New York State Bar Association
One Elk Street, Albany, New York 12207 • 518/463-3200 • http://www.nysba.org

Memorandum in Opposition

ELDER LAW AND SPECIAL NEEDS SECTION

ELDER # 19 February 17, 2016

S. 6407-A – PART B, Sec. 16 By: BUDGET
A. 9007-A – PART B, Sec. 16 By: BUDGET
Senate Committee: Finance
Assembly Committee: Ways and Means

THE ELDER LAW AND SPECIAL NEEDS SECTION OPPOSES THE PROPOSAL TO REDUCE BENEFITS FOR QUALIFIED MEDICARE BENEFICIARIES (QMB) WHO DEPEND ON MEDICAID TO ENSURE AFFORDABLE ACCESS TO HEALTH CARE - Part B section 16 – pp 22-23

The goal of the Qualified Medicare Beneficiary (QMB) program is to assure meaningful access to Medicare benefits for elderly and disabled individuals with income under 100 percent of the Federal Poverty Level. It does so by requiring Medicaid to cover Medicare Part A and Part B premiums as well as the cost-sharing per service for which a Medicare beneficiary normally must pay; e.g., co-payments. However, the federal statute allows states to limit reimbursement by paying the "lesser-of" Medicaid or Medicare rates, and most states opt for such limitation. As a result, the existing financing mechanism often means the provider must forgo the cost-sharing amounts. By law, providers may not attempt to collect any cost-sharing from QMB program enrollees.[1] An unintended consequence of this policy has been found by research studies to be that providers limit their patient pool to non-QMB program enrollees, thereby having the effect of reducing access to routine health care for QMB program enrollees.

In 2015, New York enacted a sharp cut in Medicaid reimbursement to the QMB program, limiting payment to the lesser of the Medicaid or Medicare rate for those Medicare beneficiaries who have "Original Medicare." Now, the Governor proposes to extend this restriction to those Medicare beneficiaries who are in Medicare Advantage plans.

[1] Section 1902(n)(3)(B) of the Social Security Act (the Act), as modified by section 4714 of the Balanced Budget Act of 1997; see also CMS Informational Bulletin issued January 6, 2012, titled "*Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs)*," available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf.

Example: Medicare approved charge is $100, and managed care plan reimburses provider 80% or $80. Provider wants to bill Medicaid for the coinsurance. The Medicaid rate for the service is only $70, so Medicaid declines payment. Provider may not legally bill the patient for the coinsurance – but can refuse to serve the individual altogether – thereby limiting the choice of care for low income Medicare beneficiaries.

The Governor's proposal compounds the deleterious effects of the 2015 cuts – and undercuts the recent expansion of the crucial QMB program. In 2008, the State expanded access to the QMB program and the two other Medicare Savings Programs by eliminating the asset limit for eligibility. In 2010, Congress passed the "MIPPA" law – the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) - which improved access to the QMB program by expanding outreach to low-income Medicare Part D beneficiaries, making it easier for Social Security beneficiaries to enroll, and eliminating estate recovery for the value of QMB benefits. See more at http://www.nasuad.org/policy/key-issues/mippa#sthash.W6PLxliW.dpuf.

The reimbursement cuts reverse the positive impact of expanding QMB eligibility because QMB balance billing protections are of little use if a beneficiary cannot get access to needed providers.

The specter of QMB program enrollees having fewer providers willing to treat them is not just speculative. In a July 2015 report, the U.S. Center for Medicare & Medicaid Services (CMS) issued findings confirming these patterns in research studies described in a report, "*Access to Care Issues Among Qualified Medicare Beneficiaries.*"[2] This report includes both qualitative and quantitative findings that support the hypothesis that reduced coverage of cost-sharing reduces access to care for QMB enrollees. The CMS 2015 report presented findings from two 2014 studies, one by the Lewin Group and one by the Medicaid and CHIP Payment and Access Commission (MACPAC).

The proposed expansion of the restricted reimbursement to Medicare Advantage plans poses unique problems. About one-third of the 3.3 million Medicare beneficiaries in New York State are enrolled in Medicare Advantage plans.[3] This proposal likely will not affect Special Needs Plans that cater to Dual Eligibles ("Dual-SNPs") because they are not required to charge co-payments to all enrollees. The medical providers that contract with those plans already know that they are only going to get what the plan pays them and that presumably is part of the rate negotiations between them. But it is different for

[2] Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

[3] Data as of March 1, 2015, https://www.cms.gov/Medicare/Prescription-Drug-overage/PrescriptionDrugCovGenIn/Downloads/Congressional-District-Report.zip (This is for all Medicare beneficiaries; data not available on number of QMB and Medicaid beneficiaries are in Medicare Advantage plans).

plain vanilla Medicare Advantage plans that happen to have dual eligibles among their membership, including QMBs who are the poorest of this group. These Medicare Advantage plans are prohibited from discriminating against a beneficiary based on their source of insurance. CMS Managed Care Manual, Ch.4 at 10.5.2

The plan must make its whole provider network available to all members, including those who have Medicaid or who are QMB program enrollees. If the Governor's proposal passes, the plan would have to find a way to pay providers more when they serve members who happen to be Medicaid or QMB program enrollees -- or risk having providers drop out of the network because they do not want to absorb the loss.

The harm from the proposed reduction in reimbursement will impact access to primary care physicians and specialists, and many other health providers. The fact that the proposal would continue full coinsurance reimbursement for a few carved out services – ambulance, psychologists, and outpatient hospital clinic services – does not ameliorate the harm.

Based upon the foregoing, the Elder Law and Special Needs Section **OPPOSES** this proposal, which creates budgetary savings at the expense of some of the poorest and neediest individuals in the state.

Memoradum prepared by: Matthew Nolfo, Esq.
Section Chair: JulieAnn Calareso, Esq.