

Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment Initiative

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Introduction

Medicare and Medicaid both cover home health services and durable medical equipment (DME) for Medicare-Medicaid enrollees, but overlapping coverage and differences in payment methodologies pose significant challenges to government payers, providers, and beneficiaries. These challenges may include delays in beneficiaries accessing needed services and an increase in grievances and appeals. The challenges are especially prevalent in the fee-for-service (FFS) system as compared to an integrated, capitated managed care system, where one entity is responsible for all of an enrollee's Medicare and Medicaid benefits. This technical assistance brief explores ways of improving the coordination of these overlapping benefits in the Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative's capitated model demonstrations.

Complexity and Confusion in the Current System

Medicare is the primary payer for acute care medical services for Medicare-Medicaid enrollees and generally has more stringent eligibility and utilization requirements than Medicaid for home health and DME services. Since Medicaid is by law the "payer of last resort" for services that may be covered by another payer, providers are generally required to seek and fail to receive Medicare reimbursement for these services before submitting claims to the state's Medicaid program. States vary in the extent to which they require Medicare reimbursement to be pursued, with some states requiring initial denials to be appealed through one or more layers of review. Aggressive state cost-shifting strategies can increase administrative costs and delay reimbursement for providers, and may also increase administrative costs for the federal government. And the complex and often hard-to-understand rules about who pays for what under what circumstances for these overlapping benefits can be confusing and frustrating for both beneficiaries and providers, who are often given little help in understanding the billing process and how long it may take to be resolved.

IN BRIEF: Both Medicare and Medicaid cover home health services and durable medical equipment (DME) for Medicare-Medicaid enrollees ("dual eligible individuals"), but which program covers which service, when, and under what circumstances is governed by a variety of rules in the two programs that have developed over time – and largely separately – in the fee-for-service (FFS) system. This overlapping coverage can lead to confusion, uncertainty, and frustration for Medicare-Medicaid enrollees, service providers, and payers. The Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative capitated model gives managed care plans an opportunity to provide home health services and DME to Medicare-Medicaid enrollees in a more unified, coordinated, simplified, and cost-effective way. This technical assistance brief outlines some of the problems with the current system and some options for alleviating or removing them in the Financial Alignment Initiative and other initiatives that combine coverage for Medicare and Medicaid services under one accountable entity.

Steps Toward Better Coordination

The Financial Alignment Initiative's capitated model creates an opportunity for a single managed care organization (MCO) to provide home health services and DME to Medicare-Medicaid enrollees and to manage simultaneous coverage by both Medicaid and Medicare. These MCOs, called Medicare-Medicaid Plans (MMPs) in the Financial Alignment Initiative, may be able to implement systems and processes to deliver items and services to Medicare-Medicaid enrollees in a more coordinated and seamless way than in the current FFS system. This brief draws upon interviews with representatives from a selection of states and health plans with experience operating partially integrated programs for Medicare-Medicaid enrollees, typically through Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) that partner with Medicaid MCOs. The interviews uncovered obstacles that hinder coordination of home health and DME that, if eliminated, could lead to improved integration of coverage.

Medicare does not currently require any beneficiary co-payment for home health services, but some state Medicaid programs require nominal cost sharing.

Overview of the Brief

This brief begins by describing differences in coverage of home health and DME under FFS Medicare and Medicaid. It then summarizes approaches used by managed care plans and state agencies to better integrate Medicare and Medicaid coverage of these services. Next, it provides an overview of how states participating in the Financial Alignment Initiative have proposed to deal with home health and DME, based on CMS-approved memoranda of understanding (MOUs) and three-way contracts. The brief concludes by discussing options states, health plans, and CMS could pursue within the Financial Alignment Initiative to improve coordination of these overlapping benefits. Appendices 1 and 2 give more details of Medicare and Medicaid coverage of home health services and DME.

Background

Coverage of Home Health Services in FFS

Though Medicare and Medicaid cover nearly identical home health services for

Medicare-Medicaid enrollees, Medicare has more restrictive eligibility requirements. The most significant eligibility difference is that Medicare requires beneficiaries to be considered homebound, while Medicaid programs are not permitted to impose such a restriction. In addition, Medicare does not currently require any beneficiary co-payment, while Medicaid programs may require a nominal cost sharing amount, with about a dozen states requiring copayments of \$1 to \$3 per visit).¹ The methodology used to pay providers also differs substantially. Medicare uses a prospective payment system for home health services in which services are consolidated into 60-day episodes. Medicaid programs employ a variety of payment methodologies – usually some form of FFS with per-visit or per-service payments, although New York implemented an episode-based reimbursement system in May 2012 similar to Medicare’s.² Exhibit 1 compares Medicare and Medicaid coverage of home health services for Medicare-Medicaid enrollees, with additional details in Appendix 1.

Exhibit 1: Comparison of Home Health Services Coverage

Category	Medicare FFS	Medicaid FFS*
Covered Benefits	Skilled nursing, physical therapy, occupational therapy, speech therapy, medical supplies, and assistance with daily activities. Home health aide services are covered only if they are part-time or intermittent (limited to 28 or 35 hours per week) and needed to supplement other home health services.	Nursing service, home health aide services, therapeutic services, medical supplies and equipment suitable for use in the home. States impose a variety of limits on hours and visits.
Eligibility Requirements	Beneficiary must be considered homebound and needing skilled nursing care on part-time or intermittent basis. Care is provided based on physician’s written plan of care.	Services must be provided in the home and based on physician’s plan of care. States may apply additional eligibility restrictions based on medical necessity or controlling utilization, but may not utilize waiting lists, apply geographic limits, or limit benefits only to those who are homebound.
Beneficiary Cost Sharing	None	Nominal cost-sharing allowed (e.g., \$1-\$3 co-payment per visit).
Provider Payment Methodology	Payment consolidated into 60-day episodes and adjusted based on beneficiary’s health status, resource use, and geographic location.	Payment for each service provided; methodology varies by state (e.g., based on maximum payment amount, cost-based payment with year-end settlement, prospective payment system, or negotiated rate)

* Describes federal requirements for Medicaid coverage of home health services through state plans. State Medicaid programs may also cover home- and community-based services (HCBS) through waiver authority that may be more extensive or flexible than state plan home health benefits. About 30 states also cover personal care assistance in the home as a separate state plan service, which further broadens the overall services in the home available through Medicaid.³

Coverage of Durable Medical Equipment in FFS

Much like home health services, Medicare coverage for DME is generally more restrictive than under Medicaid. Medicare requires that DME items be used primarily in the home, while Medicaid programs may consider coverage for items with the goal of avoiding institutional care, which may include use outside the home. Medicare applies an initial deductible and a 20 percent co-insurance payment to DME items, and Medicaid programs often require a nominal cost-sharing amount, usually \$1 to \$5 per service or item.⁴ For both programs, the methodology used to pay for providers varies by item and geography. For Medicare, payment in some areas is set by competitive bidding (which also requires beneficiaries to use certain providers) while other areas may utilize the Medicare fee schedule or base payment on the provider's charge. State Medicaid programs use a variety of payment methodologies, such as an amount based on Medicare or other fee schedules, a "reasonable charge," or a percent-to-charge calculation. Exhibit 2 compares Medicare and Medicaid coverage of DME items and services for Medicare-Medicaid enrollees, with additional detailed information in Appendix 2.

Challenges to Coordination of Home Health and DME Benefits for Medicare-Medicaid Enrollees in the FFS System

Medicare's role as primary payer. When both Medicare and Medicaid cover the same services or items for Medicare-Medicaid enrollees, Medicare is considered the primary payer and Medicaid is the "payer of last resort." Medicaid is required by CMS to reject claims that may be payable by Medicare or other third parties.⁵ As the secondary payer, Medicaid generally covers care not paid for by Medicare or provides wrap-around coverage such as payment for beneficiary cost-sharing. In addition, Medicaid will pay the cost of DME received from a non-participating Medicare supplier if the item is covered under the Medicaid state plan and if the state does not require that DME providers be Medicare contracted suppliers.⁶ In 2007, Medicare paid roughly two-thirds of the total expenditures for home health services for Medicare-Medicaid enrollees and approximately three-quarters of the total expenditures for DME items, with Medicaid accounting for the nearly all of the remaining expenditures.⁷

Medicare requires that DME items be used primarily in the home, while Medicaid programs may consider coverage for items with the goal of avoiding institutional care, which may include use outside the home.

Exhibit 2: Comparison of DME Coverage

Category	Medicare FFS	Medicaid FFS
Covered Benefits	Item must be: (1) durable; (2) primarily serve a medical purpose; (3) not be useful to the beneficiary without an illness or injury; and (4) appropriate for use in the home. Excludes expendable items or equipment usually used for non-medical purposes.	Medically-necessary DME for use in the home or to function in the community. States may have a list of preapproved items with established process for modifications or exceptions.
Beneficiary Cost Sharing	20 percent co-insurance, after Part B deductible has been met.	Nominal cost-sharing allowed (e.g., \$1-\$5 co-payment per item or service).
Provider Payment Methodology	Prices set by competitive bidding or based on the lesser of CMS-established state-specific fee schedules or the provider's charge.	Varies by item and state (i.e., lesser of the supplier's charge or an amount based on the maximum applicable to the Medicare program, amount based on a "reasonable charge," a percentage of charge, or a negotiated price).

States commonly require providers of home health and DME services for Medicare-Medicaid enrollees to submit proof of a Medicare denial before submitting a claim for Medicaid payment.

Medicaid efforts to maximize Medicare payment. Some Medicaid programs have developed aggressive strategies to ensure that services covered by both Medicare and Medicaid are paid by Medicare whenever possible. These “Medicare maximization” programs may involve appealing claims if Medicare payment is denied, as well as educating providers on billing techniques that increase the likelihood that Medicare, rather than Medicaid, will pay the claim.⁸ States commonly require providers of home health and DME services for Medicare-Medicaid enrollees to submit proof of a Medicare denial before submitting a claim for Medicaid payment.⁹ Researchers have found that Medicare-Medicaid enrollees in states with relatively low Medicaid home health spending often had higher Medicare home health services use – evidence of cost shifting between the state and federal public insurance programs.¹⁰

Crossover claims. Overlapping Medicare and Medicaid coverage may result in a complex billing process for providers in which claims must be split between the two programs. If Medicare agrees to pay the DME claim for Medicare-Medicaid enrollees, Medicaid is generally responsible for the 20 percent beneficiary coinsurance. However, most states cover the coinsurance only up to the amount Medicaid would pay for the service. It may or may not be worth DME providers’ time to submit a crossover claim to Medicaid to obtain this coinsurance payment, depending on the difference between what Medicare and Medicaid

would pay for the specific DME item.

Burdens on providers and beneficiaries. Differences in coverage rules, combined with Medicaid cost avoidance requirements and “Medicare maximization” strategies, can lead to reductions in access to care for Medicare-Medicaid enrollees. When providers must submit claims to more than one payer, and often multiple times, their willingness to continue providing care to this population may be strained. Beneficiaries who experience confusing delays or denials of care may give up seeking the care they need. DME can be especially problematic, since beneficiaries may not be able to obtain costly equipment, such as a wheelchair, when they need it or at all because of the requirement for a prior Medicare denial. (See text box below, DME Complexities When Medicare and Medicaid Overlap, for illustrative details.)

Opportunities for Better Integration and Coordination in Capitated Managed Care

Some states, including Arizona, California, Hawaii, Massachusetts, Minnesota, New Mexico, New York, Texas, and Wisconsin, have contracted with Medicaid MCOs operated by companies that also offer a companion Medicare Advantage D-SNP to provide at least partially integrated care to Medicare-Medicaid enrollees. Compared to FFS, plans in these partially integrated systems have increased opportunities to coordinate the delivery of needed services, including home health and DME, but they

DME Complexities When Medicare and Medicaid Overlap

Since Medicaid is the payer of last resort, state Medicaid agencies generally require that DME providers submit a bill for an item, such as a wheelchair, first to Medicare. Only after Medicare has rejected the claim or paid its share will Medicaid assess beneficiary eligibility for the DME and process a payment. Medicare, however, will only authorize payments after a good or service has been delivered to a beneficiary, which means that the beneficiary could be liable for the full cost of the DME if neither Medicare nor Medicaid approves payment – something that few Medicare-Medicaid enrollees can afford in the case of costly DME like wheelchairs.

Medicare has a voluntary prior authorization process (Advance Determination of Medicare Coverage, or ADMC), but it only applies to some limited and costly types of DME, such as customized wheelchairs. State Medicaid programs have prior authorization procedures, but in many cases Medicaid will not make a determination of medical necessity without first receiving formal notice of a Medicare denial, such as an Explanation of Benefits (EOB). This denial is required even in cases where it is clear that Medicare would not cover an item, such as a shower chair, but that Medicaid would if it was medically necessary. These separate approval and payment processes and the time lags that can accompany them often leave both providers and beneficiaries in limbo, confused and frustrated, and without needed medical equipment.¹¹

are paid separate capitated rates and often maintain separate administrative and operational systems, rather than being fully integrated.

State capitated demonstrations through CMS' Financial Alignment Initiative further increase the opportunity for improved quality and efficiency of home health and DME services for both beneficiaries and providers. Because Medicare-Medicaid Plans (MMPs) include both Medicare and Medicaid services in a single capitated benefit package, they can administer these benefits with full integration and in a manner that is more seamless than either the FFS or partially integrated systems. States and CMS can create and implement quality measurement initiatives to assess the effectiveness of home health services and DME items provided to Medicare-Medicaid enrollees through the MMPs. Medicare-Medicaid enrollees should receive improved access to care, and as a result, remain in their homes and avoid expensive inpatient treatment or transitioning to long-term care in a nursing facility.

Some Insights From Current Efforts to Coordinate Coverage of Home Health and DME

Interviews conducted in the spring and summer of 2013 with individuals in six states: Arizona, California, Massachusetts, Minnesota, New York, and Texas shed light on states' and plans' experience with overlapping Medicare and Medicaid coverage of home health and DME. The interviews included representatives of health plans with experience operating partially integrated programs for Medicare-Medicaid enrollees, typically through Medicare Advantage D-SNPs in partnership with Medicaid MCOs, and state Medicaid agency staff who have worked with capitated plans serving Medicare-Medicaid enrollees.

Managed care plans face challenges in developing coordination initiatives. Plans in states with partially integrated programs have generally not developed initiatives to improve coordination and integration of Medicare and Medicaid coverage of home health and DME, but continue to work within the restrictions and requirements of Medicare FFS. These managed care plans

described the challenge of allocating claims to Medicare or Medicaid for reporting purposes, the differing Medicare and Medicaid provider reimbursement systems for home health and DME, the administrative burden of maintaining multiple billing systems, and the complexity of continuing two grievance and appeals processes.

Some managed care plans identified strategies to achieve greater coordination. A few managed care plans have developed ways to work with or around conflicting program rules. These managed care plans have a high percentage of enrollees with disabilities and have adopted approaches that target the provision of care more effectively to high-need, high-cost populations. These managed care plans view home health services and DME as mechanisms to maintain independent living in the near term and to reduce the cost of care in the longer term. For example, one plan said that when a beneficiary enrolls, the plan begins with a clinical assessment to establish an individualized plan of care. The managed care plan does not require that the plan of care follow the Medicare homebound requirement but focuses instead on quality of life and the fullest possible "restoration." With this perspective, the initial outlays for home health services (including personal care) or DME may be higher than for other enrollees, but the managed care plan views this cost as an investment that will yield savings over time.

After the plan of care is established, these managed care plans look across the benefit package to see if the home health service or the DME item is not likely to be covered by Medicare but is expected to be covered by Medicaid. In that case, the plan takes steps to provide the care to the beneficiary without delay and to shield the beneficiary from the process of seeking denial for Medicare coverage. Acquiring the formal Medicare denial is important for the provider to receive Medicaid payment and for plans to be able to provide documentation for federal audits. However, the managed care plan does not send a letter to the beneficiary confirming the Medicare denial because this has been found to increase confusion. Instead, the process to first acquire a Medicare denial before

Managed care plans with a high percentage of enrollees with disabilities viewed home health services and DME as mechanisms to maintain independent living and reduce costs of care, so they had greater motivation to identify strategies to coordinate Medicare and Medicaid coverage.

If Medicaid coverage of home health and DME benefits is more stringent than Medicare, managed care plans have less ability to use Medicaid as a “wrap-around” benefit.

Medicaid pays remains generally invisible to the beneficiary.

Importance of Medicaid coverage.

Interviewees from managed care plans that have implemented strategies to achieve greater coordination also emphasized that their success is heavily dependent on the generosity of Medicaid coverage in that particular state. If Medicaid’s coverage of these benefits is more limited than Medicare’s, there is less ability for managed care plans to use Medicaid as a “wrap-around” benefit. This is because the capitated payments the managed care plans receive from Medicaid FFS are likely to be lower than Medicare payments for these overlapping benefits, which limits the managed care plan’s flexibility to pay for additional services.

Data reporting. Relatively generous Medicaid coverage does not minimize the challenge of reporting encounter data to either Medicare or Medicaid, interviewees said. One plan attempted, but later abandoned, a strategy of retrospectively allocating claims to Medicare or Medicaid by using a standardized formula, because auditors did not consider the allocation to be precise enough. Managed care plans also mentioned the burden of responding to different reporting requirements and performance metrics for the state and federal governments.

Appeals and grievances. Under current rules, beneficiaries who opt to appeal a denied claim can do so both at the state and federal level at the same time. Therefore, it is possible that the beneficiary will end up with contradictory results from the two appeals, further increasing confusion over appropriate coverage. Interviewees speculated that, with a clearer understanding of the different coverage policies for home health and DME and a more well-defined appeals and grievance process – as envisioned in the financial alignment initiatives – beneficiaries would be less likely to submit grievances and appeals.

Additional strategies to improve coordination. Some managed care plans have identified alternative ways of increasing the effectiveness of home health services and DME delivery to Medicare-Medicaid enrollees within the current rules.

One health plan employs personal care aides as part of an enrollee’s interdisciplinary care team, rather than relying on outside home health agencies that specialize in nursing care. A different managed care plan created a product that harnesses information technology to increase care coordination by allowing a variety of providers to access beneficiaries’ health histories. Another health plan created an internal division to perform regular maintenance and repair for DME items, particularly expensive items such as complex wheelchairs and related components. In multiple states, health plans and state officials meet regularly with home health/DME service providers to collect their feedback and address concerns on an ongoing basis.

Coordinating Coverage in the Financial Alignment Demonstrations

Memoranda of Understanding

The memoranda of understanding (MOUs) between CMS and states in the Financial Alignment Initiative allow examination of strategies to address overlapping Medicare and Medicaid coverage of home health services and DME. As of April 2014, ten states had signed capitated financial alignment MOUs with CMS, though not all addressed issues specific to overlapping coverage.

Relevant highlights from the approved MOUs include:¹²

- **Benefits and coverage.** The MOUs generally said that more detail on overlapping services would be provided in the three-way contracts. Some state MOUs (Michigan, Ohio, New York, and South Carolina) said that MMPs would be required to abide by the more generous of the applicable Medicare and Medicaid standards, and two (California and Michigan) specified that medical necessity decisions would also use the more generous standard. Massachusetts planned to add some new home care services and supports to existing home health benefits.

- **Network adequacy.** All the MOUs said that the more stringent (favorable to the beneficiary) Medicare or Medicaid standards would apply for overlapping benefits.
- **Appeals.** The MOU provisions are aimed at integrating the appeals processes to the extent possible in light of underlying state requirements, including facilitating enrollee access to both appeals processes if necessary, and requiring plans to abide by the decision that is most favorable to the enrollee in the case of conflicts.

Three-Way Contracts

Executed three-way contracts between CMS, the state, and the MMPs for the states' demonstrations contain provisions detailing how the demonstrations will improve integration and coordination of home health and DME benefits. See Exhibit 3 for a summary of key provisions and excerpts from contract language in the three-way contracts for Massachusetts, Illinois, and Ohio.¹³

Options for Better Coordination of Home Health and DME Services by MMPs

Though the MOUs and three-way contracts establish a starting place for states and CMS to address overlapping coverage, additional steps could facilitate better integration of Medicare and Medicaid policies.

Unified Coverage Requirements

MMPs could be encouraged to meld Medicare and Medicaid home health and DME coverage requirements and their operational implementation so that service authorization and provider payments could be handled as efficiently and quickly as possible. For example, under the Financial Alignment Initiative, MMPs are allowed to waive the Medicare homebound requirement. This would unify the coverage rule for the home health benefit, since Medicaid is not permitted to impose this requirement. Similarly, since Medicaid covers wheelchairs and other DME items

that can be used outside of the home while Medicare does not, the Medicare requirement that DME be suitable only for home use could be waived.

New Payment Models

In a capitated model, MMPs and DME or home health providers will have the opportunity to work out payment arrangements that allow both parties to break away from the status quo. Since Medicare uses a prospective episode-based system for home health reimbursement, for example, while Medicaid programs usually pay on a per-visit basis, MMPs and providers would have to agree to use one system or the other, or a hybrid. For DME, the Medicare FFS competitive bidding system may result in prices that are more market-based than those used in most Medicaid programs, so MMPs may want to take into account the results of this DME competitive bidding process if it is operating in their state.¹⁴ Unless MMPs use a single payment system for home health and DME, many of the problems with the current FFS system are likely to persist.

Encounter Data Reporting

Medicare implemented a new system for reporting of encounter data by Medicare Advantage plans in 2012, and states participating in the financial alignment demonstrations have Medicaid encounter data reporting requirements and systems that differ from each other and from Medicare. Alignment would be enhanced if, to the extent possible, CMS and states permitted MMPs to report home health and DME encounters in a unified way, without necessarily identifying each individual encounter as a Medicare or Medicaid service. To this end, CMS issued preliminary guidance for encounter data reporting in July 2013 permitting MMPs to begin reporting encounters for these overlapping services in a more flexible way in 2014.¹⁵ The memo states that "MMPs will have flexibility in establishing a reasonable methodology by which to attribute claims to a particular payor subject to review and approval by CMS and the states." CMS emphasized that this encounter data reporting process "should in no way

If CMS and states permitted Medicare-Medicaid Plans to report home health and DME encounters in a unified way, without necessarily identifying each individual encounter as a Medicare or Medicaid service, program alignment would be enhanced.

Exhibit 3: Provisions Related to Home Health and DME in Approved Three-Way Contracts as of December 2013¹⁶

Topic	Illinois	Massachusetts	Ohio
Covered Services	"The Contractor [MMP] must provide the full range of Covered Services. If either Medicare or Medicaid provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the Contractor must provide the most expansive set of services required by either program. The Contractor may not limit or deny services to Enrollees based on Medicare or Medicaid providing a more limited range of services than the other program." (Section 2.4, p. 41)	MMPs must provide the full range of covered services. "If either Medicare or MassHealth provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the [MMP] must provide the most expansive set of services required by either program." (Section 2.4, p. 28)	Same as Illinois. (Section 2.4, p.30) "For overlapping Medicare and Medicaid services, the ICDS Plan [MMP] shall develop policies and procedures that minimize administrative burdens and streamline how providers deliver and beneficiaries receive these services." (Section 2.4.2)
Medical Necessity	Appendix A (Covered Services) contains a unified definition. (p.227) Same as Massachusetts.	Appendix A (Covered Services) contains a unified definition (pp. 215-216) that provides in part that medically necessary services include, but are not limited to, those that: a. Prevent, diagnose, or treat health impairments; b. Attain, maintain, or regain functional capacity.	Appendix A (Covered Services) contains a unified definition. (p. 177) Same as Massachusetts.
DME	No change from current coverage rules.	Appendix B (Covered Services Definitions) contains a unified definition (pp. 219-220) and expands DME services. (p. 228)	No change from current coverage rules.
Home Health	Addendum 1: Home and Community Based Services outlines all home health services. (p. 231)	Appendix B contains a unified definition. (p. 220)	Listed under Appendix A (Covered Services). (p.217)
Medicaid Home Care Services in Addition to State Plan Home Health Benefits	Addendum 1: Home and Community Based Services outlines all home care services. (p. 231)	Appendix B outlines a new community-based home care services benefit that will be offered in the demonstration. (p. 229)	Sections 1.37 – 1.42 under the Definition of Terms sections defines components of home care services. (p.5) Sections 2.5.9 – 2.5.11 under the Care Delivery Model section outlines home care services. (p.45)
Appeals and Grievances	Process: For services and items in which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies), all initial Appeal requests will be filed with the Contractor in accordance with applicable laws and regulations. If the resolution following the Contractor's Appeal process is not wholly in favor of the Enrollee, the Appeal related to these services will be forwarded to the IRE by the Contractor. If the resolution of the IRE is not wholly in favor of the Enrollee, the Enrollee or authorized representative may then request further levels of Appeal, including a State Fair Hearing or Administrative Law Judge. (p.110)	Beneficiaries may apply simultaneously for a Medicare and a Medicaid appeal." "Any determination in favor of the Enrollee will bind the Contractor and will require payment by the Contractor for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal." (Section 2.12A.4.d, p. 109)	Process: For services and items in which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies), all initial Appeal requests will be filed with the ICDS Plan in accordance with applicable laws and regulations.(p.102)

constrain MMPs from establishing new payment models with providers,” as long as the allocation methodology does not provide incentives or disincentives to attribute claims to one payor over the other. For the longer term, CMS is working to develop a process in which MMPs can submit a single integrated set of encounter data without having to identify a given encounter as being a Medicare or Medicaid service prior to processing by CMS or the state. Some of the considerations involved in developing this process may include:

- **Rate setting.** While both home health and DME encounters are used to help set capitated rates for Medicare and Medicaid payments to MMPs, these services are not a major element of overall costs in either program, so an approximate allocation of costs between Medicare and Medicaid could be considered sufficient for rate-setting and risk adjustment purposes.
- **Program integrity.** Home health and DME services are susceptible to fraud and abuse in both Medicare and Medicaid, so both CMS and states have reasons for wanting reasonably precise per-service and per-provider data reporting for these services. However, MMPs themselves are at financial risk for fraud and abuse in a capitated reimbursement system, so detailed, outside review of these services by CMS and states may be less necessary than in FFS. While it is important to compare patterns of service use and payment in FFS and managed care settings in order to detect potential fraud and abuse, approximate allocations of encounters to Medicare and Medicaid could be considered sufficient for these analytic purposes.

Medicare Denials

The purpose of requiring providers to seek Medicare payment for home health and DME is to assure that neither the Medicaid program nor Medicare-Medicaid enrollees are required to pay for services that should be paid for by Medicare.¹⁷ That purpose is largely served when a provider submits a home health or DME claim for payment to a managed care plan that is: (1) at risk for

both Medicare and Medicaid home health and DME services on a capitated basis; and (2) limited by contract and CMS rules in the amount of cost sharing that it can impose on enrollees. The managed care plan’s incentive would be to pay home health or DME providers the lowest amount needed to comply with its agreement with the provider, but the payment would come out of the capitated amounts already jointly paid by Medicare and Medicaid to the managed care plan, so no additional financial burden would be placed on either program as a result of the managed care plan’s payment decision. The managed care plan could itself determine which payer is appropriate for a specific claim or type of claim, and record that in the encounter data submitted to Medicare and Medicaid. As noted above in the discussion of encounter data reporting, managed care plans could be allowed some flexibility in recording and reporting this information in the interest of greater administrative simplicity.

Grievances and Appeals

Improved coordination of coverage also has the potential to reduce confusion associated with the grievances and appeals processes. State demonstrations under the Financial Alignment Initiative are moving in the direction of greater integration of these processes. If decisions about which program is responsible for payment are largely handled within managed care plans, as suggested above, the issues remaining for grievances and appeals would normally involve only whether the service is coverable by either program, not which program should pay. Medicare-Medicaid enrollees may therefore find grievances and appeals less necessary. Should an appeal be required, the state or managed care plan could utilize a single entity, such as an integrated review entity (IRE) as used in Medicare today, to make determination for both public insurance programs using a unified approach.¹⁸ This strategy has the potential to allow beneficiaries to retain needed coverage and services and also to reduce out-of-pocket costs and stress associated with separate grievance and appeals processes.

Medicare-Medicaid enrollees may find grievances and appeals less necessary if coverage decisions are largely handled within managed care plans and grievances and appeals only involve whether the service is coverable by either program, not which program should pay.

Conclusion

Benefits that are covered by both the Medicare and Medicaid programs under different circumstances and different rules, such as home health and DME, have often been administratively burdensome and inefficient for Medicare-Medicaid enrollees, providers, managed care plans, and states. The CMS Financial Alignment Initiative,

and the capitated model demonstrations in particular, provide an opportunity for Medicare-Medicaid enrollees to have all their benefits coordinated by one accountable entity. States, CMS, and managed care plans can learn from both past and upcoming experiences in covering these overlapping benefits as they seek to coordinate and integrate services more fully for Medicare-Medicaid enrollees.

APPENDIX 1: Summary of Coverage for Home Health Services Under Medicare and Medicaid

Medicare Coverage of Home Health Services

Under Medicare, home health coverage includes provision of in-home treatment and services for beneficiaries who have restricted mobility and require skilled care. Home health services may involve skilled nursing, physical therapy, occupational therapy, speech therapy, and assistance with daily activities such as bathing or grooming.

To qualify for home health services, Medicare beneficiaries must be considered homebound, meaning the beneficiary leaves the home infrequently, for periods of relatively short duration, or for medical treatment such as dialysis or chemotherapy.¹⁹ In addition, the beneficiary must need part-time (fewer than eight hours a day) or intermittent (less than seven days a week) skilled nursing care and/or skilled rehabilitation, or after establishing prior eligibility, a continuing need for occupational therapy. The beneficiary must be under the care of a physician and have a written plan of care that is established and reviewed periodically by a physician. Coverage of home health skilled care does not depend on the presence or absence of a patient's potential for improvement, but rather on the patient's need for skilled care to improve or maintain his or her condition or to prevent or slow deterioration.

For beneficiaries in FFS Medicare, the payment for home health services is based on a prospective payment system that covers 60-day episodes. Medicare beneficiaries may qualify for an unlimited number of home health episodes. In 2011, Medicare home health users had an average of two 60-day episodes of care.²⁰ Prospective payment for each episode is adjusted to account for the beneficiary's clinical and functional status, predicted resource use, and geographic area.²¹ In 2011, the average Medicare provider charge for each home health visit was \$150. In total, Medicare spent roughly \$18.4 billion to provide home health services to 3.4 million FFS beneficiaries in 2011, or about 10 percent of the FFS population.²²

A co-payment or deductible requirement is not applied to home health services provided to FFS Medicare beneficiaries.²³ Medical supplies are included in the home health bundle, while durable medical equipment is not included and is subject to a 20 percent co-insurance requirement. Medical services not included in the home health bundle but covered under Part B include mental health, imaging, laboratory testing, and physician management services. Reimbursement for these medical services is based on the fee schedules for physicians and other health providers and is also subject to the 20 percent co-insurance.

Medicaid Coverage of Home Health Services

Federal regulations require states to cover home health services in their Medicaid state plans. Services covered under the home health benefit include nursing services, home health aide services, therapeutic services, and medical supplies and equipment suitable for the home. States have the option to provide additional home health services, either through a state plan amendment or waiver, which are described in greater detail in the box below.

Eligibility requirements for Medicaid-covered home health services are less restrictive than for Medicare-covered home health services in some important respects. Medicaid beneficiaries, for example, cannot be required to be homebound in order to receive home health services. At a minimum, federal regulations require that Medicaid programs provide home health services to enrollees in the home and that the services be ordered as part of a physician's written plan of care, which must be renewed every 60 days.²⁴ However, each state has the authority to implement additional eligibility restrictions on top of the federal requirements, which results in considerable state-level variation.

For federally-mandated home health services provided to FFS Medicaid beneficiaries, states may apply standards for determining the extent of coverage based on medical necessity (e.g., requiring authorization by a medical professional) or controlling utilization (e.g., limits on the time period, amount, and/or scope of the service).^{25,26} In Alabama, for example, prior approval is required to initiate home health services and for medical equipment provided in the home. The state also limits home health coverage to 104 visits per year and to two home health aide visits per week.²⁷ In Virginia, prior authorization is required after five home health visits and with a limit of 32 home health aide visits per year.²⁸ States are not allowed to maintain waiting lists or geographically limit the provisions of state plan home health services.

In 2010, 12 states had cost-sharing requirements for home health services provided to Medicaid FFS beneficiaries.²⁹ For example, Medicaid enrollees in California paid \$1 per home health visit. In South Carolina, Medicaid FFS beneficiaries paid \$2 per home health visit, but medical supplies provided in the home were exempt from cost-sharing requirements. Thirty-eight states and the District of Columbia did not have cost-sharing requirements for home health services provided to FFS Medicaid beneficiaries.

States use a variety of reimbursement methodologies for home health services, including a maximum payment amount for a particular service (perhaps relative to the payment under the Medicare program), a cost-based payment with a year-end settlement process or some documentation of actual cost to justify payment, a prospective payment process based on historical costs, or a negotiated payment rate.³⁰ In 2012, states paid home health agencies an average reimbursement of \$93.16 per home health visit; the average rate was \$86.16 for a registered nurse and \$53.81 for a home health aide.³¹ Nationally, Medicaid state plan home health expenditures in 2010 totaled \$5.7 billion and provided services to over 800,000 individuals.³²

Home Health Services within Medicaid Home- and Community-Based Service (HCBS) Waivers

In addition to the required coverage of home health services in the Medicaid state plan, states can also include home health services as part of the services provided through an HCBS waiver.

Section 1915(c) waiver authority is the primary means for states to offer HCBS to Medicaid enrollees, although some states have comparable authority through Section 1115(a) demonstration waivers. These waivers may provide relatively more flexibility in benefit package design and service delivery than services provided through the state plan.³³ Unlike Medicaid state plan authority, the waiver authority allows states to limit the availability of services geographically, target specific populations, and/or control utilization by limiting the number of enrollees. The only federal requirement for optional HCBS waivers is that states must make the service equally available to all qualifying enrollees. States providing home health services through 1915(c) waivers are also allowed to use a range of cost containment strategies, such as setting financial or functional eligibility standards.³⁴

In 2009, 48 states and the District of Columbia operated multiple 1915(c) HCBS waivers, which covered 1.4 million individuals and involved \$33.7 billion in state expenditures. Three states (Arizona, Rhode Island, and Vermont) use 1115(a) demonstrations to administer statewide Medicaid programs that include home health services for all enrollees.

Appendix 2: Summary of Coverage for DME under Medicare and Medicaid

Medicare Coverage of DME

Medicare provides coverage of DME to all beneficiaries enrolled in Part B. Medicare Advantage enrollees receive coverage for at least the same types of DME items but may have broader coverage and different cost-sharing requirements, as long as total beneficiary costs do not exceed CMS limits.

Medicare DME coverage includes medical equipment and supplies that have been ordered by a physician after a face-to-face encounter. DME coverage requires that the item be durable, primarily serve a medical purpose, generally not be useful to a beneficiary without an illness or injury, and be appropriate for use in the beneficiary's home.³⁵ A hospital or skilled nursing facility does not qualify as the beneficiary's home for DME coverage under Part B or the home health benefit, though a long-term care facility can qualify as a home.³⁶ Examples of covered DME items are hospital beds, wheelchairs, crutches, oxygen, and medication necessary to the function performed by the DME item. Medicare's DME benefit does not cover expendable items (e.g., bandages) or equipment that is primarily and customarily used for non-medical purposes (e.g., humidifiers).

Overall, Medicare pays for DME items for FFS beneficiaries based on the lesser of either the state-specific Medicare fee schedule or the provider's charge.³⁷ There are some exceptions, however. For example, the Medicare regional carrier sets the payment for customized equipment, and prices for most medications used in conjunction with DME are set at 106 percent of average sales price (ASP). Also, some DME items can be rented, and Medicare makes monthly payments for the use of the equipment.³⁸

In 2009, a competitive bidding program went into effect in nine metropolitan statistical areas (MSAs) for a selection of DME categories. The nine categories included in the competitive bid program are oxygen, standard wheelchairs, enteral nutrients, continuous positive airway pressure (CPAP) breathing assistance devices, hospital beds, walkers, negative pressure wound therapy, support surfaces, and mail order diabetic supplies. Two years later, the bid program was expanded to include a total of 100 MSAs for eight out of nine categories of DME, and the resulting prices took effect in 2013. The bid program for mail order diabetic supplies was expanded nationally in 2011.

Medicare FFS enrollees without Medicaid or other supplemental coverage pay a 20 percent cost-sharing requirement for DME items, after the \$147 Part B deductible has been met. DME items provided within the home health benefit are subject to the same cost-sharing requirements and are not included in the home health payment bundle. Medicare will only pay for DME items that beneficiaries receive from Medicare-participating suppliers; beneficiaries are likely to be responsible for 100 percent of the cost of DME from non-participating suppliers.

Medicare spent approximately \$8.2 billion on DME items in 2012.³⁹ Oxygen and related equipment was the largest DME category and accounted for roughly one-quarter of DME spending.⁴⁰ Prices from the first round of the DME competitive bidding program took effect in 2011. The Department of Health and Human Services estimated \$200 million in federal savings from the bid program in 2011 and anticipates additional savings of \$85 billion between 2013 and 2022.⁴¹

Medicaid Coverage of DME

DME can be covered as a separate state plan benefit under Medicaid, and can also be a component of the home health benefit. When DME is provided as part of the home health benefit, a physician must annually review an enrollee's need for medical supplies and equipment for use in the home.⁴² Federal guidance confirmed that states may implement reasonable standards to determine the extent of DME coverage based on medical necessity or utilization control.⁴³ States must ensure that the amount, duration, and scope of coverage are sufficient to achieve the purpose of the DME item. In addition, items cannot be excluded from coverage based solely on an enrollee's diagnosis or condition. States are allowed to develop a list of pre-approved DME items for administrative convenience, but must establish a process to seek modifications or exceptions to the list.

Medicaid programs may also consider coverage for DME to support the beneficiary's ability to function within the community in order to avoid institutionalized care. For example, Medicaid may cover heavy duty wheelchairs that could be used both at home and out-of-doors, while Medicare will only cover wheelchairs needed to maneuver within the home.⁴⁴ In addition to coverage of DME items and services as an optional benefit under the state plan and as part of the home health state plan benefit, DME can also be covered through HCBS waivers that are aimed at helping beneficiaries live in the community rather than in nursing facilities or other institutions. HCBS waivers generally permit a wider range of DME to be covered than when DME is provided as an optional state

plan benefit or as part of the home health benefit. Medicaid programs may also provide DME to enrollees preparing to leave institutionalized care that require training before use in the home.⁴⁵

In 2010, 17 states required cost-sharing payments for DME items or services provided to Medicaid FFS enrollees.⁴⁶ For example, Colorado required \$1 payment for each day of service and New Mexico required up to \$7 for each item, depending on the enrollee's income. A few states have established a co-insurance payment, such as 10 percent of the payment for DME items in Utah. In addition, many states have implemented prior approval requirements for some or all DME items. Some states also have established coverage limits, such as the \$1,950 per year maximum for incontinence products in Indiana, or Iowa's requirement that oxygen systems be limited to specific medical conditions.

In 2012, Medicaid spent approximately \$4.6 billion on DME.⁴⁷ This spending includes purchased DME items, items rented for a defined period of time, and DME items acquired through a "rent to purchase" strategy in which regular payments are made for 10-12 months until the state estimates that the cost of the item has been reached.⁴⁸

Though states' payment methodologies vary, the most common reimbursement method is paying the lesser of either the supplier's charge or an amount based on the maximum applicable to the Medicare program in the state. Alternatively, some states reimburse based on a "reasonable charge" or on a "percentage to charge," which typically uses documentation of the supplier's historical cost-to-charge ratio. Some states may also negotiate prices or individually price customized items if no code or fee has been established. In addition, states may require that specific items be purchased from a contracted vendor.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The *Integrated Care Resource Center* is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided within 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.

Endnotes

- ¹ <http://kff.org/medicaid/state-indicator/home-health-services-includes-nursing-services-home-health-aides-and-medical-suppliesequipment/>. The Medicare Payment Advisory Commission (MedPAC) has recommended a per-episode copay for Medicare home health episodes that are not preceded by a hospitalization or post-acute care use. See March 2014 MedPAC Report to the Congress, pp. 235-236, at: http://www.medpac.gov/documents/Mar14_EntireReport.pdf. Accessed April 1, 2014.
- ² For reimbursement methodologies by state, see <http://kff.org/medicaid/state-indicator/home-health-services-includes-nursing-services-home-health-aides-and-medical-suppliesequipment/>. For details on New York's new episode-based system, see http://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/.
- ³ For state-by-state details on Medicaid state plan personal care services, see <http://kff.org/medicaid/state-indicator/personal-care-services/>.
- ⁴ For state-by-state details, see <http://kff.org/medicaid/state-indicator/medical-equipment-and-supplies/>.
- ⁵ Department of Health and Human Services. State Medicaid Director Letter. April 8, 2003. Available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd040803.pdf>
- ⁶ In areas where the Medicare DME Competitive Bidding Program is in effect, Medicaid cannot pay for Medicare beneficiary cost sharing for DME provided by a supplier not included in that program, but can pay for Medicaid DME provided by a Medicaid provider, whether or not that provider is in the Medicare Competitive Bidding Program. See CMCS Informational Bulletin, August 2, 2013, for details. Available at: <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-02-2013.pdf>.
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- ¹⁰ David Grabowski. "Medicare and Medicaid: Conflicting Incentives for Long-Term Care." *The Milbank Quarterly*, Vol. 85, No. 4 (2007), pp. 579-610.
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- ¹² The full text of all the Financial Alignment Initiative approved MOUs can be found at this link: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html>.
- ¹³ The contracts are available on the Medicare-Medicaid Coordination Office web site at this link: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>
- ¹⁴ For more details on the Medicare DME competitive bidding program, including the areas in which it is operating, see: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DME_Ref_agt_FactSheet_ICN900927.pdf.
- ¹⁵ The July 26, 2013 memo titled "Preliminary Guidance for the Reporting of Encounter Data - INFORMATION" is at this link: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPEncounterData.pdf>.
- ¹⁶ The contracts are available on the Medicare-Medicaid Coordination Office web site at this link: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>
- ¹⁷ CMS State Medicaid Director Letter #03-004, April 8, 2003.
- ¹⁸ New York plans to use a state entity – the Integrated Administrative Hearing Officer – for both Medicare and Medicaid appeals in its financial alignment demonstration. See pp. 76-80 of the New York MOU at this link: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMOU.pdf>. Accessed April 4, 2014.
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- ²² Centers for Medicare and Medicaid Services, "Medicare & Medicaid Statistical Supplement, 2012 Edition," Table 7.1. Available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2012.html>. Note that Medicare payments may exceed provider charges in the prospective payment system.
- ²³ Medicare Advantage managed care plans are allowed to use beneficiary cost sharing for home health services as long as a beneficiary's total out-of-pocket costs for all services do not exceed CMS limits. For details, see pp. 120-121 in the Medicare Call Letter for 2014, issued on February 15, 2013: <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvSpecRateStats/downloads/Advance2014.pdf> (Accessed July 24, 2013).
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