

Medicaid Handbook: Interface with Behavioral Health Services

Module 8

The Relationship between Medicare and Medicaid

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Module 8: The Relationship Between Medicare and Medicaid

Although this handbook is focused on providing *Medicaid* information to state M/SUD staff, any such discussion would be incomplete without a dialogue about *Medicare's* role in providing behavioral health benefits.

Medicare is a health insurance program primarily for older adults and people with disabilities. Unlike Medicaid, Medicare is administered entirely by the federal government. Medicare funding comes from several sources, including Medicare payroll taxes, beneficiary premiums, and federal general revenue. The Medicare law is set forth in Title XVIII of the Social Security Act.

Medicare provides services to individuals who are eligible only for Medicare and to individuals who are eligible for Medicare *and* Medicaid. The latter population is commonly known as *Medicare-Medicaid enrollees*. In the past they were sometimes called *dual eligibles*, although this terminology has been replaced with *individuals who are dually eligible* for both programs. Medicare coverage is primary to Medicaid coverage for individuals enrolled in both programs. This means that Medicaid is the payer of last resort.

Many individuals with mental disorders are Medicare-Medicaid enrollees. For example, in a research study conducted by the BeST Center, BeST used Ohio Medicaid claims data to identify adults with serious mental illness (SMI). The study indicates that the majority of adults diagnosed with schizophrenia or psychosis are eligible for both Medicaid and Medicare.¹ The discussion below of service utilization and costs associated with Medicare-Medicaid enrollees shows that they are among the most chronically ill and costly individuals enrolled in both the Medicare and Medicaid programs, and they are heavy users of behavioral health services.

Affordable Care Act Emphasis on Medicare-Medicaid Enrollees

Individuals enrolled in both Medicare and Medicaid must navigate two separate systems in order to access the full range of health services to which they are entitled. This results in care that is often uncoordinated, inefficient, and costly.

Understanding that there are unique opportunities to improve the service delivery and payment systems for care provided to Medicare-Medicaid enrollees, Congress created in the Affordable Care Act the Medicare-Medicaid Coordination Office within CMS. This office is charged with making the two programs work together more effectively in order to improve care and lower costs. This collaboration is enabling states and the Center for Medicare & Medicaid Services (CMS) to work together to design coordinated efforts to improve care, share data, and share savings. These efforts were never possible before. Specifically, the Office is focused on improving quality and access to care for Medicare-Medicaid enrollees, simplifying processes, and eliminating regulatory conflicts and cost-shifting that occurs between the Medicare and Medicaid programs, states, and the federal government.²

In conjunction with this effort, in April 2011 CMMI launched a project titled *State Demonstrations to Integrate Care for Dual Eligible Individuals*. Under the project, CMS is

working with 15 states to design person-centered approaches to better coordinate care for Medicare-Medicaid enrollees. The goal is to develop, test and validate integrated delivery system and care coordination models that can be replicated in other states.³

The states selected to receive design contracts are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. Each state will be awarded up to \$1 million to develop a model that describes how it will structure and implement its planned intervention. States that engage with beneficiaries and other stakeholders and successfully complete their design contract may be eligible to receive support to implement their proposals. After federal review of the proposals, CMS will work with states to implement the plans that hold the most promise.³

A key component of these initiatives will be testing new payment and financing models to promote better care and align the incentives for improving care and lowering costs between Medicare and Medicaid.³ Some states whose planning efforts are not funded under the demonstration are pursuing integrated care delivery systems without the aid of federal funding. CMS is providing technical assistance to these states.

Some of the goals that characterize projects proposed by the states selected to receive design contracts are—

- Create an accountable care organization (ACO) with embedded medical education programs that specifically serve high-cost patients that are eligible for both Medicare and Medicaid.
- Explore the feasibility of establishing a benefit plan and network—administered and operated by the state—that combines the funding streams from Medicare and Medicaid and uses these funds to purchase coverage through a plan and network developed and administered by the state.
- Expand the state’s Program of All-Inclusive Care for the Elderly (PACE).
- Expand the state’s Medicaid program being administered through a managed care program to include Medicare Part A and B services.
- Establish local Integrated Care Organizations to create a single point of accountability for the delivery, coordination, and management of primary, preventive, acute, and behavioral health that is integrated with long-term supports and services and medication management for Medicare-Medicaid enrollees.⁴

Who is Eligible for Medicare?

To be eligible for Medicare, individuals must be: aged 65 years or older, younger than age 65 with a disability, or any age with end-stage renal disease (ESRD). Additional eligibility criteria also apply for these categories of individuals.

Generally, individuals who meet all of the criteria for Social Security disability are automatically enrolled in Medicare Parts A and B. Individuals younger than age 65 with a mental disorder, as defined by the Social Security program, may be eligible for Medicare by virtue of their entitlement to Social Security disability benefits status.

Many individuals younger than age 65 qualify for Medicare because of a mental disorder, as defined by the Social Security Administration. Under the Social Security program, the evaluation of disability *on the basis of mental disorders* requires documentation of a medically determinable impairment, consideration of the degree of limitation such impairment may impose on the individual's ability to work, and consideration of whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. *Substance addiction disorders* are included in the list of nine diagnostic categories of mental disorders.⁵

Although some individuals qualify for Medicare specifically *because* of the presence of a Social Security-approved mental disorder, many additional Medicare enrollees experience behavioral health needs. SMIs are especially prevalent among individuals younger than age 65 who are eligible for Medicare because of a disability. Approximately 37 percent of Medicare beneficiaries who are eligible because of a disability have a SMI.⁶ Medicare enrollees aged 65 and older also may have behavioral health needs.

Who Are Medicare-Medicaid Enrollees?

Medicare-Medicaid enrollees may be: (1) receiving Medicare and full Medicaid benefits, (2) receiving assistance from a state's Medicaid program to pay their Medicare premiums and, in some cases, cost sharing, or (3) receiving assistance in paying Medicare out-of-pocket costs *and* receiving full Medicaid benefits.⁷

As of 2007, more than 9 million Americans were enrolled in both Medicare and Medicaid. At that time, two-thirds of the Medicare-Medicaid enrollee population was low-income elderly, whereas one-third were individuals younger than age 65 with a disability.⁸ As of 2009, about 12 percent of Medicare-Medicaid enrollees were enrolled in a *Medicaid* managed care plan; 15 percent were enrolled in a private *Medicare* Advantage plan.⁹ Medicaid managed care is discussed more fully in Module 5.

Utilization and Cost

There is significant variation in the needs of Medicare-Medicaid enrollees. For example, a June 2011 MedPAC report to Congress indicates that although more than 25 percent have three or more limitations in the ability to perform activities of daily living, almost half have no such limitations.¹⁰ In terms of clinical conditions, 19 percent of full benefit Medicare-Medicaid enrollees have five or more chronic conditions, whereas 34 percent have one or two and 24 percent have none.⁷ These disparities indicate that the amount of care coordination needed by Medicare-Medicaid enrollees varies drastically—as does the related cost of the care.

Individuals enrolled in both Medicare and Medicaid generally have the most complex conditions and generate the highest costs for both programs. For example:

- In 2007, the total annual spending for the care of Medicare-Medicaid enrollees was \$229 billion across both programs.⁷
- In the Medicaid program, these individuals represent 15 percent of enrollees but 35 percent of all Medicaid expenditures.⁷
- In Medicare, they represent 20 percent of enrollees and 32 percent of program expenditures.⁷

- Medicare-Medicaid enrollees' health costs are nearly five times greater than those of all other people with Medicare.
- Compared with all other Medicaid enrollees, Medicare-Medicaid enrollees' health costs are nearly six times greater.
- Medicare-Medicaid enrollees are three times more likely to have a disability, and overall these individuals have higher rates of diabetes, pulmonary disease, stroke, Alzheimer's disease, and mental illness.⁸

Some social characteristics are known about Medicare-Medicaid enrollees, as demonstrated in Table 8-1. For example:

- Overall, Medicare-Medicaid enrollees have less education and much lower income than all other individuals enrolled in Medicare.
- Medicare-Medicaid enrollees are more likely than Medicare enrollees who are not dually eligible to have mental health needs.
- Medicare-Medicaid enrollees have more significant and costly health needs and require more long-term services and supports than Medicare enrollees who are not dually eligible.¹¹

Table 8-1 Comparison of Medicare-Medicaid Enrollees and All Other Medicare Enrollees, Based on Data from the Kaiser Commission (2011).

Characteristic	Medicare-Medicaid Enrollees (%)	All Other Medicare Enrollees (%)
Less than high school education	52	19
Income less than \$10,000/year	55	6
Cognitive or mental disorder	54	24
Fair to poor overall health	50	22
Nonelderly disabled	41	11
Long-term care residents	15	2

What Services Does Medicare Cover?

Medicare has four different parts that help cover specific services:

- **Part A** is known as hospital insurance. Medicare Part A helps cover medically necessary inpatient care in hospitals, including critical access hospitals and psychiatric hospitals and care in skilled nursing facilities (not custodial or long-term care). Part A also helps cover hospice care and some home health care.¹²

Most individuals do *not* pay a premium for Part A because they or a spouse have already contributed through payroll taxes deducted during their working years. Some individuals can enroll in Part A if they pay a monthly premium, which was \$441 in 2013.¹³

An individual can get Medicare Part A at age 65 *without* having to pay a premium if:

- He or she already gets retirement benefits from Social Security or the Railroad Retirement Board.
- He or she is eligible to get Social Security or Railroad benefits but has not yet filed for them.
- The individual or his or her spouse had Medicare-covered government employment.

An individual younger than age 65 can get Medicare Part A without having to pay a premium if he or she:

- Received Social Security or Railroad Retirement Board disability benefits for 24 months; individuals with amyotrophic lateral sclerosis qualify the month disability benefits begin.
- Has ESRD and meets certain requirements.¹⁴

Regardless of their eligibility for Medicaid benefits, Medicare beneficiaries with limited resources and income can get their Medicare Part A premiums and, in some cases, Medicare Part A coinsurance and deductibles paid by Medicaid.

- **Part B** is known as supplementary medical insurance. Medicare Part B helps cover medically necessary doctors' services, outpatient care, durable medical equipment, and preventive services. It also covers some other medical services that Part A does not cover, such as physical and occupational therapy and some home health care.¹² Most individuals pay a monthly premium for Part B. The standard Part B monthly premium in 2012 is \$104.90.¹³ Individuals with higher income pay a higher premium. If an individual decides not to enroll in Part B when he or she is first eligible, there may be a penalty to pay if the individual enrolls later.

Regardless of their eligibility for Medicaid benefits, Medicare beneficiaries with limited resources and income can get their Medicare Part B premiums and, in some cases, Medicare Part B coinsurance and deductibles paid by Medicaid.

- **Part D** is prescription drug coverage. This coverage is available from Medicare-approved private insurance companies from which individuals choose their drug plan. Part D plans can vary in deductibles, copayments or coinsurance, specific drugs covered, and premiums. Most individuals pay a monthly premium for this benefit. As with Part B premiums, individuals with higher income pay more. In addition, if an individual decides not to enroll in a drug plan when he or she is first eligible, there may be a penalty to pay if the individual joins later.¹²

Medicare beneficiaries with limited resources and income can get extra help from Medicare in paying out-of-pocket costs under Medicare Part D.¹⁵ This is known as the Low Income Subsidy.

- **Part C**—also known as *Medicare Advantage*—is *not* a defined benefit. Rather, Part C makes Part A and B benefits and services available through private Medicare-approved health plans for most individuals who are eligible for Medicare. Individuals with ESRD are not eligible to enroll in a Part C plan; however, if they develop ESRD

while enrolled in Part C, they can stay. Medicare Advantage Plans must follow rules established by Medicare. They must cover Part A and B services—except hospice care—but they can have different rules for how individuals access services such as specialty care or non-urgent care. Most Medicare Advantage Plans also cover Medicare prescription drug coverage (Part D). Some Advantage Plans include extra benefits such as hearing, vision and dental coverage, although there may be an additional cost.¹⁶ Premiums for Part C vary by plan.

Behavioral Health Services Covered by Medicare

Behavioral health service coverage under traditional Medicare includes medically necessary services to diagnose and treat behavioral health conditions. Medicare helps cover outpatient and inpatient behavioral health care as well as prescription drugs. Individuals who receive Medicare coverage through a Medicare Advantage Plan are covered for the same behavioral health services as those provided by traditional Medicare, although deductibles, coinsurance, or copayments may differ.¹⁷

Medicare Part A (hospital insurance) helps cover medically necessary inpatient hospital behavioral health care provided in a general hospital or in a psychiatric hospital. Medicare Part A covers an individual's room, meals, nursing care, and other related services and supplies. Medicare Part A does *not* cover the cost of private duty nursing, a telephone or television in an individual's room, personal items (like toothpaste or socks), or a private room unless medically necessary.¹⁷

Medicare Part A measures use of hospital services, including services an individual receives in a psychiatric hospital, based on benefit periods. A *benefit period* begins the day an individual is admitted to a hospital or skilled nursing facility for physical or mental health care and ends after the individual has not had hospital or skilled nursing care for 60 consecutive days. A new benefit period begins after 60 days without hospitalization have passed. There is no limit to the number of benefit periods an individual can have when he or she receives behavioral health care in a general hospital; however, deductibles and coinsurance apply to certain days of the hospital stay within a benefit period and there is a *lifetime coverage limit* of 60 hospital days beyond the 90th day in each benefit period. An individual can also have multiple benefit periods when he or she receives care in a psychiatric hospital, but Medicare imposes a *lifetime coverage limit* of 190 days of inpatient psychiatric hospital services provided in a psychiatric hospital.¹⁷

Medicare Part A also covers alcohol detoxification and rehabilitation services furnished as inpatient hospital services. Both diagnostic and therapeutic services for treating alcoholism are covered in an outpatient hospital setting. Treatment for drug abuse or other chemical dependency also is covered.

Medicare Part B (medical insurance) helps cover medically necessary outpatient behavioral health services, including visits with a psychiatrist or other physician, visits with a clinical psychologist or clinical social worker, and laboratory tests ordered by a physician. Outpatient mental health services covered under Part B may be provided in a clinic, doctor's or therapist's office, or hospital outpatient department. Services must be provided by licensed professionals permitted by state professional practice acts.¹⁷

Medicare helps cover the following outpatient services under Part B—

- Individual and group psychotherapy with physicians or certain other licensed professionals who are allowed by the state to provide these services
- Family counseling, if the main purpose is to help with treatment
- Testing to determine if the individual is getting the services he or she needs and/or if current treatment is helping
- Psychiatric evaluation
- Medication management
- Occupational therapy that is part of the individual's mental health treatment
- Certain prescription drugs that are not usually self-administered, such as some injections
- Individual patient training and education about the individual's condition
- Diagnostic tests
- Annual depression screening in a primary care setting that can provide follow up treatment and referrals¹⁷
- Annual alcohol misuse screening with brief counseling sessions for those who screen positive
- Counseling for smoking and tobacco use cessation, including intermediate and intensive counseling levels

Medicare Part B may pay for partial hospitalization services associated with treating mental illness. Partial hospitalization is a structured program of outpatient active psychiatric treatment that is more intense than standard outpatient mental health services delivered in a physician's or therapist's office. Partial hospitalization is provided during the day and does not involve an overnight stay. These programs are usually provided through hospital outpatient departments and local CMHCs. For Medicare to cover a partial hospitalization program, a physician must certify that the individual would otherwise need inpatient psychiatric treatment.¹⁷

Medicare Part B also covers structured assessment and brief intervention provided in a doctor's office or outpatient hospital department for substance use (other than tobacco). This is related to the screening, brief intervention, and referral to treatment (SBIRT) services recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA); CMS uses the SBIRT acronym for the structured assessment and brief intervention covered by Part B, without referring to the original name.

After an individual pays his or her Medicare Part B deductible, the amount of coinsurance for behavioral health services under traditional Medicare depends largely on whether the service is diagnostic or therapeutic.¹⁷ The copayment amount for a diagnostic service, as well as brief visits for managing medications of mentally ill patients, is 20 percent; in 2012, the copayment for most other outpatient behavioral health treatment services was 40 percent, but it will fall to 20 percent by 2014.

Medicare Part B does *not* cover the following services:

- Meals
- Transportation to or from mental health care services

- Support groups that bring people together to talk and socialize (unlike group psychotherapy, which is covered)
- Testing or training for job-related skills that are not part of mental health treatment.¹⁷

Medicare Part D (prescription drug coverage) helps cover prescription drugs needed to treat a mental disorder as well as prescribed smoking and tobacco use cessation agents. Almost all Medicare drug plans have a list of drugs that the plan covers, called a *formulary*. Medicare drug plans generally are not required to cover all drugs, but they *are* required to cover all or almost all antidepressant, anticonvulsant, and antipsychotic medications that may be necessary to keep an individual “mentally healthy.” Medicare reviews each drug plan’s formulary to ensure that it includes a wide range of medically necessary drugs and that it does not discriminate against certain groups, such as individuals with disabilities or mental health conditions.¹⁷ Medicare drug plans are *not* required to cover certain kinds of drugs, such as benzodiazepines and barbiturates. Some Medicare drug plans may *choose* to cover these drugs as an added benefit.

Additionally, a state Medicaid program may cover these drugs for individuals enrolled in *Medicaid*, so Medicare-Medicaid enrollees may be able to access coverage through Medicaid if Medicare does not cover a particular drug. If a physician believes that an individual needs a particular drug not covered by his or her Medicare drug plan, the individual can ask the drug plan to make an exception.¹⁷

Prescription Medications, Medicare Part D, and Medicaid Implications

With the advent of Medicare Part D in 2006, the major financial responsibility for prescription medications for those dually enrolled in Medicare and Medicaid was transferred from Medicaid to Medicare. Medicare Part D plans provide coverage for most antidepressant, anticonvulsant, and antipsychotic medications; however, these plans are not required to include coverage for benzodiazepines, barbiturates, or drugs for weight loss or gain, although many plans choose to provide this coverage. For those dually enrolled, medications not covered by Medicare may be covered by Medicaid, depending on the state.

Nationwide, Medicaid spending on all prescription drugs in 2006 fell by almost 50% of the 2005 level when financial responsibility for medications for dually enrolled individuals was transferred to Medicare Part D.¹⁸

Behavioral Health Providers Covered by Medicare

Medicare Parts A and B cover services delivered in or by the following providers:

- General hospital
- Psychiatric hospital that cares only for people with mental health conditions
- Psychiatrist or other doctor
- Clinical psychologist
- Clinical social workers
- Clinical nurse specialists
- Nurse practitioner
- Physician’s assistant

Certain conditions apply. For example, services of some providers must be performed under the general supervision of a physician. Providers also must be legally authorized to perform the services in the state.

Summary

The CMS focus on coordinating and integrating care for Medicare-Medicaid enrollees, coupled with the state's commitment to implement such programs, highlights a new opportunity to improve care and outcomes for this population—many of which have mental and substance use disorders. As these initiatives continue to grow and mature, it is imperative for behavioral health policymakers to be attuned to developments and involved in shaping policy in ways that help ensure success for consumers and providers.

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