

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
P. O. Box 942732
SACRAMENTO, CA 94234-7320
(916) 654-8076



February 20, 1998

MMCD Policy Letter 98-05

TO: Prepaid Health Plans
 County Organized Health Systems
 Primary Care Case Management Plans
 Two-Plan Model Plans
 Geographic Managed Care Plans

SUBJECT: **ENROLLMENT OF MEDI-CAL/MEDICARE DUAL ELIGIBLES AND
 MEDI-CAL BENEFICIARIES WITH COMMERCIAL HEALTH
 MAINTENANCE ORGANIZATION COVERAGE**

GOAL

The purpose of this letter is to provide Department of Health Services' policy regarding the enrollment in Medi-Cal managed care plans (MCP) of Medi-Cal beneficiaries who are also covered by the Medicare program (dual eligibles) or have private commercial health plan coverage.

BACKGROUND

Medi-Cal beneficiaries who are covered by the Medicare program have the option to receive Medicare coverage on a fee-for-service (FFS) basis or through membership in a health maintenance organization (HMO) contracting with the federal government. Dual eligibles enrolled in a Medicare HMO have an Other Health Coverage (OHC) code of "F" on the Medi-Cal eligibility file. Most California Medicare HMOs offer benefits to their Medicare members that are broader than the Medicare FFS benefit package.

In general, the Medi-Cal program will cover and pay for Medi-Cal covered health care services provided to dual eligibles under three circumstances:

1. **The service provided to the beneficiary is covered by the Medi-Cal program, but is not covered by the Medicare FFS program 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 Medi-Cal allowed rate for the Medi-Cal covered service, which may include the co-insurance 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 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 plan 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 eligible.

POLICY

It is the policy of the Department that, except for Medi-Cal county organized health systems (COHS), the Program of All-Inclusive Care for the Elderly (PACE) projects, or a Medi-Cal contracting social HMO:

1. Dually eligible Medi-Cal beneficiaries who receive their Medicare services through membership in a Medicare HMO may *not* be members of a Medi-Cal MCP unless the plan has met the conditions described in the next section of this letter. As noted above, these dual eligibles 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 Medi-Cal MCP:
 - "C" (CHAMPUS Prime HMO)
 - "K" (Kaiser HMO)

- "P" (other HMO/PHP coverage, or other coverage when the enrollee is limited to a prescribed panel of providers for comprehensive services, excluding CHAMPUS, Kaiser, or Medicare)
3. Dually eligible Medi-Cal beneficiaries who receive their Medicare services on a FFS basis or who have non-HMO commercial health insurance coverage may voluntarily enroll in any Medi-Cal MCP, if they otherwise are eligible to be a Medi-Cal plan member.
 4. Medi-Cal beneficiaries who receive Supplemental Security Income (SSI) and who experience OHC problems may call the Department'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 Medi-Cal MCP, other than a COHS, PACE, or a social HMO, may enroll dual eligibles with Medicare HMO coverage only if the following conditions are met:

1. The Medi-Cal MCP contractor enrolling the beneficiary must also be the Medicare HMO in which the beneficiary is enrolled. A health plan subcontracting with a Medi-Cal MCP contractor to provide services under the Medi-Cal MCP's contract with the Department does not meet this condition.
2. The Medi-Cal MCP must submit a written proposal to the Department that includes a comparison between the Medicare HMO coverage that will be provided to its dually eligible members and the Medi-Cal benefits package, and it must reach agreement with the Department on any required adjustments to the plan's Medi-Cal capitation rates.

The Department will adjust the plan's Medi-Cal capitation rates when the plan provides its Medicare HMO members expanded benefits coverage that is beyond basic Medicare FFS benefits coverage and that duplicates coverage for which the plan 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 dual eligibles. An adjustment to the Medi-Cal capitation rates could be required before a plan was allowed to

enroll Medi-Cal plan members into the plan's Medicare HMO, if the plan offered a pharmacy benefit to its Medicare HMO members.

3. The Medi-Cal contract with the plan must be amended formally to include authorization for the plan 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

The Department's enrollment contractor has established an edit in their system that precludes beneficiaries with an OHC code of F, K, C, or P from being enrolled in a Medi-Cal MCP through the Health Care Options Program.

An edit has been installed in the Medi-Cal Eligibility Data System (MEDS) which will disenroll beneficiaries whose MEDS records are updated after enrollment to add one of the excluded OHC codes.

It is the intent of the Department to initialize the MEDS OHC edit in the near future. Advance notice of the effective date of this action will be sent to affected beneficiaries and to plans. When the MEDS edit is activated, each plan member with an excluded OHC code will be placed on a two-month "hold" status for purposes of plan membership. The MEDS system will only show the member as eligible for FFS coverage.

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

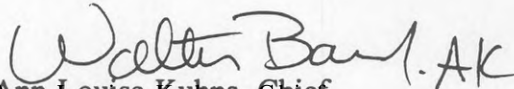
Submission of Letter of Intent and Proposal

Medi-Cal MCPs which are also Medicare HMOs and wish to enroll and/or retain their Medi-Cal plan members under both plans must submit a letter of intent to submit a proposal to retain these members to their contract manager within 30 days of the date of this policy letter.

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The plan must submit the formal written proposal described above within 60 days of the date of this letter and enter into negotiations with the Department to enroll and/or retain these members. Otherwise, the Department will implement the MEDS edit to disenroll Medi-Cal MCP members who are also enrolled in the plan's Medicare HMO and to prohibit their enrollment.

If you need more information or have additional questions, please contact your contract manager.


Ann-Louise Kuhns, Chief
Medi-Cal Managed Care Division