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DEPARTMENT OF HEALTH

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INFORMATIONAL LETTER

TRANSMITTAL: 09 OHIP/INF-1

DIVISION: Office of Health Insurance Programs

TO: Commissioners of Social Services

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SUBJECT: Medicare Advantage Plans and Medicaid Advantage Plans

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FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
05 ADM-05					

This Informational Letter (INF) provides information regarding Medicare Advantage Plans, Medicaid Advantage Plans, and Medicaid Advantage Plus Plans.

I. MEDICARE ADVANTAGE PLANS

Medicare Advantage Plans (sometimes referred to as Medicare Part C or Medicare Managed Care, or Medicare HMOs) are health plan options available to Medicare beneficiaries. In order to enroll in a Medicare Advantage Plan, the individual must have both Medicare Part A and Part B. Individuals who join these plans receive their Medicare-covered health care through the plan. The plans may or may not include prescription drug coverage. In most of these plans, there are additional services and lower co-payments than in the Medicare Program (traditional fee-for-service). Co-payments and premiums can vary by plan.

Enrollees may have to see doctors who participate in the plan or go to certain hospitals to get Medicare covered services from their Medicare Managed Care Plan. However, there is no requirement for a Medicaid recipient who is enrolled in a Medicare Managed Care Plan to only receive services from the Medicare Managed Care Plan. If an applicant receives a Medicaid covered service from a provider who is enrolled in Medicaid, but does not participate in the recipient's Medicare Managed Care Plan, Medicaid will cover the service.

For Medicaid recipients who are enrolled in a Medicare Advantage Plan, the insurance information must be entered in eMedNY in the following order:

- Enter the Health Insurance Claim Number (HC), the Medicare Part A (MA) and Part B (MB) coverage dates on the eMedNY Medicare screen.
- Enter the policy information on the commercial insurance screen, including the scope of benefits covered by the plan.
- Set the Medicare HMO indicator to "Y" for yes.

Under the scope of benefits, do not check "Comp Med A" or "Comp Med B" for individuals enrolled in Medicare Advantage Plans. "Comp Med A" and "Comp Med B" should only be entered when a person has a Medigap policy, or other policy that specifically identifies itself as a complement to Medicare.

Medicare Advantage Plans sometimes charge premiums that are either higher or lower than the traditional Part B premium. When a Medicaid recipient is enrolled in the Medicare Buy-In system in eMedNY, and the plan charges a reduced Part B premium, the State is only charged for the lesser amount. If a Medicaid recipient is enrolled in a Medicare Advantage Plan that charges a premium that is higher than the traditional Part B premium, the local district should pay the difference as a health insurance premium, if it is determined to be cost effective. Medicare Advantage Plan premiums may also be used to meet a spenddown obligation, or may be used as a deduction from income.

Medicaid will pay all deductibles, coinsurance, and co-payments for Medicaid recipients enrolled in a Medicare Advantage Plan as long as the provider is also a Medicaid enrolled provider. Instructions for providers on submitting claims for individuals enrolled in a Medicare Advantage Plan are included in the January 2007 Medicaid Update article entitled, "Medicaid Recipients with Medicare Managed Care". The information in this article states, "If the patient is enrolled in a Medicare Advantage Plan there should be no Part A or Part B coverage for the same period". This information is only intended for providers and claims processing. As stated above, Medicare coverage information must be entered into eMedNY by the local department of social services (LDSS).

The Centers for Medicare and Medicaid Services (CMS) does not auto-enroll Medicare Advantage Plan enrollees into a Medicare Part D prescription drug plan as they do for dual eligibles who are enrolled in the traditional fee-for-service Medicare Program. The Medicare Advantage Plan must facilitate its members' enrollment into a prescription drug plan associated with their managed care organization.

Not all Medicare Advantage prescription drug plans offer benchmark plans (a plan that is available to dual eligibles at no cost). Dual eligibles who are enrolled in certain Medicare Advantage Plans may have to pay an additional monthly premium for the prescription drug benefit. If a dual eligible does not want to pay the higher cost, they must disenroll from that Medicare Advantage Plan and choose a different Medicare Advantage Plan or choose traditional fee-for-service Medicare along with a stand-alone prescription drug plan that is a benchmark plan.

Individuals are responsible to pay the Medicare Part D co-payments, regardless of whether they receive their drug benefit through a Medicare Advantage Plan or a stand-alone prescription drug plan. Part D co-payments or Part D premiums cannot be submitted to Medicaid for payment or reimbursement. However, such costs may be used to meet a spenddown obligation.

II. MEDICAID ADVANTAGE and MEDICAID ADVANTAGE PLUS PLANS

New York also has two integrated care plans designed for dual eligible recipients: Medicaid Advantage and Medicaid Advantage Plus. Both plans allow dual eligibles to enroll in the same health plan for most of their Medicare and Medicaid benefits.

Both plans achieve integration of Medicare and Medicaid through a State contract with Medicare Advantage Plans (or Medicare Advantage Special Needs Plans) to provide a defined set of Medicaid wrap-around benefits to dual eligible enrollees on a capitated basis. The Medicaid Advantage Plan benefit includes acute care services not covered by Medicare; the Medicaid Advantage Plus Plan benefit also covers Medicaid long-term care benefits. To enroll in a Medicaid Advantage Plus Plan, recipients must be eligible for nursing home level of care. If such individuals are residing in the community, they must document current resources (RVI 2) and be otherwise eligible in order to participate. If the person enters a nursing home for other than short term rehabilitation, he/she must document resources for the lookback period (RVI 1) in order to continue to be eligible to participate.

Dual eligible beneficiaries may enroll in the same managed care organization's Medicare Advantage Plan or Medicare Advantage Special Needs Plan (SNP) and corresponding Medicaid Advantage or Medicaid Advantage Plus Plan product. The Managed Care Organization (MCO) receives two capitation payments; one from CMS for the Medicare Advantage product and one from the State for the Medicaid Advantage or Medicaid Advantage Plus product. The State capitation paid to the MCO includes the Part C cost sharing (co-payments/deductibles, and Part C premiums, if any) associated with the Medicare Advantage product and the actuarial value of the services covered by the Medicaid Advantage or Medicaid Advantage Plus wrap. Because the State pays the plan directly for any recipient cost-sharing associated with the Medicare Advantage product, Medicaid will not pay Medicaid enrolled providers for co-payments or deductibles for covered benefits for recipients enrolled in Medicaid Advantage or Medicaid Advantage Plus.

However, enrollees in Medicaid Advantage or Medicaid Advantage Plus are entitled to all Medicaid services they would normally get under the State Medicaid Plan. Therefore, any Medicaid services not included in the combined Medicare and Medicaid Advantage or Medicaid Advantage Plus benefit package offered by the health plan continue to be available to the enrollee when provided by any Medicaid enrolled provider on a Medicaid fee-for-service basis.

Participation by Medicare Advantage Plans or SNPs in Medicaid Advantage or Medicaid Advantage Plus is voluntary. Enrollment in these integrated plans by dual eligibles is also voluntary, and is not limited to the open enrollment period. Medicaid Advantage Plus Plans may also enroll individuals who have a spenddown.

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