MACPAC

Medicaid and CHIP Payment and Access Commission

Policy Issues Concerning the Medicare Savings Programs

Katie Weider and April Grady

October 31, 2014

Presentation Outline

- Overview of the Medicare Savings Programs (MSPs)
- Review of findings from a new study on state Medicaid payment policies for Medicare cost sharing
- Policy issues on payment and access
- Review of MSP eligibility and enrollment
- Policy issues on MSP eligibility and enrollment

Context

- MSPs are mechanisms by which Medicaid pays for Medicare premiums and cost sharing for certain low-income Medicare beneficiaries
- Medicare costs for beneficiaries are potentially high
- Incomes for dually eligible beneficiaries are extremely low
- Cover 8.8 million out of the total 10.7 million dually eligible beneficiaries

Medicare Savings Programs

- Four separate MSPs
- Evolved over time
- Different people, benefits, financing
- Federal minimums with state options to expand eligibility
- Administered by the states

Medicaid Assistance with Medicare Costs

	Established by	Medicare Premiums	Medicare Cost Sharing	Total Enrollees in 2013
QMB (<100% FPL)	OBRA 1986	X	X	6,908,769
SLMB (100-120% FPL)	OBRA 1990	X	If also eligible for full Medicaid	1,312,821
QI (120-135% FPL)	BBA 1997	X		576,178
QDWI (<200% FPL)	OBRA 1989	X		105
Non-MSP Full Benefit Dually Eligible Beneficiaries	N/A	*	*	1,933,510

*States can use their own funds to cover non-MSP full benefit dually eligible beneficiaries' premiums, however federal match is only available if the beneficiary is a recipient of cash assistance. States pay Medicare cost sharing for non-MSP full benefit dually eligible beneficiaries through the state's Medicaid plan, but may elect to only pay for Medicare services that are also covered by the state's Medicaid program.

State Medicaid Payment Policies for Medicare Cost Sharing

- States may either pay the full Medicare cost-sharing amount, or the lesser of either:
  - the full Medicare deductible and coinsurance or
  - the difference between the Medicaid rate and the amount already paid by Medicare
- MACPAC March 2013 report documented policies for all states and found that states are more likely to use lesser-of policies

MACPAC Study on Effect of Cost Sharing Policies on Use of Services

- Previous work did not examine the effect of these payment policies on access
- Current study analyzed Medicare and Medicaid enrollment and claims data to examine whether Medicaid payment policies have an impact on utilization of selected Medicare services by dually eligible beneficiaries in fee for service (FFS)

Study Design

- Looked at the association between the percentage of Medicare cost sharing paid by a state Medicaid program and the service use of dually eligible beneficiaries
- Medicare-only beneficiaries were used as a comparison group to control for other state factors (aside from cost-sharing payment policy) that might influence utilization differences across states

Data Sources

- Medicare and Medicaid Analytic eXtract enrollment and claims data for 2009
  - Used to calculate the percentage of Medicare cost sharing paid by Medicaid, and to construct measures of service use
- Excluded some states because of high managed care enrollment or data quality problems
  - 18 or 20 states included in the study, depending on the measure of service use

Study Findings

- Medicaid payments varied across study states
- Higher Medicaid payment of Medicare cost sharing is associated with:
  - an increased likelihood of having an outpatient office visit, using preventive services, and having an outpatient psychotherapy visit
  - a decreased likelihood of using safety net provider services (defined as FQHCs, RHCs, and hospital outpatient departments)

Effect of Higher Medicaid Payments for Medicare Cost Sharing

Type of Medicare visit	Percentage of beneficiaries with a visit				Difference at 100% minus difference at 66%
	Medicaid pays 66%		Medicaid pays 100%		
	Dually eligible	Medicare-only	Dually eligible	Medicare-only	
Any office or outpatient E&M	83.9	85.6	84.8	84.2	+2.3
Any office or outpatient E&M with PCP	67.2	71.8	68.8	70.0	+3.5
Any FQHC or RHC	7.5	5.0	7.4	6.3	-1.4
Any outpatient psychotherapy	4.9	1.9	5.9	1.7	+1.2

Note: E&M is evaluation and management; PCP is primary care provider; FQHC is federally qualified health center; RHC is rural health clinic. **Source:** RTI analysis of 2009 Medicare and Medicaid enrollment and claims data for MACPAC.

Policy Questions on Payment and Access

- Should providers be paid the full amount of Medicare cost sharing for dually eligible beneficiaries?
- If so, how should that be accomplished?
  - All services versus targeted services
  - States pay and receive regular federal match
  - States pay and receive higher federal match
  - Medicare pays; however, this is beyond MACPAC's statutory authority to recommend

MSP Eligibility and Enrollment

- States can vary MSP eligibility levels
- MSP enrollment is low relative to number of those eligible
- MSP enrollment requires beneficiaries to:
  - have knowledge of the MSP program
  - submit an application, which includes information on income and assets

Policy Questions on Eligibility and Enrollment

- Should strategies for MSP education and outreach be improved?
- Should eligibility for the MSPs be expanded?
- Should there be a single eligibility determination for MSP and Part D low-income subsidy enrollment administered by the Social Security Administration?

Next Steps

- Explore how cost sharing burden might be affected by other policy changes
- Further develop policy options for the December meeting