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Director

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

DATE: FEBRUARY 8, 2013

ALL PLAN LETTER 13-003
SUPERSEDES ALL PLAN LETTER 13-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: COORDINATION OF BENEFITS: MEDICARE AND MEDI-CAL

PURPOSE:

The purpose of this All Plan Letter (APL) is to clarify the reimbursement responsibilities for Medi-Cal Managed Care Plans (MCPs) to Medicare providers for the cost of Medicare services they provide to MCP beneficiaries, who are also Medicare beneficiaries (Duals), as well as applicable Medicare deductibles and coinsurance.

This APL supersedes Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 98-05 as it relates to Duals requirements. The applicable portions of PL 98-05 are restated in this APL. Policy Letter 98-05 is no longer operative for any purpose.

ISSUE:

There have been questions from Medicare providers (both MCP network providers and out-of-network providers) on how to receive reimbursement from MCPs for Medicare services provided to MCP beneficiaries, when the services are not fully reimbursed by Medicare, including the cost for Medicare deductibles and coinsurance.

REQUIREMENTS:

There has not been a change in requirements for reimbursing Medicare providers that serve MCP Duals. MCPs are required to reimburse Medicare providers for Medi-Cal services that are not covered by Medicare and for all applicable Medicare deductibles and coinsurance, as long as collectively they do not exceed the maximum allowable Medi-Cal fee-for-service (FFS) reimbursement rates, as follows:

- For Medicare network providers that have a contractual arrangement with a MCP, it is the responsibility of the MCP and the Medicare provider to establish a reimbursement methodology.

- For out-of-network Medicare providers that do not contract with a MCP, the MCP is responsible for directly reimbursing the Medicare provider.

It should also be noted that under no circumstances should a provider of Medi-Cal services submit claims to, or demand or otherwise collect reimbursement from, a Medi-Cal beneficiary or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal Managed Care Program's scope of benefits as well as any applicable Medicare deductibles or coinsurance.

BACKGROUND:

For the MCP Duals population, MCPs have always been responsible for providing medically necessary Medi-Cal services that are not covered by Medicare and for reimbursement to Medicare providers when total Medicare costs, including deductibles and coinsurance, do not exceed the Medi-Cal allowable FFS reimbursement rates.

Deductibles are the Medicare beneficiary's financial obligation before Medicare will begin reimbursement for services. This is usually a set annual amount; the Medi-Cal program pays the deductibles on behalf of the Medi-Cal beneficiary.

Coinsurance is an amount a Medicare beneficiary may be required to pay after payment of deductibles for the beneficiary's share of cost for Medicare services. This is usually a percentage amount (e.g. 80 percent paid by Medicare; 20 percent paid by the beneficiary). The Medi-Cal program may pay the coinsurance on behalf of the Medi-Cal beneficiary.

Payment

- Medicare costs are calculated as part of a MCP's capitated rate.
- In general, for most Medicare services provided to MCP beneficiaries, Medicare pays 80 percent of the Medicare allowable rate with the remaining 20 percent coinsurance being covered by the MCP, up to the allowable Medi-Cal FFS rate. MCPs also cover Medicare deductibles as long as the total cost for all services, deductibles, and coinsurance does not exceed the Medi-Cal FFS rate.
- The reality in most cases is that Medi-Cal does not reimburse for most Medicare services, including deductibles and coinsurance because the Medicare rate is typically higher than the Medi-Cal rate. However, there are some exceptions. For long-term care services, Medi-Cal does pay the full coinsurance and deductible.

Recent Developments

In the past, most Duals received their Medi-Cal services through the FFS system for services not covered by Medicare. Although some Duals were enrolled in MCPs for their Medi-Cal services, the number of MCP Duals was very small relative to the total enrollment of Medi-Cal beneficiaries in MCPs. Now, thousands of Duals are enrolling in MCPs to receive Community-Based Adult Services (CBAS), and many more will be mandatorily enrolled as a result of the Coordinated Care Initiative (CCI), enacted under Senate Bill 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012).

Duals are not required to choose a Medi-Cal managed care primary care physician (PCP). Beneficiaries have the option to continue to receive services through their Medicare PCP while simultaneously enrolled in a MCP. This is true regardless of whether the Medicare provider is part of a MCP's provider network, or an out-of-network provider.

PAST POLICY UNDER PL 98-05 STILL IN EFFECT:

PL 98-05 addressed the Department of Health Care Service's (DHCS) policy regarding enrollment into MCPs by Medi-Cal eligibles that are either Duals or Medi-Cal eligibles who have private commercial health plan coverage. The following policies are restated and are still in effect under this new APL 13-001.

- Duals have the option to receive their Medicare services on a FFS basis or through membership in a health maintenance organization (HMO) contracting with the federal government. Medicare HMOs generally offer benefits that are broader than the Medicare FFS benefit package. Duals enrolled in a Medicare HMO are coded as having "Other Health Coverage" (OHC) in the Medi-Cal eligibility file with a code designation of "F."

In general, the Medi-Cal program covers and pays for Medi-Cal covered health care services provided to Duals under three circumstances:

1. The service provided to the beneficiary is covered by the Medi-Cal program but is not covered by Medicare FFS or the Medicare HMO in which the beneficiary is enrolled.
2. The Medi-Cal beneficiary has exhausted his or her annual or lifetime Medicare FFS or Medicare HMO benefit coverage for the services billed.

3. The beneficiary receives Medicare on a FFS basis and has incurred a Medicare co-insurance or deductible obligation and the amount Medicare has paid the provider is less than the amount the Medi-Cal program would have paid the provider had the service been billed to the Medi-Cal program. Medi-Cal will pay the difference up to the allowable rate for the Medi-Cal covered service, which may include the coinsurance or deductible.
- The Medi-Cal program is by law, the payor of last resort; therefore, before billing the Medi-Cal program, Medi-Cal health care providers are required to bill the Medicare Program (or any other commercial HMO in which a Medi-Cal beneficiary may be enrolled and, in the circumstances 1 and 2 above, obtain a denial notice or confirmation that Medicare (or commercial HMO) benefits have been exhausted or are not covered. Medi-Cal MCP capitation rates assume that Medi-Cal MCP contractors will similarly direct their providers to obtain, or the MCP will otherwise arrange for, reimbursement from the Medicare FFS program or the responsible Medicare (or commercial HMO) before assuming the obligation to cover and pay for a service provided to a Dual.
 - It is the policy of DHCS that, except for Medi-Cal county organized health systems (COHS), the Program of All-Inclusive Care for the Elderly (PACE), or a Medi-Cal contracting social HMO, the following applies:
 1. Duals who receive their Medicare services through membership in a Medicare HMO may not be members of a MCP unless the MCP has met the conditions described in the next section of this letter. As noted above, these Duals will be identified with an OHC code of "F."
 2. Medi-Cal beneficiaries with any of the following OHC codes designating membership in a privately paid commercial HMO may not be members of a MCP:
 - "C" (CHAMPUS Prime HMO)
 - "K" (Kaiser HMO)
 - "P" (other HMO/Prepaid Health Plan coverage, or other coverage when the beneficiary is limited to a prescribed panel of providers for comprehensive services, excluding Kaiser HMO, or Medicare)
 3. Duals who receive their Medicare services on a FFS basis or who have non-HMO commercial health insurance coverage may voluntarily enroll in any MCP if they are otherwise eligible to be a MCP member.

4. Medi-Cal beneficiaries who receive Supplemental Security Income (SSI) and who experience OHC problems may call DHCS's Third Party Liability Branch toll-free at 1-800-952-5294 for assistance. Medi-Cal beneficiaries who do not receive SSI and who experience OHC problems may call their County Welfare Office for assistance.

Conditions for Enrollment of Dual Eligibles with Medicare HMO Coverage

A MCP, other than a COHS, PACE, or a social HMO, may enroll Duals with Medicare HMO coverage only if the following conditions are met:

1. The MCP contractor enrolling the beneficiary must also be the Medicare HMO or plan partner of the MCP in which the beneficiary is enrolled. The list of matching MCPs and Medicare HMOs can be found at:
<http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx>
2. The MCP must submit a written proposal to DHCS that includes a comparison between the Medicare HMO coverage that will be provided to its Duals and the Medi-Cal benefits package, and it must reach agreement with DHCS on any required adjustment to the MCP's Medi-Cal capitation rates.

DHCS will adjust the MCP's capitation rates when the MCP provides its Medicare HMO members expanded benefits coverage that is beyond basic Medicare FFS benefits coverage, and that duplicates coverage for which the MCP would be reimbursed by the Medi-Cal program. For example, the Medi-Cal capitation rates assume that little or no pharmacy coverage will be provided under the Medicare program to Duals. An adjustment to the Medi-Cal capitation rates could be required before a MCP was allowed to enroll Medi-Cal MCP members into the MCP's Medicare HMO, if the MCP offered a pharmacy benefit to its Medicare HMO members.

3. The Medi-Cal contract with the MCP must be amended formally to include authorization for the MCP to enroll its Medi-Cal members into its Medicare HMO and incorporate into the contract any rate adjustments or other agreements developed under the process described in 2 above.

Systems Edits

DHCS's enrollment contractor has an edit in its system that precludes beneficiaries with an OHC code of K, C, or P from enrolling in a MCP through the Health Care Options Program. This edit is also part of the Medi-Cal Eligibility Data System (MEDS). It

disenrolls beneficiaries whose MEDS records are updated with an OHC code after the beneficiary has already enrolled in a MCP. A MCP beneficiary with an excluded OHC code is then placed on a two-month "hold" status for purposes of MCP membership, with the MEDS system showing that the beneficiary is eligible only for FFS coverage.

If the OHC code for a beneficiary in "hold" status is incorrect, and the beneficiary arranges with the County Welfare department to clear their eligibility record of the incorrect code prior to the MEDS renewal date in the second month of hold, MCP membership will automatically be reestablished. If the OHC code is correct or the beneficiary's MEDS record is not corrected prior to the renewal date in the second "hold" month, the beneficiary will be disenrolled.

If you have any questions regarding this APL, please contact your Contract Manager.

Sincerely,

ORIGINAL SIGNED BY MARGARET TATAR

Margaret Tatar, Chief
Medi-Cal Managed Care Division