

# Communication with Dual Eligible Members: DRAFT 1/12/16

New 2015 proposals are meant to focus on modernizing and acknowledging the movement of dual eligible into Medicaid managed care through “Aligning Medicaid managed care policies to a much greater extent with those of Medicare Advantage and the private market”

Topic	OHA Rules & Review-2015	Medicare Rules & Review--2016	OK for Same Parent Company CCO and MA	OK for CCO and MA affiliated through specific business affiliation and data sharing agreements
<p><b>Communication About Care Coordination and Opportunities to Align Benefits for Dual Eligibles Between Affiliated MA and CCO</b></p>	<p>410-141-3300 Coordinated Care Organization (CCO) Member Education and Information Requirements:            (6) The following shall not constitute marketing or an attempt by the CCO to influence client enrollment:            (a) <u>Communication to notify dual-eligible members of opportunities to align CCO provided benefits with a Medicare Advantage or Special Needs Plan;</u>            (b) <u>Improving coordination of care;</u>            (c) <u>Communicating with providers’ serving dual-eligible members about unique care coordination needs;</u> or            (d) <u>Streamlining communications to the dually-enrolled member to improve coordination of benefits.</u>            (8) CCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes</p>	<p><b>Follow any Medicare rules for HSD approvals on MA/DSNP communication</b></p> <p><b>Medicare Marketing Guidelines</b>  <a href="https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2016-Medicare-Marketing-Guidelines-Updated.pdf">https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2016-Medicare-Marketing-Guidelines-Updated.pdf</a></p> <p><u>Marketing guidelines, Section 20 – Materials Not Subject To Marketing Review</u> [2 CFR 422.2260, 422.2262, 423.2260, 423.2262]</p> <ul style="list-style-type: none"> <li>• Enrollee newsletters that do not include any plan-specific information (examples of plan-specific information include information about benefits, premiums, co-pays, deductible, benefits, how to enroll, networks)</li> <li>• OMB-approved forms/documents, except when otherwise specified by CMS</li> <li>• General health promotion materials that do not include any specific plan related information (examples of general health promotion materials include health education and disease management materials). In general, health promotion materials should meet CMS’ definition of “educational” (Refer to section 70.8, Educational Events)</li> </ul>	<p>YES, CCO letter approvals by OHA</p> <p>Integrated Communications such as EOB and IDN are option</p>	<p>YES, CCO letter approvals by OHA</p> <p>Data sharing agreements must contain provisions on beneficiary information sharing for care coordination/care transitions/benefit coordination communication processes.</p>

	<p>member orientation, member handbook, and health education. As a CCO transitions to fully coordinating a member’s care, the CCO is responsible only for including information about the care they are coordinating. CCOs shall update their educational material as they add coordinated services. Member education shall:</p> <p>(a) <u>Include information about the coordinated care approach and how to navigate the coordinated health care system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;</u></p> <p>Additional rules to look at : 410-141-3270 Coordinated Care Organization Marketing Requirements</p> <p>(d) “Outreach” means any communication from a CCO to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular CCO. Outreach activities include, but are not limited to, the act of raising the awareness of the CCO, the CCO’s subcontractors and partners, and the CCO contractually required programs and services; and the promotion of healthful behaviors, health education and health related events.</p>	<ul style="list-style-type: none"> <li>• Medication Therapy Management (MTM) program materials (see Appendix 1)</li> <li>• Ad hoc Enrollee Communications Materials (see definition in Appendix 1)</li> <li>• Materials used at educational events for the education of beneficiaries and other interested parties (refer also to 70.8)</li> <li>• Coordination of Benefits notifications (as provided in Chapter 14 of the Medicare Prescription Drug Benefit Manual)</li> <li>• Health Risk Assessments</li> <li>• Value-Added Items and Services (refer to Chapter 4 of the Medicare Managed Care Manual) See definition in Appendix 1</li> <li>• Documents encouraging enrollees to use preventive services</li> <li>• Marketing materials created by State government</li> </ul> <p><b>Plan supplemental benefits you should be aware of for care coordination that could be included in MA benefits:</b> items such as outlined in MCM, Chapter 4, 30.2 and 30.3 including options such as Enhanced Disease Management, Bathroom Safety Devices, Counseling Services (beyond traditional Medicare), Educational Activities based on chronic disease/illness, Health Education, Vision and Dental services, etc. Converse directly with MA plan for details.</p> <p><b>MCM, Chapter 4: 110.4– Rules for All MAOs to Ensure Coordination of Care</b> (Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)</p> <p><b>MCM Chapter 4: 200 – Part C Explanation of Benefits (EOB)</b> (Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15) The Part C EOB is an ad hoc enrollee communication that provides MA enrollees with clear and timely information about their medical claims to support informed decisions about their healthcare options. MAOs are required to issue EOBs that include the information reflected in the CMS-</p>		
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		<p>developed templates. For additional information, please see the final templates and instructions at:  <a href="http://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationMaterial.html">http://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationMaterial.html</a></p> <p><b>MCM Chapter 4: 210  Educating and Enrolling Members in Medicaid and Medicare Savings Programs:</b>  MCM Chapter 4: 210.2–Relationship to D-SNP Eligibility / Enrollment (Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)  This guidance on educating and enrolling enrollees in financial assistance programs in no way affects or relates to an MAO’s responsibility for determining an enrollee’s, or potential enrollee’s, eligibility to enroll in the MAO’s Dual-Eligible Special Needs Plan (D-SNP). Refer to the Medicare Managed Care Manual Chapter 2 for guidance on D- SNP eligibility and enrollment  MCM Chapter 4 : 210.6–Required Elements of Education / Enrollment Assistance Programs (Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01 -01-15)</p>		
<p><b>Medicare Seamless Conversion:</b>  Seamless conversion is an existing statutory and regulatory enrollment mechanism that permits organizations that offer both a Medicare Advantage (MA) plan and a non - MA health plan</p>	<p>Not prohibited in OARS, we are working on increasing the advance notice to CCOs on Medicare match to 90 day notice from 30 day notice, but given list of change requests for HP in advance, may be 2017 before we have that in place.</p>	<p><b>Seamless conversion is authorized in statute and further specified in regulation and guidance.</b></p> <ul style="list-style-type: none"> <li>Section 1851(c)(3)(A)(ii) of the Social Security Act states that in order to provide seamless continuation of coverage, an individual who is enrolled in a health plan (other than a MA plan) offered by a MA organization at the time of the initial election period, and who fails to elect to receive coverage from another health plan organization, is deemed to have elected the MA plan offered by the organization.  <a href="http://www.ssa.gov/OP_Home/ssact/title18/1851.htm">http://www.ssa.gov/OP_Home/ssact/title18/1851.htm</a></li> <li>The Code of Federal Regulations (CFR), Title 42, § 422.66 (Coordination of enrollment and disenrollment through MA organizations) states that if Medicare - eligible individuals fail to select a MA plan, they are automatically enrolled in fee for service/original Medicare. Seamless conversion</li> </ul>	<p>Yes, with CMS approval</p>	<p>Not available when not same parent company</p>

<p>(e.g., Medicaid, employer) to seamlessly convert individuals in the non - MA plans into the MA plan when those individuals first become Medicare eligible.<sup>1</sup></p>		<p>must be offered to all individuals who are Medicare eligible (i.e., individuals whose Medicare eligibility is based on disability, as well as age).  <a href="http://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol3/pdf/CFR-2012-title42-vol3-sec422-66.pdf">http://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol3/pdf/CFR-2012-title42-vol3-sec422-66.pdf</a></p> <ul style="list-style-type: none"> <li>• <u>Section 40.1.4 (Seamless Conversion Enrollment Option for Newly Medicare Advantage Eligible Individuals) Chapter 2 of the Medicare Managed Care Manual states that in order to provide seamless enrollment into a MA plan for newly Medicare-eligible individuals who are currently enrolled in other health plans offered by the same organization, the plan must identify individuals currently enrolled in a health plan offered by the organization no later than 90 days prior to the initial date of Medicare eligibility.</u> A written notice must be provided to each identified individual at least 60 days prior to the date of conversion. The notice must include clear information instructing the individual on how to opt-out, or decline, the seamless conversion enrollment.  <a href="http://cms.hhs.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/FINAL_MA_Enrollment_and_Disenrollment_Guidance_Update_for_CY2012_-_Revised_872012_for_GY2013_v3.pdf">http://cms.hhs.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/FINAL_MA_Enrollment_and_Disenrollment_Guidance_Update_for_CY2012_-_Revised_872012_for_GY2013_v3.pdf</a></li> </ul>		
<p><b>Integrated Member Communication Tools:</b></p>	<p>State can approve plan IDN with OHA integrated NOA information on a case by case basis, holding off on statewide work on statewide Oregon IDN until new Medicaid Managed Care rule is final.</p>	<p>CMS requires IDN use by MA/DSNP plans. New form released in November.</p>	<p>Integrated ID Cards  Integrated IDN  Integrated EOB  Integrated Member Handbooks</p>	<p>In general, if details are being shared through appropriate Business Associate agreements outlining member data sharing &amp; protections, approvals may</p>

				be granted on integrated communications
<b>Use of PRE-Manage to monitor real-time hospitalization/upload member information to receive notifications, HIE where applicable</b>	Allows for real-time connection with EDIE hospitalization information	Medicare Advantage plans could also purchase/use Pre-Manage. Duals linked through both plans memberships, no issues on data sharing	Yes	Yes
<b>2016-2017 DSNP contract requirements to increase care coordination communication</b>	Newly executed OHA DSNP contracts for 2016-2017 include some additional provisions for DSNP plans: 6.1. The Health Plan shall work to ensure information sharing for Medicaid and Medicare benefits coordination, and work to facilitate communication for care coordination and care transitions with network providers and facilities for all full dually-eligible members. 6.2. Information sharing about DSNP benefits and care coordination of benefits with Medicaid and Medicare for members or potential members are allowable under this Agreement and do not constitute marketing by the DSNP plan per provisions in OAR 410-141-3250 (5) and OAR 410-141-3300 (6). Provisions in this Agreement do not set-aside Health Plan's obligations or	CMS requires DSNPs to have contracts with the states that contain at minimum federal MIPPA provisions. D-SNPs must submit MIPPA contracts with states to CMS for review by July 1 of the year before the D-SNP federal contract year begins (by July 1, 2015 for calendar year 2016, for example). At a minimum D-SNP MIPPA contracts with states must document: 1. The D-SNP's responsibility, including financial obligations, to provide or arrange for Medicaid benefits; 2. The categories of eligibility for dually-eligible beneficiaries to be enrolled under the SNP (full benefit, Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), etc.); 3. The Medicaid benefits covered under the SNP; 4. The cost-sharing protections covered under the SNP; 5. The identification and sharing of information on Medicaid provider participation; 6. The verification of enrollees' eligibility for both Medicare and Medicaid; 7. The service area covered by the SNP; and 8. The contract period for the SNP.	Yes	Yes

	<p>requirements for communication and marketing under Medicare rules.</p> <p>6.3. Ensure CCO, MCO and FFS full dually-eligible members have information to access care coordination services as needed as defined in OAR 410-141-3170 by connecting members with CCO care coordination leads or the State Medicaid Agency Fee-For-Service (FFS ) contracted care coordination program for integration of care.</p> <p>6.4. The Health Plan shall publish a contact phone number at each plan that will be available for members’ questions around care coordination, provider access and responding to billing questions, and for providers to inquire about Medicaid or Medicare benefit coordination or billing. and for providers to inquire about Medicaid or Medicare benefit coordination or billing.</p> <p>6.5. Health Plan care coordination policies and procedures:</p> <p>6.5.a. In order to support coordinated care for all full dually-eligible members, the Health Plan shall develop written policies during Agreement year 2016 that will be used by Health Plan in contract year 2017 to ensure timely notification of the full dually-eligible member’s Medicaid CCO, MCO, or State Medicaid Agency care coordination staff or contractors of Health Plan determined relevant 1) planned or unplanned inpatient admissions, 2)</p>	<p><b>Integrated Care Resource Center Technical Assistance Brief (Feb 2015):</b> Individuals dually eligible for Medicare and Medicaid (Medicare-Medicaid enrollees) are among the highest-cost enrollees in both programs.<sup>1</sup> Many of them have complex health care needs that require services from both Medicare and Medicaid.<sup>2</sup> The lack of coordination between these two programs can make it difficult for enrollees to navigate the two systems to get the care they need, and can add to the cost of both programs. Most primary and acute care services (physician, hospital, prescription drug, and related services) for Medicare-Medicaid enrollees are covered through Medicare, and (for those eligible), most long-term services and supports (LTSS) – including home-and community-based services, nursing facility services, personal care assistance, and related services – through Medicaid. Medicare-Medicaid enrollees who receive LTSS are the most costly for Medicaid and among the most costly for Medicare,<sup>3</sup> and linkages between primary and acute care services and LTSS are not well developed in either program. Enabling Medicare-Medicaid enrollees to receive coverage of all of their services through one entity can substantially reduce the complexities they must deal with and provide the opportunity for greater coordination of care and lower costs.</p>		
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	<p>high priority health concerns identified through member health assessments, and 3) sharing of key provisions of discharge planning documents.</p> <p>6.5.b. Health Plan shall submit a summary of the adopted policy(s) to OHA as part of 2016 contract year reporting per Section 12.2.</p> <p>6.6. For all dually-eligible members receiving Medicaid covered Long Term Services and Supports (LTSS) through the Oregon DHS Aging and People with Disabilities (APD) programs, the Health Plan shall make “reasonable efforts” to coordinate benefits and services. Reasonable efforts include outreach and coordination with regional work under CCO-LTSS Memorandums of Understanding (as on file with OHA), or a direct connection with regional Medicaid LTSS for care coordination. A short written description of Health Plans “reasonable effort approach” shall be submitted to the State Medicaid Agency on an annual basis as outlined in Section 12.2. of this contract.</p>			