

2018 SMP/SHIP

NATIONAL CONFERENCE

August 20–23 • Chicago, IL

CMS Programs Targeting
Beneficiaries with Low Income or
Otherwise Dually Eligible

8/22/18

Medicare's Limited Income NET Program

Administered by Humana®

SMP/SHIP National Conference

August 20 – 23 2018

Humana.





Medicare's Limited Income Newly Eligible Transition Program (LINET)

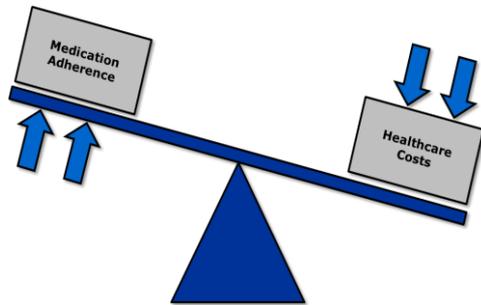
LINET is a CMS Demonstration program that provides temporary prescription coverage for Medicare beneficiaries who qualify for Low Income Subsidy (LIS) and have no prescription drug coverage

- Beneficiary must have Part D Eligibility & Medicaid or any type of LIS
- Provides prescription coverage at the pharmacy counter
- Enrollment is processed by claim submission
- Limited pharmacy network restrictions
- No premiums - LIS based copay
- Coverage usually lasts about two months
- Retroactive reimbursement may be available for out-of-pocket expenses

Overview

Program Goals

- Improve health outcomes for vulnerable populations particularly during the transition from Medicaid to Medicare
- Reduce cost of care related to poor med adherence during the transition
- Improve beneficiary experience as they navigate into a new healthcare system



Enrollments

- 725,000 enrollments in 2017
 - >5 million enrollments since program inception
 - Growing at ~ 7% per year YOY

Updates

- Immediate Needs
- Days Supply
- New Medicare Cards
- Special Enrollment Period (SEP)
- Opioid overutilization program



LINET Update – Immediate Needs

- LINET Immediate Need guidelines:
 - Should be viewed as a last resort access to medications for critical situations
 - Beneficiary has 3 days or less of medication
 - Intended for Beneficiaries who are Medicare eligible, but cannot prove LIS eligibility
 - Purchasing medication would put a financial hardship on beneficiary
- Immediate Need Volume
 - Program designed to handle 40-50 Immediate Need requests per month
 - Currently averaging ~3,000 requests per month
 - ~ 24% are ultimately determined to be ineligible
- Benefits:
 - Provides safety net for Medicare beneficiaries who are at risk for access to care issue
- Drawbacks:
 - Ineligible claims create a financial burden for the program
 - Beneficiaries who are determined not to be eligible are responsible for reimbursement of costs



LINET Update – Immediate Needs

Things SHIP Counselors can do to help:

- Request an Immediate Need only in cases where the beneficiary is in dire medication need within the next 2-3 days
 - In all other cases, please use the normal enrollment process
 - Normal enrollment process only takes a couple days to complete (4 days on average)
 - Removes the need for the beneficiary to submit proof of eligibility
 - If a beneficiary pays for a claim while awaiting eligibility, they can be reimbursed through the DMR process (Direct Member Reimbursement)
- Help beneficiaries understand they need LIS to be eligible for the program
 - Let them know they will need to present proof of LIS to successfully access program benefits
 - If we can't verify their status, and the beneficiary doesn't provide proof, they will be limited to 21 days of access



LINET Update – Immediate Needs

Things SHIP Counselors can do to help:

- Remind beneficiaries to watch for important plan communications
 - Make sure the Pharmacy and SSA have the beneficiaries correct address on file
 - We will communicate through mail while we work to establish eligibility
 - When the beneficiary is enrolled, they will also be mailed a Welcome Packet explaining their benefits and containing things like
 - Temporary ID card
 - DMR form
 - LINET Factsheet
 - Contact information for questions



LINET Update – Days Supply

- LINET Days Supply Limitation – 2018
 - Days supply limited to 60 days for all medications
 - Previously allowed 90 days supply
 - Went live in February 2018
- Reasons for the change:
 - Average enrollment in LINET <60 days
 - Aligning the days supply with the average length of enrollment will reduce overall program costs
- No complaints received to date from Beneficiaries or Pharmacists



LINET Update – New Medicare Cards

- LINET began accepting/receiving new MBIs on 4/1
- To date – no enrollment or access to care issues have been experienced
- LINET will be able to utilize both the HICN and MBI during the transition phase - 18 month period
 - Critical for LINET which relies on HICN and now MBI
 - Most plans use unique member ID assigned by the plan
- Things to emphasize with beneficiaries:
 - Keeping their address current with SSA
 - Having a copy or memorizing their HICN or MBI
 - This information can no longer be provided by our Call center



LINET Update – Special Enrollment Period (SEP)

Beginning in 2019

- The SEP for dual-eligible and LIS beneficiaries is changing:
 - From: Open-ended monthly SEP
 - To: Once per calendar quarter during the first nine months of the year
- There are exceptions:
 - SEP enrollment criteria can be waived for the following reasons:
 - After a CMS or state-initiated enrollment - also known as a Passive enrollment
 - After a change to an individual's LIS or Medicaid status
- Effect to LINET
 - No Effect on LINET enrollee's
 - LINET enrollment is considered a Passive enrollment
 - Beneficiaries enrolled into LINET will be given an exception to new SEP guidelines
 - Allowed to enroll out of LINET into another plan at anytime
 - Once enrolled into another plan they will be subject to the new SEP guidelines



LINET Update - Opioid Overutilization Program

- In 2018 LINET changed Opioid prescription limits
 - Part of national effort to curb the opioid epidemic and dispensing abuses
 - Reduced to a 30 Day Supply Limitation
 - Exceptions provided for Diagnosis of Cancer
- 2019 LINET Opioid Limits
 - Opioids will be limited to 7 Day Supply for “new opioid users”
 - Those with no identified Opioid Rx within the last 60 days
 - Exceptions include:
 - Long-term care facility residents
 - Hospice, palliative, end-of-life care
 - Diagnosis of Cancer – can be inferred by pharmacy claims
 - Exceptions can be requested by calling the LINET Help Desk
 - 1-800-783-1307
 - Providers will be asked to provide additional information to help make a determination



LINET - For More Information

- LINET Advocacy Line: 1-866-934-2019
 - State Health Insurance Assistance Program (SHIPs)
 - Caseworkers, Ombudsmen and other advocates
- LINET Help Desk: 1-800-783-1307
 - Beneficiaries
 - Pharmacies
- Online: www.Humana.com/LINET
 - Web module for Advocates
 - Documents available:
 - LINET program brochure
 - Four Steps for Pharmacy Providers
 - Frequently asked questions
 - Free continuing education for pharmacists and pharmacy techs
- Email:
 - LINET mailbox: LINEToutreach@Humana.com
 - CMS mailbox: MedicareLINET@CMS.hhs.gov



LINET

Questions?



Thank You

Thank you for your interest in
LINET



Medicare-Medicaid Coordination Office Updates



Julie Jones
August 22, 2018

Presentation Overview

MMCO overview and Financial Alignment Initiative Updates

Medicare Communication and Marketing Guidance and Updates for Medicare-Medicaid Plans

D-SNP Default and Passive Enrollment Changes

Reducing Improper Billing of Qualified Medicare Beneficiaries (QMB)

Enrollment in QMB Program for Persons Lacking Part A

Medicare-Medicaid Coordination Office Introduction

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

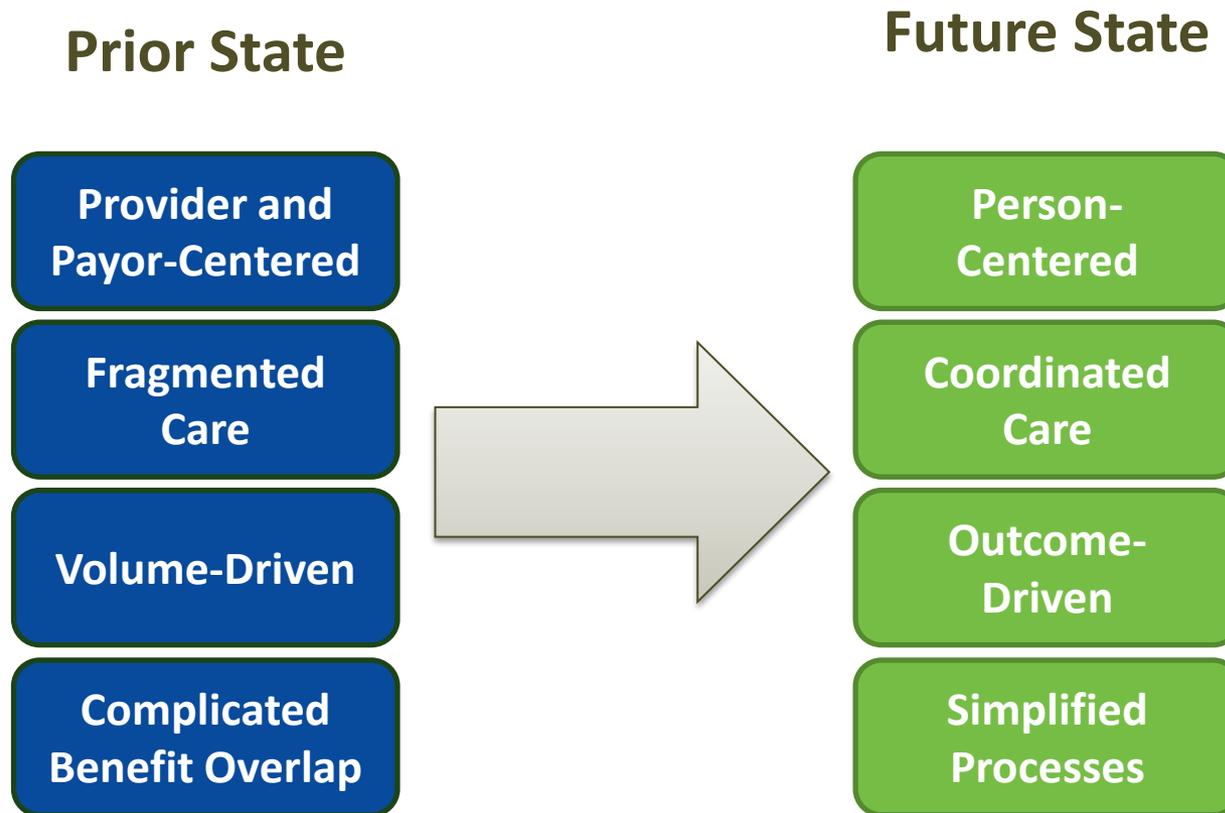
Ensure full **access** to services to which they are entitled

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

Dual Eligibility – Delivery System Transformation



Financial Alignment Initiative

Background:

- A longstanding barrier to coordinating care for the dually eligible population is the financial misalignment between Medicare and Medicaid. That is, investments or disinvestments in one program may result in savings or costs to the other program.
- CMS is testing 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 services for the dually eligible population.

Financial Alignment Initiative

- Currently have 10 Capitated Financial Alignment Model Demonstrations
 - California, Illinois, Massachusetts, Michigan, New York (2), Ohio, Rhode Island, South Carolina, and Texas
- 1 Managed Fee-For-Service Financial Alignment Model Demonstrations
 - Washington
- Minnesota approved for alternative model via D-SNPs

Capitated Model Demonstration

Start Dates, End Dates, and Enrollment

State	Implementation Date	Current End Date	Enrollment as of July 2018
California	April 2014	December 31, 2019	115,452
Illinois	March 2014	December 31, 2019	54,770
Massachusetts	October 2013	December 31, 2019	20,893
Michigan	March 2015	December 31, 2020	40,323
New York (FIDA)	January 2015	December 31, 2019	3,891
New York (FIDA-IDD)	April 2016	December 31, 2020	970
Ohio	May 2014	December 31, 2019	75,889
Rhode Island	July 2016	December 31, 2020	13,393
South Carolina	February 2015	December 31, 2020	11,293
Texas	March 2015	December 31, 2020	42,173
TOTAL			379,047

FAI Independent Evaluation

Precursor findings

ASPE Minnesota results

MedPAC

Financial Alignment Initiative

Contracted with RTI International

Evaluation includes qualitative and quantitative components

Evaluation reports for Washington, Massachusetts and Minnesota released;
additional reports expected this year

Issue briefs with early implementation findings are available

Medicare Communications and Marketing Guidance

- The 2019 Medicare Communications and Marketing Guidelines (MCMG) was released on July 20, 2018.
 - [www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/CY2019 Medicare Communications and Marketing Guidelines.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/CY2019_Medicare_Communications_and_Marketing_Guidelines.pdf)
- Based on CMS-4182-F Final Rule and April 12, 2018 request for feedback
- Additional update released on August 10, 2018.

Medicare Communications and Marketing Guidance

- Changes to Subpart V as a result of the final rule include:
 - Updated definition of marketing to focus on materials and activities that aim to influence enrollment decisions.
 - Created and defined the new term “communications”
- CMS will provide training at the MA & PDP Fall Conference on September 6.

Medicare Communications and Marketing Guidance

- MMCO released additional guidance for MMPs and Minnesota Senior Health Options (MSHO) plans to address critical issues related to the submission of materials for the Annual Enrollment Period (AEP) on August 3 and August 20, 2018.
- MMCO will be working with States this fall to update the State-specific marketing guidelines for MMPs and MSHO plans.

D-SNP Default Enrollment

- Formerly seamless conversion
- Limited to beneficiaries:
 - Newly eligible for Medicare Advantage
 - In Medicaid MCO whose sponsoring organization also offers a D-SNP
 - Continuing enrollment in Medicaid MCO when default enrolled into the D-SNP
- State must have approved use of default enrollment in their State Medicaid Agency Contract with D-SNP

D-SNP Default Enrollment

- D-SNP must provide notice to beneficiaries 60 days prior to enrollment that includes:
 - Information on difference in premiums, benefits, and cost-sharing
 - Ability to decline default enrollment
 - Ability to enroll in Original Medicare and a stand-alone Prescription Drug Plan, or choose another Medicare Advantage plan
 - Alternative Medicare health and drug plan options
 - How to access care
 - Initial enrollment materials

D-SNP Passive Enrollment

- Limited expansion of authority (42 CFR 422.60(g)) for CMS to conduct passive enrollment (in consultation with state Medicaid agency) to promote continuity of care for full-benefit dual eligible beneficiaries currently enrolled in an integrated D-SNP.

D-SNP Passive Enrollment

- Intended for limited circumstance in which integrated care coverage would otherwise be disrupted, such as:
 - During a state re-procurement of Medicaid managed care contracts that results in current Medicaid managed care plans not being renewed,
 - When beneficiaries are enrolled in an integrated D-SNP that non-renews its MA contract at the end of the contract year, or
 - When D-SNP eligibility criteria change and certain enrollees no longer meet them
- Doesn't apply when dual eligible beneficiaries are in Medicaid or Medicare fee-for service

D-SNP Passive Enrollment

- Plan requirements include:
 - Fully integrated D-SNP or a D-SNP that meets a high level of integration
 - Substantially similar provider and facility networks and covered benefits
 - At least 3 star plan, low enrollment contract, or new MA plan
 - No prohibition on new enrollment
 - Limits on premiums and cost-sharing
 - Operational capacity to enroll beneficiaries and agree to enrollments

D-SNP Passive Enrollment

- Beneficiary enrollment notices
 - first no fewer than 60 days prior to enrollment
 - second no fewer than 30 days in advance of effective date
 - Notices must describe:
 - Costs and benefits of plan
 - Process for accessing care
 - Ability to decline the enrollment or choose another plan

Reducing Improper Billing of Qualified Medicare Beneficiaries (QMB)

Changes to help providers identify QMBs and comply with QMB billing requirements

HIPAA Eligibility Transaction System (HETS) to verify a patient's QMB status prior to claims submission for Medicare Fee-For-Service (FFS)

Provider Remittance Advice includes QMB status effective July 2018

Medicare Summary Notice for (FFS) beneficiaries includes QMB status and billing protections effective July 2018

Reducing Improper billing of QMBs

Activities to raise awareness of changes include:

New CMS QMB billing web page

Medicare Learning Network (MLN) e-mail newsletter articles, FAQs, and training for providers

Presentations for SHIPs and beneficiary advocates

Reiterated Medicare Advantage plan responsibilities in 2019 Call Letter

Enrollment in QMB program for Persons Lacking Part A

CMS worked with SSA to revise the Program Operations Manual System (POMS) instructions to process Part A enrollments for persons who must pay a premium to enroll in Part A and wish to apply for QMB status

Revised SSA policy allows conditional enrollment in Premium-Part A

Only receive Part A coverage if state approves QMB application

Enrollment in QMB program for Persons Lacking Part A

Allowed to complete application even if owe Part A or B premiums

Conditional enrollment process different depending on whether a Part A Buy-in State or Group Payer state

SSA can provide person with screen shot of Part A application to use to apply for QMB status at State

CMS is working with SSA to educate field offices and States on process

Resources

QMB billing webpage

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html

POMS webpage <http://policy.ssa.gov/poms.nsf/lnx/0600801140>

HETS webpage

www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp

Resources

MLN website

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>

MMCO Website

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html

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Q & A

Any questions??