

# Integrated Managed Care: Behavioral Health Billing for Duals

February 2020

## Background

Individuals who have both Medicare and Apple Health Medicaid coverage represent a population referred to as 'dual-eligible', or 'duals'. These individuals have two tiers of coverage, with Medicare considered primary and Apple Health secondary. In integrated managed care regions, HCA enrolls clients with both Medicaid and Medicare into one of the integrated regional service areas Behavioral Health Services Only (BHSO) coverage in order to access Medicaid-covered behavioral health services. Behavioral Health services only are offered by the managed care plans that also offer Apple Health integrated managed care coverage.

Prior to integration, Behavioral Health Organizations (BHOs) which covered behavioral health services for dual-eligible Apple Health clients often did not enforce the requirement for behavioral health providers to bill Medicare as primary, since Apple Health Medicaid uses provider types that are not eligible to provide Medicare behavioral health services.

## Medicare Parts A, B, C, and D

The original Medicare program, Title XVIII of the Social Security Act, provides hospital insurance, known as Part A coverage, and supplementary medical insurance, known as Part B coverage. Individuals age 65 or older (and for certain disabled individuals under age 65) are automatically enrolled in Part A. Part B is an optional program, as it is premium based. Apple Health clients, however, have their Medicare Part B premium covered through their Apple Health benefit. Therefore, these individuals will generally always have Part A and Part B.

Medicare MCOs, also known as Medicare Advantage health plans or Part C, contract with Medicare to combine Part A and Part B benefits through Federal contracting regulations. Part C MCOs provide all Part A and Part B coverage, and follow the same Federal rules regarding benefit design and cost sharing.

Part D is a pharmacy benefit, which Medicare clients enroll in through a variety of different managed care plans. This coverage replaces their Apple Health prescription drug coverage. If a beneficiary enrolls in a Medicare Advantage (Part C) plan that offers Part D coverage such as a Dual-Eligible – Special Needs Plan (D-SNP) or a regular Medicare Advantage plan, the beneficiary can remain with the same company for both plans.

## Cost-sharing

Both Medicare Part A and Part B apply cost sharing, which encompasses deductibles, coinsurance, and copayment amounts for Medicare Part A and Part B covered services. The Health Care Authority offers a Medicare Savings Program, which pays the cost-sharing amount for duals-eligible clients, so they have no out-of-pocket expenses.

Providers may not bill a dual-eligible client for cost sharing, or for the balance remaining after Medicare and Apple Health payment (also known as balance billing). These clients are protected from balance billing even when the Medicare and Apple Health plans' payment amounts to the provider are less than the Medicare rate (or less than the provider's customary charges). Providers may not accept dual-eligible patients as "private pay" in order to bill them directly, and must accept Medicare assignment for all Apple Health patients, including duals.

## QMB PLUS and SLMB PLUS

There are two categories of dual eligible clients HCA enrolls in a Behavioral Health Service Only (BHSO) plan with an Apple Health integrated MCO: QMB Plus and SLMB Plus.

QMB stands for Qualified Medicare Beneficiary. Duals will have the:

- QMB-plus program, or as seen in ProviderOne, "CNP-QMB", also called "full duals". The CNP represents Apple Health's full scope-of-care; Or
- QMB-only program, also called "partial duals". These clients are not enrolled in managed care and only have HCA coverage for cost sharing associated with services covered by Medicare.

Federal law prohibits all Medicare providers from billing QMBs for all Medicare deductibles, co-insurance, or co-payments. All Medicare and Medicaid payments received for furnishing services to a QMB are considered payments in full.

SLMB stands for Specified Low-Income Medicare Beneficiary, and only pays for Medicare premiums – no other cost sharing such as deductible and copay. A SLMB Plus is similar to a QMB Plus, meaning that clients are considered Full Dual eligibles and have all Apple Health benefits. HCA pays cost sharing and Part B premiums. The SLMB Plus designation is not visible in a client's ProviderOne eligibility screen, but the client will appear as actively enrolled in a BHSO program in the managed care screen.

Clients on SLMB Plus will have a spenddown, similar to a deductible, which over-income Apple Health applicants use to qualify for benefits. Once these clients meet their spenddown after paying for services out-of-pocket, SLMB Plus coverage begins, and the client will become enrolled with a managed care plan for BHSO coverage, until their next spenddown period begins. Because these clients move back and forth between being a full-dual (SLMB Plus) and a partial dual (SLMB Only), based on their spenddown, it can be difficult to determine who pays for their crisis services – the BH-ASO or the Medicaid MCO/Behavioral Health Services Only (BHSO).

- The BH-ASO is responsible for paying for crisis services for the SLMB Only client, using their state only funds. HCA pays for their Medicare Part B. If the client is not actively enrolled in the BHSO in the managed care screen, they have not met their spenddown yet and are not eligible for full Medicaid benefits.
- The MCO who provides BHSO pays for crisis services for the SLMB Plus client. HCA pays for their Medicare Part B. If the client is actively enrolled in the BHSO, they have met their spenddown and are now eligible for full Medicaid benefits.

SLMB-only clients can be billed for all cost-sharing resulting from services paid by Medicare, as SLMB-only clients do not have Apple Health coverage, and for billing purposes can be considered Medicare-only.

For all types of Medicare, note that ProviderOne and Medicare should always have the same information as to what kind of Medicare a given client has, because the two programs conduct a daily data share that keeps each system up-to-date. There is no requirement for a client who makes changes to their Medicare to report this to Apple Health, nor for Apple Health providers to update us with any changes to a client's Medicare status.

## Crossover claims

A claim is a 'crossover claim' when the services are payable by both Medicare and Apple Health. Crossover claims can be processed in two ways:

- Transmitted electronically from Medicare to the Apple Health, after Medicare pays. This only happens once, upon initial processing by Medicare. The Explanation of Medicare Benefit (EOMB) is included in the transmittal.
- Billed by providers with an attached EOMB, showing the amount Medicare paid (typically this happens if a provider is making an adjustment or resubmission after Medicare's initial crossover submission).

If Medicare denies the entire claim and the provider then bills Apple Health, the claim is not considered a crossover claim. It is then processed by Apple Health as primary payer. Providers must attach an EOMB showing why Medicare denied the claim, unless it is not a service Medicare covers (see below).

## Services Medicare Does Not Cover

Services Medicare does not cover, but Apple Health does, can be billed directly to the appropriate Apple Health integrated managed care plan responsible for the client's BHSO benefit without an EOMB showing why Medicare is not paying. Since these are not considered Crossover claims, Apple Health is always considered the primary payer and there is no need to show that Medicare denied the services in order for them to be payable by Apple Health.

## Services Medicare Covers But Medicare Denied

Medicare sometimes has limits or does not always cover a specific procedure, but Apple Health will still require providers bill Medicare as primary to obtain an EOMB showing why the service was not covered (e.g., the service limit was met). The only claims which do not require an EOMB are for those for service Medicare never covers. Services Medicare sometimes covers will always require an EOMB be attached to the Apple Health claim.

## Providers Unable to Contract with Medicare

Medicare can advise which provider types they allow for each service, which will not always be the same provider types Apple Health allows. This is because Medicare has a more limited set of mental health and substance use disorder providers that are allowed to provide behavioral health services to in order for Medicare to pay.

Providers who are unable to contract with Medicare are also unable to bill Medicare, which means they have no EOMB to attach to their Apple Health claim. Apple Health only requires an EOMB from provider types who can contract with Medicare, but not all payment systems are able to track which providers can contract with Medicare, so providers should contact the responsible MCO to see if there is any additional documentation necessary to show Medicare is unable to contract with them.

## Inpatient services

Medicare imposes a lifetime maximum of 190 days on inpatient psychiatric hospital services, after which no further inpatient psychiatric benefits are available to that individual. If the client is enrolled in a Medicare Advantage MCO, they need to follow the directions of the dual-eligible's MCO.

Before this limit is met, hospitals do not need prior authorization from Apple Health to admit the individual, but after that limit is met, Apple Health covers these services only if the provider first obtains Prior Authorization. If the client meets the limit during a hospital stay, the hospital must request prior authorization from Apple Health for the remaining expected days.

## Opioid Treatment Programs

For Dual-Eligible individuals currently receiving Opioid Treatment services (OTP), Medicare is the primary payer. Services must be provided by a Medicare-enrolled OTP provider. Newly Medicare-enrolled OTP providers can get a retrospective billing date for up to 30 days prior to the effective date of Medicare enrollment, but no earlier than January 1, 2020. OTP providers are advised to enroll with Medicare so they may receive payment for services and avoid disruption to services. See [SAMHSA's guidance for providers](#) for details at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Downloads/OTP-Letter.pdf>

## Pharmacy services

Clients with Medicare and Apple Health must enroll in a Part D plan upon becoming dual-eligible. Part D replaces the Apple Health prescription drug coverage. Apple Health does not pay for co-pays or provide coverage of drugs not covered by Medicare, except for some Apple Health over-the-counter drugs. For more details, see the Prescription Drug Program Billing Guide on the [HCA Medicaid Provider Guides page](#).

Note that clients with Medicare Part D still have Apple Health coverage non-pharmaceutical pharmacy products on the [Fee-for-Service drug coverage list](#).

## For more information

This tip sheet should provide a solid groundwork for understanding the benefits of dual-eligible clients. Those interested in learning more may find the following resources helpful:

- The [Medicare Learning Network](#) provides free educational materials for health care professionals on CMS programs, policies, and initiatives. A good resource to start with there is the [Medicare and Medicaid Basics](#) booklet.
- CMS provides [Internet-Only Manuals](#), including the [Medicare Claims Processing Manual](#) and the [Medicare Secondary Payer Manual](#), which provide Medicare billing information.
- [WAC 182-502-0110](#) details the general conditions of payment for Medicare coinsurance, copayments, and deductibles, including statutory authority references.
- The [Medicare and You](#) booklet has lots of helpful information for dual-eligible clients.
- CMS regularly updates providers about changes in benefits:
  - Providers who already contract with Medicare and would like updated service coverage information should register for [CMS email updates](#).

- Providers who do not contract with Medicare because they provide services Medicare does not currently cover should still sign up for updates with [Medicaid.gov](https://www.Medicaid.gov) website. In addition to receiving updates about Medicaid, it provides a way for non-Medicare providers to learn when Medicare is going to start covering their services.
- CMS hosts a [Medicare-Medicaid Coordination](#) page with guides listed for each of the provider types Medicare coverage currently affects.
- To see which specific procedure codes Medicare covers, visit the CMS [Fee Schedule](#) page.