JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Coordinated Care Initiative (CCI) ADVANCED: Consumer Protections & Balance Billing

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FIGHTING SENIOR POVERTY THROUGH LAW

Justice in Aging is a national non-profit organization that fights senior poverty through law. We secure health and economic security for older adults of limited income and resources by preserving their access to the courts, advocating for laws that protect their rights, and training advocates around the country to serve the growing number of older Americans living in poverty.

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Today's Discussion

Overview of CCI

Consumer Protections

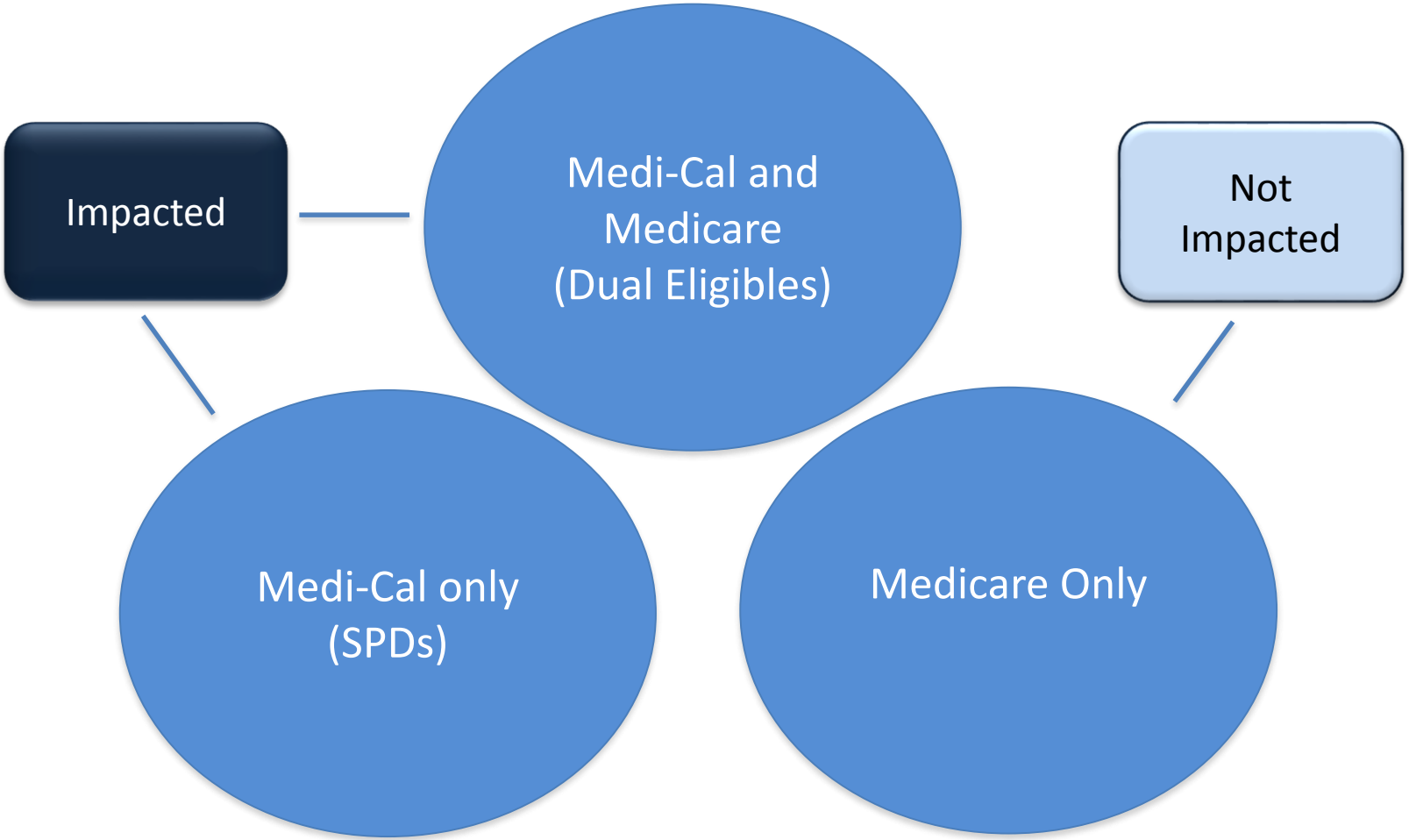
Glossary

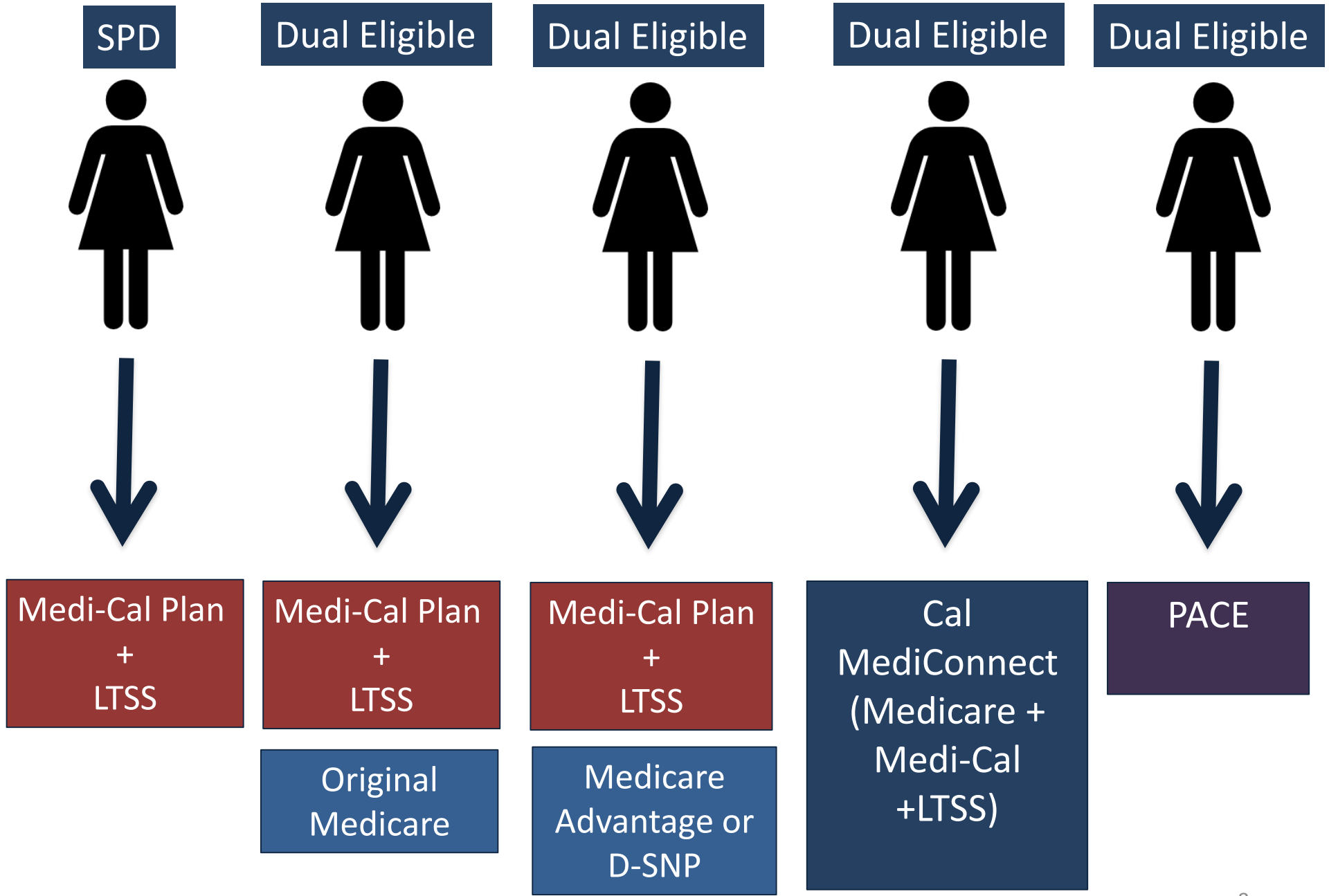
- Coordinated Care Initiative (CCI)
  - Cal MediConnect
- Dual Eligible (Dual)
- Duals-Special Needs Plan (D-SNP)
- Fee-for-Service (FFS)
- Long Term Support and Services (LTSS)
  - In-Home Supportive Services (IHSS), Community Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), Nursing Facility
- Medi-Cal Managed Care
- Program of All-Inclusive Care for the Elderly (PACE)
- Seniors and Persons with Disabilities (SPDs)

CCI = three big changes

CCI Change	Description
Mandatory Medi-Cal Managed Care	Duals and previously excluded SPDs must in enroll in Medi-Cal Managed Care
LTSS Integration	LTSS added to Medi-Cal Managed Care plan benefit package
Medicare Integration (Cal MediConnect)	For duals, integration of Medicare and Medi-Cal benefits into one managed care plan.

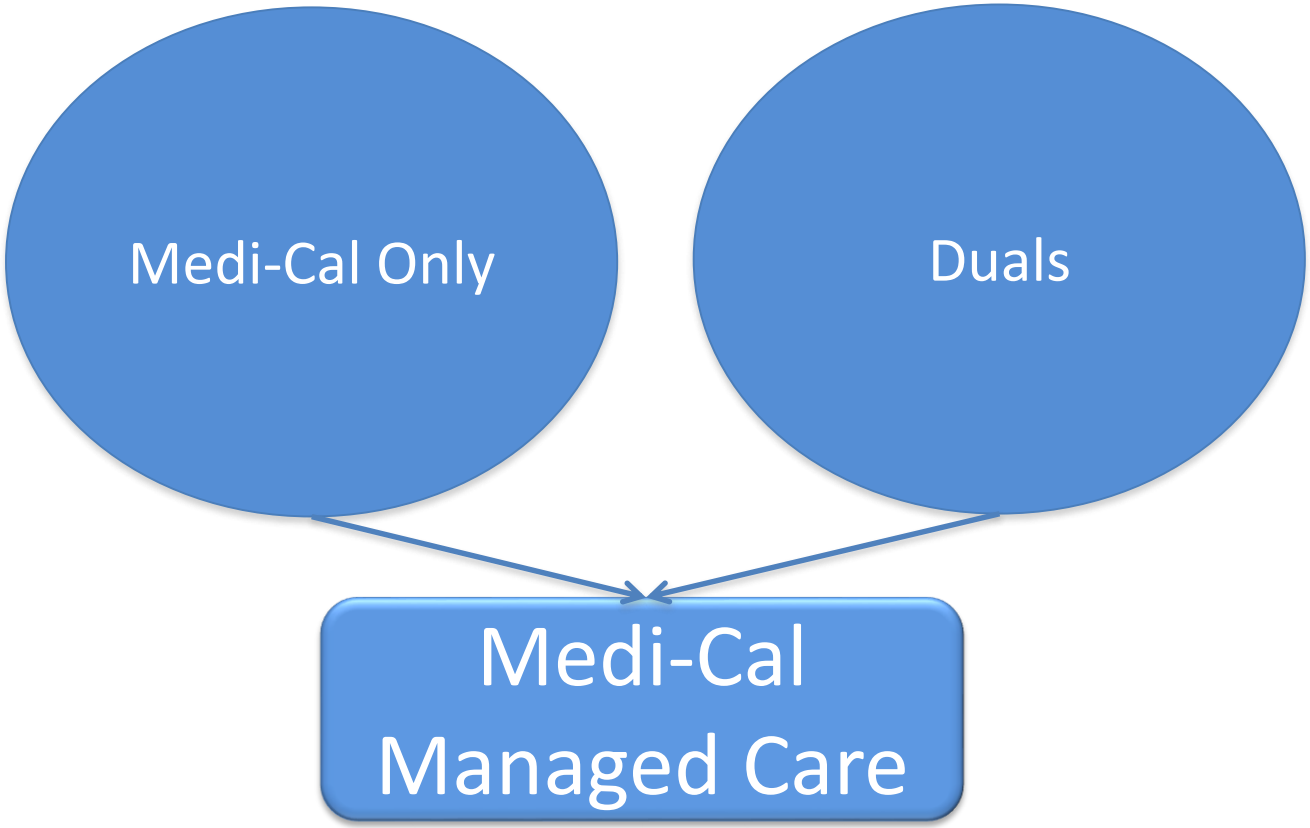
CCI impacts duals & seniors and persons with disabilities with Medi-Cal




SPD
Dual Eligible
Dual Eligible
Dual Eligible
Dual Eligible
Medi-Cal Plan + LTSS
Medi-Cal Plan + LTSS
Original Medicare
Medi-Cal Plan + LTSS
Medicare Advantage or D-SNP
Cal MediConnect (Medicare + Medi-Cal +LTSS)
PACE

Medi-Cal Managed Care is Mandatory

Even if a Dual Opts Out of Cal MediConnect, must still enroll in Medi-Cal MC



Cal MediConnect: Continuity of Care

If certain criteria is met, a Cal MediConnect plan must allow a beneficiary the right to maintain his or her current out-of-network providers and service authorizations at the time of enrollment for a period of

Six (6) months for Medicare

Twelve (12) months for Medi-Cal services

Plans can provide extended continuity of care

http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-005.pdf

Cal MediConnect: Continuity of Care

Criteria

1. Must have an existing relationship with the Provider

   -Must see **PCP provider** at least **once** in 12 months proceeding enrollment in plan for non-emergency visit

   -Must see **specialist** at least **twice** in 12 months proceeding enrollment in plan for a non-emergency visit

The plan must first use data provided by CMS and DHCS to determine pre-existing relationship. If relationship cannot be established through data, then plan can ask beneficiary to provide documentation of the relationship.

Cal MediConnect: Continuity of Care

Criteria

2. Provider must accept payment and enter into agreement with plan.

3. Provider does not have documented quality of care concerns

Cal MediConnect: Continuity of Care

Exceptions

Nursing Facilities – a beneficiary residing in a nursing facility prior to enrollment will not be required to change the nursing facility during the demonstration.

Durable Medical Equipment providers – no continuity of care for providers

Ancillary Services – no continuity of care for providers

Carved-out services – no continuity of care

IHSS – an individual does not need to make any request to continue to see an IHSS provider

Cal MediConnect: Continuity of Care

Prescription Drugs

Part D rules apply – one time fill of– a 30-day supply unless a lesser amount is prescribed – of any ongoing medication within the first 90 days of plan membership, even if the drug is not on the plan's formulary or is subject to utilization controls.

-Residents in institutions get further protections

-Part D rules apply to both Medi-Cal and Medicare-covered drugs

Cal MediConnect: Continuity of Care

Other Protections

Health plan must complete services for the following conditions:

-Acute

-Serious chronic

-Pregnancy

-Terminal illness

-Surgeries or other procedures previously authorized as part of documented course of treatment

CAL. HEALTH & SAFETY CODE § 1373.96(c)(1)

Cal MediConnect: Continuity of Care

Updates

- Providers can now request Continuity of Care
- Request must be processed within 3 days if there is risk of harm to the beneficiary (30 days is most time permitted)
- Retroactive Continuity of Care is permitted - Providers or beneficiary can now request continuity of care after service delivery
  - Request must come within 30 calendar days of first service following enrollment

Cal MediConnect: Continuity of Care

DISENROLL

-A beneficiary can disenroll from Cal MediConnect at any time for any reason.
-Disenrollment is effective the first day of the following month
-Must stay in Medi-Cal managed care

Medi-Cal Managed Care: Continuity of Care

- 12 months - keep seeing current providers and maintain service authorizations and receive services that are set to occur within 180 days of enrollment.
- Must have an "existing relationship"
  - Seen the provider at least once within 12 months (from date of plan enrollment)
- Provider must accept plan reimbursement rate or Medi-Cal rate
- Provider must meet quality of care standards
- Continuity of care does not extend to durable medical equipment, medical supplies, transportation, or other ancillary services
- Nursing facility residents can continue to reside in an out-of-network facility.

Medi-Cal Managed Care: Continuity of Care

- Medical Exemption Request (MER) for SPDs
  - Available in two-plan or GMC Counties
  - Acts to avoid enrollment in managed care entirely for a certain amount of time
  - Available to individuals with complex medical conditions (e.g., cancer)
  - Administered by Health Care Options (enrollment broker)

MER process not available to duals

What is the Medi-Cal Plan Responsible For if You're a Dual and Not Enrolled in CMC

- The Medi-Cal plan is responsible for benefits Medicare does not pay for:
  - Long-Term Services and Supports – In-Home Supportive Services , MSSP, CBAS, and Nursing Facility Care
  - Medi-Cal transportation services
  - Durable Medical Equipment
  - Certain Prescription Drugs
  - Medi-Cal Supplies

- The Medi-Cal Plan Pays the Medicare Provider the 20% Co-Insurance
  - The Medicare provider DOES NOT have to be contracted with the Medi-Cal plan to bill the plan for the 20% co-insurance

What is balance billing?

The low income definition

Balance billing is the practice in which Medicare providers seek to bill a beneficiary for Medicare cost sharing. Medicare cost sharing can include deductibles, coinsurance, and copayments.

What are Medicare Savings Programs (MSP)?

Low-income Medicare beneficiaries can get help from Medi-Cal to pay for Medicare Parts A and B, assuming they meet certain criteria.

Types of Medicare Saving Plans

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualifying Individual (QI)
- Qualified Disabled Working Individual (QDWI)

Affected Beneficiaries

- Full benefit dual eligibles (FBDE) are QMB+ and SLMB+. Includes those who have spent down their share of cost (SOC).
- QMB: At or below 100% FPL and QMB resource limits.
- In CA, most QMBs are also FBDE (QMB Plus) but some are QMB only (higher resources). Many FBDEs are QMBs (≤100%FPL).

In California balance billing protection is broad

All full benefit dual eligibles are protected.

All QMB-onlys are protected.

Federal law: 42 U.S.C. Sec. 1396a(n)(3)(B) (Sec. 1902(n)(3)(B) of the Social Security Act)

Summary of MSPs and Legal Protections[1]

Type of Program	Income Qualification	Resource Qualification for 2015 (single/married)	State Covers Part A?	State Covers Part B?	Protected under the QMB law (42 U.S.C. sec. 1396a(n)(3)(B))?	Protected under the MA regulation (42 C.F.R. sec. 422.504(g)(1)(iii))?	Protected under state law (Cal. Welf. & Inst. Code sec. 14019.4)?
QMB	No more than 100% FPL	$7,280/$10,930	YES	YES	**YES**	**YES**	NO
QMB+	No more than 100% FPL	$7,280/$10,930	YES	YES	**YES**	**YES**	**YES**
SLMB	Between 100-120% FPL	$7,280/$10,930	NO	YES	NO	NO	NO
SLMB+	Between 100-120% FPL	$7,280/$10,930	NO	YES	NO	**YES**	**YES**
QI	Between 120-135% FPL	$7,280/$10,930	NO	YES	NO	NO	**YES, ONLY THOSE ON MEDI-CAL (120-124% FPL)**

Local Advocates can help

- HICAP

  1-800-434-0222
- CCI Ombudsman

  1-888-804-3536

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  http://dualsdemoadvocacy.org/
- Contact us:
  - Denny Chan – dchan@justiceinaging.org
  - Amber Cutler – acutler@justiceinaging.org
- Department of Health Care Services
  - www.calduals.org

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