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TO: Dual Eligible Special Needs Plans (D-SNPs) and State Medicaid Agencies
Contracting with D-SNPs

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SUBJECT: Frequently Asked Questions on Coordinating Medicaid Benefits and Dual
Eligible Special Needs Plans Supplemental Benefits

CMS developed these frequently asked questions (FAQ) to help states and Medicare Advantage organizations better coordinate Medicaid benefits and Medicare supplemental benefits, especially those offered through Dual Eligible Special Needs Plans (D-SNPs).

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law. This document supersedes and clarifies guidance in Medicare Managed Care Manual chapters 4 and 16b prohibiting Medicare Advantage supplemental benefits that “duplicate” Medicaid benefits. This guidance is directed to states and Medicare Advantage organizations that offer D-SNPs.

1. How can my state get our D-SNPs to help us coordinate Medicaid benefits with overlapping D-SNP supplemental benefits?

42 CFR 422.107 requires each Medicare Advantage organization offering a D-SNP to have a contract with the state Medicaid agency that describes, among other things, the organization’s responsibility to coordinate Medicaid benefits. States have broad flexibility to include provisions in their D-SNP contracts. States may include provisions related to the supplemental services the D-SNP offers, how the Medicare Advantage organization shares information about those services, and processes for coordinating benefits across programs.

2. Can D-SNPs offer supplemental benefits beyond coverage of Medicare Parts A, B, and D?

Yes, like other Medicare Advantage plans, D-SNPs can offer supplemental health care benefits not covered by Medicare Parts A, B, and D under longstanding CMS policy interpreting the applicable law and 42 CFR § 422.100(c)(2).¹ Since D-SNPs generally do not charge a premium, the costs of supplemental benefits are generally paid through “rebate dollars”—the amount the D-SNP receives if its bid to provide Medicare Part A and B benefits is below the benchmark for its service area. The D-SNP receives a percentage of the amount by which the benchmark exceeds its bid—the rebate, which can be used to pay for supplemental benefits.² D-SNPs in contracts with higher star ratings receive a higher percentage of that difference.

3. Our state covers Medicaid benefits for dually eligible enrollees on a fee-for-service (FFS) basis. Some of the D-SNP’s supplemental benefits (e.g. dental, non-emergency transportation) that may overlap with Medicaid benefits. Are D-SNPs allowed to provide such benefits? How can the state ensure Medicare pays first for such overlapping benefits?

When Medicaid services are covered on a FFS basis, D-SNPs can provide Medicare supplemental benefits that overlap with Medicaid benefits. Under section 1902(a)(25) of the Social Security Act, states that deliver these benefits through Medicaid FFS must coordinate benefits with the D-SNP to ensure that Medicaid does not pay for benefits that are covered by Medicare as D-SNP supplemental benefits. For example, a state could ensure that dually eligible enrollees use up the number of trips provided by the D-SNP before using the overlapping Medicaid transportation benefits. States can also use their contracts with D-SNPs to require these plans to take specific actions, such as providing information on benefits or service use to the state or its Medicaid providers, to enable successful and seamless coordination of benefits.

4. Our state provides a capitation payment to D-SNPs operating in the state to cover dental services for full-benefit dually eligible enrollees. Can the D-SNP also provide dental services as a Medicare Advantage supplemental benefit?

Yes, as long as the D-SNP (and its Medicaid MCO affiliate) are not paid twice, once by Medicare and once by Medicaid, for covering the identical benefit to the same enrollees in the same contract year. As noted above, under section 1902(a)(25) of the Act, Medicaid should not pay for a benefit that Medicare covers to the same extent for the same individual. This principle applies whether the benefits are paid for on a fee-for-service or capitation basis.

States can use their contracts with D-SNPs under 42 CFR § 422.107 to meet these requirements and ensure Medicaid funds provided to the D-SNP only pay for Medicaid benefits. These state

¹ The regulation at 42 CFR § 422.100(c) was amended by a recent final rule, Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4190-F2), which appeared in the Federal Register on January 19, 2021 (86 FR 5864), to codify the requirements and criteria for supplemental benefits. Supplemental benefits can take the form of reductions in cost sharing for Medicare benefits beyond the limits on cost sharing for Medicare Advantage plans or coverage of additional items and services.

² Under 42 CFR § 422.260, Medicare Advantage plans may use rebates to pay the premiums for supplemental benefits or to pay all or part of the Part B or Part D premiums for the plan’s enrollees. As a type of Medicare Advantage plan, D-SNPs have the same flexibilities.

contracts with D-SNPs, in combination with state Medicaid benefit design, can help create benefits that are in addition to Medicare benefits and complementary across programs. For example, a D-SNP that also has a Medicaid managed care contract could use both Medicare and Medicaid dollars to provide a benefit that, on an actuarial basis, equals the value of the benefit from the combination of both funding streams. The plan must be able to clearly identify, for Medicaid managed care rate setting purposes, claims that are payable under the Medicaid program after exhaustion of the Medicare benefit.

In all cases, the capitation rate for the Medicaid benefit must be actuarially sound and based on the cost of furnishing only the Medicaid-covered benefits (42 CFR §§ 438.3(c) and (e); 438.4 through 438.7). Similarly, the rebate revenue allocated for the Medicare Advantage supplemental benefit package must reflect the organization's estimate of the revenue required to furnish the Medicare Advantage supplemental benefits only (42 CFR §§ 422.252 through 422.256, 422.266).

5. What if a state has a capitated contract with a different entity (e.g., a specialty dental plan or transportation vendor) for services that overlap with the D-SNP's supplemental benefits?

As noted above, Medicare is the primary payer whenever Medicare and Medicaid cover the same services. As such, the state and its capitated vendor must coordinate to avoid duplication of services or duplicate payment for services delivered as Medicare Advantage supplemental benefits. For example, the state can make an adjustment to the base data used for Medicaid rate development to address coordination of benefits, such as when both Medicare Advantage and Medicaid cover a benefit, to ensure Medicaid rate development appropriately accounts for Medicaid being the payer of last resort. Avoiding this circumstance is one more advantage of integrated care – capitating the same organization for all services – over fragmentation.

6. Our state offers a limited preventive dental benefit of two cleanings per year through Medicaid FFS. The D-SNPs in our state all cover these two dental cleanings as Medicare Advantage supplemental benefits. Does our state have to cover an additional two dental cleanings for a D-SNP enrollee who has used up the D-SNP benefit?

No, a state can determine that the use of the D-SNP supplemental benefit has exhausted the identical Medicaid benefit. A state may make such a determination in cases where it believes provision of the Medicaid benefit in addition to the Medicare supplemental benefit is not medically necessary or cost-effective. Alternatively, a state can provide an overlapping Medicaid benefit once the D-SNP supplemental benefit is exhausted, if, for example, it believes the additional benefits would improve the care and support received by dually eligible individuals through the two programs. See the discussion of transportation benefits in Q&A #3 above and of respite care in Q&A #10 below. In either case, a state should work with its contracted D-SNPs to ensure Medicare Advantage coverage is primary to any Medicaid coverage.

7. How would a D-SNP apply supplemental benefits that reduce Part A and B cost sharing, such as deductibles and coinsurance, when the enrollee is a dually eligible individual?

In general, the same obligations apply as described for duplicate or overlapping coverage of items and services. How it works depends on whether the state pays for cost sharing through Medicaid FFS or pays the D-SNP a capitated amount to cover the state's obligation to pay Medicare cost sharing. For example, if a D-SNP does not impose the Part B deductible but otherwise uses Part B cost sharing, it would have the following effects:

- It would reduce to \$0 the amount the state Medicaid FFS pays providers serving QMBs and other full-benefit dually eligible enrollees in the D-SNP for the Part B deductible.
- If the state pays the D-SNP (or its affiliate) for coverage of Medicare cost sharing otherwise payable by the state, it would eliminate any cost for coverage of the Part B deductible from those payments to the plan. As explained in the Q&As #3 through 6 above, D-SNPs cannot receive duplicate payments for coverage of the Part B deductible – once, in the form of the capitated payments from the state for Medicaid coverage and again by including the cost of eliminating the Part B deductible in the supplemental benefits that are paid by the Medicare rebate.

8. Our state pays a capitated rate to the D-SNP for coverage of the Medicaid-covered benefit of payment of Medicare cost sharing, but the state pays less than the full Medicare cost sharing amount due to the application of a “lesser-of”³ payment method for Medicare cost sharing. Could a D-SNP in our state combine Medicaid capitated payments and Medicare rebate dollars to fully or partially cover Medicare cost sharing—i.e. the amount a dual eligible beneficiary would pay if not subject to cost sharing protections⁴?

Yes, provided that the State capitation payment and MA bid do not both pay for the same costs. The amount paid using MA rebates must be based on the actuarial value of the reduction in cost sharing that is part of the MA plan benefit design and the State capitation payment must be based on the actuarial value of cost sharing paid for Medicare Parts A and B services under the “lesser of” payment method. The overall reduction in cost sharing must be actuarially equivalent to the cost sharing paid for by the Medicaid capitated payment PLUS the Medicare rebate dollars allocated to further reductions in cost sharing compared to the actuarial value of cost sharing in Original Medicare.

9. Outside of contracting with the D-SNP to cover Medicaid benefits (e.g., payment of Medicare cost sharing, coverage of additional benefits, etc.), are there ways a state can influence how a D-SNP delivers care?

Yes, a state may work with D-SNPs with service areas in the state to include (and, through the state Medicaid agency contract at 42 CFR § 422.107, require inclusion of) specific elements of

³ Under the “lesser of” policy, a state caps its payment of Medicare cost sharing at the Medicaid rate for a particular service. For example, if the Medicare (or Medicare Advantage) rate for a service is \$100, of which \$20 is beneficiary coinsurance, and the Medicaid rate for the service is \$90, the state would only pay \$10. If the Medicaid rate is \$80 or lower, the state would make no payment

⁴ Qualified Medicare Beneficiaries and Full Benefit Medicare Beneficiaries have protections from being charged cost sharing for Medicare Parts A and B services. See <https://www.cms.gov/files/document/medicaremedicaidenrolleecategories.pdf> for the protections that apply to different categories of dually eligible individuals.

the model of care (MOC) at 42 CFR § 422.101(f) and how the D-SNP delivers covered items and services consistent with the MOC. Each SNP is required by 42 CFR § 422.101(f) to have a model of care, and each D-SNP is required by 42 CFR § 422.107 to have a contract with the state in which the D-SNP operates. There is no prohibition on a state imposing specific requirements for the D-SNP model of care; compliance with the approved MOC is included in the D-SNP's bid to provide basic benefits under 42 CFR § 422.101(f). For example, the state Medicaid agency contract required by 42 CFR § 422.107 could require the D-SNP to include specific community-based providers for development of individualized care plans required by MOCs or to provide nurse practitioners for in-home care for high-risk enrollees when in-home services are required by the individualized care plans. The state Medicaid agency contract required by 42 CFR § 422.101(f) may require the D-SNP to use health care providers (rather than plan staff) for care coordination functions and/or set minimum payment amounts for such providers.

10. Our state contracts with FIDE SNPs to deliver Medicaid long-term services and supports to its enrollees who meet the state eligibility criteria to receive such services. How can these FIDE SNPs use the flexibility Medicare Advantage plans have to deliver similar services as supplemental benefits in a way that expands the availability of these services and supports?

A state may use the agreement required by 42 CFR § 422.107 between the state and the D-SNP to require the FIDE SNP to expand availability of an item or service that is also covered under Medicaid. For example, the state may require the FIDE SNP to have coverage of an item or service that is only covered under Medicaid for certain beneficiaries by offering a Medicare supplemental benefit that:

- Covers the item or service as a supplemental benefit (provided the requirements for supplemental benefits are met) for enrollees who are not eligible to receive the item or benefit under Medicaid; or
- Fills in in gaps or provides coverage that exceeds the amount, duration or scope of the Medicaid coverage of the item or service

All Medicare Advantage plans, including D-SNPs, must comply with uniformity requirements in designing and offering supplemental benefits under section 1854(c) of the Act and 42 CFR §§ 422.2 (definition of Medicare Advantage plan), 422.100(d), and other regulations. CMS will consider the supplemental benefits as meeting the uniformity requirements in cases where some dually eligible enrollees receive the benefit under the FIDE SNP's Medicaid contract while other enrollees receive the benefit as a supplemental benefit because they are not eligible for Medicaid benefits under state eligibility criteria.

For example, a state could contract with the FIDE SNP to offer a supplemental benefit for coverage of home- and community-based services to its enrollees who either 1) meet the state Medicaid criteria to receive Medicaid home- and community-based services but are on waiting lists, or 2) do not receive full Medicaid benefits (partial-benefit dually eligible individuals) or do not meet state Medicaid criteria to receive home- and community-based services, and are therefore ineligible to receive such benefits under the FIDE SNP's Medicaid managed care contract.

Alternatively, a state could contract with its FIDE SNP to use Medicare rebate dollars to pay for a supplemental benefit that the state wants the FIDE SNP to provide in addition to the Medicaid-funded benefit the FIDE SNP provides. For example, depending on the state's contracting and benefit design, a D-SNP could provide its enrollees with two total weeks of respite care even though the Medicaid benefit is limited to one week by providing a supplemental benefit for respite care. The FIDE SNP would provide the first week of respite care—as a Medicare supplemental benefit—and the second week of respite care in its role as a Medicaid managed care plan (where Medicaid is the secondary payer).