

CHAPTER 6

Effects of Medicaid Coverage of Medicare Cost Sharing on Access to Care

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Key Points

- Since its enactment in 1965, Medicaid has played a role in paying for some Medicare premiums and cost sharing for certain low-income Medicare beneficiaries.
- Today, almost 20 percent of Medicare beneficiaries receive assistance with Medicare premium or cost-sharing assistance either through one of the four separate Medicare Savings Programs or through full Medicaid benefits. This is valuable assistance with Medicare's out-of-pocket costs, as more than three-quarters of dually eligible beneficiaries have incomes below \$15,000.
- The Commission is concerned, however, that current Medicaid policies regarding Medicare cost sharing may reduce access to care for dually eligible Medicare beneficiaries relative to their non-dually eligible counterparts.
- Since 1997, the Medicaid statute has explicitly allowed states to pay less than the full Medicare cost-sharing amount if it would lead a provider to receive more than the state's Medicaid rate for the same service. And although Medicaid payment is only one factor that may affect access to care, new research conducted for MACPAC finds that paying a higher percentage of Medicare cost sharing increases dually eligible beneficiaries' likelihood, relative to that of non-dually eligible Medicare beneficiaries, of using selected Medicare outpatient services and decreases the use of safety net provider services.
- Additionally, the administrative complexity associated with processing claims can hinder Medicaid payment for cost sharing and contribute to access barriers for dually eligible beneficiaries.
- Current interest in redesigning Medicare's cost-sharing policies provides an opportunity to reexamine the roles of both Medicare and Medicaid in providing assistance for low-income Medicare beneficiaries.
- Changes to Medicaid's coverage of Medicare's out-of-pocket costs must be considered in conjunction with changes to Medicare payment and how revisions to either program would affect beneficiaries, providers, and federal and state budgets.
- Future Commission work will focus on eligibility and enrollment issues related to Medicare Savings Programs, and areas where Medicaid policy changes can improve access for low-income Medicare beneficiaries.

CHAPTER 6: Effects of Medicaid Coverage of Medicare Cost Sharing on Access to Care

Medicare and Medicaid together play a role in providing access to necessary health services for the 10.7 million low-income seniors and people with disabilities who are dually eligible for both programs (MACPAC 2014a). For these dually eligible individuals, Medicare is the primary payer for services such as physician visits, hospital stays, post-acute skilled care, and prescription drugs. State Medicaid programs wrap around Medicare's coverage, providing financial assistance in the form of payment of Medicare premiums and cost sharing (including deductibles and coinsurance) as well as benefits not covered by Medicare, such as long-term services and supports. Dually eligible beneficiaries are among the poorest and sickest individuals covered by either Medicare or Medicaid, and they rely on this joint coverage to meet their health care needs.

Despite successfully reducing beneficiaries' out-of-pocket health care costs, Medicaid's provision of benefits for low-income Medicare beneficiaries warrants further examination. One aspect to consider is whether certain policies regarding Medicaid payment of Medicare cost sharing may reduce access by creating disincentives for providers to serve people who are enrolled in both Medicare and Medicaid.¹ As a result of federal budget reconciliation legislation passed in 1997, the Medicaid statute allows states to pay less than the full Medicare cost-sharing amount if it would lead a provider to receive more than the state's Medicaid rate for the same service. For selected services in 2012, Medicaid fee-for-service (FFS) physician fees averaged 66 percent of Medicare

physician fees. This means that Medicaid payment for cost sharing associated with Medicare services provided to dually eligible beneficiaries is almost always less than what would have been paid for Medicare beneficiaries without Medicaid coverage (Zuckerman and Goin 2012).

Charged with assessing access and payment issues under Medicaid, MACPAC is responsible for examining the impact of this policy on beneficiaries, providers, states, and the federal government. While the lesser-of policy that allows states to pay less than the full Medicare cost-sharing amount may help states moderate spending, new MACPAC research, described in this chapter, concludes that the policy may create access barriers for dually eligible beneficiaries. There also are administrative difficulties with Medicaid's payment of Medicare cost sharing that warrant the attention of policymakers. For example, the processes used to pay Medicare cost-sharing amounts involve claims transfers between Medicare and Medicaid and, in some cases, duplicate submissions of claims that may be inefficient for both states and providers.

However, it is important to recognize that Medicaid's coverage of Medicare premiums and cost sharing for dually eligible beneficiaries reflects an evolving 50-year relationship between Medicaid and Medicare, and between the federal government and the states. Given the interconnected nature of the programs and their wide-ranging impacts, changes to Medicaid's coverage of Medicare's out-of-pocket costs cannot be considered in isolation, nor without an examination of how they would affect beneficiaries, providers, and federal and state budgets. Given current policy interest in redesign of Medicare's cost-sharing policies, it is the Commission's view that the role of both Medicare and Medicaid in providing assistance for low-income Medicare beneficiaries should be reexamined.

The Commission has a continuing focus on issues affecting dually eligible beneficiaries, including Medicaid's payment of Medicare cost sharing. In

its March 2013 report to Congress, the Commission examined Medicaid's role in covering Medicare cost sharing and documented states' payment policies. Here, we examine the effects of those policies on access to care. This chapter begins with a brief overview of Medicaid assistance for low-income Medicare beneficiaries, describing the legislative history of the Medicare Savings Programs (MSPs) and other relevant provisions. Next, it highlights findings from a new analysis conducted for MACPAC on the effect of states' Medicaid payments for Medicare cost sharing on dually eligible beneficiaries' use of selected outpatient Medicare services. It then reviews the administrative processes used to pay Medicare cost-sharing amounts. It concludes with a discussion of Medicaid's role in covering Medicare costs in an evolving health care system.

History of Medicaid Assistance for Low-Income Medicare Beneficiaries

Medicare's out-of-pocket costs can be a financial burden for low-income beneficiaries. In 2014, Medicare Part B's yearly deductible and monthly premiums together exceeded \$1,400 for most beneficiaries (CMS 2014a). Individuals dually eligible for Medicare and Medicaid are particularly vulnerable to these costs, as many of them have extremely low annual incomes. More than three-quarters (79 percent) of all dually eligible beneficiaries had an annual income less than \$15,000 in 2012 (CMS 2012). For the 10.7 million beneficiaries who were dually eligible in 2013, Medicaid is an important supplement to Medicare coverage.

When enacted in 1965, one of Medicaid's roles for dually eligible beneficiaries was to provide assistance with their out-of-pocket Medicare costs. At the time, Medicare had no means testing provisions, and Medicaid was the vehicle

for assisting those with low incomes. Over time, both programs have evolved, with Medicaid covering additional Medicare beneficiaries and costs, and Medicare implementing its own income-based policies.

Today, almost 20 percent of Medicare beneficiaries receive Medicare premium or cost-sharing assistance through the four separate MSPs or through non-MSP eligibility for full Medicaid benefits (MedPAC and MACPAC 2015). The MSPs are those for:

- qualified Medicare beneficiaries (QMBs);
- specified low-income Medicare beneficiaries (SLMBs);
- qualifying individuals (QIs); and
- qualifying disabled and working individuals (QDWIs).

This section discusses major milestones in the history of Medicaid's role in serving low-income Medicare beneficiaries, which highlights the importance of considering future changes in the context of both programs, as responsibility for coverage and financing of various benefits for this population have shifted over time (Table 6-1). It also highlights MSP eligibility criteria (Table 6-2). MACPAC's March 2013 *Report to the Congress on Medicaid and CHIP* provides more detailed information on the MSPs.

Original Medicare buy-in for beneficiaries receiving cash assistance. Since the inception of the Medicare and Medicaid programs in 1965, Medicaid has paid Medicare premiums for certain low-income Medicare beneficiaries. This is referred to as Medicare buy-in. In addition to Medicare Part B premiums, the original Medicaid statute also provided for payment of Part A and Part B deductibles and other cost sharing for dually eligible beneficiaries. Under this provision, states and the federal government jointly finance Medicare beneficiary premiums and cost sharing (beneficiaries overall currently pay 25 percent

TABLE 6-1. Legislative Milestones in Medicaid Coverage of Premiums and Cost Sharing for Low-Income Medicare Beneficiaries

1965	The Medicare and Medicaid programs were enacted as Title XVIII and Title XIX, respectively, of the Social Security Act of 1965 (P.L. 89–97). For low-income individuals entitled to both Medicare and Medicaid, the statute provided for Medicaid payment of Part B premiums as well as Part A and Part B deductibles and other cost sharing. However, it only allowed states to receive federal matching payments for Part B premiums paid on behalf of individuals receiving cash assistance through certain means-tested programs.
1967	The Social Security Amendments of 1967 (P.L. 90–248) prohibited federal financial participation for Medicaid services that could have been paid for by Medicare Part B if an individual had been enrolled.
1986	The Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) created the qualified Medicare beneficiary (QMB) program as a state option.
1988	The Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100–360) enacted provisions that required states to cover QMBs.
1989	The Omnibus Budget Reconciliation Act of 1989 (P.L. 101–239) created the qualified disabled and working individuals (QDWI) program and prohibited providers from billing QMB beneficiaries for any amount that exceeds the Medicare rate.
1990	The Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508) established the special low-income Medicare beneficiary (SLMB) program.
1997	The Balanced Budget Act of 1997 (P.L. 105–33) created the qualified individuals (QI) program; provided states the option to pay the lesser of (1) the full amount of Medicare deductibles and coinsurance or (2) the amount, if any, by which Medicaid’s rate for a service exceeds the amount already paid by Medicare; and specified that providers cannot bill beneficiaries for the difference between the Medicaid payment and the full Medicare cost-sharing amount when Medicaid pays less than the full amount of Medicare cost sharing.
2003	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173) established the Medicare Part D program and the Part D low-income subsidy (LIS) program, and also required higher-income Medicare beneficiaries to pay a higher percentage of the Part B premium.

Notes: This table includes legislative milestones relating only to Medicaid coverage of premiums and cost sharing for low-income Medicare beneficiaries. Legislation and provisions relating to other benefits and eligibility for these individuals are not included in this table.

Source: MACPAC 2013.

of per capita Part B costs, previously 50 percent when Medicare was enacted), and Medicare is the primary payer for Medicare-covered services (O’Sullivan 2004). The original Medicare buy-in only allowed states to receive federal matching payments for Part B premiums paid on behalf of individuals receiving cash assistance through certain means-tested programs. This group included the lowest-income Medicaid beneficiaries and excluded individuals with higher incomes, such as those who spend down to a medically needy

eligibility level through out-of-pocket payments for health care or who qualify at a higher eligibility level but contribute most of their income toward nursing home costs (Carpenter 1998).

QMB program for all individuals in poverty.

Under the Omnibus Budget Reconciliation Act of 1986 (OBRA 86, P.L. 99-509), Medicaid coverage of Medicare costs was expanded by way of the qualified Medicare beneficiary program. The QMB program now requires states to cover Medicare

Part B premiums, as well as Medicare Part A and Part B deductibles and coinsurance, for Medicare beneficiaries with incomes up to 100 percent of the federal poverty level (FPL) and limited assets. The QMB program also pays Part A premiums for beneficiaries who do not qualify for premium-free Medicare Part A. The QMB program is the largest of all the MSPs, enrolling 6.9 million individuals in 2013 (MACPAC 2014a).

OBRA 86 initially created the QMB program as a state option, but it became mandatory in 1988, through the Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100-360). When Congress made the QMB program mandatory, it did so under the assumption that the new costs of covering these individuals would be offset by decreases in Medicaid spending resulting from Medicare service expansions, including a prescription drug benefit. However, less than two years after its enactment, the Medicare service expansions of the MCCA were repealed. As a result, Medicaid's QMB expansion costs were not offset, and states faced an additional financial burden (Carpenter 1998).

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239) also amended Medicare to prohibit providers from billing QMB beneficiaries for any amount that exceeds the Medicare rate, a practice sometimes referred to as balance billing. Later, the Balanced Budget Act of 1997 (BBA, P.L. 105-33) specified that providers cannot bill beneficiaries for the difference between the Medicaid payment and the full Medicare cost-sharing amount when Medicaid pays less than the full amount of Medicare cost sharing. As a result of these policies, providers may not receive the full Medicare rate (which is the sum of Medicare program payment plus the beneficiary cost-sharing liability) when serving dually eligible beneficiaries.

Expansion of coverage for working individuals with disabilities. OBRA 89 established the qualifying disabled and working individual program to allow people with disabilities who have incomes up to 200 percent FPL and limited assets to maintain

Medicare Part A coverage after returning to work. The QDWI program only pays for Medicare Part A premiums. It is the smallest MSP, enrolling fewer than 200 beneficiaries in 2013 (MACPAC 2014a).

Changes to cover premiums for additional beneficiaries through the SLMB and QI programs and reduce states' obligations for Medicare cost sharing. Medicaid's role in paying for Medicare premiums grew further through the Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508). OBRA 90 created the specified low-income Medicare beneficiary program, which provides Medicaid coverage of Medicare Part B premiums for Medicare beneficiaries with incomes between 101 and 120 percent FPL and limited assets. In 2013, 1.3 million individuals were enrolled in the SLMB program (MACPAC 2014a).

Medicaid's role was again expanded in 1997 when the qualifying individual program was established in the BBA. The QI program requires Medicaid coverage of Medicare Part B premiums for Medicare beneficiaries who have incomes between 121 and 135 percent FPL and limited assets, and who are otherwise ineligible for Medicaid. In 2013, there were approximately 600,000 individuals enrolled in the QI program (MACPAC 2014a).²

The QI program was designed to have a minimal financial impact on states by providing them with 100 percent federal financing through capped allotments and the ability to impose annual limitations on the number of individuals enrolled in the QI program. If a state exceeds its allotted amount, it is fully responsible for payment of QI enrollees' additional Medicare Part B premiums. Funding is allocated yearly and is dependent on congressional appropriations and program reauthorizations (MACPAC 2013). Although states have sometimes run short on QI funds, allotments have been adjusted across states to mitigate any impacts, and the appropriation amounts have been increased over time (CMS 2010). Most recently, the Protecting Access to Medicare Act of 2014 (P.L. 113-93) extended the program until March 31, 2015.

In 1997, the BBA created one other financial protection for states by providing them with the authority to pay less than the full amount of Medicare cost sharing for dually eligible beneficiaries if the provider payment would exceed the state's Medicaid rate for the same service. This provision is discussed in further detail later in this chapter.

Transfer of responsibility for drug coverage from Medicaid to Medicare Part D. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also referred to as the Medicare Modernization Act, MMA, P.L. 108–173), primary responsibility for dually eligible beneficiaries' drug coverage shifted from Medicaid to a new Medicare Part D. However, states were required to maintain a financial contribution for dually eligible beneficiaries' drug costs in the form of phased-down state contributions (often referred to as clawback payments) to the federal government.

In addition, MMA for the first time created two income-related provisions in Medicare. The first required higher-income Medicare beneficiaries to pay a higher percentage of the Part B premium. (A similar policy was later extended under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) to Medicare Part D.) The second income-related provision established the Part D low-income subsidy (LIS) program, which helps pay for Medicare Part D premiums and cost sharing for low-income Medicare beneficiaries. Individuals participating in the QMB, SLMB, or QI MSPs and dually eligible beneficiaries who receive full Medicaid benefits through a non-MSP pathway are automatically eligible for the Part D LIS program.

Not all dually eligible beneficiaries qualify for MSPs. Although legislative changes have expanded Medicaid's original Medicare buy-in provision, states also pay for Medicare premiums and cost sharing outside of the MSPs. In 2013, 1.9 million Medicare beneficiaries received full Medicaid benefits, but had incomes too high to qualify for premium and cost-sharing assistance through a MSP. These dually eligible beneficiaries qualify

for Medicaid through pathways that include the medically needy option, the special income level option for institutionalized individuals, and home and community-based services waivers. States pay Medicare cost sharing for these individuals through the state's Medicaid plan, but may elect to pay only for Medicare services that are also covered by the state's Medicaid program (MACPAC 2013).³ For these beneficiaries, states may use their own funds to pay for Medicare premiums. Unlike the QMB, SLMB, QDWI, and QI programs, federal matching is only available under Medicaid for Medicare premium costs in these situations if the beneficiary is a recipient of cash assistance, including State Supplementary Payments and Temporary Assistance for Needy Families (OIG 2013a).

State Medicaid Payment Amounts for Medicare Cost Sharing

States are not obligated to pay the full amount of Medicare cost sharing if the provider payment would exceed the state's Medicaid rate for the same service. With the enactment of the mandatory QMB program in 1988, state Medicaid programs were required to pay for QMB Medicare cost sharing, but the law did not specify whether states were obligated to pay the full amount or only up to the state Medicaid rate. In 1991, the guidance issued by the Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid Services) allowed states to pay less than the full Medicare cost-sharing amount. As a result, providers brought lawsuits arguing that this guidance, and states' practice of paying less than the full Medicare cost sharing amount did not fulfill states' obligations under their Medicaid plans to pay for Medicare cost sharing for QMBs. Federal court decisions were mixed and created uncertainty with regard to how much states must pay for Medicare cost sharing (MACPAC 2013). However, as previously noted, in 1997, BBA granted

TABLE 6-2. Medicaid Eligibility and Benefits by Type of Dually Eligible Beneficiary

Type	Full or partial Medicaid benefits	Federal income and resource limits for eligibility (individual/couple) in 2014	Benefits	Number of beneficiaries in 2013 (millions)
Medicare Savings Program (MSP) beneficiaries				
Qualified Medicare beneficiaries (QMB)	Partial: QMB only	<ul style="list-style-type: none"> • At or below 100% of the federal poverty level (FPL) • \$7,160/\$10,750 	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part A premiums (if needed) • Medicare Part B premiums • At state option, certain premiums charged by Medicare Advantage plans • Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program) 	1.4
	Full: QMB plus	<ul style="list-style-type: none"> • At or below 100% FPL • \$2,000/\$3,000 	Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part A premiums (if needed) • Medicare Part B premiums • At state option, certain premiums charged by Medicare Advantage plans • Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D) • All Medicaid-covered services 	5.5
Specified low-income Medicare beneficiaries (SLMB)	Partial: SLMB only	<ul style="list-style-type: none"> • 101%–120% FPL • \$7,160/\$10,750 	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part B premiums 	1.0
	Full: SLMB plus	<ul style="list-style-type: none"> • 101%–120% FPL • \$2,000/\$3,000 	Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part B premiums • At state option, certain premiums charged by Medicare Advantage plans • Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid • All Medicaid-covered services 	0.3
Qualified individuals (QI)	Partial	<ul style="list-style-type: none"> • 121%–135% FPL • \$7,160/\$10,750 	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part B premiums 	0.6
Qualified disabled and working individuals (QDWI)	Partial	<ul style="list-style-type: none"> • At or below 200% FPL • \$4,000/\$6,000 	Lost Medicare Part A benefits due to their return to work but eligible to purchase Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part A premiums 	Fewer than 200 individuals

TABLE 6-2. (continued)

Type	Full or partial Medicaid benefits	Federal income and resource limits for eligibility (individual/couple) in 2014	Benefits	Number of beneficiaries in 2013 (millions)
Non-MSP beneficiaries				
Other full benefit, dually eligible beneficiaries	Full	<ul style="list-style-type: none"> Income limit varies, but generally at or below 300% of the federal Supplemental Security Income benefit rate (about 225% FPL for an individual) \$2,000/\$3,000 	Eligible under a mandatory or optional Medicaid pathway, not eligible for MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> At state option, certain premiums charged by Medicare Advantage plans Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid All Medicaid-covered services 	1.9

Notes: Medicaid benefits for dually eligible beneficiaries are jointly financed by the federal government and states. Resource limits for QMB, SLMB, and QI are adjusted annually for inflation. Not all income and resources (e.g., the value of a house, vehicle, etc.) are counted toward limits. In addition, states may use less restrictive methodologies for counting income and resources and can eliminate asset tests, which enables them to expand eligibility above the limits shown here. Eleven 209(b) states may use more restrictive limits and methodologies when determining eligibility for full Medicaid benefits.

Sources: CMS 2014b; MACPAC 2014a; MedPAC and MACPAC 2015.

explicit authority to states to use the lesser-of policies. Since this time, states have had the option to pay, for a given Medicare service received by a dually eligible beneficiary, the lesser of (1) the full amount of Medicare deductibles and coinsurance or (2) the amount by which Medicaid’s rate for the same service exceeds what Medicare has already paid (this amount is zero in cases where Medicaid’s rate is lower than Medicare’s payment).

MACPAC’s March 2013 *Report to the Congress on Medicaid and CHIP* documents states’ lesser-of payment policies. In 2012, 39 states chose to use lesser-of policies for at least one service type, which would lead them to pay less than the full Medicare cost-sharing amount when the payment rate for Medicaid is lower than for Medicare. While the number of states with lesser-of policies that allow them to pay less than the full Medicare cost-sharing amount has grown since 1997, a recent MACPAC examination of state websites indicates that there have been few changes since MACPAC’s 2012 review.

Although the BBA allows states to achieve savings by paying less than the full amount of Medicare cost sharing, there is evidence that these policies reduce dually eligible beneficiaries’ use of certain outpatient Medicare services. However, the magnitude and direction of this effect varies by provider and service type.

Analysis of the Effect of State Medicaid Payment for Medicare Cost Sharing on the Use of Certain Outpatient Services

While MACPAC documented state policies in its March 2013 report, it did not examine the effect of these payment policies on access to care at that time. More recently, MACPAC contracted with RTI International (RTI) to analyze the effects of

states' Medicaid payment policies for Medicare cost sharing on access to selected Medicare services for dually eligible beneficiaries with FFS coverage, including office-based and other outpatient evaluation and management (E&M), prevention, federally qualified health center (FQHC), rural health clinic (RHC), and psychotherapy visits (Haber et al. 2014a). These services were selected for analysis because they are considered indicators of realized access to primary care and other forms of outpatient services, and can be assessed using claims (Kennell and Associates 2011). Overall, outpatient services represent 30 percent of Medicare spending on FFS full-benefit dually eligible beneficiaries (MedPAC and MACPAC 2015). And they are important entry points into the health care system. The study did not look at the impact of lesser-of policies on provider participation, which can be considered another measure of access.

Data and methods. Medicare and Medicaid Analytic eXtract (MAX) enrollment and claims data from 2009 for beneficiaries with FFS coverage were examined to determine the association between the percentage of Medicare cost sharing covered by state Medicaid payments and utilization of selected Medicare outpatient services. The effect of cost-sharing payments on the likelihood that a dually eligible beneficiary used a particular service was estimated using multivariate analyses. Non-dually eligible Medicare beneficiaries served as a comparison group to control for other state factors that might influence utilization differences across states.

A total of 20 states were included in the analyses of E&M and safety net provider services, and 18 states were included in the analysis of outpatient psychotherapy services. Individuals enrolled in Medicare Advantage (MA) or comprehensive Medicaid managed care plans were excluded. (For complete study methodology and results, see Haber et al. 2014a.)

Findings: The relationship between state policy and actual payments for cost sharing. The study first

examined the average percentage of Medicare cost sharing covered by Medicaid payments for office-based E&M and outpatient psychotherapy visits. In all states examined, including those identified in MACPAC's earlier work as paying cost sharing in full, Medicaid payments in 2009 covered less than 100 percent of the full Medicare cost-sharing amount.⁴ In 2009, cost-sharing payments for office-based E&M services in full payment states ranged from 65 to 98 percent of Medicare cost-sharing amounts. In states that reported a policy of paying less than 100 percent of Medicare cost sharing (lesser-of policy states), cost sharing payments for E&M office visits ranged from 11 to 93 percent, with most states paying less than 50 percent of the cost sharing.

With few exceptions, Medicaid cost-sharing payment percentages were higher for office-based E&M services compared to outpatient psychotherapy services. In 2009, cost-sharing payments for outpatient psychotherapy in full payment states ranged from 15 to 71 percent. In lesser-of payment states, cost sharing payments for outpatient psychotherapy ranged from 2 to 70 percent (Haber et al. 2014a).

Findings: Effects of payment policies on the use of providers and services. The study then looked at the effects of the payment policies on access to health care providers and services. The analyses show that paying a higher percentage of Medicare cost sharing increased dually eligible beneficiaries' likelihood, relative to non-dually eligible Medicare beneficiaries, of having office and other outpatient E&M visits and using preventive services, but decreased their likelihood of using safety net provider services. Also, paying a higher percentage of Medicare cost sharing increased dually eligible beneficiaries' likelihood, relative to non-dually eligible Medicare beneficiaries, of receiving outpatient psychotherapy. For example, if Medicaid pays 20 percent of Medicare cost sharing, the predicted percentage of dually eligible beneficiaries with an office or outpatient E&M visit is 82.6 percent. However, if Medicaid pays 100 percent of Medicare cost sharing, the predicted percentage of dually eligible beneficiaries with an office or

TABLE 6-3. Predicted Share of Dually Eligible and Non-Dually Eligible Beneficiaries with a Medicare Visit at 20 Percent and 100 Percent Medicaid Payment of Medicare Cost Sharing

Type of Medicare visit	Predicted percentage of beneficiaries with a visit						Relative to non-dually eligible, predicted percentage point effect on share of dually eligible beneficiaries with a visit when moving from 20% to 100% Medicaid payment (difference in difference)
	Medicaid pays 20%			Medicaid pays 100%			
	Dually eligible	Non-dually eligible	Difference	Dually eligible	Non-dually eligible	Difference	
Any office or outpatient E&M	82.6	87.3	-4.7	84.8	84.2	+0.5	+5.3
Any office or outpatient E&M with PCP	64.9	74.4	-9.3	68.8	70.0	-1.2	+8.1
Any FQHC or RHC	7.7	3.6	+4.1	7.4	6.3	+6.3	-2.9
Any outpatient psychotherapy	3.7	2.1	+1.6	5.9	1.7	+1.7	+2.6

Notes: E&M is evaluation and management; PCP is primary care provider; FQHC is federally qualified health center; RHC is rural health clinic. Multivariate regression model results were used to predict utilization for dually eligible and non-dually eligible beneficiaries assuming the Medicaid payment percentages shown, with all other independent variables set to the average value of the study population. All predicted effects are statistically significant at p<0.05 level.

Source: Haber et al. 2014b.

TABLE 6-4. Predicted Effects of Moving from Varying Levels to 100 Percent Medicaid Payment of Medicare Cost Sharing on the Share of Dually Eligible Beneficiaries with a Medicare Visit, Relative to Non-Dually Eligible Medicare Beneficiaries

Type of Medicare visit	Predicted percentage point effect on share of dually eligible beneficiaries with a visit when moving from lower percentage to 100% Medicaid payment of Medicare cost sharing, relative to non-dually eligible						
	Medicaid payment percentage for Medicare cost sharing						
	20%	30%	40%	50%	66%	80%	90%
Any office or outpatient E&M	+5.3	+4.6	+4.0	+3.3	+2.3	+1.3	+0.7
Any office or outpatient E&M with PCP	+8.1	+7.1	+6.1	+5.1	+3.5	+2.0	+1.0
Any FQHC or RHC	-2.9	-2.6	-2.3	-2.0	-1.4	-0.9	-0.4
Any outpatient psychotherapy	+2.6	+2.3	+2.0	+1.7	+1.2	+0.7	+0.4

Notes: E&M is evaluation and management; PCP is primary care provider; FQHC is federally qualified health center; RHC is rural health clinic. Multivariate regression model results were used to predict utilization for dually eligible and non-dually eligible beneficiaries assuming the Medicaid payment percentages shown, with all other independent variables set to the average value of the study population. All predicted effects are statistically significant at p<0.05 level.

Source: Haber et al. 2014b.

outpatient E&M visit is 84.8 percent. Relative to non-dually eligible Medicare beneficiaries, this represents a 5.3 percentage point increase in the share of dually eligible beneficiaries with an office or outpatient E&M visit (Table 6-3). Presumably, beneficiaries' ability to access services in part reflects the providers' responses to payment amounts.

In addition, predicted utilization rates for Medicare services vary when moving from a range of Medicaid cost-sharing payment percentages (20, 30, 40, 50, 66, 80, and 90 percent) to 100 percent (Table 6-4). As expected, moving from 20 to 100 percent Medicaid payment of Medicare cost sharing had the greatest effect on utilization across all Medicare services examined. Moving from 90 to 100 percent Medicaid payment of Medicare cost had the smallest effect.

- **Evaluation and management services.** In 2009, relative to non-dually eligible Medicare beneficiaries, paying 100 percent of the Medicare cost-sharing amount, compared to paying 50 percent, increased the likelihood that a dually eligible beneficiary had any office or other outpatient E&M visit by 3.3 percentage points; for 100 percent compared to 20 percent, the increase was 5.3 percentage points. The findings also suggest that, in 2009, paying 100 percent of the cost-sharing amount, compared to 50 percent, increased dually eligible beneficiaries' likelihood of having a primary care physician visit by 5.1 percentage points; for 100 percent compared to 20 percent, the increase was 8.1 percentage points. However, it is unclear whether these results would differ in later years due to changes in Medicaid payment policy. During calendar years (CY) 2013 and 2014, all state Medicaid programs were required to raise to Medicare levels payments to primary care physicians for certain primary care services. This is referred to as the Medicaid primary care payment increase (CMS 2013a). (The Medicaid primary care payment increase is discussed in detail in Chapter 8.)
- **Preventive services.** Relative to non-dually eligible Medicare beneficiaries, the predicted percentage of dually eligible beneficiaries receiving a flu shot was 2.8 percentage points higher with 100 percent coverage of Medicare cost sharing, compared to 66 percent coverage, in 2009. A similar, but smaller, effect was noted for mammogram services. In 2009, 100 percent coverage of Medicare cost sharing increased the likelihood of female dually eligible beneficiaries receiving a mammogram by 0.8 percentage points, compared to 66 percent coverage and relative to Medicare beneficiaries.
- **Safety net provider services.** The analysis found that, in 2009, relative to non-dually eligible Medicare beneficiaries, paying 100 percent of the Medicare cost sharing amount, compared to 50 percent, decreased the likelihood that a dually eligible beneficiary had received care at a safety net provider by 2.0 percentage points; for 100 percent compared to 20 percent, the decrease was 2.9 percentage points. With regard to this finding, it is possible that dually eligible beneficiaries found it more difficult to access care from office-based providers when Medicaid paid a lower percentage of Medicare cost sharing (Rosenbaum and Shin 2011).
- **Cost sharing and the use of outpatient psychotherapy services.** Paying a higher percentage of Medicare cost sharing was associated with an increased likelihood that dually eligible beneficiaries received outpatient psychotherapy, relative to non-dually eligible Medicare beneficiaries. In 2009, relative to non-dually eligible Medicare beneficiaries, paying 100 percent of the Medicare cost-sharing amount compared to 50 percent increased the likelihood of a dually eligible beneficiary having any outpatient psychotherapy by 1.7 percentage points; for 100 percent compared to 20 percent, the increase was 2.6 percentage points. However, it is unclear whether

these results would differ in later years due to changes in Medicare payment policy. In 2009, the time period for the analysis, Medicare paid 50 percent of the Medicare fee schedule amount for mental health services. MIPPA gradually increased Medicare's payment of mental health services, and, beginning in 2014, Medicare paid 80 percent of the fee schedule amount, which is the same rate as for any other Medicare Part B claim (CMS 2009).

- **Number of visits.** Paying a higher percentage of Medicare cost sharing did not have a significant effect on the annualized number of outpatient E&M visits or safety net provider visits, among those already using those services. However, the annualized number of outpatient psychotherapy visits overall was greater at higher Medicaid payment percentages for Medicare cost sharing.

Results from this study are consistent with an earlier study that found that access to outpatient physician visits for dually eligible beneficiaries was reduced relative to non-dually eligible beneficiaries in states that limited their Medicare cost-sharing payment amounts (Mitchell and Haber 2003). However, neither of these two studies examined the effects of Medicaid payment policies for Medicare cost sharing on dually eligible beneficiaries' use of institutional providers, such as hospitals or nursing facilities. As discussed below, institutional providers may receive Medicare bad debt payments that help to offset unpaid cost-sharing amounts.

Administration of Payments for Medicare Cost Sharing

In addition to access barriers created by state Medicaid policies on Medicare cost sharing, inefficient billing processes for certain providers serving dually eligible beneficiaries may also limit access to care. Providers also cite patient non-compliance, delayed payments, and paperwork

requirements as other factors influencing their participation in Medicaid (MACPAC 2013).

Claims payment processes. Regardless of whether or not states have a policy to pay less than the full Medicare cost-sharing amount, procedures for state payment of Medicare cost sharing may vary depending on whether an individual is enrolled in Medicare FFS or a Medicare Advantage managed care plan. Among the 9.6 million dually eligible beneficiaries in CY 2010, 7.6 million were enrolled exclusively in FFS Medicare and 2 million were enrolled for at least part of the year in a Medicare Advantage plan. Of those in an MA plan, 1.5 million were in an MSP or full-benefit Medicaid category that made them eligible for Medicaid payment of Medicare cost sharing (MACPAC 2014b). The remaining individuals were eligible only for Medicaid payment of Medicare premiums.

Nearly all states have implemented automatic crossover systems for most types of Medicare FFS claims, which allow providers to submit a claim for a dually eligible beneficiary only to Medicare. Once the FFS claim is submitted, Medicare pays its portion and then automatically forwards the claim to the state to enable Medicaid to pay the deductible and coinsurance amounts. Automatic crossover systems are intended to minimize the need for providers to self-report Medicare claims data and improve the accuracy of Medicaid payments for dually eligible beneficiaries. However, these automatic systems are new in some cases and states may experience difficulties with implementation (NYSOSC 2013). Regardless of whether a crossover system is automatic, it may be difficult to determine an appropriate payment amount in states with lesser-of policies if their Medicaid payment methodologies differ from those used by Medicare (OIG 2013b).

Additionally, in some cases, FFS claims do not cross over automatically to Medicaid, and providers must submit separate claims for Medicare cost-sharing amounts directly to the Medicaid program. This can occur with new enrollees before Medicare

lists them as having Medicaid, when a provider bills Medicare with a national provider identifier number that has not been reported to the state Medicaid program, when there are incorrect or missing taxonomy codes, or due to technical problems (Colorado Department of Health Care Policy and Financing 2015, Illinois Department of Healthcare and Family Services 2015, North Carolina Department of Health and Human Services 2015, CMS 2013b, New York Department of Health 2010).

Because Medicare Advantage plans may pay providers amounts that differ from Medicare FFS, Medicaid payment of Medicare cost sharing for dually eligible beneficiaries enrolled in Medicaid Advantage plans also may differ. In addition, Medicare Advantage claims may not automatically cross over to Medicaid, and providers may be required to separately submit claims for Medicare Advantage beneficiaries' Medicare cost sharing to the Medicaid program. In lieu of paying these claims directly, some states contract with and pay a capitated rate for Medicare Advantage plans to directly administer Medicare cost-sharing payments to providers on behalf of the plans' dually eligible enrollees.

Both states and providers may have difficulty with Medicaid payment of Medicare cost sharing for dually eligible beneficiaries in Medicare Advantage plans. Because states do not have access to Medicare Advantage plans' provider fee schedules, they may not be able to determine how much the state actually owes for a given claim. In this situation, providers must be able to submit documentation of the Medicare Advantage plan's payment to the state Medicaid program in order to obtain payment for any Medicare cost sharing. This can be problematic for providers, as they may also be paid a capitated rate by the Medicare Advantage plan and may not be able to identify the plan payment for a particular service (CMS 2008).

In any case, Medicaid payment amounts for Medicare cost sharing for dually eligible beneficiaries will depend on the Medicare

Advantage plan's contracted Medicare rate and the amount of cost sharing, both of which may differ from Medicare FFS amounts. In states with a policy to pay less than the full Medicare cost-sharing amount, both the state and any state-contracted Medicare Advantage plans may limit their payment of Medicare cost sharing to the lesser of the full amount or the amount, if any, by which the Medicaid rate exceeds the Medicare Advantage plan's contracted rate for the services (Arizona Health Care Containment System 2014).

Medicare bad debt payments. Medicare also plays a role in paying for some uncompensated amounts resulting from states paying less than the full Medicare cost-sharing amount through bad debt payments to certain providers. Providers cannot directly bill dually eligible beneficiaries for any outstanding portion of Medicare cost sharing that Medicaid does not pay. However, certain providers (hospitals, skilled nursing facilities, swing bed hospitals, critical access hospitals, federally qualified health centers, rural health centers, community mental health centers, and end stage renal disease facilities) can receive bad debt payments from Medicare to help recoup these costs (CMS 2013c). Medicare will pay these providers 65 percent of these otherwise allowable costs for all Medicare beneficiaries (Middle Class Tax Relief and Job Creation Act of 2012 [P.L. 112-96], CMS 2013c). Medicare bad debt payments can reduce the amount of unpaid cost sharing for some providers (CMS 2013c, MACPAC 2013). As an alternative to back-end payments for bad debt resulting from state Medicaid policies, some have suggested that up-front payment of dually eligible beneficiaries' cost sharing would be more direct and administratively efficient (Burke and Prindiville 2011). Additionally, up-front payments would eliminate providers' need to carry the cost until bad debt payments are made, potentially improving access by increasing providers' willingness to participate in the program.

Conclusion

The Commission's concerns regarding current policies on Medicaid payment of Medicare cost sharing are twofold. First, the lesser-of policies permitted by the BBA reflect Medicaid's longstanding practice of paying physicians less than Medicare. While this policy allows flexibility in how states pay for Medicare cost sharing, there is evidence that paying less than the full Medicare cost-sharing amount has a negative effect on access to care for dually eligible beneficiaries. Second, the complex administrative processes used to pay Medicare crossover claims may unnecessarily hinder payment to some providers and could, therefore, also contribute to barriers to access.

The Commission discussed several policy options for addressing these issues within the context of Medicaid, for example, requiring the program to pay the full amount of Medicare cost sharing on behalf of some or all dually eligible beneficiaries for targeted services or for all services. However, this could result in providers receiving higher payments for dually eligible Medicaid beneficiaries relative to non-dually eligible Medicaid beneficiaries, which raises questions of equity within the Medicaid population. The Commission also discussed the broader impact of low Medicaid physician fees on access to care for all Medicaid beneficiaries.

It is the Commission's view that changes to Medicaid policies regarding Medicare cost sharing must be considered in the context of broader discussions of how best to provide cost-sharing assistance to low-income Medicare beneficiaries. Although payment is only one factor that may affect access to care, the Commission remains concerned that current Medicaid policies regarding Medicare cost sharing may have a negative effect on access to care for dually eligible Medicare beneficiaries relative to their non-dually eligible counterparts.

Policymakers are discussing revisions to the structure of the Medicare benefit. These include proposals to increase income-adjusted premiums

under Medicare Part B and Part D, combining Medicare deductibles, and creating an out-of-pocket maximum for beneficiaries (OMB 2014, Davis et al. 2013, MedPAC 2012, KFF 2011, BPC 2010). Since Medicaid pays for certain dually eligible beneficiaries' Medicare premiums, as well as some of their cost sharing, such changes in Medicare policy would have implications for Medicaid's coverage and financing of dually eligible beneficiaries. As the Medicare policy discussions—particularly those related to benefit redesign—unfold, Medicaid's role in paying for Medicare premiums and cost sharing should be reexamined.

It is also important to recognize that while state Medicaid payment policies on Medicare cost sharing may affect dually eligible beneficiaries' access to care, other low-income Medicare beneficiaries who do not receive MSP or full-benefit Medicaid coverage face out-of-pocket costs for Medicare premiums and cost sharing that can present a substantial financial burden and potentially limit their access to necessary services. Low enrollment of eligible individuals has been an ongoing problem for the MSPs, which can be a result of varying state MSP eligibility policies, lack of program awareness, and burdensome enrollment processes. Without access to the financial assistance offered by the MSPs and full Medicaid benefits, some low-income Medicare beneficiaries may avoid seeking care (Komisar et al. 2005).

Future Commission work will include examinations of MSP eligibility and enrollment issues, and focus on areas where Medicaid policy changes may be most advantageous and cost effective in improving access to coverage and services for low-income Medicare beneficiaries.

Endnotes

¹ Section 1900(b) of the Social Security Act on MACPAC's duties reads:

"...(2) Specific topics to be reviewed.—Specifically, MACPAC shall review and assess the following:

...(G) Interactions with Medicare and Medicaid.—consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.

...(11) Consultation and coordination with MedPAC.—

(A) In general.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) Information sharing.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

...(13) Coordinate and consult with the Federal Coordinated Health Care Office.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals."

² The Balanced Budget Act of 1997 (BBA, P.L. 105-33) created the Qualifying Individual-2 program (QI-2). The QI-2 program covered Medicare Part B premiums for beneficiaries dually eligible for Medicare and Medicaid with incomes between 135 and 175 percent FPL. However, the

federal authority for QI-2 expired on December 31, 2002, and the program was terminated (BBA, P.L. 105-33).

³ Services for adults under age 65 residing in certain psychiatric facilities is one example of a situation where Medicare may cover a service but Medicaid does not. Current federal law prohibits federal Medicaid reimbursement for people age 22 (and age 21 under certain circumstances) to 64 who reside in a facility defined by Medicaid as an institution for mental diseases (IMD). However, Medicare will cover 190 days in a psychiatric hospital, which could include facilities defined by Medicaid as IMDs, across a person's lifetime (CMS 2015).

⁴ This may result from factors such as providers failing to submit crossover claims that are not automatically transferred from Medicare to Medicaid and technical difficulties processing claims.

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