



AN ANALYSIS OF THE CMS “TEN
OPPORTUNITIES TO BETTER SERVE
INDIVIDUALS DUALY ELIGIBLE
FOR MEDICAID AND MEDICARE”

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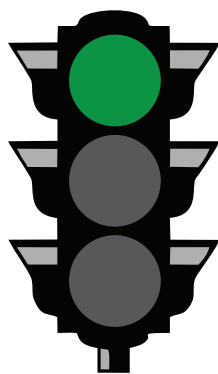
An Analysis of the CMS “Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare”

There are close to 12 million individuals who are enrolled in both Medicare and Medicaid. Compared to Medicare-only or Medicaid-only populations, this population tends to have more significant health and functional support needs. In 2013, [more than half](#) (56 percent) of dually-eligible beneficiaries had at least one activity of daily living limitation compared to just 26 percent of the non-dual Medicare population. Individuals who are dually eligible also have higher health care costs: dually eligible beneficiaries account for 20 percent of the Medicare population but accounted for 34 percent of Medicare spending in 2013.

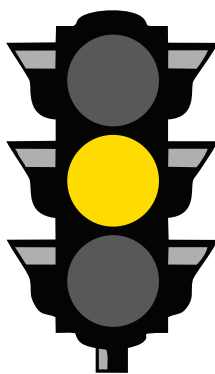
More and more states are interested in finding ways to better integrate care (and financing) for this population, with the goals of both improving care and reducing costs. In December 2018, the Centers for Medicare and Medicaid Services (CMS) released a [State Medicaid Director Letter](#) which outlines ten opportunities to better serve dual eligibles.

While several of these opportunities may genuinely help to reduce unnecessary administrative burden and may potentially promote integration between the two programs, some present great risk for beneficiaries. This fact sheet summarizes and provides our initial assessment of the ten opportunities, in order to provide advocates a fuller understanding of the options CMS is presenting to states. We urge advocates to reach out to their state agencies to better understand which, if any, of these options they are considering and to work to protect the interests of dually eligible beneficiaries.

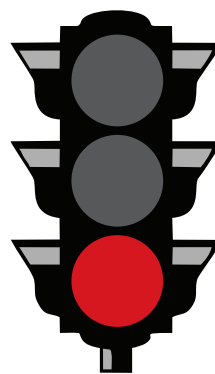
We use the following symbols to indicate our take on each opportunity:



**Yes – but
monitor details**



**Proceed
with Caution**



Risky!

The opportunities discussed below fall into three categories:

1. Medicare-Medicaid Integrated Care
2. Medicare Data
3. Improving beneficiary experiences and reducing administrative burden

Medicare-Medicaid Integrated Care



Opportunity #1: State contracting with D-SNPs

CMS encourages states to use Medicare Improvements for Patients and Providers Act (MIPPA) contracts to support and shape local integrated care approaches. [MIPPA requires D-SNPs](#) to maintain a contract with each state in which they operate.

Requiring D-SNPs to maintain a state contract is positive, but the devil is in the details with this arrangement. While a contract is required, it is not mandatory that the state work with the Medicare Advantage (MA) Organization operating a D-SNP on integration. For those states that do enter into a contract to work with the D-SNP, advocates need to pay close attention to key contract design elements such as care management services, provider networks and financial arrangements and incentives.



Opportunity #2: Default enrollment into a D-SNP

New Medicare regulations established through the [Final Parts C & D Rule for 2019](#) allow for Medicaid beneficiaries who are already in a managed care setting, and who subsequently become Medicare-eligible, to be automatically enrolled into a D-SNP that is affiliated with the same managed care organization.



Opportunity #3: Passive enrollment to preserve continuity of integrated care

New Medicare regulations established through the Final Parts C & D Rule for 2019 allow CMS to passively enroll full-benefit duals from an integrated D-SNP that is no longer available to the individual into another comparable D-SNP in instances where integrated care coverage would otherwise be disrupted.

[Dual-Eligible Special Needs Plans \(D-SNPs\)](#), which are now a [permanent part of the Medicare program](#), are a specialized type of Medicare Advantage plan that exclusively serves dually eligible beneficiaries. With enrollment in D-SNPs at just over 2 million, only a handful of states have built integrated programs [by limiting enrollment in D-SNPs to those affiliated with a Medicaid managed care organization](#).

THE DETAILS MATTER:

Advocates should be wary of options that involve passive or default enrollment, which can be viewed as a means to drive higher enrollment numbers without a concomitant improvement in quality. This is a population with disproportionately complex medical and social needs – passive or default enrollment into managed care programs only undermines their ability to make informed decisions. By taking away choice from beneficiaries, especially if the options are paired with a [fixed lock-in period](#), they may be forced to stay in a plan that does not necessarily meet their needs and which can have a detrimental impact on their health and well-being.



Opportunity #4: Integrating care through PACE

The [Programs of All-Inclusive Care for the Elderly](#) (PACE) provide comprehensive medical and social services to adults 55 and older who meet a state’s criteria for nursing home level of care. Most PACE enrollees are dually eligible. [Research on PACE](#) has shown that it is an effective program for people with complex health conditions. CMS [now accepts the participation of for-profit organizations](#) in the program, whereas the program was originally limited to not-for-profit organizations.

CMS encourages states to incorporate PACE into their integrated care strategy. It also encourages states with existing PACE sites to improve cost-efficiency by periodically re-examining their rate-setting methods to ensure they are appropriate. We support the inclusion of PACE as part of an integrated care strategy; we believe there should be careful oversight, particularly given the entry of for-profit plans into the market and to ensure that rates are sufficient to support comprehensive, whole-person care.

Medicare Data

Access to data is an important part of understanding the dually-eligible population and what their needs are. Advocates should find out what data their state currently has access to and how they are using that information.

CMS has unlocked important Medicare data to help states improve care coordination. Data now available to states includes:

- Medicare claim and summary data for use of Medicare Part A, B and D services
- Functional assessment data gathered as part of home health and skilled nursing services
- Integrated Medicare-Medicaid data sets (MMLEADS)



Opportunity #5: Reducing the administrative burden in accessing Medicare data for use in care coordination

CMS requires agreements from states to ensure that those requesting data adhere to privacy and security requirements and data release policies. CMS is allowing states to transition from using Data Use Agreements to data request attestations to streamline the data request process, thereby reducing the administrative burden that serves as a barrier for states to obtain important data.



Opportunity #6: Program integrity opportunities

CMS currently allows state Medicaid agencies to seek approval to use Medicare claims and assessment data for dually eligible beneficiaries for activities related to care coordination. Under this new option, states could also use the data for program integrity purposes, including investigating improper billing and coding.

Improving beneficiary experiences and reducing administrative burden

The following represent good opportunities to help alleviate states' administrative burdens and improve beneficiary experience. We would caution against using data and file sharing to promote auto-enrollment.



Opportunity #7: MMA file timing

CMS encourages states to submit their file identifying all dual eligibles ([MMA file](#)) as frequently as possible, up to once a day (most states submit on a weekly basis). CMS uses the MMA files for a variety of functions, including auto-enrolling full-benefit dually eligible beneficiaries into Medicare prescription drug plans and deeming full- and partial-benefit dually eligible beneficiaries automatically eligible for the Medicare Part D Low Income Subsidy (LIS, sometimes called Extra Help). Frequent updates can help achieve state efficiencies, improve beneficiary experience and reduce burden for providers, and we support this approach.



Opportunity #8: State buy-in file [data exchange](#)

Under the state buy-in program, states can enter into Medicare Part A and B buy-in agreements to make it easier to enroll Medicaid recipients in Medicare and pay premiums on their behalf. States have the option to submit buy-in files to CMS daily or monthly. Likewise, states can choose to receive CMS response files daily or monthly. CMS is encouraging daily submissions and we support this approach. Daily submissions, and the ability to for states to receive daily response files from CMS, spread state staff workload more evenly across the month, enable errors to be corrected more quickly, and connect new beneficiaries more quickly to Medicare benefits.



Opportunity #9: Improving Medicare Part A buy-in

CMS encourages states to execute Medicare Part A buy-in agreements. These agreements permit a state to directly enroll dually eligible beneficiaries in Medicare Part A at any time of the year, without late enrollment penalties. Additionally, without a Part A buy-in agreement, applying for Part A buy-in requires an application and eligibility determination by both the Social Security Administration and Medicaid, requiring beneficiaries and eligibility workers to complete a multi-step application process which is complex and administratively burdensome. As of 2015, there were [36 states](#) that have these types of agreements.



Opportunity #10: Opportunities to simplify eligibility and enrollment

Low-income Medicare beneficiaries who meet certain income and asset limits qualify for the Part D Low-Income Subsidy (LIS), which provides assistance with Medicare Part D premiums and cost-sharing. Many of these beneficiaries also qualify for Medicaid coverage of their Medicare Parts A and B premiums and cost-sharing through the Medicare Savings Programs (MSPs). CMS is reminding states that they can use the authority under the Social Security Act to better align the LIS and the [Medicare Savings Program](#) eligibility criteria and help promote more efficient enrollment processes. We believe this could reduce the burden on enrollees and we support more states to take on this approach.



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