



Centers for Medicare & Medicaid Services

State Resource Center

## State Options for Designing D-SNP Contracts with Medicare Advantage Organizations

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## State Resource Center: State Options for Designing Dual SNP Contracts with Medicare Advantage Organizations

*Note: This is a resource document providing options to States for their consideration as they contract with Medicare Advantage (MA) organizations offering dual eligible Special Needs Plans (D-SNPs). All contracting arrangements between a State and an MA organization must satisfy the requirements in CMS regulations and guidance. This document in no way establishes requirements for States in contracting with MA organizations for D-SNPs.*

### Introduction

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The Medicare Modernization Act (MMA) of 2003 introduced a new type of coordinated care health plan, the Special Needs Plan (SNP), into the MA program. SNPs are unique because they can target enrollment to “special needs” beneficiaries identified as: (1) institutionalized beneficiaries, (2) beneficiaries with severe or disabling chronic conditions, or (3) beneficiaries who are dually eligible for Medicare and Medicaid (dual eligibles). SNPs provide an opportunity to improve care for these targeted groups through improved coordination and continuity of care. In addition, D-SNPs can fully integrate Medicare and Medicaid benefits through a single managed care organization.

As the name implies, Dual Eligible SNPs (D-SNPs) target individuals dually eligible for Medicare and Medicaid. However, the proliferation of D-SNPs has illuminated the challenges that States, the Centers for Medicare & Medicaid Services (CMS) and MA organizations jointly face in effectively sharing information and integrating benefits. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, as amended by the Patient Protection and Affordable Care Act (Affordable Care Act) of 2010 as well as the promulgation of regulations, reflect an effort to improve Medicare and Medicaid benefit integration by mandating that MA organizations seeking to offer a D-SNP obtain a contract with the State Medicaid Agency(ies) in the state(s) in which it wants to offer a D-SNP. MA organizations currently offering D-SNPs can continue to do so through Plan Year 2012 without a contract so long as they do not change the D-SNP type or seek to expand the plan’s service area. Starting in Plan Year 2013, MIPPA requires that MA organizations have a fully executed State Medicaid Agency contract with the applicable Medicaid agency in the state in which they want to offer a D-SNP.

Specifically, MIPPA Section 164 requires that all MA organizations have “a contract with the State Medicaid Agency to provide benefits, or arrange for benefits to be provided, for which such individual is entitled to receive as medical assistance under title XIX. Such benefits may include long-term care services consistent with State policy.” The regulations authorizing contracting requirements (42 CFR § 422.107) have provided some additional guidance on this requirement; specifically the contract must document, at a minimum:

1. The MA organization's responsibility, including financial obligations, to provide or arrange for Medicaid benefits;

2. The category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the SNP, as described under by the Social Security Act at sections 1902(a), 1902(f), 1902(p), and 1905;
3. The Medicaid benefits covered under the SNP;
4. The cost-sharing protections covered under the SNP;
5. The identification and sharing of information on Medicaid provider participation;
6. The verification of enrollee's eligibility for both Medicare and Medicaid;
7. The service area covered by the SNP; and
8. The contract period for the SNP.

In Chapter 16 (b) Section 40.5.1 of the *Medicare Managed Care Manual*<sup>1</sup>, CMS provides its interpretation of MIPPA Section 164, as amended by the Affordable Care Act and Chapter 42 Section 422.107 of the CFR. Specifically, this chapter gives direction for developers of contracts between D-SNPs and State Medicaid Agencies, and details the type of information that must be contained within the contracts to meet the eight minimum MIPPA contract elements.

To address State inquiries with respect to the coordination of State and Federal policies for D-SNPs, CMS established a State Resource Center to provide States with helpful information to enable the successful negotiation and award of contracts to these plans, as well as to assist States in improving the coordination of Medicare and Medicaid processes. In response to several inquiries from States regarding the contracting rules, CMS developed a series of contracting options specific to the elements that States may wish to consider when developing compliant D-SNP contracts. CMS identified these after a review of several historical and existing contract documents between States and Medicaid managed care organizations, other publications and documentation, and interviews with State Medicaid Agency officials, CMS experts, health plan officials, and advocacy groups. While the options expressed in this paper do not reflect an exhaustive list of all possible paths a State may follow in creating a compliant contract, CMS intends for the options to provide States with a framework for moving forward in the contracting process. CMS encourages States to work closely with MA organizations (with CMS as a secondary resource) during contract development to ensure that a final contract meets CMS' contracting requirements. Please note that neither MIPPA nor the Affordable Care Act require States to enter into a contract with an MA organization for a D-SNP. In addition, please note that MA organizations offering D-SNPs must continue to comply with applicable MA program requirements regardless of their contractual relationship with a State.

In discussing the State contracting options for D-SNPs, it is important to understand and identify the Title XIX services States must provide for Medicaid beneficiaries, particularly since Medicare covers some of these services and is the primary payer on all services covered by both programs. Unless waived under Section 1115 of the Social Security Act, federal law requires State Medicaid plans to cover a core set of services for those who are categorically eligible for Medicaid benefits. Appendix B includes the full list of mandatory benefits. The services most likely to benefit dual eligible are:

- Inpatient hospital (excluding inpatient services in institutions for mental disease);
- Outpatient hospital;

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<sup>1</sup> Available at <http://www.cms.hhs.gov/Manuals/IOM>

- Other laboratory and x-ray;
- Nursing facility services;
- Physicians' services;
- Medical and surgical services of a dentist; and
- Home health services for beneficiaries who are entitled to nursing facility services under the State's Medicaid plan.

States that opt to include "medically needy" individuals in their Medicaid plans, or that use a waiver, may provide additional services. For some individuals dually eligible for Medicare and Medicaid, known as Qualified Medicare Beneficiaries (QMBs), Medicaid pays the dual eligible's Medicare premiums, deductibles and coinsurance. Medicaid covers other Medicare costs for individuals in other dual eligible categories; please refer to Appendix B for details.

Lastly, MA organizations must comply with CMS MA contracting timeline requirements. These requirements, expressed in the table below, affect when a State and an MA organization may negotiate benefits as well as when contracts between States and MA organizations must be finalized and effectuated. Each year CMS publishes a *Call Letter* that identifies the applicable dates and timelines for the following Plan Year. Please refer to the most recent *Call Letter*, available on CMS' website<sup>2</sup>, for current deadlines.

Date	Associated Deadline/Event
Feb. 21, 2012	2013 Applications are due to CMS
April 2, 2012	2013 Final Call Letter released
May 25, 2012	MA and SNP Part D denial notices and conditional approval letters are sent out.
Late May/June 2012	CMS sends qualification determinations to applicants based on review of the 2013 applications for new contracts or service area expansions.
June 4, 2012	Deadline for submission of CY 2013 bids
June 6, 2012	Release of the 2013 Marketing Module in HPMS
June 7, 2012	Release Medicare Marketing Guidelines for CY 2013
June 2012 – Late Sept. 2012	CMS completes review and approval of 2013 bid data (Submit attestations, contracts, and final actuarial certifications).
July 1, 2012	All D-SNPs are required to submit their State Medicaid Agency contract to CMS.
Aug. 20, 2012	D-SNP applicants to submit responses to deficiencies found in its contract with its respective State Medicaid Agency(ies) to the Home Region.
Aug. 30, 2012	Approval letters sent to D-SNPs for contracts with State Medicaid Agency.
Mid-Sept. 2012	All MAO 2013 contracts with CMS are fully executed (this is not a State Medicaid Agency Contract – it is the contract between CMS and the MAO).

<sup>2</sup> This document is available on the CMS website at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2013Announcement.html>

<b>Date</b>	<b>Associated Deadline/Event</b>
Sept. 30, 2012	CY 2013 standardized, combined Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) is due to current members of all MA plans, MA-PD plans, PDPs and cost-based plans offering Part D. MA and MA-PD plans must ensure current members receive the combined Annual Notice of Change/Evidence of Coverage (ANOC/EOC) by September 30th.  Exception: Dual Eligible SNPs that are fully integrated with the State may mail an ANOC with the Summary of Benefits for member receipt by September 30, 2012 and then send the EOC for member receipt by December 31, 2012. Fully Integrated Dual Eligible SNPs that send a combined, standardized ANOC/EOC for member receipt by September 30, 2012 are not required to send an SB to current members.
Oct. 1, 2012	MAOs allowed to begin marketing their CY 2013 plan benefits.
Oct. 6 – 31, 2012	CMS mails the 2013 Medicare & You handbook to Medicare beneficiaries.
Oct. 15 – Dec. 7, 2012	2013 Annual Election Period
Nov. 9, 2012	New MAOs submitting an application for Contract Year 2014 must submit a non-binding Notice of Intent to Apply.
Dec. 31, 2011	Fully Integrated Dual Eligible SNPs that did not send an EOC with the ANOC by September 30, 2011, must send the EOC by December 31, 2011.
Jan. 1, 2013	Plan Benefit Period Begins
Early Jan., 2013	Release of CY 2014 Applications
Late Feb., 2013	Applications due for CY 2014

## Required MIPPA Elements and State Options

The following sections present the eight contracting elements CMS established using its regulatory authority to implement the MIPPA contract requirements as well as various options States may wish to adopt in order to meet these requirements.

### **Element 1: The contract must document the MA organization's responsibility, including financial obligations, to provide or arrange for Medicaid benefits**

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A review of existing integrated contracts between States and organizations providing Medicaid managed care plans<sup>3</sup> in concurrence with a D-SNP revealed a significant amount of variability regarding the scope of Medicaid benefits provided or arranged for by the D-SNP. A State's ability and interest in integrating its Medicaid program with Medicare via a D-SNP will determine whether it chooses to pursue a coordination of benefits arrangement or integrate some or all of its Medicaid benefits into the D-SNP. In addition, the level of integration may also vary based on which groups of dual eligibles the State chooses to include in the contract.<sup>4</sup>

While all contracts must specify that the D-SNP is responsible for member-directed care coordination of both Medicaid and Medicare services, CMS has also determined that all contracts must provide or arrange for some level of value. This type of arrangement may involve a capitated payment from the State to the MA organization to provide benefits. Nonetheless, contracts limiting the MA organization's responsibilities to administrative services only (e.g. cost-sharing, data-sharing) will not sufficiently meet the contracting requirements.

### **Element 2: The contract must document the category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the D-SNP**

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It is important that the contract between the MA organization and the State Medicaid Agency clearly documents which category(ies) of dual eligibles may enroll in the D-SNP because there are several different categories of dually eligible individuals. A D-SNP must enroll the Medicaid population identified in the executed State Medicaid Agency contract as the target population. A MA organization may not impose more restrictive or expansive Medicaid eligibility requirements for enrollment into the D-SNP than the State imposes for enrollment into the Medicaid program, unless agreed to by the State under the contract.

In order to be compliant with the requirements, any contract between a State and an MA organization must detail categories of Medicaid eligibility for enrollment into the D-SNP. For example, a 2008 model contract for Virginia's Acute and Long-Term Care Services (VALTC) managed care program contains language that successfully meets this requirement. The contract specifies that, in order to be eligible for the program, individuals need to be "existing and newly enrolled full benefit dual eligibles: individuals enrolled in Medicare and eligible for Medicaid coverage. The Virginia Administrative Code classifies these participants as 'Qualified Medicare Beneficiaries (QMB) Plus.'" The contract also describes individuals who are not eligible for the

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<sup>3</sup> Note: CMS does not require that a MA organization offering a D-SNP also offer a Medicaid MCO product.

<sup>4</sup> Appendix B includes a list of the different dual eligible subset populations. A State can choose to allow a D-SNP to enroll all dual eligibles or specific category(ies) of dual eligibles.

managed care program as follows: “This program also will not include ‘non’ full benefit dual eligibles [commonly referred to as partial duals] such as: Qualified Medicare Beneficiaries (QMBs), Special Low Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs), or Qualified Individuals (QI).” Please refer to Appendix A for specific contract language.

### Element 3: The contract must document the Medicaid benefits covered under the D-SNP

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As expressed in Element 1 (requiring the contract to document the MA organization’s responsibility to provide or arrange for Medicaid benefits), State contracts for D-SNPs are likely to vary widely in the scope of covered Medicaid benefits. Element 3 accounts for this variability by requiring that the contract include information on benefit design and administration related to all Medicaid benefits covered under the D-SNP as well as document the benefits for which the MA organization is responsible for providing or arranging. If the list of services is an attachment, it must be referenced in the body of the contract per a July 17, 2009 CMS memo<sup>5</sup>. As the party responsible for providing care coordination, the D-SNP needs to be fully aware of all the services entitled to its dually eligible enrollees as well as the party responsible for covering each service. This knowledge is essential to the D-SNP’s ability to coordinate the member’s benefits and prevent overlapping services. Possible scenarios include:

- Service covered under the D-SNP through Medicaid capitation;
- Service covered under the D-SNP through Medicare capitation (includes mandatory supplemental benefits<sup>6</sup>);
- Service covered under fee-for-service Medicaid; or
- Service covered under Medicaid through other State-arranged contracts (e.g. home and community-based waiver services or other carve-out services such as behavioral health).

As an MA organization must enter into two separate contracts for the D-SNP – one contract with CMS to provide the MA benefits and another contract with the State Medicaid Agency to provide the Medicaid benefits – States may use this opportunity to influence the composition of the benefits covered under *both* contracts. (Note: MA organizations that already have an existing contract with a State Medicaid Agency to provide just Medicaid benefits can modify their existing State contract to incorporate the eight contract elements.) In doing so, States may choose to negotiate with the MA organization to cover certain Medicaid benefits under the

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<sup>5</sup> The memo is available at:

[http://www.cms.gov/SpecialNeedsPlans/Downloads/SNPs\\_HPMS\\_DE\\_ContractElements07-17-09.pdf](http://www.cms.gov/SpecialNeedsPlans/Downloads/SNPs_HPMS_DE_ContractElements07-17-09.pdf).

<sup>6</sup> “Mandatory supplemental benefits” are benefits available to all enrollees in an MA plan and are paid for by premiums and cost-sharing or, most likely in the case of a D-SNP, by rebate dollars. MA organizations are permitted to retain up to 70 percent of rebate dollars (the difference between the CMS benchmark and the lower amount bid by the MA organization for its package of all Medicare services) and must apply these dollars to reduce premiums and cost-sharing or provide additional benefits. Any supplemental benefits funded by rebate dollars must be directly health related and not covered by Medicare (e.g., vision, dental benefits). The Affordable Care Act reduced the size of the rebate that plans may receive based on their quality Star Rating. By 2014, plan rebates fall from 75 percent to 50 percent for plans that receive three or fewer stars under CMS’ quality Star Rating system. Plans with 3.5 or 4 stars will receive a rebate of 65 percent, and plans with 4.5 or 5 stars will receive a 70 percent rebate. For additional information on the quality star rating system, please refer to a Kaiser Family Foundation Issue Brief *Reaching for the Stars: Quality Ratings of Medicare Advantage Plans, 2011* (<http://www.kff.org/medicare/upload/8151.pdf>).

organization's MA contract with CMS, if the benefits in question are allowable under Medicare.<sup>7</sup> New York, for example, has negotiated with MA organizations to provide routine hearing and vision care services – Medicaid benefits in the State – through the organizations' MA contracts with CMS. It should be noted that any benefits arrangements between States and MA organizations cannot require a Medicare bid change after the first Monday in June, when all MA organizations must submit their bids to CMS. Contracts between States and MA organizations cannot exclude any Medicare benefits included in the MA organization's bid submitted to CMS or provide for additional Medicare benefits not included in the MA organization's bid.

Should a State and an MA organization agree to cover some Medicaid benefits under the MA organization's contract with CMS, the Medicaid benefits in question would be structured as mandatory supplemental benefits. If these Medicaid services provided under the CMS contract are not equal to or greater than the benefit required in the Medicaid State Plan, other arrangements will need to be made to ensure that enrollees receive the Medicaid services for which they are entitled. If a State chooses to enter into this type of arrangement, then the financial responsibility for these Medicaid benefits must be expressed in the contract, i.e., the contract must express if these services are to be paid for by Medicare or Medicaid. In addition to negotiating with a D-SNP to cover additional Medicare-covered services, i.e., mandatory supplemental services, a State can negotiate with the D-SNP to provide supplemental benefits paid for by Medicaid.

#### **Element 4: The contract must document the cost-sharing protections covered under the D-SNP**

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MIPPA requires that all contracts between States and MA organizations include a provision documenting the D-SNP's cost-sharing protections. Title XIX of the Social Security Act mandates certain Medicaid cost-sharing protections, including enrollee liability protections. In addition, MIPPA 165 required that, as of January 1, 2010, a D-SNP may not subject any full-benefit dual eligible or qualified Medicare beneficiary<sup>8</sup> enrolled in the plan to any cost-sharing that exceeds the amount of cost-sharing that would be permitted under Title XIX if the beneficiary was not enrolled in the D-SNP. The contract between the State and an MA organization must specify all applicable cost-sharing protections.

A review of several existing and historical contracts between States and Medicaid managed care organizations (some of whom also operate D-SNPs) reveals little significant variation in State approaches for satisfying Title XIX requirements (all Medicaid managed care organizations have had to comply with Title XIX cost protections for several years). The following are two possible options for satisfying this requirement.

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<sup>7</sup> Please refer to Chapter 4, Sections 10.2 and 10.9 of the Medicare Managed Care Manual (<http://www.cms.hhs.gov/manuals/downloads/mc86c04.pdf>) for the explanation of a "benefit" offered by an MA organization.

<sup>8</sup> Please refer to Section 1905(p)(1) of the Social Security Act for a complete definition of a "qualified Medicare beneficiary."

### Option 1: Include specific language on cost-sharing protections in the contract

CMS recommends that States clearly describe the cost-sharing protections required of a D-SNP in the contract. States can find several examples of explicit language pertaining to required Title XIX cost-sharing protections in existing and historical contracts between States and Medicaid managed care organizations. Please refer to Appendix A for specific contract language. Examples include:

***Adherence to enrollment fees, premiums and other cost-sharing requirements.*** A review of existing contracts between States and Medicaid managed care organizations revealed little variability in how States craft language pertaining to premiums, deductibles and other cost-sharing protections contained in Title XIX.

- A 2010 Massachusetts contract includes a provision stating that the contractor will not charge enrollees co-insurance, co-payments, deductibles, financial penalties, or any other amount for any service provided under the contract.

***Adherence to enrollee protections from liability requirements.*** Several recent contracts contain explicit language related to Section 1932 of Title XIX, which requires Medicaid managed care organizations to protect enrollees from being held liable for payments that are the responsibility of the managed care organization. For example:

- Virginia's 2008 Acute and Long-Term Care Services model contract explicitly states that, "pursuant to Section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6))", the contracted organization and any subcontractors must not hold an enrollee liable for 1) debts of the organization, 2) payment for services provided by the organization/subcontractor if the organization/subcontractor has not received payment from the State or the organization, and 3) any payments made for covered services to a provider that are in excess of the amount that the enrollee would have paid if the organization had provided the service directly.
- New Mexico's 2009 Coordinated Long-Term Services model contract includes a provision stating that D-SNPs (or their subcontractors) may not "collect any additional payment for Cost-Sharing Obligations from a Dual Eligible Member other than amounts specified in the State Plan or otherwise allowed by Federal law."
- Wisconsin's 2011 Partnership Program model contract includes a provision requiring all subcontractors to ensure that providers do not hold enrollees liable for any costs that are the responsibility of the contracted organization.
- Massachusetts's 2012 Senior Care Options contract states that "in accordance with 42 USC §1396 u-2(b)(6)", the contracted organization must not hold and enrollee liable for 1) debts of the organization, 2) payments for services provided by the organization in the event the organization fails to receive payment from the State or CMS for the services, and 3) payments to a subcontractor that are in excess of the amount that the enrollee would have paid if the organization had directly provided the services.

**Adherence to sanctions requirements.** Per Section 1932 of Title XIX, a State may not enter into or renew a contract with a Medicaid managed care organization unless the State sanctions the organization for “imposing premiums or charges on enrollees in excess of the premiums or charges permitted” under Title XIX. The following example reflects a common approach for meeting this requirement:

- New York’s 2011 Medicaid Advantage Plus model contract states that the contractor is subject to “sanctions and penalties as are authorized by local laws and ordinances and resultant administrative codes, rules and regulations related to the Medical Assistance Program” for practices including “imposing premiums or charges on Enrollees that are in excess of the premiums or charges permitted under the Medicaid Advantage Plus program.”

**Adherence to MIPPA 165 requirements.** To comply with the prohibition against co-payments for full benefit dual eligible members or qualified Medicare beneficiary enrolled in the D-SNP that would exceed required payments under Title XIX if the individual was not enrolled in the D-SNP product, States can mandate compliance in the contract’s cost sharing section.

- A 2011 Texas contract includes the following clause: “The MA Dual SNP will not impose cost sharing on a Dual Eligible Member that exceeds the amount of cost sharing that would be permitted with respect to the Dual Eligible Member under Medicaid if the Dual Eligible Member were not enrolled in an MA product.”

**Option 2: Cite the sources of the cost-sharing protections requirements in the contract rather than include the specific requirements**

Rather than articulate specific cost-sharing protections in the contract, States may wish to cite the requirements D-SNPs must adhere to in order to be compliant with all applicable cost-sharing protections requirements. Examples include:

- Virginia’s 2008 Acute and Long-Term Care Services contract includes a provision for imposing sanctions against the contractor should the contractor require premiums or charges “in excess of the premiums or charges permitted under Title XIX” of the Social Security Act..

New Mexico’s 2009 Coordinated Long-Term Services model contract cites the cost-sharing protections regulations in its definition of a co-payment; specifically, that the co-payment amount must be consistent with 42 §§ CFR 447.53 through 447.56. These regulations express Medicaid cost-sharing exclusions for categorically eligible or medically needy groups and also articulate the requirement that “no provider may deny services, to an individual who is eligible for the services, on account of the individual's inability to pay the cost sharing.”

- Wisconsin’s 2011 Partnership Program model contract states “Cost share is imposed on members in accordance with 42 CFR 447.50 to 42 CFR 447.60. The Department will ensure that a member who has a cost share is not required to pay any amount in cost share which is in excess of the average cost, as determined by the Department, of waiver services in a given month for all MCO waiver participants in the same target group.”

- Massachusetts's 2012 Senior Care Options contract states that the organization must not 1) charge enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under the contract (except as otherwise noted in the contract), 2) deny any service provided under the contract to an enrollee for failure or inability to pay, and 3) deny any service provided under the contract to an enrollee who incurred a bill that has not been paid prior to becoming MassHealth eligible.

#### **Element 5: The contract must document the identification and sharing of information on Medicaid provider participation**

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A key element in improving the D-SNP's potential for better integrating Medicare and Medicaid benefits for dual eligibles is to ensure that MA organizations are aware of which providers in the service area accept Medicaid and, more importantly, that MA organizations contract with an adequate number of Medicaid providers so that dual eligibles can seamlessly access both sets of benefits within a single network. MA organizations, per Chapter 4 of the *Medicare Managed Care Manual*, are required to "maintain and monitor a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services to meet the needs of the population served;"<sup>9</sup> as such, the D-SNP contract must account for some level of data sharing between the MA organization and the State, regardless of the services performed by the D-SNP, by including a process for the State to identify and share information on providers contracted with the State Medicaid Agency for inclusion in the D-SNP provider directory. However, as stated earlier, data sharing alone will not satisfy the contracting requirements.

Many existing contracts between States and Medicaid managed care organizations typically provide detailed requirements for the contractor to regularly update the State with changes to the contractor's provider network. Information on how the States will use the shared data and on the frequency of data transmission from the State to the MA organization must also be detailed in the contracts in order to meet Element 5. Example language is provided below:

- Health Plan will coordinate with the Agency to identify and share information on Medicaid provider participation to ensure network adequacy and promote continuity of care. Health Plan shall electronically transmit provider participation files to Agency on a periodic basis upon request by the Agency. Health Plan shall include in the provider participation files all network providers contracted by Health Plan to serve its Members who are Dual Eligible Beneficiaries. Agency agrees to define reasonable requirements for the provider participating files for Health Plan's provider network that are also participating Medicaid providers under the State Medicaid Plan. Agency will provide that Health Plan with access to a list of participating Medicaid providers on at least a quarterly basis in a format agreed to by the Parties.

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<sup>9</sup> As mentioned previously, D-SNPs must meet all applicable MA program requirements.

## Element 6: The contract must document the verification of enrollee's eligibility for both Medicare and Medicaid

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Existing contracts between States and Medicaid managed care organizations – including contracts mandating that the Medicaid managed care organization also offer a MA D-SNP – generally limit the scope of eligibility verification to eligibility for Medicaid. However, these contracts do provide insight on how a State can structure a future contract to include a detailed provision – required by CMS – for the State Medicaid Agency to provide the MA organization with access to real-time information verifying the eligibility of enrolled dual eligible members. The following paragraphs express several possible options for how this requirement may be satisfied.

### Option 1: Include a data-sharing provision in the contract for the State and D-SNP to exchange real-time Medicaid eligibility information

For a State that wishes to pursue a contract with an MA organization who is not already operating in the State as a Medicaid managed care organization, or for an exclusive fee-for-service Medicaid State, the State may wish to negotiate with the MA organization to include a data-sharing provision in the contract requiring the D-SNP to regularly provide the State with individual-level enrollment information. Under this option, the State is responsible for making a real-time determination of Medicaid eligibility based on the enrollment information provided by the D-SNP and informing the D-SNP of this determination. That is, the State is required to provide an automatic Medicaid eligibility determination to the MA organization as it receives an enrollee eligibility inquiry from the MA organization. Concurrently with submitting enrollment information to the State, the D-SNP will be responsible for verifying Medicare eligibility using the existing Medicare eligibility verification processes for MA organizations.

In addition to initially verifying Medicaid eligibility, the D-SNP is responsible for regularly verifying that the enrollee remains eligible for continued enrollment in the plan. Per Section 20.11 of Chapter 2 of the *Medicare Managed Care Manual*<sup>10</sup>, the D-SNP must “verify continuing eligibility (e.g., full or partial dual status, as applicable) at least as often as the State Medicaid Agency conducts re-determinations of Medicaid eligibility.” Therefore, under this option, the contract between the State and the sponsoring MA organization should include a provision for the D-SNP to send eligibility verification data to the State at least as often as the State conducts re-determinations of its Medicaid-eligible population. Example language is provided below:

- Alabama’s 2012 Coordination of Benefits contract includes initial eligibility verification language. “The Parties agree to exchange eligibility information on categories of Dual Eligible Beneficiaries, including QMB only, QMB plus SLMB only, SLMB plus, QU, QDWI, and FBDE, for the purpose of verifying Medicaid eligibility for enrollment in health Plan’s MA-PD plans. The Agency agrees to allow access to Medicaid eligibility systems to verify initial eligibility for enrollment in MA-PD plans. The Agency

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<sup>10</sup> This document is available on the CMS website at:

[http://www.cms.gov/MedicareMangCareEligEnrol/Downloads/DRAFT\\_MA\\_Enrollment\\_and\\_Disenrollment\\_Guidance\\_Update\\_for\\_CY2012.pdf](http://www.cms.gov/MedicareMangCareEligEnrol/Downloads/DRAFT_MA_Enrollment_and_Disenrollment_Guidance_Update_for_CY2012.pdf).

acknowledges that Health Plan may also use Member provided data to establish Medicaid eligibility for enrollment in Health Plan's A-PD plans. Health Plan or its Medicaid enrolled Subcontractor will utilize the Agency's on-line eligibility system and the Alabama Voce Response Inquired (IVR) System to verify recipient' Medicaid eligibility.

**Ongoing Eligibility Verification.**

1. The Parties may enter into a mutually agreed upon Trading Partner Agreement to allow Health Plan or its designee to access Agency's information on an ongoing basis to verify Dual Eligible Beneficiaries' Medicaid eligibility for continued enrollment in Health Plan's MA-PD plans. Agency agrees that the following data elements shall be available to Health Plan: (i) Category of Dual Eligible Beneficiary, as defined by the Agency's Benefit Plan; (ii) Medicaid coverage status; and other data element could be made available if the plan wishes to enter into a data use agreement with the Agency.
2. The Parties agree to work in good faith to resolve any eligibility discrepancies that Health Plan or Agency may identify.
3. Agency agrees that Agency's eligibility files shall be derived from the system Agency uses to determine individual's eligibility under the State Medicaid Plan and that such file's data shall not be based solely on Medicare Part D low-income subsidy data.
4. To the extent Health Plan determines allowable, Health Plan may undertake certain activities intended to facilitate eligibility redeterminations, such as assistance with applications for medical assistance on behalf of its Members and conducting Member education regarding maintaining Medicaid eligibility."

**Option 2: Include a provision in the contract describing the process by which the D-SNP verifies Medicaid eligibility through a third party vendor**

For States who do not wish to respond to Medicaid eligibility inquiries directly, or lack the information technology resources to successfully transmit eligibility data to the D-SNP, the State may direct the D-SNP to use a third party vendor with whom the State has a contractual relationship for verifying Medicaid eligibility in real time on the State's behalf. Under this option, the D-SNP is still responsible for verifying Medicare eligibility as well as for re-determining the enrollee's Medicaid eligibility (determined through enrollee documentation, submission of enrollee data to the State for verification, or other approved method) at least as frequently as the State performs this re-determination.

**Option 3: Include a provision in the contract describing the process by which the D-SNP verifies Medicaid eligibility based on documentation provided by the enrollee**

Rather than rely exclusively on the State (or a third party vendor) to verify Medicaid eligibility from submissions of individual-level enrollment data, the D-SNP can make a determination of Medicaid eligibility based on documentation submitted by potential enrollees. Per Section 20.11 of Chapter 2 of the *Medicare Managed Care Manual*, the D-SNP may confirm Medicaid eligibility through receipt of a copy of the enrollee's current Medicaid card or a letter from the State Medicaid Agency confirming the enrollee's eligibility for Medicaid. Under this option, the D-SNP is still responsible for verifying Medicare eligibility through the process described in

Option 1 as well as re-determining the enrollee's Medicaid eligibility (determined through enrollee documentation, submission of enrollee data to the State for verification, or other approved method) at least as frequently as the State performs this re-determination.

**Option 4: Expand upon existing Medicaid managed care contractual eligibility requirements to include a provision for verifying Medicare eligibility**

For an MA organization that already has a contract with a State to operate as a Medicaid managed care organization, no additional data-sharing protocol is required to verify Medicaid eligibility so long as the MA organization has real-time access to this information. When the D-SNP receives an enrollment application, it will determine if the applicant is already receiving Medicaid benefits under the organization's Medicaid managed care contract; if so, re-verifying Medicaid eligibility is not required. If the D-SNP does not have existing information on the applicant, the D-SNP will follow its existing protocols for verifying the applicant's Medicaid eligibility with the State. The D-SNP will follow standard CMS protocols for Medicare eligibility verification and enrollment into the MA plan as well as periodic re-determinations of Medicaid eligibility.

New York's 2011 MA model contract provides examples of eligibility verification for "known" applicants (i.e., applicants who are already enrolled in the contractor's Medicaid managed care product) as well as "unknown" applicants. The New York MA program provides integrated Medicaid and Medicare services to dual eligibles. All contractors participating in the program must be participants in New York's Medicaid managed care program and must also have contracts from CMS to operate as an MA plan.

- The New York contract articulates a process where the State (via the Local Department of Social Services (LDSS)) is responsible for processing enrollment applications to "transfer" applicants who are already members of the contractor's Medicaid managed care product into the contractor's MA product (i.e., the D-SNP) without re-verifying Medicaid eligibility. For "unknown" applicants who are not already enrolled in the contractor's Medicaid managed care product, the contract articulates the following process for verifying Medicaid and Medicare eligibility:
  - Before submitting an enrollment application for an unknown applicant to the LDSS, the contractor is responsible for verifying Medicare A and B eligibility – such as by obtaining a Medicare card from the applicant or querying CMS systems – and providing documentation demonstrating Medicare eligibility to the LDSS.
  - The LDSS determines the eligibility status of the enrollee, i.e., determines if the applicant is eligible for Medicaid and that documentation has been provided indicating the applicant is also eligible for Medicare, and sends the applicant notice of acceptance or denial of enrollment into the MA program. The contractor is responsible for transmitting the applicant's information to CMS for enrollment in the contractor's MA plan (D-SNP). Should CMS reject the MA enrollment request, the contractor is responsible for informing the LDSS, who will then retroactively disenroll the enrollee from the Contractor's Medicaid Advantage Plus Plan.
- A 2011 contract between Minnesota and a concurrent Medicaid managed care organization/D-SNP for providing integrated Medicaid and Medicare benefits under the

Minnesota Senior Health Options (MSHO) program provides another example of effective use of existing data-sharing protocols to verify Medicaid and Medicare eligibility. MSHO is a voluntary program providing integrated Medicare and Medicaid acute and long-term care services to qualifying senior citizens who would otherwise be enrolled in a mandatory Medicaid-only managed care program; as such, Medicaid eligibility has generally already been established at the time of enrollment. The contract articulates a process for verifying Medicare eligibility where the MSHO contractor is responsible for querying CMS' systems to verify the enrollee's Medicare status and submitting a copy of the CMS eligibility screen print along with the enrollment application to the State for ultimate verification of eligibility for the MSHO program.

### **Element 7: The contract must document the service area covered by the D-SNP**

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States can meet this straightforward requirement by including the service area in the contract, specifically, the counties in the State that the D-SNP will cover. At minimum, all counties included in the CMS-approved contract service area for the D-SNP must be included in the contract between the State and the MA organization.

- New York's 2011 Medicaid Advantage Plus contract states "The Service Area described in Appendix M of this Agreement, which is hereby made a part of this Agreement as if set forth fully herein, is the specific geographic area within which Eligible Persons must reside in order to be eligible to enroll in the Contractor's Medicaid Advantage Plus Product." Appendix M of that model contract notes "The Contractor's Medicaid Advantage Plus service area is comprised of the following Counties in their entirety:" with space for specific counties to be included.
- Wisconsin's 2011 Partnership Program contract provides a section (under MCO Specific Contract Terms) for "Geographic Coverage Where Enrollment Is Accepted" that lists specific counties comprising the service area.

**Please note that the D-SNP's Medicare contract service area cannot be modified after the MA organization submits its bid to CMS on the first Monday in June.** In addition, each November, new D-SNPs and those seeking to expand their service areas are required to submit the Notice of Intent to Apply (NOIA) for the services areas they intend to submit applications for in the following year.

### **Element 8: The contract must document the contract period for the D-SNP**

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Any contract between a State Medicaid Agency and an MA organization must clearly document the effective dates of the agreement. In order for CMS to approve the contract, the contract must span the entire MA contract implementation year (i.e., January 1 through December 31). In addition, contracts may incorporate an evergreen provision allowing for automatic renewal (with or without mention of any rate changes). States that already have contracts in place with D-SNPs may extend their existing contracts so that they cover the entire MA contract year, provided that the contracts meet all other MIPPA requirements.

- A 2009 Massachusetts Senior Care Options contract with one particular D-SNP (administered by the Executive Office of Health and Human Services or EOHHS) states “This Contract shall be in effect for a period of five years, from January 1, 2009 through December 31, 2013. At the option of EOHHS, the Contract may be extended for up to five additional one-year terms. EOHHS may exercise its extension option by providing written notice to the Contractor of its intent to do so at least sixty days prior to the expiration of the Contract term. The extension shall be under the same terms and conditions as the initial terms.”
- A 2011 Minnesota Senior Health Options model renewal contract states “the STATE and the MCO have agreed to renew the 2010 Contract, numbered Bxxxxx, for the next Contract Year, January 1, 2011 through December 31, 2011.”

## Appendix A: Contract Language Examples

This Appendix presents selected excerpts from several existing and historical contracts between States and Medicaid managed care organizations.<sup>11</sup> These excerpts are intended to provide States with useful language examples to aid States in their development of compliant contracts with MA organizations. The first column of the table refers to one of the eight elements included in the main text of the document; the second column describes either the element or an option to meet each element; and the third column provides examples of contract language States included in their contract with an MA organization.

Req. #	Element or Option Description	Contract Language Example(s)
2	The contract must document the category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the D-SNP	<p><i>From the 2008 Virginia Acute and Long-term Care Services (VALTC) model contract:</i></p> <p>“Existing and newly enrolled full benefit dual eligibles: individuals enrolled in Medicare and eligible for Medicaid coverage. These participants are included in the Virginia Administrative Code as “Qualified Medicare Beneficiaries (QMB) Plus.” This program will not include individuals who are required to “spend down” income in order to meet Medicaid eligibility requirements. This program also will not include “non” full benefit dual eligibles such as:</p> <ul style="list-style-type: none"><li>• Qualified Medicare Beneficiaries (QMBs),</li><li>• Special Low Income Medicare Beneficiaries (SLMBs),</li><li>• Qualified Disabled Working Individuals (QDWIs), or</li><li>• Qualified Individuals (QI)”</li></ul> <p>Note: This contract was obtained through the Virginia Department of Medical Assistance Services, who has approved its use in this paper</p>
4	Option 1: Include specific language on cost-sharing protections in the contract - <i>Adherence to enrollment fees, premiums and other cost-sharing requirements</i>	<p><i>From the Massachusetts Senior Care Options contract:</i></p> <p>The contract states that “in accordance with 42 USC §1396 u-2(b)(6)”, the contracted organization must not hold and enrollee liable for 1) debts of the organization, 2) payments for services provided by the organization in the event the organization fails to receive payment from the State or CMS for the services, and 3) payments to a subcontractor that are in excess of the amount that the enrollee would have paid if the organization had directly provided the services.</p>

<sup>11</sup> All contracts noted with asterisks (\*) were obtained via the Center for Health Care Strategies’ website ([http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=606732](http://www.chcs.org/publications3960/publications_show.htm?doc_id=606732)).

Req. #	Element or Option Description	Contract Language Example(s)
4	Option 1: Include specific language on cost-sharing protections in the contract - <i>Adherence to enrollment fees, premiums and other cost-sharing requirements</i>	<p><i>From a 2011 Minnesota Senior Health Options contract:</i></p> <p>"The MCO is responsible for payment of Medicaid covered Medicare cost sharing where applicable." In addition, "the MCO will not bill or hold the Enrollee responsible in any way for any charges or deductibles, for Medically Necessary Covered Services or services provided as alternatives to Covered Services as part of the MCO's Care Management Plan. The MCO shall ensure that its subcontractors also do not bill or hold the Enrollee responsible in any way for any charges or deductibles for such services. The MCO shall further ensure that an Enrollee will be protected against liability for payment when: (A) The MCO does not receive payment from the STATE for the Covered Services; (B) A health care Provider under contract or other arrangement with the MCO fails to receive payment for Covered Services from the MCO; (C) Payments for Covered Services furnished under a contract or other arrangement with the MCO are in excess of the amount that an Enrollee would owe if the MCO had directly provided the services, and D) A non-Participating Provider does not accept the MCO's payment as payment in full."</p> <p>Note: This contract was obtained through the Minnesota Department of Human Services, which has approved its use in this paper</p>
4	Option 1: Include specific language on cost-sharing protections in the contract - <i>Adherence to enrollee protections from liability requirements</i>	<p><i>From the New Mexico 2009 Coordinated Long-Term Services (CLTS) model contract</i><sup>12</sup>:</p> <p>"Members shall be held harmless against any liability for debts of the CONTRACTOR that were incurred within the Agreement in providing the CLTS benefit package to the Member, excluding any Member's liability for copayments or Member's liability for overpayment resulting from benefits paid pending the result of a Fair Hearing."</p>

<sup>12</sup> New Mexico posted this contract on its website (<http://www.hsd.state.nm.us/mad/CCoLTSContracts.html>, accessed 8/30/2011) and provided permission for excerpts to be used in this document.

Req. #	Element or Option Description	Contract Language Example(s)
4	Option 1: Include specific language on cost-sharing protections in the contract <i>- Adherence to enrollee protections from liability requirements</i>	<p><i>From the 2008 Virginia Acute and Long-term Care Services (VALTC) model contract:</i></p> <p>“Pursuant to Section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6)), the MCO and all of its subcontractors shall not hold a participant liable for:</p> <ul style="list-style-type: none"> <li>i. Debts of the MCO in the event of the MCO’s insolvency;</li> <li>ii. Payment for services provided by the MCO if the MCO has not received payment from the Department for the services or if the provider, under contract or other arrangement with the MCO, fails to receive payment from the Department or the MCO; or</li> <li>iii. Payments to providers that furnish covered services under a contract or other arrangement with the MCO that are in excess of the amount that normally would be paid by the participant if the service had been received directly from the MCO.</li> </ul> <p>The MCO, including its network providers and subcontractors, shall not bill an enrollee for any services provided under this contract. The MCO shall assure that all in network provider contracts include requirements whereby the enrollee shall be held harmless for charges for any Medicaid covered service.”</p>
4	Option 1: Include specific language on cost-sharing protections in the contract <i>- Adherence to enrollee protections from liability requirements</i>	<p><i>From the 2011 Wisconsin Partnership Program model contract<sup>*13</sup>:</i></p> <p>The payments by the MCO and/or any third party payer will be the sole compensation for services rendered under the contract. The subcontractor agrees not to bill members and to hold harmless individual members, the Department and CMS in the event the MCO cannot pay for services that are the legal obligation of the MCO to pay, including, but not limited to, the MCO’s insolvency, breach of contract, and provider billing. The MCO and the subcontractor may not bill a member for covered and noncovered services, except in accordance with provisions in Article VII, Sections I. Billing Members, and J. Department Policy for Member Use of Personal Resources, page 82.</p>

<sup>13</sup> Wisconsin posted this contract on its website (<http://www.dhs.wisconsin.gov/wipartnership/ProPublications.htm>, accessed 8/30/2011) and provided permission for excerpts to be used in this document.

Req. #	Element or Option Description	Contract Language Example(s)
4	Option 1: Include specific language on cost-sharing protections in the contract – <i>Adherence to sanctions requirements</i>	<p><i>From the 2011 New York Medicaid Advantage Plus model contract</i><sup>14</sup>:</p> <p>“Contractor is subject to imposition of sanctions as authorized by 42 CFR 422, Subpart O. In addition, for the Medicaid Advantage Plus Program, the Contractor is subject to the imposition of sanctions as authorized by State and Federal law and regulation, including the SDOH’s right to impose sanctions for unacceptable practices as set forth in 18 NYCRR Part 515 and civil and monetary penalties as set forth in 18 NYCRR Part 516 and 43 CFR § 438.700, and such other sanctions and penalties as are authorized by local laws and ordinances and resultant administrative codes, rules and regulations related to the Medical Assistance Program or to the delivery of the contracted for services.</p> <p>Unacceptable practices for which the Contractor may be sanctioned include, but are not limited to . . . Imposing premiums or charges on Enrollees that are in excess of the premiums or charges permitted under the Medicaid Advantage Plus Program.”</p>
4	Option 2: Cite the sources of the cost-sharing protections requirements in the contract rather than include the specific requirements	<p><i>From the New Mexico 2009 Coordinated Long-Term Services (CLTS) model contract:</i></p> <p>“Co-payment’ means a monetary amount specified by the State that the Member pays directly to the provider at the time Covered Services are rendered consistent with 42 C.F.R. §§447.53 through 447.56.”</p>
4	Option 2: Cite the sources of the cost-sharing protections requirements in the contract rather than include the specific requirements	<p><i>From a 2009 Washington Medicare/Medicaid Integration Partnership contract</i><sup>15</sup>:</p> <p>“DSHS, CMS or the Office of the Inspector General (OIG) may impose intermediate sanctions, in accord with 42 CFR 438.700, 42 CFR 438.702, 42 CFR 438.704, 45 CFR 92.36(i)(1), 42 CFR 422.208 and 42 CFR 422.210, against the Contractor for . . . Imposing on enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract.”</p>
4	Option 2: Cite the sources of the cost-sharing protections requirements in the contract rather than include the specific requirements	<p><i>From the 2008 Virginia Acute and Long-term Care Services (VALTC) model contract:</i></p> <p>The State may sanction the organization “if the managed care organization . . . imposes premiums or charges enrollees in excess of the premiums or charges permitted under Title XIX of the Act.”</p>

<sup>14</sup> New York posted this contract on its website ([http://www.health.state.ny.us/health\\_care/managed\\_care/mltc/pdf/map\\_model\\_contract.pdf](http://www.health.state.ny.us/health_care/managed_care/mltc/pdf/map_model_contract.pdf)), accessed 8/30/2011) and provided permission for excerpts to be used in this document.

<sup>15</sup> Washington posted this contract on its website (<http://hrsa.dshs.wa.gov/mip/pdf/2009Contractamendment.pdf>), accessed 8/30/2011) and provided permission for excerpts to be used in this document.

Req. #	Element or Option Description	Contract Language Example(s)
4	Option 2: Cite the sources of the cost-sharing protections requirements in the contract rather than include the specific requirements	<p><i>From the Massachusetts Senior Care Options contract*:</i></p> <p>Massachusetts's Senior Care Options contract states that the organization must not 1) charge enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under the contract (except as otherwise noted in the contract), 2) deny any service provided under the contract to an enrollee for failure or inability to pay, and 3) deny any service provided under the contract to an enrollee who incurred a bill that has not been paid prior to becoming MassHealth eligible.</p>
6	Option 4: Expand upon existing Medicaid managed care contractual eligibility requirements to include a provision for verifying Medicare eligibility	<p><i>From a 2010 Minnesota Disability Health Options contract:</i></p> <p>"Prior to submitting an enrollment form to the STATE the MCO must verify Medicare status (Parts A and B) of the Potential Enrollee via the Medicare Advantage and Prescription Drug user Interface (MARx) or other system as directed by the STATE and CMS. A copy of the CMS eligibility screen print must be included with any enrollment form submitted to the STATE."</p>

## Appendix B: Definitions of Key Concepts

### I. Dual Eligible Categories

This section describes the various categories of individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit<sup>16</sup>. Collectively, they are known as dual eligibles.

**Medicaid Only:** Eligible for Medicaid benefits, categorically, or through optional coverage groups such as medically needy or special income levels for institutionalized or home and community-based waivers, but do not meet the income or resource criteria for QMB or SLMB. Federal financial participation (FFP) is Federal medical assistance percentage (FMAP).

**Qualified Medicare Beneficiary (QMB):** Entitled to Medicare Part A, income of 100% FPL or less, and resources that do not exceed twice the SSI limit (\$6,680\* for an individual, and \$10,020\* for a couple). FFP is FMAP.

**QMBs with Full Medicaid Benefits (QMB-Plus):** Entitled to Medicare Part A, income of 100% FPL or less, and resources that do not exceed twice the SSI limit (\$6,680\* for an individual, and \$10,020\* for a couple), and are eligible for full Medicaid benefits. FFP is FMAP.

**Specified Low-income Medicare Beneficiary (SLMB):** Entitled to Medicare Part A, income above 100% FPL but less than 120% FPL, and resources that do not exceed twice the SSI limit (\$6,680\* for an individual, and \$10,020\* for a couple). FFP is FMAP.

**SLMBs with Full Medicaid Benefits (SLMB-Plus):** Entitled to Medicare Part A, income above 100% FPL but less than 120% FPL, and resources that do not exceed twice the SSI limit (\$6,680\* for an individual, and \$10,020\* for a couple), and are eligible for full Medicaid benefits. FFP is FMAP.

**Qualifying Individual (QI-1):** Entitled to Medicare Part A, income at least 120% FPL but less than 135% FPL, and resources that do not exceed twice the SSI limit (\$6,680\* for an individual, and \$10,020\* for a couple) and not otherwise eligible for Medicaid benefits. FFP is 100% Federal.

**Qualifying Individual (QI-2):** Entitled to Medicare Part A, income at least 135% FPL but less than 175% FPL, and resources that do not exceed twice the SSI limit (\$6,680\* for an individual, and \$10,020\* for a couple) and not otherwise eligible for Medicaid benefits. FFP is 100% Federal.

**Qualified Disabled and Working Individual (QDWI):** Lost Medicare Part A benefits due to return to work, but is eligible to enroll in and purchase Medicare Part A. Must have income of 200% FPL or less and resources that do not exceed twice the SSI limit (\$4,000\* for an

<sup>16</sup> For additional information, please refer to:

[http://www.cms.gov/mlnproducts/downloads/medicare\\_beneficiaries\\_dual\\_eligibles\\_at\\_a\\_glance.pdf](http://www.cms.gov/mlnproducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf)

\*Amounts accurate per CMS Publication No. 10126, last revised March 2011. Publication accessed on July 8, 2011. (<http://www.medicare.gov/publications/pubs/pdf/10126.pdf>).

individual, and \$6,000\* for a couple) and not otherwise eligible for Medicaid benefits. FFP is FMAP.

## II. Medicaid Benefits

Unless waived under Section 1115 of the Social Security Act, State Medicaid plans are required to cover a core set of services for those who are categorically eligible for Medicaid benefits. These mandatory benefits include:

- Inpatient hospital (excluding inpatient services in institutions for mental disease);
- Outpatient hospital including Federally Qualified Health Centers (FQHCs) and if permitted under State law, rural health clinic and other ambulatory services provided by a rural health clinic which are otherwise included under States' plans;
- Other laboratory and x-ray;
- Certified pediatric and family nurse practitioners (when licensed to practice under State law);
- Nursing facility services for beneficiaries age 21 and older;
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21;
- Family planning services and supplies;
- Physicians' services;
- Medical and surgical services of a dentist;
- Home health services for beneficiaries who are entitled to nursing facility services under the State's Medicaid plan:
  - Intermittent or part-time nursing services provided by home health agency or by a registered nurse when there is no home health agency in the area,
  - Home health aides, and
  - Medical supplies and appliances for use in the home;
- Nurse mid-wife services;
- Pregnancy related services and service for other conditions that might complicate pregnancy; and
- 60 days postpartum pregnancy related services.

Additional services may be provided in States who opt to include “medically needy” individuals under their Medicaid plans, or who use a waiver to expand covered benefits. For some individuals dually eligible for Medicare and Medicaid, known as Qualified Medicare Beneficiaries (QMBs), Medicaid pays the dual eligible’s Medicare premiums, deductibles and coinsurance. Medicaid covers other Medicare costs for individuals in other dual eligible categories.