Integrating care for dually eligible beneficiaries has the potential to improve care for this high-need, high-cost population.

This tool shares steps that states can take to advance integration, starting with simple actions to better understand dually eligible populations and improve their access to care. For states that are ready to go further, the tool describes pathways to integration based on states’ policy goals and the structure of their delivery system. The tool provides key considerations and resources for each path. States can use this tool to explore their options and chart their own path toward integration.

The Integrated Care Resource Center is a national initiative of the Centers for Medicare & Medicaid Services’ Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the Integrated Care Resource Center are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.
ICRC staff are also available to provide technical assistance to states wishing to explore options for integrating care for dually eligible beneficiaries. Requests for ICRC technical assistance can be sent to: ICRC@chcs.org
Initial Considerations

As a group, dually eligible beneficiaries are the highest-need and highest-cost population in both Medicare and Medicaid because they often have:

- Multiple chronic physical health conditions
- Co-occurring behavioral health conditions
- A need for long-term services and supports (LTSS)

Although dually eligible beneficiaries are likely to benefit from coordinated care, less than 10% nationally are receiving integrated care.\(^1\),\(^2\)

The first steps toward integrating Medicare and Medicaid services are:

- Understanding Your Dually Eligible Beneficiaries
- Assessing Environmental Factors and Opportunities to Integrate Care
Understanding Your Dually Eligible Beneficiaries

Reports available through CMS and other sources provide detailed information on dually eligible beneficiaries. States can use these reports to design more integrated programs for this population. Available reports feature county- and state-level information on beneficiary characteristics, such as gender, ethnicity, age, services used, chronic conditions, and spending.

For more detailed information about these reports and how states can use them, review these resources.
Resources: Understanding Your Dually Eligible Beneficiaries

How States Can Better Understand Their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources (Integrated Care Resource Center/May 2018). This tool describes CMS resources that provide state- and county-level demographic data.

- To find the number and types (QMB, QMB+, SLMB, SLMB+, FBDE) of dually eligible beneficiaries, go to page 3: “Dually Eligible Beneficiary State and County Monthly Enrollment Snapshots.”
- To find data on beneficiaries’ chronic conditions and their use of Medicare and Medicaid services, go to page 7: “Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS).”
- To find data on Medicare and Medicaid spending and payments, go to page 23.

Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid (MedPAC and MACPAC/January 2018). The data book presents national-level information that states can use as a point of comparison for state- and county-level information.

- To find national data on dually eligible beneficiaries’ share of Medicare and Medicaid enrollment and spending, go to Exhibit 5.
- To find national data on physical and behavioral health conditions, go to Exhibit 8.
- To find national data on service utilization and spending on Medicare and Medicaid services, go to Exhibits 14 and 15.

Working with Medicare Webinars (ICRC/ongoing). These webinars provide basic information for states about working with Medicare and coordinating benefits for dually eligible beneficiaries.
Assessing Environmental Factors and Opportunities to Integrate Care

Successful integrated care needs a strong foundation of:

- **Infrastructure** (e.g., staff, information technology resources, management systems), either within the state Medicaid agency or in outside entities, such as managed care organizations

- **Stakeholder support** (e.g., from the governor, legislators, other state agencies, beneficiary advocates, and providers) for integration

- **Medicare knowledge** on the part of state staff and state-contracted entities

- **Managed care plans** or other entities that the state can contract with to integrate Medicare and Medicaid services for dually eligible enrollees

To learn more about understanding your current Medicare and Medicaid landscape and the characteristics of dually eligible beneficiaries in your state, review these [resources](#).
Resources: Assessing Environmental Factors and Opportunities to Integrate Care

**Medicare Basics: An Overview for States Seeking to Integrate Care for Medicare-Medicaid Enrollees** (Integrated Care Resource Center/June 2017). This brief provides a concise overview of Medicare and Medicare Advantage.

**How States Can Better Understand Their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources** (Integrated Care Resource Center/May 2018). This guide shows how to use CMS data resources to better understand dually eligible beneficiaries, including their characteristics, service utilization, costs, and care needs.

**SNP Comprehensive Reports** (CMS). Monthly CMS reports that show enrollment in Medicare Advantage Special Needs Plans (SNPs) by plan, state, and coverage area.

**Medicare Advantage 2017 Spotlight: Enrollment Market Update** (Kaiser Family Foundation/June 2017). This annual Kaiser report contains rates of Medicare Advantage enrollment penetration by state (Table 1) and the top three Medicare Advantage plans in each state (Table A6).

**Medicaid Managed Care Enrollment Report and Program Characteristics, 2016** (CMS/spring 2018). This annual CMS report shows enrollment in all forms of Medicaid managed care, by plan and by state. Tables 3 and 5 show enrollment of dually eligible beneficiaries by state, program, and plan.
Addressing Foundational Issues in Integrating Care

States can build a stronger base for integration by addressing some foundational issues. Making these administrative changes may improve dually eligible beneficiaries’ access to Medicare shared savings programs while reducing the burden on state staff and providers. Administrative changes to consider include:

- Executing Part A Buy-In Agreements
- Exchanging Files with CMS More Frequently
- Using Medicare Data to Improve Integration
Executing Part A Buy-In Agreements

Most Medicare beneficiaries do not have to pay a monthly premium for Medicare Part A coverage, but some do. Low-income people may decline Part A enrollment because of this financial burden. The Qualified Medicare Beneficiary (QMB) program covers this premium for eligible beneficiaries, but beneficiaries must enroll in Part A to access that program, and Part A enrollment is generally restricted to an annual open-enrollment period.

To remedy this, 36 states and the District of Columbia have Part A buy-in agreements with CMS to facilitate Part A enrollment for QMB-eligible beneficiaries. 3

The benefits of Part A buy-in agreements include:

- Allowing enrollment in Medicare Part A at any time of the year
- Eliminating penalties for late enrollment in Part A
- Enabling beneficiaries to receive integrated care through Medicare Advantage plans or Medicare-Medicaid plans (without Part A, dually eligible beneficiaries cannot enroll in these managed care plans)
- Potentially reducing Medicaid costs because Medicare becomes the primary payer for inpatient or acute-care services that would otherwise be covered by Medicaid

For more information about executing Part A buy-in agreements, review these resources.
Resources: Executing Part A Buy-In Agreements

Program Operations Manual System (POMS): State Buy-In and Group Payer Provisions for QMBs (Social Security Administration). This section of the POMS provides a current list of Part A buy-in states, along with policies and procedures for Part A buy-in states.

State Medicaid agencies can get more information about entering into Part A buy-in agreements by emailing statebuy-in@cms.hhs.gov with “Part A Payer Conversation” in the subject line.
Exchanging Files with CMS More Frequently

States exchange files ("MMA" files\(^4\)) with CMS to identify dually eligible beneficiaries and to generate Part A and B premium notices ("buy-in" files). States must submit these files at least monthly, but more frequent file submission offers several benefits:

• Beneficiaries can access Medicare subsidies faster, enabling quicker access to Medicare Part A and B services without out-of-pocket costs

• States, health plans, and providers can more clearly communicate with beneficiaries about cost-sharing liability

• Medicaid administrative processes can be streamlined

• Provider burden can be reduced

Many states already exchange files with CMS daily. Before deciding to submit files more frequently, states will need to determine whether their administrative and data systems will support this change.

For more information about state/CMS file exchange, review these resources.
Resources: Exchanging Files with CMS More Frequently

**State Medicare Modernization Act (MMA) File of Dual-Eligible Beneficiaries Q&A** (CMS/October 2017). This resource provides a high-level overview of MMA files and the benefits of frequent submission, along with contact information for inquiring about more frequent MMA submission.

**Medicare Advantage Prescription Drug State User Guide** (CMS/September 2017). This comprehensive guide provides information on the content of MMA files and guidelines for file submission. Sections 4.1, 4.3, and 5.1 give details on submission requirements and timing for exchanging MMA request files.

**Effects of Medicaid Coverage of Medicare Cost-Sharing on Access to Care** (Medicaid and CHIP Payment and Access Commission/March 2015). Chapter 6 of this report explains how states may receive federal financial participation (i.e., FMAP) to help pay Part B premiums for most dually eligible individuals.
Using Medicare Data to Improve Integration

As states design and implement integrated care programs, the ability to access Medicare data can help with care coordination and program oversight. States that obtain Medicare data and link these data to their own Medicaid data can create a more complete view of dually eligible beneficiaries’ service use and spending.

Efforts that can be improved by linked data include those designed to:

• Reduce overutilization of emergency departments
• Create predictive modeling tools
• Inform care planning and care coordination
• Support beneficiary outreach and engagement
• Support auditing

For more information on using Medicare data to improve integration, review these resources.
Resources: Using Medicare Data to Improve Integration

**State Data Resource Center (SDRC).** This website offers a range of data-support services to state Medicaid agencies. SDRC helps states submit Medicare data requests and process and use the data they receive.

**Medicare-Medicaid Data Integration: What Can the Master Beneficiary Summary File Do for You?** (SDRC/June 2018). This webinar introduces and describes the segments of the Master Beneficiary Summary File and how these data can be useful in analytics focused on dually eligible beneficiaries. *To request webinar slides and recordings, please email SDRC.*

**Public Data Files and the Dual-Eligible Population** (SDRC/May 2018). This webinar explores how state Medicaid agencies can combine free Public Use Files with other Medicare data types to start programs to combat fraud, waste, and abuse for their dually eligible populations. *To request webinar slides and recordings, please email SDRC.*
Options for Integrating Care for Dually Eligible Beneficiaries

**Capitated Managed Care**
Many states integrate care through contracts with managed care plans responsible for delivering both Medicare and Medicaid services. One promising approach is to link Medicaid managed long-term services and supports (MLTSS) programs with Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs). Questions to consider include:

- Does the state have an MLTSS program or experience contracting with Medicaid MCOs? Can this be developed?
- Does the state have options to enhance Medicaid MLTSS and D-SNP contracting to further integration?
- Can the state align enrollment between Medicare D-SNPs and Medicaid MLTSS plans?

**Managed Fee-for-Service**
Managed fee-for-service (MFFS) involves contracting with entities that coordinate service delivery beyond what is done in fee-for-service. States have commonly used two approaches to MFFS: health homes and primary care case management (PCCM). Questions to consider include:

- Does your state want to improve care for dually eligible beneficiaries who are often not well served in fee-for-service systems?
- Are capitated MCOs not available or capable of meeting your state’s needs, or does opposition to capitated managed care make MFFS options more feasible?
- Has your state established a health home program or PCCM program that can be tailored to advance integration?
Capitated Managed Care Options

Many states recognize the potential to reduce costs and improve quality when dually eligible beneficiaries enroll in integrated health plans. Because nearly half of all dually eligible beneficiaries use long-term services and supports (LTSS), states developing capitated health plan arrangements are increasingly contracting with health plans to integrate LTSS and Medicare services.

Some states have achieved integration by conducting Financial Alignment Initiative demonstrations, in partnership with CMS. In these demonstrations, Medicare and Medicaid benefits are coordinated through a single health plan.

Others are advancing integration by aligning Medicaid managed long-term services and supports (MLTSS) plans and Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs). States at varying stages of MLTSS and/or D-SNP program design or contract development may wish to explore the following options:

- Managed Long-Term Services and Supports (MLTSS)
- D-SNP Contracting
- Advanced D-SNP Contracting Options
- Programs of All-Inclusive Care for the Elderly (PACE)
- Improving Care for Dually Eligible Nursing Facility Residents
Managed Long-Term Services and Supports (MLTSS)

Nearly half of the nation’s Medicaid programs have shifted LTSS from fee-for-service to managed care via managed LTSS (MLTSS) programs.

The design of an MLTSS program can affect the level of clinical integration and administrative alignment that can be achieved through linkages with D-SNPs. In fully integrated models, Medicaid MLTSS and linked D-SNPs receive Medicaid and Medicare payments for LTSS, primary, acute, and behavioral health services, and Medicaid enrollment and contracting strategies promote alignment.

States should consider the degree to which they can support a fully aligned (MLTSS/D-SNP) enrollment model, in which beneficiaries are enrolled in aligned D-SNP and MLTSS plans through the same parent company.

States exploring aligned enrollment options may wish to review these key considerations for D-SNP contracting.

For more information on developing MLTSS programs and aligning D-SNP and MLTSS enrollment, review these resources.
Summary of Essential Elements of Managed Long-Term Services and Supports Programs (CMS). This resource outlines 10 key elements for strong MLTSS programs. It can be used to develop an MLTSS design framework and state-specific guiding principles. CMS considers these key elements in its review, approval, and oversight of MLTSS programs.

Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment (Integrated Care Resource Center/April 2018). This tip sheet outlines benefits and considerations for states working to align enrollment between D-SNPs and Medicaid MLTSS plans. Enrollment in aligned plans creates incentives to offer high quality, cost-effective care and avoid unnecessary hospitalization and institutionalization.
D-SNP Contracting

Dual-Eligible Special Needs Plans (D-SNPs) offer a higher level of integration than regular Medicare Advantage plans or traditional Medicare fee-for-service. Some key requirements and considerations for using this option include the following:

• D-SNPs must have a contract with the state to facilitate coordination of Medicare and Medicaid services for enrollees.

• The requirements established between state Medicaid agencies and D-SNPs determine the level of administrative, clinical, and financial integration that can be achieved.

• States with the most detailed and extensive contracts with D-SNPs have (1) Medicaid MLTSS programs, (2) experienced D-SNPs that contract with the state, and (3) Medicaid agency leaders and staff who are knowledgeable about both Medicaid and Medicare managed care.

States exploring D-SNP contracting options may wish to review these key considerations for D-SNP contracting.

For more information on D-SNP contracting, review these resources.
Resources: D-SNP Contracting

State Contracting with Medicare Advantage Dual-Eligible Special Needs Plans: Issues and Options (Integrated Care Resource Center/November 2016). This tool provides basic information on D-SNP contracting and summarizes state approaches that go beyond minimum D-SNP contract requirements.

Key Medicare Advantage Dates and Action Items for States Contracting with Dual-Eligible Special Needs Plans (Integrated Care Resource Center/September 2017). This tool summarizes the key CMS deadlines that states should be aware of when contracting with D-SNPs.

Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment (Integrated Care Resource Center/April 2018). This tip sheet outlines benefits and considerations for states working to align enrollment between D-SNPs and Medicaid MCOs. Enrollment in aligned plans creates incentives to offer high quality, cost-effective care and avoid unnecessary hospitalization and institutionalization.
Key Considerations: D-SNP Contracting

States may wish to consider the following as they seek to integrate care for dually eligible beneficiaries, particularly when designing MLTSS programs and related policies:

• **Assessing state and D-SNP capacity:** States considering D-SNP contracting should assess which D-SNPs already operate in the state (or are interested in doing so) and whether the state can design and implement meaningful integration requirements.

• **Understanding and aligning with Medicare contracting dates and processes:** States should be aware of CMS’s Medicare Advantage enrollment and contracting processes, which require submission of plan bids and other critical documents within certain time frames. States can choose to align Medicaid managed care contracting and enrollment processes with Medicare to promote coordination.

• **Leveraging opportunities to fully integrate care:** States developing or expanding MLTSS programs can achieve a significant degree of alignment by contracting with Fully Integrated Dual-Eligible Special Needs Plans to cover Medicaid benefits, including LTSS.

Review Additional D-SNP Contracting Considerations
Additional Considerations: D-SNP Contracting

(continued from Key Considerations: D-SNP Contracting)

• **Promoting aligned enrollment between MLTSS and D-SNP health plans for dually eligible beneficiaries:** States can require MLTSS plans to operate D-SNPs, limit D-SNP contracts to MLTSS contractors, and/or develop mechanisms that encourage enrollment in the most integrated options available. Limiting enrollment in D-SNPs to beneficiaries who enroll in a Medicaid plan through the same parent company is an effective way to achieve alignment.

• **Promoting integrated options:** States invested in linking Medicaid enrollment and service delivery with Medicare options can develop targeted outreach approaches to encourage enrollment in integrated options. This outreach can be conducted by state agencies, health plans, or other partners.

For more information about D-SNP contracting and aligning enrollment, review these resources on [MLTSS](#) and [D-SNP contracting](#).
Advanced D-SNP Contracting Options

State investment in D-SNP contracting and MLTSS program development can advance alignment over time through strategies that encourage aligned enrollment, coordinated benefits, and improved beneficiary access to care.

The resources in this section highlight lessons and strategies in key areas:

• Increasing enrollment in integrated health plans
• Providing value-added services for enrollees
• Preventing improper billing of enrollees
• Integrating behavioral and physical health care
• Improving coordination of home health and DME benefits

For more information on advanced D-SNP contracting, review these resources.
Resources: Advanced D-SNP Contracting Options

State and Health Plan Strategies to Grow Enrollment in Integrated Managed Care Plans for Dually Eligible Beneficiaries (Integrated Care Resource Center/June 2017). This brief highlights state and health plan approaches that support enrollment growth and retention in integrated programs.

Providing Value-Added Services for Medicare-Medicaid Enrollees: Considerations for Integrated Health Plans (Center for Health Care Strategies/January 2017). This brief explores how health plans are addressing the service needs of dually eligible beneficiaries beyond the scope of traditional Medicare and Medicaid services to improve their health outcomes and address social determinants of health.

Preventing Improper Billing of Medicare-Medicaid Enrollees in Managed Care: Strategies for States and Dual-Eligible Special Needs Plans (Integrated Care Resource Center/February 2018). Although providers are prohibited from billing Qualified Medicare Beneficiaries (QMBs) for cost-sharing, improper billing continues to be an issue. This brief explores strategies that states and D-SNPs can use to prevent improper billing.

Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working with Managed Care Delivery Systems (Integrated Care Resource Center/August 2017). This brief highlights state efforts to achieve behavioral and physical health integration for dually eligible beneficiaries in managed care.

Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment Initiative (Integrated Care Resource Center/April 2014). The options for improving coordination of home health services and durable medical equipment described in this brief apply not only to states with Financial Alignment Initiative demonstrations—but also to states using other capitated managed care models in which one entity is responsible for all of an enrollee’s Medicare and Medicaid benefits.
Programs of All-Inclusive Care for the Elderly (PACE)

PACE organizations deliver fully integrated Medicare- and Medicaid-covered services, including primary, acute, specialty, and long-term services and supports. Enrollment is voluntary. About 90% of PACE participants are dually eligible beneficiaries. To be eligible, participants must be age 55 or older, live in a PACE service area, be certified nursing-home eligible in their state, and be able to live safely in the community at the time of enrollment. If participants need nursing facility care after joining a PACE program, the PACE organization must cover the cost.

PACE organizations must qualify as Medicare providers. States can choose to provide PACE to Medicaid beneficiaries as a state plan option. As of 2018, there are 124 PACE programs running 255 PACE centers in 31 states, serving about 42,000 participants. Medicare and Medicaid pay capitated rates to PACE organizations, which assume full financial risk for the benefits covered under each program. Unlike insurer-based health plans offering MLTSS and D-SNP products, which rely mostly on contracted provider networks, PACE organizations are a provider-based model in which interdisciplinary teams of health professionals serve people in adult day centers and have direct-care relationships with enrollees.

For more information on PACE, review these resources.
Resources: Programs of All-Inclusive Care for the Elderly (PACE)

**CMS PACE webpage** (CMS/December 2017). This page provides an overview of PACE, additional information for states, and access to PACE resources, including program applications and manuals, quality measures, marketing guidelines, and audit information.

**Strategies for Incorporating PACE into State Integrated Care Initiatives: A Toolkit for States** (National PACE Association/March 2014). This toolkit suggests strategies for states to incorporate PACE into their broader integrated care strategies.

**PACE Medicaid Rate-Setting: Issues and Considerations for States and PACE Organizations** (National PACE Association/September 2016). This document explores rate-setting strategies that states can use to support PACE programs within the context of their long-term care policies and goals.

**Effect of PACE on Costs, Nursing Home Admissions, and Mortality: 2006–2011** (Assistant Secretary for Planning and Evaluation/March 2015). This report examines the effects of PACE on Medicare and Medicaid expenditures, use of nursing facilities, and mortality.

**PACE for States** (CMS). This collection of resources helps states submit documentation and fulfill requirements to operate PACE programs.
Improving Care for Dually Eligible Nursing Facility Residents

In both fee-for-service and capitated managed care systems, states can take steps to improve care for dually eligible residents of nursing facilities. One area of focus is reducing avoidable hospitalizations, which are common among dually eligible beneficiaries and have been shown to lead to poor health outcomes and higher costs.  

States using fee-for-service payment systems can make changes in those systems to encourage nursing facilities to reduce resident hospitalizations. States with managed care systems can promote efforts to reduce hospitalizations through contract requirements, performance incentives, and performance improvement projects.

For more information about reducing avoidable hospitalizations among dually eligible beneficiaries, review these resources.

See references.
Resources: Improving Care for Dually Eligible Nursing Facility Residents

Reducing Avoidable Hospitalizations for Medicare-Medicaid Enrollees in Nursing Facilities: Issues and Options for States (Integrated Care Resource Center/April 2015). This brief outlines options for states interested in reducing avoidable hospitalizations among dually eligible residents of nursing facilities. Options for capitated managed care are on pages 2–5; fee-for-service options begin on page 5.

CMS Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (NFI) Since 2012, CMS has overseen an initiative to reduce avoidable hospitalizations among dually eligible long-stay residents of nursing facilities. Results from Phase 1 of the initiative (2012–2016) showed reductions in all-cause hospitalizations and Medicare expenditures. Phase 2 of the initiative, which involves testing a new payment model, began in October 2016.

• See slides 33–39 of the ICRC April 2018 Working with Medicare Webinar on Medicare and Medicaid Nursing Facility Benefits for a brief summary of and resources from the NFI.

Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans (Integrated Care Resource Center/November 2017). This brief describes value-based payment (VBP) approaches used in select states and managed care plans. It discusses ways to design, administer, and evaluate state VBP programs.
Managed Fee-for-Service Options

Managed fee-for-service (MFFS) approaches offer states an opportunity to improve service delivery and care quality for dually eligible beneficiaries. Well-designed MFFS programs should have a clear vision of integration and involve an accountable entity capable of coordinating the fragmented pieces of the fee-for-service system. To be successful, major up-front investments in management, staff, and information systems may need to be made at the state and/or accountable-entity level.

Options and resources for states implementing MFFS models include:

• Using Primary Care Case Management (PCCM) to Serve Dually Eligible Beneficiaries
• Serving Dually Eligible Beneficiaries Through Medicaid Health Homes
• Improving Care for Dually Eligible Nursing Facility Residents
• Using DME Policies to Improve Medicare-Medicaid Integration
Using Primary Care Case Management (PCCM) to Serve Dually Eligible Beneficiaries

Primary care case management (PCCM) is a Medicaid state plan option in which the Medicaid agency contracts with primary care providers and/or a care coordination entity to “provide, locate, coordinate, and monitor...services for Medicaid beneficiaries who select or are assigned into the program by the state.”

The PCCM entity is responsible for 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.

For more information on integrating care for dually eligible beneficiaries through PCCM, review these resources.
Resources: Using Primary Care Case Management (PCCM) to Serve Dually Eligible Beneficiaries

**Integrating Care for Medicare-Medicaid Enrollees Using a Managed Fee-for-Service Model** (Integrated Care Resource Center/February 2012). This brief reviews PCCM and related managed fee-for-service models and identifies key program design elements needed to manage care for high-need, high-cost beneficiaries with multiple conditions.

**Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States** (Center for Health Care Strategies/September 2009). This paper provides a brief history of PCCM programs and includes case studies of enhanced PCCM programs in five states.
Serving Dually Eligible Beneficiaries Through Medicaid Health Homes

The Medicaid health home state plan option is a mechanism to improve care coordination and management for beneficiaries who have chronic physical or behavioral health conditions. Health homes are not an actual “home” but instead can be (1) based in primary care or behavioral health providers’ offices, (2) virtual, or (3) located in other settings suited to beneficiaries’ needs.

Health home services must include:
• Comprehensive care management
• Care coordination
• Health promotion
• Comprehensive transitional care/follow-up
• Individual and family support
• Referral to community and social support services

States receive a 90% enhanced Federal Medical Assistance Percentage for health home services for the first eight quarters after the program’s effective date.

For more information on using Medicaid health homes to serve dually eligible beneficiaries, review these resources.
Resources: Serving Dually Eligible Beneficiaries Through Medicaid Health Homes

**Health Home Information Resource Center** (CMS). This CMS resource center helps states develop health home models to coordinate the full range of medical, behavioral health, and long-term services and supports needed by Medicaid beneficiaries with chronic health conditions.

**Developing Health Homes to Effectively Serve Medicare-Medicaid Enrollees** (Integrated Care Resource Center/September 2013). This brief outlines challenges that states face when including dually eligible beneficiaries in health homes. It describes considerations for developing programs that will best meet the needs of this population.

**COMING SOON: Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State’s Experiences** (Integrated Care Resource Center/August 2018). This case describes the MFFS Financial Alignment Initiative demonstration in Washington State, which is based on a health home platform.
Using DME Policies to Improve Medicare-Medicaid Integration

Because Medicare coverage and Medicaid coverage for durable medical equipment (DME) differ in complex ways, dually eligible beneficiaries may face obstacles and delays when trying to access these services. 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.

To improve beneficiaries’ experience and reduce administrative burden, states can:
- Develop provisional prior-authorization procedures for certain DME items
- Publish lists of DME items not covered by Medicare and allow DME suppliers to bill Medicaid directly for these items

These changes can help clarify whom to bill when, while reducing administrative burden and improving beneficiary access. States can design tools and documents to reflect state-specific billing processes and statutory requirements.

For more information on improving DME access for dually eligible beneficiaries, review these resources.
Resources: Using DME Policies to Improve Medicare-Medicaid Integration

Strategies to Support Dual-Eligible Beneficiaries’ Access to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (CMS/January 2017). This informational bulletin describes steps that states can take to improve DME access for dually eligible beneficiaries, including prior-authorization strategies.

Facilitating Access to Medicaid Durable Medical Equipment for Dually Eligible Beneficiaries in the Fee-for-Service System: Three State Approaches (Integrated Care Resource Center/June 2018). This brief profiles state approaches to DME administration in a fee-for-service environment.

Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment Initiative (Integrated Care Resource Center/April 2014). This brief provides information about DME administration in the Financial Alignment Initiative, which may be relevant in other capitated managed care environments as well.

Medicare National Coverage Determinations Manual, Chapter 1, Part 4 (June 2017). Section 280.1 (page 126) of this manual provides a list of DME items not covered by Medicare, which may help states develop lists for DME providers indicating the items that can be billed directly to Medicaid.
References


4 MMA files are named after the Medicare Prescription Drug Improvement and Modernization Act of 2003. For details on these files, see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/StateMMAFile.html
