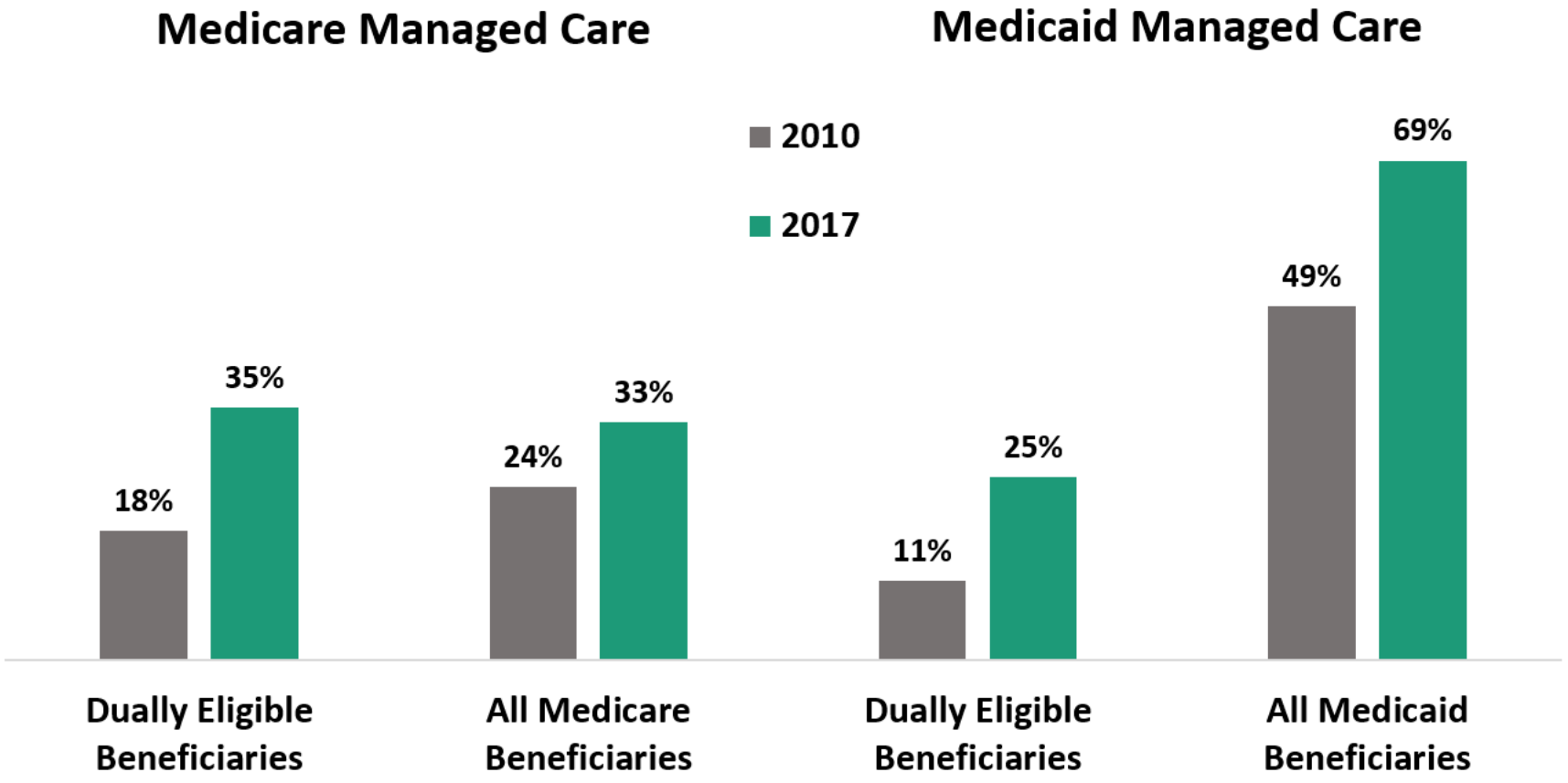
Comparison of Managed Care Enrollment in Medicare and Medicaid, CY 2010 and CY 2017



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.

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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

For more information, see: P. Montebello. "Facilitating Access to Medicaid Durable Medical Equipment for Dually Eligible Beneficiaries in the Fee-for-Service System: Three State Approaches." ICRC, June 2018. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Access_to_DME_in_FFS_06-2018.pdf

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
- **Building a Stronger Foundation for Medicare- Medicaid Integration: Opportunities in Modifying State Administrative Processes** (October 2018): https://www.integratedcareresourcecenter.com/resource/building-stronger-foundation-medicare-medicaid-integration-opportunities-modifying-state
- **Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment** (April 2018): https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Aligning_Enrollment.pdf

D-SNP Contracting Related

- **Working with Medicare Webinar on D-SNP Contracting** (July 2019): https://www.integratedcareresourcecenter.com/webinar/update-state-contracting-d-snps-basics-and-meeting-new-federal-requirements-2021
- **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
- **Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans** (November 2019): https://www.integratedcareresourcecenter.com/resource/sample-language-state-medicaid-agency-contracts-dual-eligible-special-needs-plans

ICRC Resources

D-SNP Information Sharing:

- **Key Questions and Considerations for States Implementing New D-SNP Information-Sharing Requirements** (December 2019): https://www.integratedcareresourcecenter.com/webinar/key-questions-and-considerations-states-implementing-new-d-snp-information-sharing
- **State Options and Considerations for Sharing Medicaid Enrollment and Service Use Information with D-SNPs** (December 2019): https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Medicaid_Enrollment_Service_Use_Info_12_2019.pdf
- **Information Sharing to Improve Care Coordination for High-Risk Dual Eligible Special Needs Plan Enrollees: Key Questions for State Implementation** (September 2019): https://www.integratedcareresourcecenter.com/resource/information-sharing-improve-care-coordination-high-risk-dual-eligible-special-needs-plan
- **State Options and Considerations for Sharing Medicaid Enrollment and Service Use Information with D-SNPs** (December 2019): https://www.integratedcareresourcecenter.com/resource/state-options-and-considerations-sharing-medicaid-enrollment-and-service-use-information-d
- **Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations** (August 2019): https://www.integratedcareresourcecenter.com/resource/promoting-information-sharing-dual-eligible-special-needs-plans-improve-care-transitions

ICRC Resources

Benefits:

- **Medicare Basics: An Overview for States Seeking to Integrate Care for Medicare-Medicaid Enrollees** (June 2017): http://www.integratedcareresourcecenter.com/PDFs/ICRC_Medicare_Basics_Updated_June_2017.pdf
- **Working with Medicare Webinar: Coordination of Medicare and Medicaid Behavioral Health Benefits** (October 2018): https://www.integratedcareresourcecenter.com/webinar/coordination-medicare-and-medicaid-behavioral-health-benefits
- **Working with Medicare Webinar: Medicare and Medicaid Nursing Facility Benefits: The Basics and Options for Improved Coordination and Quality** (May 2018): https://www.integratedcareresourcecenter.com/PDFs/ICRC_WWM_NF_Benefits_05-03-18_FINAL_for_508_review_rev.pdf
- **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
- **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
- **Facilitating Access to Medicaid Durable Medical Equipment for Dually Eligible Beneficiaries in the Fee-for-Service System: Three State Approaches** (June 2018): https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Access_to_DME_in_FFS_06-2018.pdf

CMS Resources on D-SNP Integration

- **CMS. "Additional Guidance on CY 2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs)." HPMS Memo. January 17, 2020. Available at:** https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf

- **CMS. "CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)." HPMS Memo. October 7, 2019. Available at:** https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DSNPsIntegrationUnifiedAppealsGrievancesMemorandumCY2021110072019.pdf

- **Final Rule on D-SNP Integration 2019 (CMS-4185-F):** https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

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