ICRC Study Hall Call:

Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment Initiative

September 8, 2014
2:00-3:00 PM Eastern

The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica Policy Research and the Center for Health Care Strategies.

Participants

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Agenda

I. Welcome, Introductions, and Roll Call

II. Issues in Overlapping Coverage for Home Health and Durable Medical Equipment

III. Home Health and DME Benefits for Dual Eligibles: Approaches taken by Health Plan of San Mateo

IV. Questions and Discussion

V. Concluding Remarks

Issues in Overlapping Coverage for Home Health and Durable Medical Equipment

Jim Verdier
Integrated Care Resource Center and
Mathematica Policy Research
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Introduction and Overview

- Home health services and durable medical equipment (DME) are covered by both Medicare and Medicaid, but the eligibility and payment rules in each program are different
- This is especially problematic for Medicare-Medicaid enrollees ("dual eligible individuals"), since they and their providers must navigate two separate and sometimes confusing and conflicting systems
- The problems are greatest in the fee-for-service (FFS) system
- Health plans that cover both Medicare and Medicaid benefits can provide these overlapping benefits in more coordinated and seamless ways
- The Health Plan of San Mateo has developed approaches to coordination that other health plans and states can learn from

Illustrative Differences in the FFS Rules

- Home health services
  - Eligibility
    - Medicare – beneficiaries must be homebound
    - Medicaid – states cannot impose this restriction
  - Payment
    - Medicare – prospective payment for 60-day episodes
    - Medicaid – per-visit or per-service payments
- DME
  - Eligibility
    - Medicare – must be used primarily in the home
    - Medicaid – can be used outside the home if it serves goal of avoiding institutional care
  - Payment
    - Varies by item and geography in both programs
    - Both programs use fee schedules, but Medicare is now using competitive bidding in many areas

Biggest Sources of Confusion and Conflict in FFS

- Medicaid, by law, is “payer of last resort”
  - Medicare must deny coverage or payment before Medicaid will pay
- States seek to maximize Medicare payment
  - May require appeals of Medicare denials
- Providers seek to maximize reimbursement and minimize hassle
- Beneficiaries often caught in the middle
- Medicare and Medicaid appeals and grievances processes are separate and very difficult to navigate

How Capitated Managed Care Can Help

- If a single health plan covers both Medicare and Medicaid benefits:
  - No formal Medicare denial is necessary
  - Health plan can provide the services an enrollee needs, as long as either Medicare or Medicaid would cover and pay for
  - Payment to providers can be in amounts that health plan and providers agree on
  - Home health services and DME can be viewed as investments that may reduce use of expensive institutional care
  - Appeals and grievances may be fewer if there are fewer denials for "technical" FFS reasons

Some Problems May Still Remain

- State Medicaid coverage of and payment for home health services and DME may be limited, so health plans may not have financial resources needed to be flexible on coverage decisions
- Differences in Medicare and Medicaid FFS payment systems may make it difficult for health plans and providers to agree on “blended” payment approaches
- Medicare and Medicaid encounter data reporting requirements may require continuation of distinctions between Medicare and Medicaid

For More Information

James Verdier, Sonya Streeter, Danielle Chelminsky, and Jessica Nysenbaum. *Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment Initiative.* Integrated Care Resource Center Technical Assistance Brief, April 2014. Available at: http://www.integratedcareresourcecenter.net/PDFs/ICRC%20-%20Improving%20Coordination%20of%20HH%20and%20DME%20-%204-29-14%20(2).pdf

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Home Health and DME Benefits for Dual Eligibles

Approaches taken by Health Plan of San Mateo

Dr. Fiona Donald
HPSM Medical Director

September 8, 2014

Health Plan of San Mateo-Background

- San Mateo County is located South of San Francisco
- County Population is 747,000 based on 2013 data
- HPSM founded in 1987 as managed care entity
- HPSM currently serves 113,000 county residents through six programs
- Mandatory Medicaid enrollment into managed care
- Dual eligible Special Needs Plan since 2006
- Duals Demo – April 1, 2014

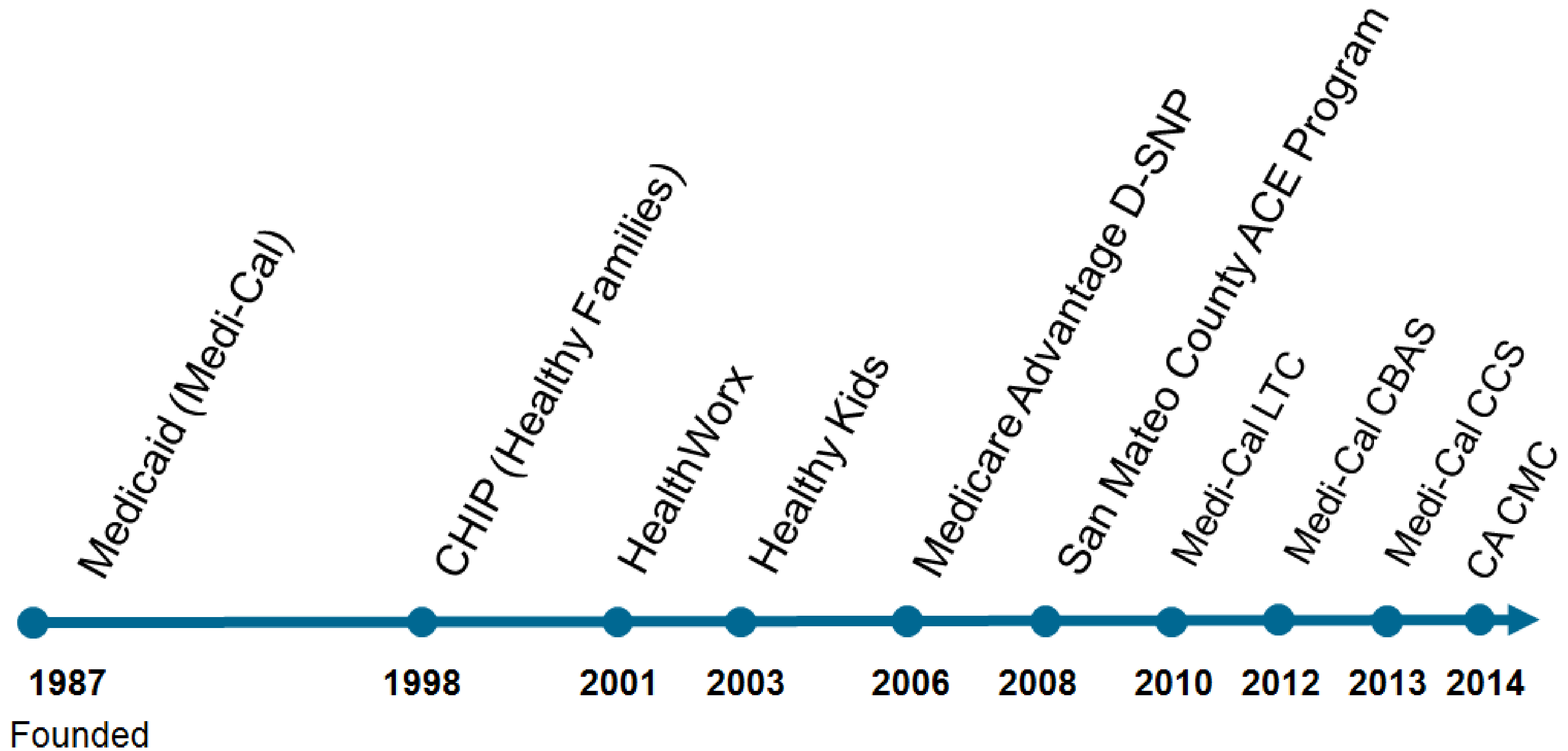
HPSM Enrollment

Programs	August 2014
Medicaid	**89,600**
Medicare D-SNP	**8,700**
Medicare-Medicaid Duals Demo	**2,900**
CCS Pilot	1,400
HealthWorx	1, 000
ACE Program (TPA)	20,600
Total	**113,000***

Programs

*** Medicare enrollment (duals) included in Medicaid count.**

HPSM Background



Approach to Coordination of Medicare and Medicaid benefits

- Goal of maximizing health status, level of independence and appropriate access to all services for which beneficiary is eligible
- Includes all Medicare benefits under parts A, B and D
- Includes all Medicaid benefits including wrap around services, Medicaid only services
- Duals Demo has expanded scope of integration to include home and community based services as well as long term services and supports

Approach to Coordination of Medicare and Medicaid Benefits

- Beneficiary
  - Goal is to create seamless processes for approval and denial and coordination of services, including grievance and appeals
- Providers
  - Goal is to develop payment structure and relationships to support coordination and access
- Compliance and Managed Care Requirements
  - Develop and monitor processes and reporting functions to meet all Medicare and Medical and program needs

HPSM uses Managed Care Principles and Practices to address Integration of Benefits

Beneficiary

- Integrated beneficiary notification of approvals and denials of services, regardless of source of benefit
- Integrated beneficiary grievance and appeal process

Provider

- Development of contracts with rates for services that incorporate both Medicare and Medicaid as appropriate
- Remittance advice contains information on how service is covered under Medicare and Medicaid but payment is consolidated

Grievance and Appeals in Duals Managed Care: Beneficiary

- Integrated Grievance and Appeal process at HPSM
- Member files grievance and/or appeal through single source
- HPSM reviews and determines if grievance and or appeal is Medicare or Medicaid benefit. If services can be covered under both programs, grievance and appeal rights are applied so that they are most favorable to beneficiary
- IDN has been useful tool

Beneficiary Denials in Duals Managed Care-IDN

- Integrated Denial Notice
- Notice of Denial of Medical Coverage (Form CMS 10003-NDMCP)
- Consolidates Medicare Advantage coverage and payment denial notices and integrates, where applicable, Medicaid appeal rights information
- Medicare health plans, Fully Integrated Dual Eligible (FIDE) plans and Medicare-Medicaid Plans within the Financial Alignment Demonstrations will issue IDN
- Effective November 1, 2013

HPSM Leverages Managed Care Principles: Payment to Providers

- HPSM has established “behind the scenes” claims processes to allow streamline payment processes for providers
  - If service is a Medicare benefit, HPSM claims will pay Medicare allowable, then claim will loop to Medicaid for deductible
  - If service is a Medicaid benefit, HPSM claims will “deny” under Medicare and then loop for payment under Medicaid benefit
- Provider receives RA to indicate under which program service is paid, but payment comes from single source, HPSM

HPSM Leverages Managed Care Principles: Revenue

- Capitated Payment in Duals Demo

  3 sources

  - Medicare C
  - Medicare D
  - Medicaid

- Blended rate allows flexibility to achieve goals of coordinated care to benefit both beneficiary and providers

Reporting Requirements for Dual Eligibles

- Encounter data reported separately to CMS and State as required by contract
- Prior to Duals Demo, encounter data reported separately to CMS and State
- Duals Demo-encounter data reported to CMS and then forwarded to State

How have we approached integration for Home Health and DME?

- Benefits
  - Determine if benefit is Medicare vs Medicaid
- Claims Configuration
  - Configure claims payment system to pay or deny under appropriate line of business—Medicare vs Medicaid
  - Allows accurate reporting of encounter data and consolidates payment to providers
- Beneficiary notification and appeals
  - Use integrated notifications when possible
  - Ensure rights are protected under appropriate program

Potential Barriers to Coordination-Home Health: FFS conflicts

- Beneficiary
  - Medicare – beneficiaries must be homebound
  - Medicaid – states cannot impose this restriction
- Providers
  - Medicare – prospective payment for 60-day episodes
  - Medicaid – per-visit or per-service payments
  - Rate differences between Medicare and Medicaid

Home Health Services for Duals in Managed Care

- HPSM has contracted with Home Health providers and developed contracted rates for per visit services
- HPSM has not employed PPS pricing
- Services that are exclusively Medicare services are contracted at a Medicare rate: if and when beneficiary exhausts Medicare benefit or criteria for Medicare service is no longer met, Medicaid services rates would go into effect based on benefit
- All Home Health services beyond initial assessment require prior authorization

Home Health Services for Duals in Managed Care--Example

Services required

- Homebound beneficiary receives skilled nursing visits for wound care and meets Medicare criteria for skilled nursing for wound dressing changes for 10 daily visits.
- After 10 visits, wound has improved significantly such that daily simple dressing change can be done. Application and removal of bandage required which can be performed by non licensed staff.
- No family caregiver to perform this service

Services rendered and paid

- HPSM approves 10 skilled nursing visit and pays Medicare rate for skilled visits
- HPSM coordinates Medicaid paramedical services to do bandage change (not a skilled service) and reimburses at appropriate rate
- Home Health skilled nursing visits are reevaluated and occur once per week for wound check
- Member and provider are notified of change and all appeal rights under Medicare and Medicaid

Potential Barriers to Coordination- DME

- Beneficiary
  - Medicare – must be used primarily in the home
  - Medicaid – can be used outside the home if it serves goal of avoiding institutional care
- Providers
  - Overlapping coverage within items
  - Rate differences between Medicare and Medicaid

DME benefits in Duals Managed Care

- HPSM has contracted with national and independent DME providers to provide Medicare and Medicaid DME benefits
- Most providers provide services in both DME coverage categories
- By having providers that offer both Medicare and Medicaid DME benefits, beneficiaries can interact with a single provider
- All DME over a monthly threshold dollar amount required prior authorization

DME Services in Duals Managed Care-Example

Services Required

- Young disabled beneficiary with progressive neurological condition requires power wheelchair for MR-ADLs in the home. Beneficiary also uses wheelchair to complete shopping/banking and benefits from seat lift elevator attachment for power chair. Power Seat lift elevator is determined to be medically appropriate to allow beneficiary to accomplish goals of independent community living but is only used outside the home when in community.
- Medicare DME: must be used within the home
- Medicaid DME: can be used outside if avoid institutional care

Services Administered

- DME company submit prior authorization request for power wheelchair and accessories.
- HPSM reviews request and determines that all items requested are eligible for coverage under Medicare and Medicaid benefit.
- Authorization is provided and beneficiary and provider are notified with single notice.
- HPSM sends provider an RA indicates which items are covered under Medicare and Medicaid
- Provider notified of payment appeal rights as appropriate

Concluding Thoughts

- Capitated Payments and Application of Managed Care Principles have allowed HPSM to administer Medicare and Medicaid benefits to allow improved coordination of service for beneficiary and provider
- Managed Care structure allows potential conflicting FFS barriers to be overcome
- Development of expertise and familiarity with both Medicare and applicable State Medicaid processes to ensure that beneficiary and provider rights are addressed
- Knowledge of both programs has been essential to successful integration

Questions

Contact information

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Questions & Discussion

About ICRC

- Established by CMS to advance integrated care models for Medicare-Medicaid enrollees and other Medicaid beneficiaries with high costs and high needs
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send additional questions to: ICRC@chcs.org