Key Issues for Dual Eligible Beneficiaries: Integrated Care and Protection from Medicare Cost-Sharing

Vanessa Duran
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services

August 3, 2016

Overview

- The Medicare-Medicaid Coordination Office
- Key Issues for Dual Eligible Beneficiaries
  - The Financial Alignment Initiative
  - Reducing Inappropriate Billing of Qualified Medicare Beneficiaries (QMBs)
- Resources for More Information

Medicare-Medicaid Enrollee Delivery System Transformation

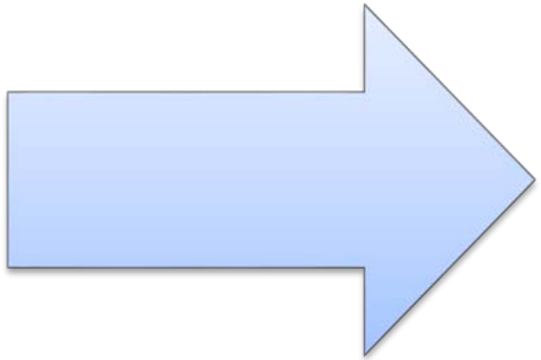
CURRENT STATE

Provider and Payer-Centered

Fragmented Care

Volume-Driven

Complicated Benefit Overlap



FUTURE STATE

Person-Centered

Coordinated Care

Outcomes-Driven

Simplified Processes

Medicare-Medicaid Coordination Office - Introduction

Section 2602 of the Affordable Care Act

Purpose: Improve quality, reduce costs, and improve the experience for individuals who receive Medicare and Medicaid benefits

- Ensure full **access** to services to which they are entitled
- Improve **coordination** between the federal government and states
- Develop **innovative** care coordination and integration models
- Eliminate financial **misalignments** that lead to poor quality and cost shifting

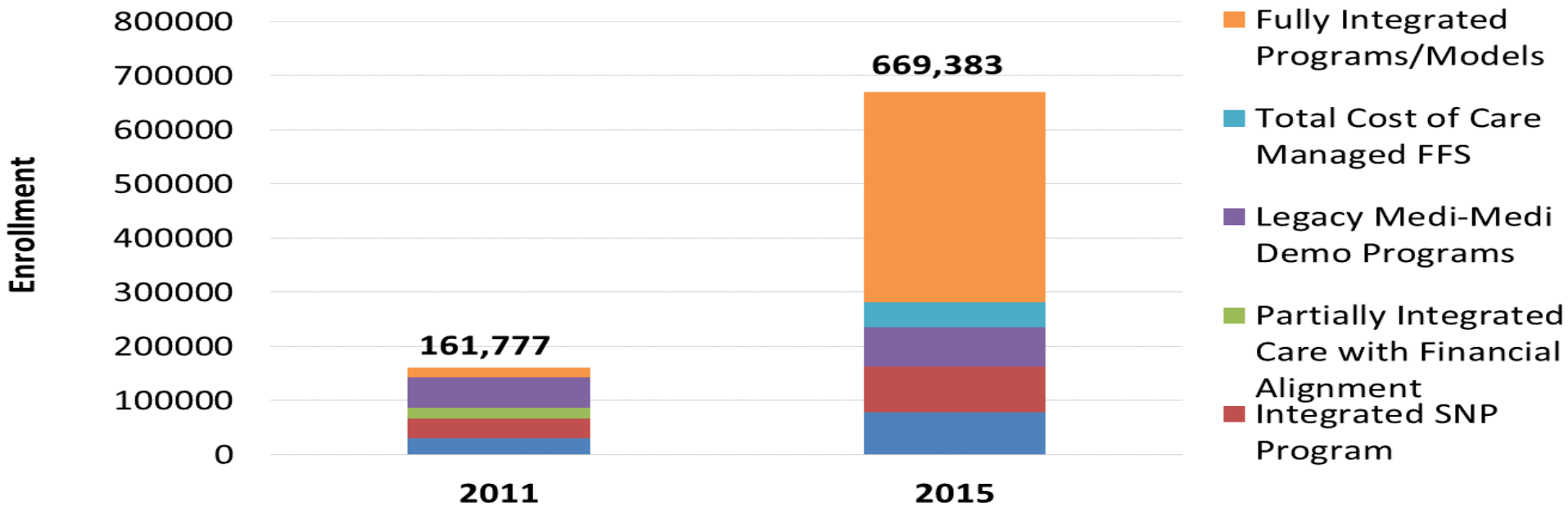
Medicare-Medicaid Coordination Office - Vision

Vision: Promote an improved experience for persons with both Medicare and Medicaid by:

- Focusing on **person-centered models** that promote coordination
- Developing a **more easily navigable and simplified** system of services
- Ensuring **individual access** to needed services and incorporating **individual protections** into each aspect of the new demonstrations
- Establishing **accountability** for outcomes across Medicare and Medicaid
- Requiring robust **network adequacy** standards for both Medicare and Medicaid
- Evaluating **data** on access, outcomes, and individual experience to ensure individuals receive higher quality, more cost-effective care

Financial Alignment Initiative

Growth of Integrated Care Enrollment among Dually Eligible Beneficiaries



Source: Analysis performed by the Integrated Care Resource Center, under contract with CMS. "Fully Integrated Programs/Models" include MMP and PACE enrollment through June 2015. "Total Cost of Care Managed FFS" includes enrollment in the Colorado and Washington Managed Fee-For-Service demonstrations under the Medicare-Medicaid Financial Alignment Initiative. "Legacy Medi-Medi Demo Programs" includes enrollment in FIDE SNP programs in Massachusetts, Minnesota, and Wisconsin that began as demonstrations. "Partially Integrated Care with Financial Alignment" refers to the North Carolina Medicare Health Care Quality Demonstration; no 2015 information is included for 2015 because the initiative had ended. "Integrated SNP Program" and "Partially Integrated SNP Program" enrollment includes programs in which a Medicare-Medicaid enrollee receives both Medicare and Medicaid services from companion or aligned Medicare D-SNPs and Medicaid managed care plans.

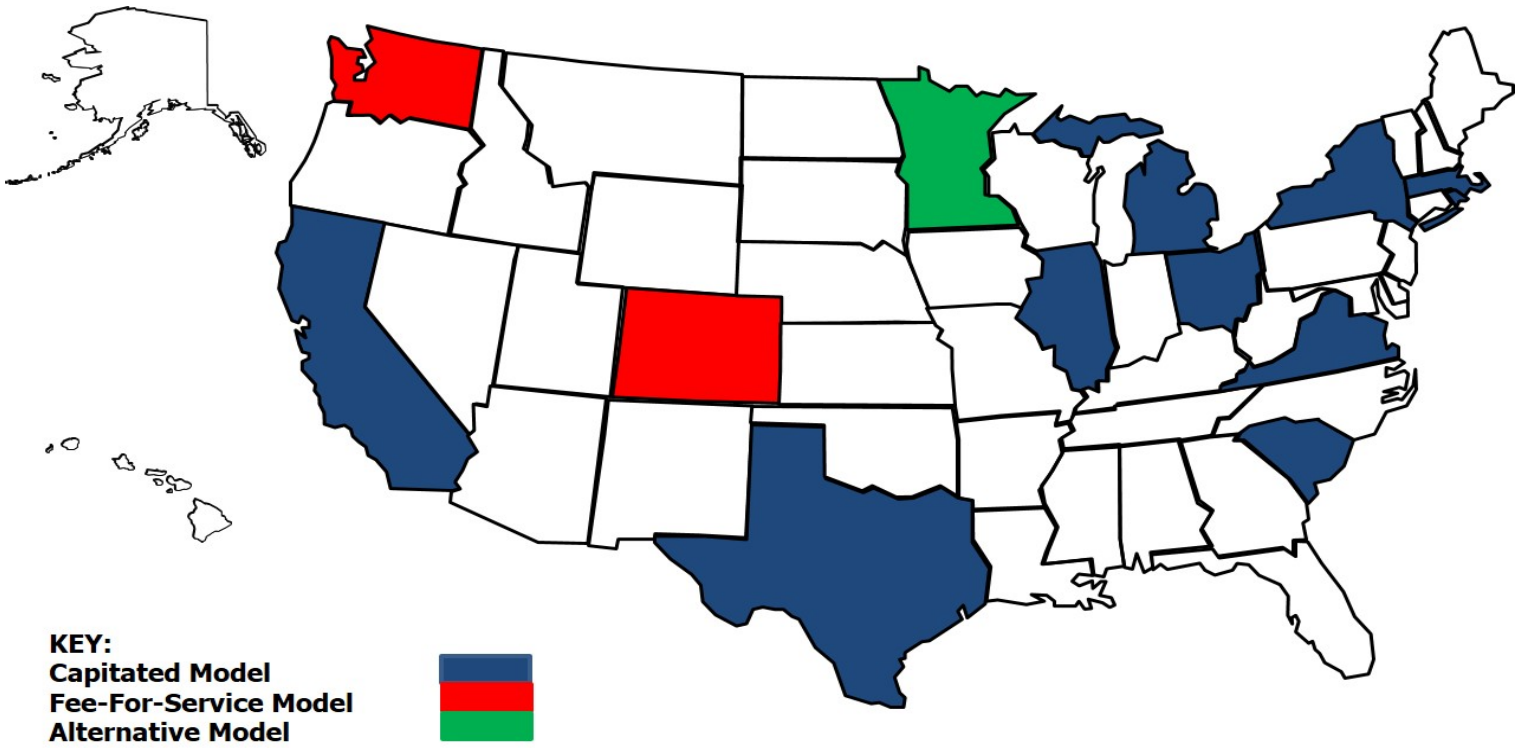
Financial Alignment Initiative - Background

- **Background:** In 2011, CMS announced new models to integrate the service delivery and financing of both Medicare and Medicaid through federal-state demonstrations to better serve the population.

- **Goal:** Increase access to quality, seamlessly integrated programs for Medicare-Medicaid enrollees.

- **Demonstration Models:**
  - **Capitated Model:** Three-way contracts among states, CMS, and health plans to provide comprehensive, coordinated care in a more cost-effective way.
  - **Managed FFS Model:** Agreements between states and CMS under which states would be eligible to benefit from savings resulting from initiatives to reduce costs in both Medicaid and Medicare.
  - **Alternative Model:** Agreement to integrate care for Medicare-Medicaid enrollees building on the State's current infrastructure (MN)

Financial Alignment Initiative - States



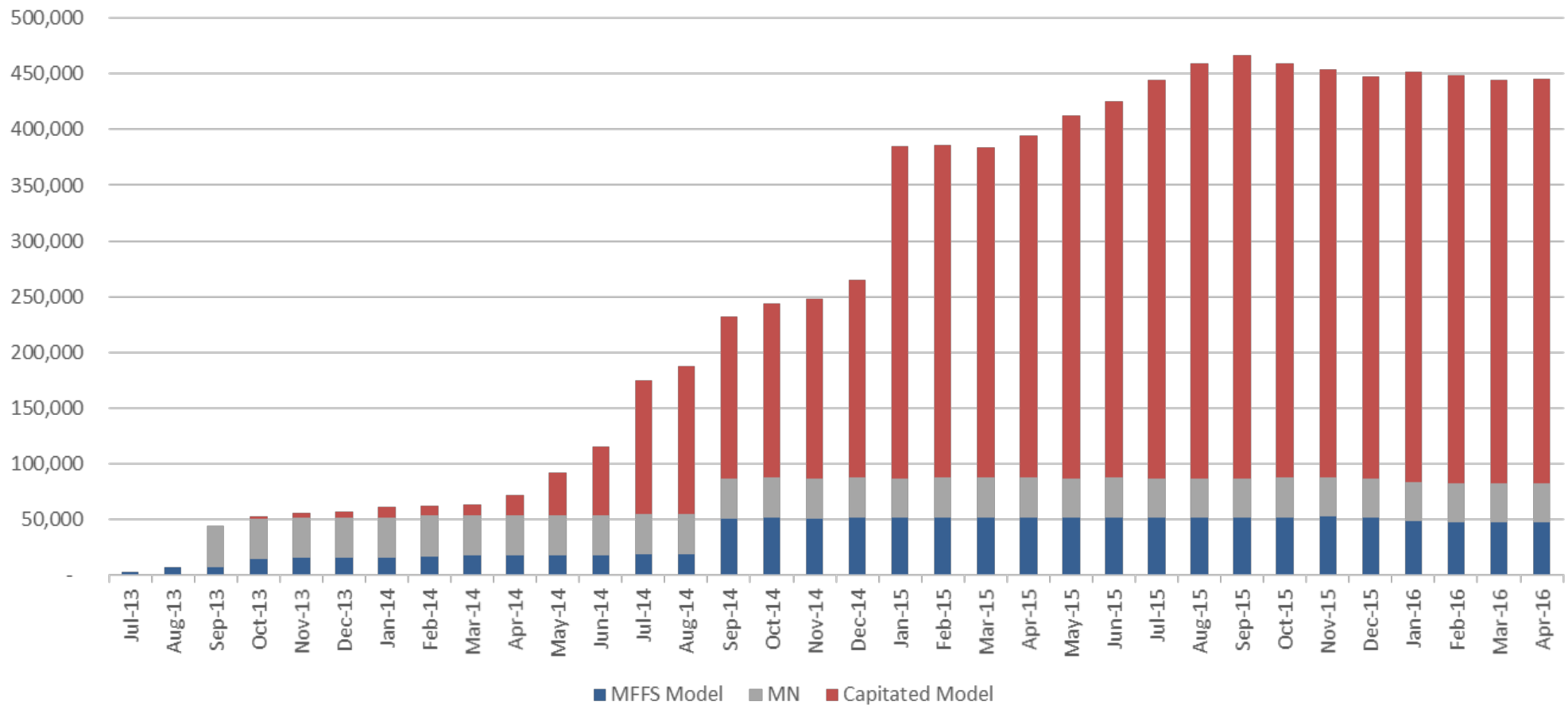
The Vision of the Capitated Model

- Enrollment assistance and options counseling
- Integrated set of enrollee materials and single ID card
- Person-centered care planning
- Choice of plans and providers
- Minimum travel and distance times
- Limitations on wait and appointment times
- Continuity of care provisions
- Care coordination and assistance with care transitions
- Integrated grievances and appeals process
- Substantive participating provider training requirements

Financial Alignment Initiative - Update

- Positive momentum
  - Dramatic increase in the number of Medicare-Medicaid beneficiaries in financially integrated or total cost-of-care models
  - Hundreds of thousands of assessments, increasing every day
  - Major investments in new care coordination infrastructure
- Lessons learned
  - Communications and enrollment
  - Provider outreach and engagement
  - Earning beneficiary engagement
  - Unmet need

Monthly Enrollment by Demonstration Type



Massachusetts One Care

- 2 Medicare-Medicaid Plans (MMPs)
- 9-county service area: Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester
- Marketing began September 2013
- Enrollment began October 2013
- Passive enrollment began January 2014
- Enrollment as of June 2016: ~13,000

California Cal MediConnect

- 11 MMPs
- 7-county service area: San Mateo, Riverside, San Bernardino, San Diego, Los Angeles, Santa Clara, Orange
- Marketing began February 2014 (varies by county)
- Enrollment began April 2014 (varies by county)
- Approximately 12 waves of passive enrollment in each county (except San Mateo)
- Enrollment as of June 2016: ~123,000

Illinois Medicare-Medicaid Alignment Initiative

- 7 MMPs
- 2-region service area (21 counties): Greater Chicago area and Central Illinois
- Marketing began February 2014
- Opt-in enrollment began March 2014
- Passive enrollment began June 2014
- Enrollment as of June 2016: ~48,000

Virginia Commonwealth Coordinated Care

- 3 MMPs
- 5-region service area (107 localities):
  - Phase 1: Tidewater, Central Virginia
  - Phase 2: Northern Virginia, Roanoke, Western Virginia
- Marketing began March 2014
- Opt-in enrollment began April 2014
- Passive enrollment began July 2014
- Enrollment as of June 2016: ~28,000

MyCare Ohio

- 5 MMPs
- 7-region service area (29 counties): Central, East Central, Northeast, Northeast Central, Northwest, West Central, Southwest
- Marketing began April 2014
- Opt-in enrollment began May 2014
- Passive enrollment began January 2015
- Enrollment as of June 2016: ~63,000

New York Fully Integrated Duals Advantage Demonstration

- 17 MMPs
- 8-county service area (Greater New York City and Long Island):
  - Phase 1: Bronx, Kings, Nassau, New York, Queens, and Richmond
  - Phase 2: Suffolk and Westchester
- Marketing for Phase I began December 2014
- Opt-in enrollment for Phase I began January 2015
- Passive enrollment began April 2015
- Enrollment as of June 2016: ~5,500

South Carolina Healthy Connections Prime

- 4 MMPs
- Statewide
- Marketing began December 2014
- Opt-in enrollment began February 2015
- Passive enrollment began April 2016
- Enrollment as of June 2016: ~6,000

MI Health Link (Michigan)

- 7 MMPs
- 4-region service area (25 counties): Upper Peninsula, Southwest counties, Wayne, Macomb
- Marketing began February 2015
- Opt-in enrollment began March 2015
- Passive enrollment began May 2015
- Enrollment as of June 2016: ~41,000

Texas Dual Eligibles Integrated Care Project

- 5 MMPs (STAR+PLUS Plans)
- 6-county service area: Bexar, Dallas, El Paso, Harris, Hidalgo, Tarrant
- Marketing began February 2015
- Enrollment began March 2015
- Passive enrollment began April 2015
- Enrollment as of June 2016: ~43,000

New York Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities

- 1 MMP
- Focus on Medicare-Medicaid beneficiaries with intellectual and developmental disabilities
- 9-county service area (Greater New York City, Long Island, and Westchester and Rockland counties)
- Marketing began March 2016
- Opt-in enrollment only:
  - — Began April 2016
  - — Enrollment as of June 2016: ~ 200

Rhode Island Integrated Care Initiative

- 1 MMP
- Only individuals enrolled in the Medicaid managed long-term care plan operated by the same parent organization are eligible for passive enrollment
- Statewide service area
- Marketing began June 2016
- Opt-in enrollment began July 2016

Minnesota

- MOU signed in September 2013
- Built on existing Minnesota Senior Health Options (MSHO) program
- 8 different health plans, Medicaid Managed Care Organizations (MCOs)/Medicare Advantage Special Needs Plans for Dual Eligibles (D-SNPs)
- Improve beneficiary experience and administrative efficiency (aligned appeals timeframes, member materials and surveys)
- Serving more than 35,000 beneficiaries

Reducing Inappropriate Billing of Qualified Medicare Beneficiaries (QMBs)

Background

- Over ten million persons in both Medicare and Medicaid ("dual eligible beneficiaries") in 2013
  - Almost seven million (65%) enrolled in Qualified Medicare Beneficiary Program (QMB)
- QMB is a Medicare Savings Program
- Through QMB, Medicaid pays Medicare premiums and cost-sharing (subject to State limits)
  - 80% of QMBs also have full Medicaid (QMB-plus) and 20% have QMB only (QMB-only)

Federal Billing Protections for QMBs

- Federal law bars all Medicare providers from charging QMBs for Medicare cost-sharing (“balance billing”)
  - Social Security Act Sections 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A)
- This rule applies to all Medicare providers:
  - Original Medicare and Medicare Advantage
  - Medicare-only and Medicaid
  - Out-of-state

State Policies to Pay QMB Providers for Medicare Cost-Sharing

- Although Medicaid covers QMB premiums, deductibles, and co-insurance, the Balanced Budget Act of 1997 allows States to limit their payment of Medicare deductibles and coinsurance

- States can limit QMB payments by adopting “Lesser-of” policies:
  - Apply the Medicare or Medicaid reimbursement rate, *whichever is less*
  - Usually eliminate or reduce the Medicare cost-sharing reimbursement

- As of 1/2015, most states apply “lesser of” policies to physician services except:
  - AR, IA, ME, MO, MS, NE, OH, OK, SD, VT, WY are “full payment” States
  - ID & TX use “other” payment limits
  - (MACPAC 2015)

CMS Evaluation of Access for QMBs

- Study of QMB access has two parts:
  - Effect of “lesser-of” policies
  - Beneficiary perspective on access and billing
- See 2015 report

  https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf

CMS' 2015 Findings Regarding Beneficiary Perspectives

- Erroneous billing persists
- Many pay cost-sharing
- Unpaid bills referred to collections
- Appeals process is challenging
- Billing processes are confusing and complex

CMS' 2015 Findings Regarding Access

- QMBs' access to care is compromised
  - Reduced use of primary, routine and preventative care
  - Increased use of acute care services

Medicare-Medicaid Coordination Office Priorities

- Reduce incidence of balance billing:
  - Strengthen CMS information and supports for beneficiaries
  - Revise instructions to plans and providers and conduct targeted outreach
  - Explore administrative reforms to promote provider compliance
- Minimize negative effects on access to care

Revised Instructions to Providers

- Revised Medicare Learning Network (MLN) article regarding QMB balance billing

  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf

- Revised MLN fact sheet regarding dual eligibles:

  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

- Proposed Physician Fee Schedule Rule reminder

Instructions and Clarifications for Medicare Advantage (MA) Plans

- Annual instructions to MA plans and clarification of existing CMS policy
  - Reminds MA plans they must educate providers regarding billing rules
  - Clarifies that CMS anti-discrimination provision means that MA providers cannot refuse to serve enrollees based on QMB status
- CY 2017 MA Call Letter:

  https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2017.pdf
- Updated MA Policy Guidance: Section 10.5.2:

  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf

Resources for More Information

- **Medicare-Medicaid Coordination Office:** ww.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/
- **Financial Alignment Initiative**: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-CoOffice/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html
- **CMS Bulletin for States:** https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-07-2013.pdf
- **MACPAC Report to Congress:** https://www.macpac.gov/wp-content/uploads/2015/03/Effects-of-Medicaid-Coverage-of-Medicare-Cost-Sharing-on-Access-to-Care.pdf
- **MMCO Q&A regarding balance billing:** https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/MedicareMedicaidGeneralInformation.html
- **Consumer Financial Protection Bureau Toolkit:** Information for QMBs (p. 209): http://files.consumerfinance.gov/f/201603_cfpb_your-money-your-goals_toolkit_english.pdf