



# Medicare 101 and 201: Key Issues for State Programs for Medicare-Medicaid Enrollees

March 13, 2014  
2:00-3:00 PM Eastern  
Phone: 800-273-7043; Passcode: 596413

# Welcome and Introductions



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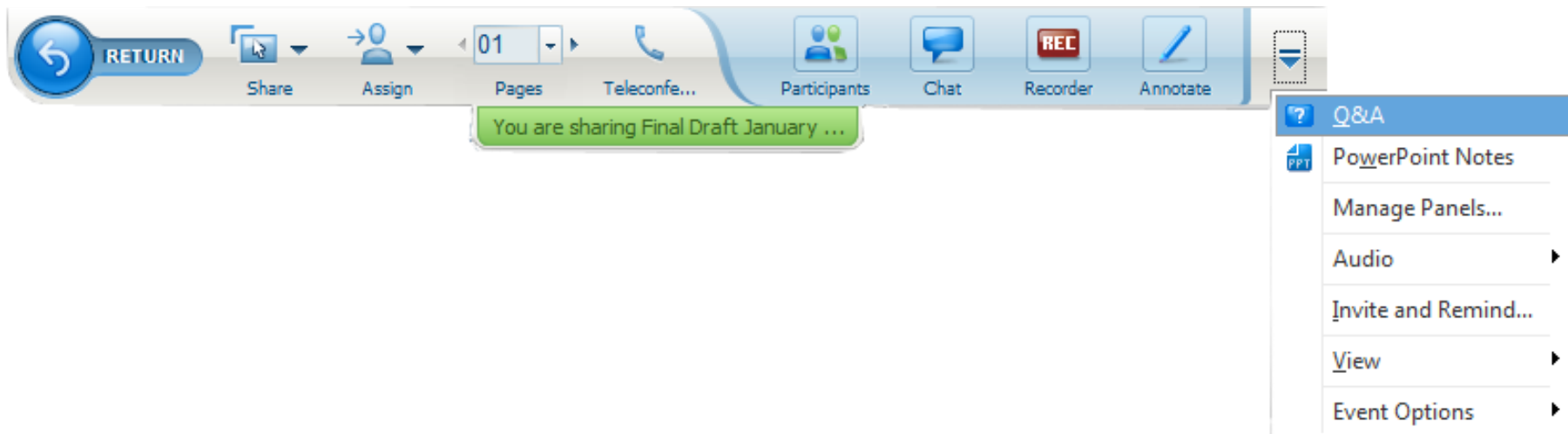


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# Questions?

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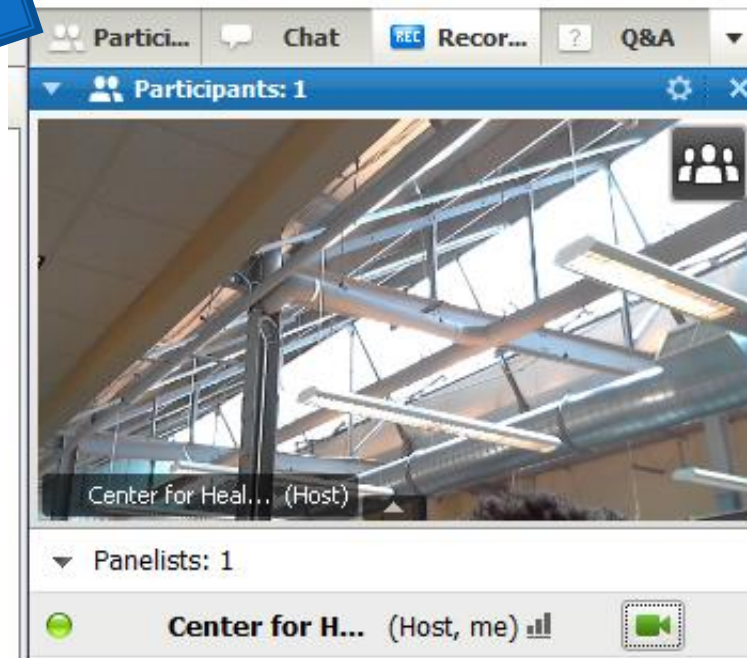
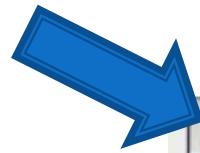
Your questions will be viewable only to ICRC staff.



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# Agenda

- I. Welcome, Introductions and Roll Call
- II. Medicare Basics
- III. Medicare Managed Care for Medicare-Medicaid Enrollees
- IV. Selected Medicare Coverage Issues
- V. Questions and Answers
- VI. Next Steps
- VII. Links to Main Sources Cited and Additional Resources

# Purpose and Goals of This Call

- ▶ Highlight some key Medicare coverage issues that have special relevance for state integrated care initiatives
  - Medicaid payment for Medicare beneficiary cost sharing
  - Overlapping Medicare and Medicaid coverage of some benefits (home health, DME, etc.)
  - Medicare home health and related Medicaid services
  - Competitive bidding for Medicare DME
  - Medicare coverage of mental health and skilled care
- ▶ Identify opportunities for states to provide more integrated care for Medicare-Medicaid enrollees through contracting with Medicare Advantage (MA) and other managed care plans
- ▶ Direct states to more information on Medicare eligibility, enrollment, payment systems, coverage policies, and managed care

# Medicare Basics



# Profile of Medicare-Medicaid Enrollees

- In 2011, 10.2 million Americans were enrolled in both Medicare and Medicaid (“dual eligible individuals”)
  - 73% were full benefit enrollees, and the rest were partial benefit (Medicaid paid only Medicare beneficiary premiums and/or cost sharing)
- Population characteristics:
  - 60% are age 65 or older and qualify as a result of age and low income/assets
  - 40% are under age 65 and qualify as a result of physical and/or mental disabilities and chronic illnesses, as well as low income/assets
  - Medical conditions and Alzheimer’s/dementia are more common in over-65 enrollees; behavioral health conditions and intellectual disabilities are more common in those under 65
  - More than 40% use long-term services and supports (LTSS)

Sources: MMCO Data Analysis Brief “Medicare-Medicaid Dual Enrollment from 2006 through 2011,” February 2013; MedPAC-MACPAC Data Book, “Beneficiaries Dually Eligible for Medicare and Medicaid,” December 2013.



# Medicare-Medicaid Enrollment and Spending Trends

- Enrollment trends between 2006 and 2011:
  - 17.7% increase in Medicare-Medicaid enrollees compared to 12.5% in Medicare-only beneficiaries
  - Larger enrollment growth for full-benefit enrollees under age 65 (15.6%) compared to those over age 65 (5.2%)
- In CY 2009, federal and state governments spent \$272 billion on Medicare-Medicaid enrollees
  - 34% of total spending for each program
  - 19% of Medicare enrollees and 14% of Medicaid enrollees

# Pathways to Medicare Eligibility and Enrollment

- ▶ Medicare eligibility requires 10 years of Medicare-covered employment, and person must be:
  - U.S. citizen or permanent legal resident
  - Age 65 and older, or
  - Under age 65 and have a permanent disability (received SSDI benefits for at least two years), or
  - Diagnosed with end stage renal disease (ESRD)
- ▶ Medicare Advantage enrollment periods
  - Annual Enrollment Period: October 15 to December 7 (coverage begins January 1)
  - Special Enrollment Period;
    - Available all year for dual eligibles; can enroll or disenroll at any time
    - Also available if a person moves out of a plan's service area, if enrollee's plan leaves the Medicare program, and in other special situations
- ▶ For more details on all Medicare enrollment periods, including initial enrollment, Original (FFS) Medicare, and Part D, see July 2013 ICRC "Medicare Basics" TA brief (Table 2)

# Medicare Coverage

	Part A	Part B	Part C	Part D
Benefits	Inpatient hospital stays, care in a skilled nursing facility, hospice care, some home health	Physician and outpatient services, medical supplies, preventive services	Medicare Advantage (Medicare managed care): includes Parts A, B, and D	Prescription Drugs
Costs	<ul style="list-style-type: none"> <li>• Free, with 40 credits of Medicare-covered employment</li> <li>• Deductible</li> </ul>	<ul style="list-style-type: none"> <li>• \$104.90 premium (new enrollees in 2014)</li> <li>• 20% co-insurance</li> </ul>	<ul style="list-style-type: none"> <li>• Part B premium</li> <li>• Plan premium</li> <li>• Cost sharing</li> </ul>	<ul style="list-style-type: none"> <li>• Premium</li> <li>• Deductible</li> <li>• Cost sharing</li> <li>• Coverage gap</li> </ul>

For more details, see:

- ICRC “Medicare Basics” TA brief, Table 1 and Appendix A
- MedPAC-MACPAC Data Book, Tables 2 and 3

Source: Medicare Advantage and D-SNPs, An Introduction to Medicare and Medicare Advantage, Centers for Medicare and Medicaid Services, Division of Medicare Advantage Operations State Resource Center, July 28, 2011.

# Medicaid Payment of Medicare Beneficiary Premiums and Cost Sharing

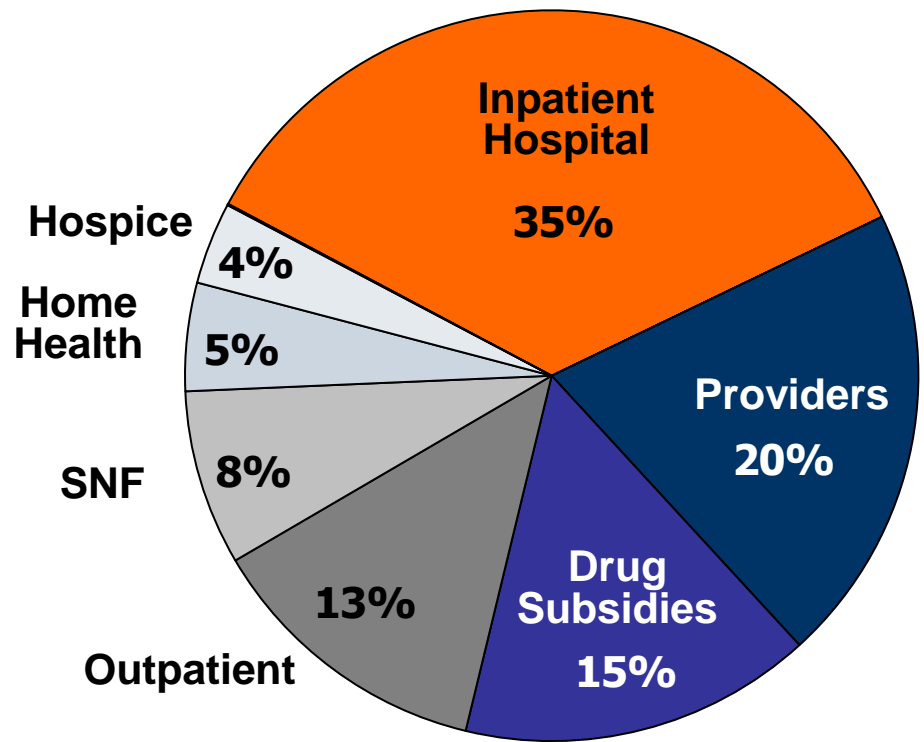
- **Full Benefit Medicare-Medicaid enrollees**
  - Medicaid pays for all Medicaid benefits and Medicare beneficiary premiums and cost sharing
- **Partial Benefit Medicare-Medicaid enrollees**
  - Medicaid pays some or all Medicare premiums and beneficiary cost sharing
  - Partial benefit categories
    - **Qualified Medicare beneficiaries (QMB)** ( $\geq 100\%$  Federal Poverty Level (FPL))
      - Part A and B premiums and cost sharing
    - **Specified low-income Medicare beneficiaries (SLMB)** (101% - 120% FPL)
      - Part B premiums and cost sharing for SLMB plus
    - **Qualified individuals (QI)** (121% - 135% FPL)
      - Part B premiums
    - **Qualified disabled and working individuals** ( $\geq 200\%$  FPL)
      - Part A premiums
- For more details, see Table 1, pp. 4-5 in December 2013 MedPAC-MACPAC Dual Eligibles Data Book

# Distribution of Total Medicare Spending for Medicare-Medicaid Enrollees, 2008

## Medicare

- National program for individuals age 65+ and younger adults with disabilities (on SSDI)
- Eligibility tied to work history but not tied to income or health status
- Covers medical care, prescription drugs, and is the primary source of medical insurance for dual eligible beneficiaries
- Financial obligations can be steep for beneficiaries

### Distribution of Medicare Spending for Dual Eligible Beneficiaries in Medicare FFS by Service, 2008



**Average Per Capita Medicare FFS Spending: \$13,805**

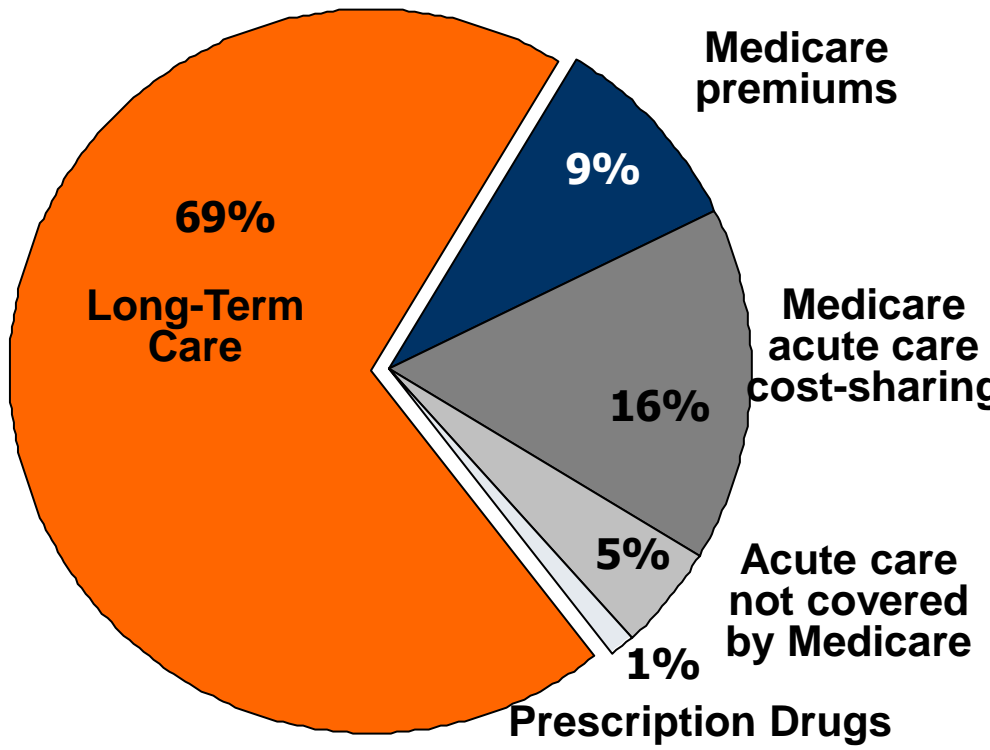
NOTE: Medicare Advantage spending excluded from this analysis.  
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2008.

# Distribution of Total Medicaid Spending for Medicare-Medicaid Enrollees, 2008

## Medicaid

- Federal-state partnership with states operating programs for low-income families, disabled & elderly
- Eligibility tied to income, age and disability, varies by state
- Pays for Medicare premiums, cost-sharing and other benefits
- Primary payer for long-term care

**Distribution of Medicaid Spending for Dual Eligible Beneficiaries by Service, 2008**



**Average Per Capita Medicaid Spending: \$16,087**

NOTES: Home health and dental services comprise less than 1% of Medicaid spending. Medicare premiums paid by Medicaid also includes cost-sharing for Qualified Medicare Beneficiaries only. SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY2008 MSIS and CMS Form-64.



# **Medicare Managed Care for Medicare-Medicaid Enrollees**



# Medicare Fee-For-Service and Managed Care Enrollment, CY 2009

Type of Medicare enrollment	Percent of dual-eligible beneficiaries enrolled					Non-dual Medicare beneficiaries
	All	Under age 65	Age 65 and older	Full benefit	Partial benefit	
FFS only	79	85	76	83	69	75
MA only	16	11	20	13	26	23
Both FFS and MA	4	4	4	4	5	2

**Note:** Matrix includes all dual-eligible beneficiaries. Percentages may not sum to 100 due to rounding.

In 2009, 20 percent of Medicare-Medicaid enrollees were in Medicare managed care for at least part of the year, vs. 25 percent of other Medicare beneficiaries.

Source: MedPAC-MACPAC Data Book, "Beneficiaries Dually Eligible For Medicare and Medicaid," December 2013, Exhibit 11.

# Medicaid Fee-For-Service and Managed Care Enrollment, CY 2009

Type of Medicaid enrollment	Percent of dual-eligible beneficiaries enrolled					Non-dual Medicaid beneficiaries
	All	Under age 65	Age 65 and older	Full benefit	Partial benefit	
FFS only	58	57	59	47	92	27
FFS and limited-benefit managed care only	30	30	31	38	4	35
At least one month of comprehensive managed care	12	13	11	14	4	37

**Note:** Matrix includes all dual-eligible beneficiaries. The non-dual Medicaid beneficiary category excludes nondisabled Medicaid beneficiaries under age 65 and Medicaid beneficiaries age 65 and older who do not have Medicare coverage. Percentages may not sum to 100 due to rounding.

In 2009, 12 percent of Medicare-Medicaid enrollees were in comprehensive Medicaid managed care, vs. 37 percent of other Medicaid beneficiaries.

Source: MedPAC-MACPAC Data Book, "Beneficiaries Dually Eligible For Medicare and Medicaid," December 2013, Exhibit 12

# Medicare Managed Care Options for Medicare-Medicaid Enrollees

- ▶ Medicare Advantage (MA) plans
  - Usually combined with Part D Rx drug coverage (MA-PD plans)
- ▶ MA Special Needs Plans (SNPs) for specified populations:
  - Beneficiaries with specified severe and disabling chronic conditions (C-SNPs)
  - Beneficiaries who live in long-term care institutions or who have an institutional level of care need (I-SNPs)
  - Beneficiaries dually eligible for Medicare and Medicaid (D-SNPs)
- ▶ Some D-SNPs qualify as Fully Integrated Dual Eligible SNPs (FIDE SNPs)

# State Medicaid Agency Contracts with D-SNPs

- ▶ D-SNPs are required by federal law (MIPPA) to have contracts with states, as of 2013
  - Contracts must contain some specific features, but states can add others (42 CFR §422.107)
  - Minimum requirements include D-SNP responsibility to provide or arrange for Medicaid benefits, beneficiary cost sharing protections, information sharing, eligibility verification, service area covered, and contract period
  - ICRC is preparing an analysis of 2014 D-SNP contracts in selected states
- ▶ As of February, 2014, there were 353 D-SNPs with total national enrollment of 1,534,234
  - D-SNPs operate in 39 states and PR, but 63 percent of plans and 65 percent of enrollees are in 11 states (CA, FL, NY, TX, PA, AZ, GA, TN, SC, AL, and MN)
  - 17 percent of total enrollment is in PR

# D-SNP Enrollment by State, February 2014

State	Number of D-SNP Plans	Total D-SNP Enrollment
California	30	219,449
Florida	71	162,184
New York	43	151,864
Texas	24	110,460
Pennsylvania	10	93,949
Arizona	11	66,570
Georgia	9	59,538
Tennessee	6	43,291
South Carolina	4	37,286
Alabama	4	30,651
Minnesota	11	28,661

Source: CMS SNP Comprehensive Report, February 2014.

# Fully Integrated Dual Eligible SNPs (FIDE SNPs)

- ▶ To be a FIDE SNP,\* D-SNPs must:
  - Provide access to Medicare and Medicaid benefits under a single managed care organization
  - Have a state contract that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with state policy, under risk-based financing
  - Coordinate the delivery of Medicare and Medicaid health and long-term care services
  - Coordinate or integrate enrollment, member materials, communications, grievances and appeals, and quality improvement
  
- ▶ As of February 2014, there were 36 FIDE SNPs located in six states (AZ, CA, MA, MN, NY, WI), with a total enrollment of 85,723 (42% is in MN)

\*FIDE SNP requirements are in CMS Medicare Managed Care Manual, Chapter 16b (Special Needs Plans), Section 20.25.

# **Selected Medicare Coverage Issues**



# Medicaid Payment of Medicare Cost Sharing

- Medicare beneficiary cost sharing
  - Deductibles, coinsurance, copayments
    - Amounts specified each year for Original (FFS) Medicare
    - Medicare Advantage plans may charge less
    - Covered by Medicaid for Medicare-Medicaid enrollees, but not always up to full Medicare-approved amount
      - Beneficiaries cannot be billed for the balance, so must be absorbed by providers
- Cross-over claims
  - 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
  - If one managed care plan is responsible for both Medicare and Medicaid services, all of this can be handled within the plan
    - Reduces burden on providers, beneficiaries, and state Medicaid agencies

# Bad Debt

Under specified circumstances, Medicare will reimburse providers for a portion of the Medicare deductibles and coinsurance for Medicare-Medicaid enrollees that state Medicaid agencies do not pay as “bad debt”

- Prior to FY 2013, Medicare reimbursed hospitals for 70% of the bad debt attributable to Medicare-Medicaid enrollees, and skilled nursing facilities (SNFs) and other providers for 100 percent
- 2012 federal legislation reduced the hospital percentage to 65%, starting in FY 2013, and the percentage for SNFs and other providers to 88% in FY 2013, 76% in FY 2014, and 65% in FY 2015
  - See Federal Register, Vol. 77, No. 218, November 9, 2012, pp. 67518-67531 (<http://www.gpo.gov/fdsys/pkg/FR-2012-11-09/pdf/FR-2012-11-09.pdf>) for details

# Coordination of Care for Overlapping Benefits

- Both Medicare and Medicaid provide coverage for home health, durable medical equipment (DME), nursing facility services, and hospice for Medicare-Medicaid enrollees
- Which program covers what, when, and under what circumstances is complicated and confusing for providers, beneficiaries, and payers, especially in the FFS system
  - Home health
    - Medicare requires beneficiaries to be homebound, but Medicaid does not
    - Medicare consolidates provider payment into 60-day episodes of care, while most Medicaid programs pay by service or by visit
  - DME
    - Medicare requires DME to be used primarily in the home, while Medicaid programs generally allow broader use
    - Medicare sets state-specific fee schedules or uses competitive bidding, while Medicaid uses a variety of payment methods, with Medicare payment often used as a ceiling

# Coordination of Care for Overlapping Benefits (Cont.)

- Nursing facility services
  - Medicare pays for short-term post-acute skilled care, while Medicaid pays for longer-term custodial care
    - Lines between the two can be difficult to draw
- Hospice
  - Medicare is primary payer, but Medicaid may “wrap around” if Medicaid coverage is more generous than Medicare’s
    - Lines may be difficult to draw
  - Medicaid is required to pay hospice providers an additional amount equal to at least 95 percent of the “room and board” portion of the Medicaid per diem nursing facility rate for dual eligibles in nursing facilities, while Medicare pays other hospice costs
    - Can result in overlapping or duplicate payments for hospice services
- Making one managed care plan responsible for both Medicare and Medicaid services provides an opportunity for greater coordination, simplicity, and efficiency
- Some issues may still remain with encounter data reporting, grievances and appeals, and program integrity monitoring
- Forthcoming ICRC technical assistance brief has more details on home health and DME overlaps and coordination opportunities

# Medicare Home Health and Related Medicaid Services

- ▶ Medicare generally does not cover “non-medical” long-term services and supports (LTSS), so dual eligibles rely heavily on Medicaid for LTSS
- ▶ Medicare home health coverage overlaps with Medicaid section 1945 state plan home health benefit
- ▶ Personal care assistance is a separate Medicaid state plan benefit in about two-thirds of states
  - No Medicare counterpart
- ▶ Medicaid HCBS waivers also cover home health, personal care assistance, and other community LTSS
  - No Medicare counterpart
- ▶ Another opportunity for better coordination in capitated managed care
- ▶ Table on next slide shows use of these services for dual eligibles in FFS in CY 2009

# Use of Medicare Home Health and Related Medicaid Services by Full-Benefit Dual Eligible Individuals, CY 2009

Selected FFS Service	Full-Benefit FFS Dual Eligible Beneficiaries Under Age 65			Full-Benefit FFS Dual-Eligible Beneficiaries Age 65 and Older		
	Percent using services	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
<b>MEDICARE SERVICES</b>						
Inpatient Hospital	23%	\$18,570	28%	32%	\$17,909	29%
Skilled Nursing Facility	4	15,644	4	16	16,749	13
Home Health	8	5,802	3	18	6,908	6
Other Outpatient	92	4,738	29	96	6,186	30
<b>MEDICAID SERVICES</b>						
Inpatient Hospital	13%	\$2,875	2%	14%	\$1,730	1%
Outpatient	90	2,762	15	85	2,152	11
Institutional LTSS	8	65,064	33	31	35,622	64
HCBS State Plan (Home Health and Personal Care Assistance)	12	8,053	6	17	11,095	11
HCBS Waiver	16	41,284	39	11	15,274	10

# Competitive Bidding for Medicare Durable Medical Equipment (DME)

- Medicaid spent \$4.6 billion on DME in 2011, and Medicare spent \$7.7 billion
  - Most states limit Medicaid payment for DME to the maximum Medicare would pay for the item
  - Medicare has historically used CMS state-specific fee schedules for DME
- Medicare started a competitive bidding program for DME in 2009
  - Gradually being expanded to more geographic areas and more items
  - States and health plans should consider revising/updating their DME payment schedules to take into account results of this Medicare program
  - For more detail on the program, including geographic areas covered, see <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOSCompBidProg.pdf>



# Medicare and Medicaid Mental Health Coverage

- Medicare mental health coverage has historically been more limited than Medicaid coverage
  - Inpatient psychiatric care in a free-standing psych hospital limited to 190 days in a lifetime
  - Beneficiary coinsurance for outpatient mental health services was higher than for other services (50% vs. 20%) until 2010
    - 2008 federal law gradually phased down beneficiary share to 20% as of 2014
- Medicare pays for some services Medicaid does not
  - Medically necessary services in an institution for mental disease (IMD) for persons between ages 22 and 64
- Some states exclude or “carve out” mental health services from Medicaid capitated managed care benefit packages
  - Can present program design challenges in programs for Medicare-Medicaid enrollees, especially those under 65 who may have substantial mental health needs

# FFS Dual-Eligible Beneficiaries With Selected Conditions, CY 2009

Condition	Percent of FFS dual-eligible beneficiaries	
	Under age 65	Age 65 and older
<b>COGNITIVE IMPAIRMENT</b>		
Alzheimer's disease or related dementia	4	23
Intellectual Disabilities and Related Conditions	8	1
<b>MEDICAL CONDITIONS</b>		
Diabetes	22	34
Heart Failure	8	24
Hypertension	38	66
Ischemic heart disease	14	35
<b>BEHAVIORAL HEALTH CONDITIONS</b>		
Anxiety Disorders	18	10
Bipolar Disorder	13	2
Depression	29	19
Schizophrenia and other psychotic disorders	14	7

# Medicare Skilled Care Coverage: *Jimmo* Settlement

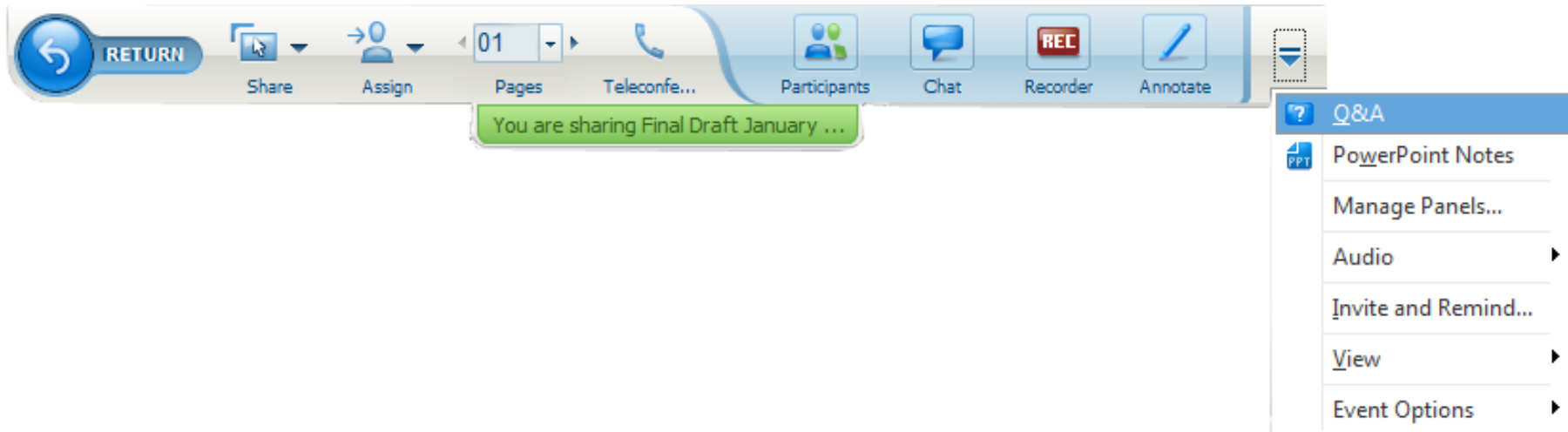
- January 2013 *Jimmo vs. Sebelius* settlement agreement clarified that Medicare coverage of skilled care (skilled nursing facility, home health, outpatient therapy) is not based on an “improvement standard”
  - Claims cannot be denied based on beneficiary’s lack of restoration or improvement potential
- For more detail on settlement and its implications, **see:** <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOSCompBidProg.pdf>

# Questions and Answers

# Questions?

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

Your questions will be viewable only to ICRC staff.



# Next Steps

- ▶ MMCO/ICRC goal is to help states improve integration of services for Medicare-Medicaid enrollees
- ▶ Please let us know on what Medicare issues you would like more information

# Links to Main Sources Cited

- Medicare-Medicaid Coordination Office (MMCO). Data Analysis Brief “Medicare-Medicaid Dual Enrollment from 2006 through 2011.” February 2013: [http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual\\_Enrollment\\_2006-2011\\_Final\\_Document.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf)
- Medicare Payment Advisory Commission (MedPAC) and Medicaid and CHIP Payment and Access Commission (MACPAC). Data Book. “Beneficiaries Dually Eligible for Medicare and Medicaid.” December 2013: [http://www.medpac.gov/documents/Dec13\\_Duals\\_DataBook.pdf](http://www.medpac.gov/documents/Dec13_Duals_DataBook.pdf)
- Integrated Care Resource Center. “Medicare Basics: An Overview for States Seeking to Integrate Care for Medicare-Medicaid Enrollees.” July 2013: <http://www.integratedcareresourcecenter.com/pdfs/ICRC%20Medicare%20Basics.pdf>
- CMS SNP Comprehensive Reports
  - Monthly reports of enrollment in three SNP types, by state and by plan
  - <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html>



# Additional Resources

- CMS Medicare-Medicaid Coordination Office
  - <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html>
- Integrated Care Resource Center
  - Contains resources, including briefs and practical tools to help address implementation, design, and policy challenges
  - [www.integratedcareresourcecenter.com](http://www.integratedcareresourcecenter.com)
- CHCS: “Integrating Care for Dual Eligibles: An Online Toolkit”
  - Contains policy resources and tools to help advance integrated care models  
[www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=606732](http://www.chcs.org/publications3960/publications_show.htm?doc_id=606732)
- Mathematica Policy Research: “Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans,” June 2011
  - [http://medpac.gov/documents/Jun11\\_ManagingDualEligibles\\_CONTRACTOR.pdf](http://medpac.gov/documents/Jun11_ManagingDualEligibles_CONTRACTOR.pdf)



# About ICRC

- Established by CMS to advance integrated care models for Medicare-Medicaid enrollees and other Medicaid beneficiaries with high costs and high needs
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies
- Visit <http://www.integratedcareresourcecenter.com> to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send additional questions to: [integratedcareresourcecenter@cms.hhs.gov](mailto:integratedcareresourcecenter@cms.hhs.gov)