



## **Coordinating Dual Eligibles' Medicare and Medicaid Managed Medical Assistance Benefits**

Medicare beneficiaries who have limited income and resources may get help paying for their Medicare premiums and out-of-pocket medical expenses from Medicaid. Medicaid may also cover additional services beyond those provided under Medicare. Dual eligible Medicare and Medicaid recipients are eligible for some form of Medicaid benefit, whether that Medicaid coverage is limited to certain costs, such as Medicare premiums, or the full benefits covered under the Medicaid State Plan. This fact sheet provides education about coverage for dual eligible recipients, as well as requirements under the Florida Statewide Medicaid Managed Care program.

### **Overview**

The Medicare program provides hospital insurance (Medicare Part A) and supplementary medical insurance (Medicare Part B), either through a fee-for-service (FFS) or capitated arrangement.

- Original Medicare is fee-for-service coverage where the federal government pays health care providers directly for Medicare Part A and/or Part B benefits. For individuals with original Medicare coverage, out-of-pocket expenses (cost-sharing) may include coinsurance, copayments, deductibles, and premiums.
- Medicare Advantage plans (known as Medicare Part C) are also available for recipients with Medicare Part A and B. These health plans provide all Medicare Part A and Part B benefits, but are offered by private companies, mostly through capitated arrangements. For individuals enrolled in a Medicare Advantage plan, cost-sharing may also include coinsurance, copayments, deductibles, and premiums.
  - A Dual Eligible Special Needs Plan (D-SNP) is a type of Medicare Advantage plan that is designed to provide targeted services to Medicare recipients who are in institutions, are dual-eligible recipients, or have a severe or disabling chronic condition.

Individuals who qualify for full Medicaid benefits are called full benefit dual eligibles. State Medicaid programs may cover cost sharing expenses for full benefit dual eligibles, as well as other health care services that Medicare does not cover, such as most types of long-term care services, behavioral health, dental, etc.

## **Florida Statewide Medicaid Managed Care Program**

The Statewide Medicaid Managed Care program consists of two components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program.

- The MMA program provides medical, dental, and behavioral health services to infants, children and adults on Medicaid.
- The LTC program provides nursing facility and home and community-based long-term care services to elders and adults with disabilities on Medicaid who meet nursing home level of care.

Approximately 85% of Florida Medicaid recipients are required to receive their health services through an MMA plan. Florida law specifies the Medicaid recipients who cannot enroll in a plan (excluded from participation) and those who may choose to enroll in an MMA plan, but are not required to do so.

Full benefit dual eligibles, including those enrolled in a Medicare Advantage Plan that is not fully liable for all Medicaid services covered under the MMA program, are mandatory for enrollment in an MMA plan.

Full benefit dual eligibles enrolled in a Medicare D-SNP or a Medicare Advantage plan that is fully liable for all Medicaid services covered under the MMA program are excluded from enrollment in an MMA plan.

Dual eligible recipients whose Medicaid benefits are limited (**partial duals**) are excluded from enrollment in the SMMC program (both LTC and MMA). The categories that are excluded are:

- Qualified Medicare Beneficiaries (QMB), without other full Medicaid coverage;
- Specified Low-Income Medicare Beneficiaries (SLMB), without other full Medicaid coverage; and
- Qualifying Individuals (QI).

## **Managed Medical Assistance (MMA) Plans' Responsibilities**

Because Medicare and the MMA program cover similar services for this population, coordination between the two programs is necessary to ensure that enrollees receive services appropriately. This section provides an overview of the requirements and expectations for MMA plans when coordinating a dual eligible enrollee's Medicare and MMA benefits.

### **Authorization Requirements**

- For dual eligibles, Medicare is the primary payer for any medical services covered by Medicare, and Medicaid is the payer of last resort. If an enrollee requires a Medicare covered service, the enrollee must follow Medicare's service authorization protocols.
- The MMA plan is not responsible for authorizing a Medicare covered service for a dually eligible MMA enrollee.

## **Primary Care Services Covered by Medicare**

- The MMA plan is responsible for ensuring that all enrollees have a primary care physician (PCP). If an enrollee does not have or does not choose a PCP, the plan must assign one to the enrollee upon enrollment in the MMA plan.
- **However, if a dual eligible is already receiving primary care services through Medicare, and has a PCP, the enrollee does not have to choose a new PCP through the MMA plan. If the dual eligible does not have a PCP, the plan should assist the enrollee in choosing a PCP that accepts their Medicare coverage.**
- The MMA plan **cannot** require the enrollee to give up his or her existing Medicare authorized PCP nor prevent the enrollee from receiving primary care services from their Medicare physician.

#### **Other Medical Services covered by Medicare:**

- When Medicare is the primary payer, the MMA plan cannot require that the enrollee choose a provider that is a part of its network in order to receive the service.
- In those instances where the enrollee is receiving a service that has limited coverage under Medicare, and Medicaid may eventually become the primary payer (e.g., behavioral health services), the enrollee may want to choose a provider that accepts both Medicare and Medicaid payment. Once Medicaid becomes the primary payer:
  - The MMA plan is responsible for authorizing the service using its usual MMA program authorization protocols.
  - The MMA plan may restrict the enrollee's choice of service providers to those providers that are in the MMA plan's network for services authorized and reimbursed by the MMA plan.
- The MMA plan is responsible for coordinating the enrollee's care with Medicare and ensuring that the MMA plan does not authorize or provide duplicative services.

#### **Medical Services not covered by Medicare:**

- Some services covered under the MMA program may not be covered by Medicare (e.g., dentures).
- In these cases, if the full benefit dual eligibles require such a service, the enrollee's MMA plan is responsible for authorizing the service using its usual MMA program authorization protocols.
- The MMA plan may restrict the enrollee's choice of service providers to those providers that are in the MMA plan's network for services authorized and reimbursed by the MMA plan.

#### **Contracting and Payment**

- The MMA plan is responsible for covering Medicare deductibles and co-insurance payments made by the providers or enrollees, according to guidelines in the Florida Medicaid Provider General Handbook.
  - If the Medicare payment exceeds the Medicaid payment so that no Medicaid payment is made, then the Medicaid copayment or coinsurance is not paid.
  - If the provider has collected the Medicaid copayment or coinsurance from the enrollee, the provider must reimburse it to the enrollee.
- If a provider is primarily receiving reimbursement through Medicare for the recipient's services, and is only billing Medicaid for any copayments, coinsurance, or deductibles, the provider does not have to contract with or enter into an agreement with the MMA plan to receive reimbursement.
  - **However, the Medicare provider will need to be fully enrolled in or be registered with the Florida Medicaid program in order to be reimbursed for any copayments, coinsurance, or deductibles from the MMA plan. All Medicare providers that currently receive Medicare crossover payments from Medicaid are already enrolled in Medicaid and do not need to take any action to enroll. If the provider is not enrolled, please review the Florida Medicaid Provider General Handbook for more information on how to register with Medicaid.**
  - If the provider does not have a contract or agreement with the plan, the copayment or coinsurance amounts will be calculated using the Medicaid FFS rates as published in the Medicaid fee schedules.

### **Additional Frequently Asked Questions**

1. I am a QMB, but I do not qualify for Medicaid to pay for my services. Am I considered a full dual eligible, and I am required to enroll in the MMA program?

***No, if you are a QMB, but do not qualify for full Medicaid benefits, you are not considered a full benefit dual eligible and you cannot enroll in the MMA program. This is also true if you only have QMB or SLMB coverage. In those cases, you cannot enroll in a Medicaid managed care plan.***

2. I am a Medicare provider, but I am not contracted with any of the MMA plans. If I only need to be reimbursed for crossover payments from the plan, do I have to undergo a credentialing process first?

***No. If a provider will only be requesting reimbursement for any cost sharing amounts, the provider does not have to be fully enrolled or credentialed by the MMA plan.***

3. If I am a Medicare provider that does not accept Medicaid, can I bill the dual eligible recipient for any cost sharing amounts?

***Yes. After verifying that a patient is eligible for Medicaid and prior to rendering a service, the provider must inform the recipient in advance that he does not accept Medicaid payment for the specific service to be rendered and he must inform the***

*recipient of their responsibility for charges not covered by Medicare. The provider must document in the recipient's medical record that the recipient was informed and agrees to the service. [see the Florida Medicaid Provider General Handbook, page 1-7]*

*Please note: if the recipient is also a QMB, the provider CANNOT bill the dual eligible recipient for any cost sharing amounts. Under the Balanced Budget Act, QMBs are relieved of the liability to pay any Medicare cost sharing to any Medicare providers or Medicare managed care entities, whether those providers participate in Medicaid or not. Providers or managed care entities are subject to sanctions if they charge recipients for any cost sharing. This also applies to recipients who are eligible for Supplemental Security Income (MS aid category) and who are also eligible for Medicare, as they are automatically considered QMB eligible with full Medicaid. [see the Florida Medicaid Provider General Handbook page 3-28]*

4. If Medicare is the primary payer for the service, do we (providers) have to obtain authorization from the MMA plan before rendering services?

*No. For dual eligibles, Medicare is the primary payer for any medical services covered by Medicare, and Medicaid is the payer of last resort. If an enrollee requires a Medicare covered service, the enrollee must follow Medicare's service authorization protocols. The MMA plan is not responsible for authorizing a Medicare covered service for a dually eligible MMA enrollee and cannot require prior authorization for services for which Medicare is the primary payer.*

5. I am eligible for **Medicare (non-QMB) and full Medicaid coverage** and I am enrolled in an MMA plan. My physician, who accepts Medicare, is not contracted with my MMA plan and is not registered with the Florida Medicaid program. Since my physician is not contracted with an MMA plan or registered with Florida Medicaid, can my physician bill me for any Medicare copayments, coinsurance, and deductibles?

*Yes. However, the provider must inform the enrollee in advance that he does not accept Medicaid payment for the specific service to be rendered. The provider must document in the enrollee's medical record that the enrollee was informed and agrees to the service and any payment obligations.*

6. I am eligible for **Medicare (QMB Plus) and full Medicaid coverage**. I am enrolled in an MMA plan. My physician, who accepts Medicare, is not contracted with my MMA plan and is not registered with the Florida Medicaid program. Since my physician is not contracted with an MMA plan or registered with Florida Medicaid, can my physician bill me for any Medicare copayments, coinsurance, and deductibles?

*No. Medicaid is responsible for deductible, coinsurance, and copayment amounts for Medicare Part A and Part B covered services for QMB recipients. Federal law prohibits a provider or managed care plan from billing a QMB recipient for any cost sharing amounts – this is known as balance billing. Federal law provides that the Medicare payment and any Medicaid payment are considered payment in full to the provider for services rendered to a QMB recipient. Providers may not accept QMB recipient as "private pay" in order to bill the recipient directly.*