Provider Enrollment and Third Party Liability for Services Rendered to Dually Eligible Individuals

Section 1: Requiring Providers to Enroll in Medicare

Q1. Can a state require providers to enroll in Medicare as a condition of enrollment in Medicaid?

A1. Yes. To the extent authorized by state law, states may specify Medicaid provider enrollment requirements in a state provider manual, policy manual, state regulations, or as otherwise provided in state law. This may include a state requirement for providers to enroll as Original Medicare (i.e., fee-for-service) providers as a condition of Medicaid provider enrollment. States may only require provider types that are eligible to enroll in Medicare to do so.

It would not be reasonable for a state to require that Medicaid providers enroll with all Medicare Advantage plans, however, as Medicare Advantage organizations may have standards that go beyond the standards under Medicare for being qualified, and may impose other conditions for being a part of the Medicare Advantage plan network.[1] With the exception of dual eligible special needs plans (D-SNPs) that hold a contract with the state per 42 CFR 422.107, states do not have a mechanism to require a Medicare Advantage plan to contract with specific providers.[2] The Medicare Advantage plan and provider determine the network contract to provide services to the plan enrollees.

Section 2: Provider Enrollment and Medicaid Payment

Q3. Is a state required to pay primary for a service provided to a full-benefit dually eligible individual enrolled in Original Medicare by a Medicaid-enrolled provider when the provider is not also enrolled in Original Medicare?

A3. If the state does not have a documented policy that requires providers to enroll in Original Medicare as a condition of enrollment in Medicaid, as described in Section 1, then the state would pay primary for a Medicaid-covered service provided by a Medicaid-enrolled provider for a full-benefit dually eligible individual when the provider is not also enrolled in Original

[1] For information on other Medicare health plans, which have some of the same rules as Medicare Advantage plans as well as some special rules and exceptions, please see here: https://www.medicare.gov/health-drug-plans/medicare-health-plans/your-coverage-options/other-medicare-health-plans.

[2] While there are minimum federal requirements for the state Medicaid agency contract (SMAC), states may include additional provisions in their D-SNP SMAC to promote better integration, including provisions regarding provider participation.

Medicare.[3] Generally, providers that are not enrolled in Original Medicare cannot bill Medicare, so Medicare would not be liable. Medicare would not cover services rendered by a provider that is not enrolled in Medicare. Therefore, the service is considered non-covered by Original Medicare and the state would pay primary for the service to a full-benefit dually eligible individual (meaning the state would be required to pay claims to the maximum Medicaid payment amount established for the covered service in the State Plan).

If the state does have a documented policy or law that requires providers to enroll in Original Medicare as a condition of enrollment in Medicaid, as described in Section 1, then the provider would need to enroll in Medicare and bill Medicare as the primary payer for services covered by Medicaid and Medicare for full-benefit dually eligible individuals. If a balance remains after Medicare has paid the provider or denied payment for a substantive (i.e., non-procedural) reason, the provider can submit the claim to the state for payment of the balance, up to the maximum Medicaid payment amount established for the service in the State Plan.

We note that if the provider *is enrolled* in Original Medicare and provides a service covered by Medicare and Medicaid to a full-benefit dually eligible individual, then the provider should bill Original Medicare as the primary payer as Medicaid is generally the payer of last resort for services provided to full-benefit dually eligible individuals.

Q4. Is a state required to pay primary for a service provided to a full-benefit dually eligible individual enrolled in a Medicare Advantage plan by a Medicaid-enrolled provider when the provider is not also in the Medicare Advantage plan's network?

A4. Only under certain circumstances would a Medicare Advantage plan pay a Medicaid-enrolled provider outside the Medicare Advantage plan's network for a Medicare-covered service received by a dually eligible individual, and it depends on the type of Medicare Advantage plan in which the dually eligible individual is enrolled. Certain Medicare Advantage plans, such as health maintenance organization (HMO) plans, generally require enrollees to get covered items and services from providers in the plan's network. Some HMO plans have a point-of-service (POS) option that allows enrollees to go out-of-network for certain services, such as dental services. Other Medicare Advantage plans, such as preferred provider organization (PPO) plans and private fee-for-service (PFFS) plans, generally allow enrollees to get covered items and services from any provider, but the plan may charge higher cost-sharing for providers outside the plan's network.[4]

When the state should pay primary: As described in Section 1, even when the state has a documented policy that requires providers to enroll in Medicare as a condition of enrollment in

[3] For more information on Medicaid coordination of benefits and third party liability, please see the COB/TPL Handbook found here: https://www.medicaid.gov/medicaid/eligibility/coordination-of-benefits-third-party-liability/index.html.

[4] For more information on Medicare Advantage plans and network providers, see here. With the exception of those services for which Medicare Advantage plans must pay out-of-network providers, including but not limited to emergency and urgently needed services, (see Chapter 4 of the Medicare Managed Care Manual for more information), an Medicare Advantage plan may choose not to pay claims from out-of-network providers or may require enrollees to pay at a higher cost.

Medicaid, the state generally cannot compel a Medicare Advantage plan to accept a provider into the plan's network. Therefore, the state should pay primary for Medicaid-covered services provided by a Medicaid-enrolled provider to a full-benefit dually eligible individual when the Medicaid provider is unable to bill the Medicare Advantage plan – such as is the case for an out-of-network provider when the dually eligible individual is enrolled in an HMO plan.

If the out-of-network provider cannot bill the Medicare Advantage plan, as is the case with some Medicare Advantage plans, then the plan would not be a liable third party because the plan would not cover services rendered by a provider not in the plan's network. Therefore, the service is considered non-covered by the Medicare Advantage plan, it is not Medicare-covered, and the state would pay primary (meaning the state would be required to pay claims to the maximum Medicaid payment amount established for the covered service in the State Plan). We note that a Medicare Advantage plan is required to cover all Medicare-covered services in-network or authorize coverage out-of-network, and that if the plan ever referred a dually eligible individual to an out-of-network provider, that service should be treated as authorized out-of-network absent notice to the enrollee that it is not covered under the plan.

When the Medicare Advantage plan should pay primary: If the Medicare Advantage plan covers services rendered from out-of-network providers (as may be the case for Medicare Advantage PPO, PFFS, or HMO-POS plans), then the out-of-network provider should bill the Medicare Advantage plan for primary payment. These Medicare Advantage plans generally will only pay an out-of-network provider when:

- the provider is already enrolled in Original Medicare, and
- the services provided are covered under Medicare Parts A and B.

A state may also require an out-of-network provider to first bill the Medicare Advantage plan when:

- the service is not covered under Medicare Parts A and B (such as a dental service covered as a Medicare Advantage supplemental benefit), and
- the Medicare Advantage plan covers the supplemental service out-of-network.[5]

Q5. How can the state process a claim for a dually eligible individual from a Medicaid-only provider without a Medicare denial?

A5. To denote non-coverage by a third party in the state's payment system, the state can use a specific code to override the cost avoidance edit and pay the claim as primary payer. The state would instruct providers to maintain annual documentation to substantiate third-party non-coverage when using such override codes, and the state could conduct provider audits to assure

[5] Note: Medicare Advantage plans that allow enrollees to get covered items and services from any provider generally require an out-of-network provider already enroll in Original Medicare before billing the Medicare Advantage plan for services covered under Medicare Parts A and B. However, Medicare Advantage plans generally do not require out-of-network providers enroll in Original Medicare for supplemental services covered by the Medicare Advantage plan.

that the providers have appropriate annual documentation of such non-coverage.[6] If the state later establishes that a third party was liable for the claim, the state must seek to recover the payment from the provider.

As a reminder, Medicare is not a liable third party for a service rendered to a dually eligible individual from a Medicaid-only provider, because Medicare does not cover services rendered by a provider not enrolled in Medicare. Providers not enrolled in Original Medicare should not submit a claim to Medicare for payment and therefore cannot receive a Medicare remittance advice indicating a denial. Similarly, an out-of-network provider may be unable to submit a claim to a Medicare Advantage plan and subsequently receive a denial depending on the type of plan and service rendered.

Section 3: Provider Enrollment and Medicaid Payment of Medicare Cost-Sharing

Q6: Do states need to enroll a Medicare-enrolled provider, including Medicare Advantage in-network providers, in Medicaid for the state to pay for Medicare cost-sharing for a dually eligible individual?

A6: In accordance with 42 CFR 455.410(d), states must have a mechanism to allow enrollment of all Medicare-enrolled providers and suppliers – including in-network providers and suppliers – that serve certain dually eligible individuals for purposes of processing claims for Medicare cost-sharing.[7] States may wish to consider a separate enrollment process or provider enrollment category specifically for Medicare providers and suppliers for purposes of state payment of Medicare cost-sharing, consistent with existing law. Once Medicare adjudicates a claim for a Medicare-covered service, the claim either automatically crosses over to the state or, in some cases, the provider then submits the claim to the state and the state would normally be liable for state payment of Medicare cost-sharing.

Some states have contracts with Medicare Advantage plans to capitate payment of Medicare cost-sharing for dually eligible individuals enrolled in that Medicare Advantage plan.[8] When the state capitates payment of Medicare cost-sharing to the Medicare Advantage plan, the

[6] For more information on how state may handle never-covered services, please see the Medicaid COB-TPL Handbook, found here: https://www.medicaid.gov/medicaid/eligibility/coordination-of-benefits-third-party-liability/index.html.

[7] Under this policy, states must accept enrollment of all Medicare-enrolled providers and suppliers, including out-of-state providers and suppliers, (even if a provider or supplier is of a type not recognized as eligible to enroll in the state Medicaid program), if the provider or supplier otherwise meets all Federal Medicaid enrollment requirements. These federal requirements include, but are not limited to, all applicable provisions of 42 CFR Part 455, subparts B and E. This applies only to providers who chose to enroll in Medicaid for purposes of submission and adjudication of cost-sharing claims. We understand that a Medicare-enrolled provider or supplier may choose not to enroll with a state Medicaid agency or as a Medicaid MCO network provider, and the state or Medicaid MCO cannot compel the provider or supplier to do so. This policy does not require states to recognize or enroll additional provider types for purposes other than submission of cost-sharing claims, adjudication of cost-sharing claims, and issuance of a Medicaid remittance advice. (86 FR 45498 through 45501)

[8] See the COB/TPL Handbook for more information on Medicaid Coverage of Medicare Cost-Sharing in Part C: https://www.medicaid.gov/medicaid/eligibility/coordination-of-benefits-third-party-liability/index.html

Medicare Advantage plan includes Medicare cost-sharing payment in the plan's payment to the provider; the provider does not need to submit a separate claim to the state for Medicare cost-sharing and therefore does not need to enroll with the state.

If a provider declines to enroll with the state, the state's system may reject the claim for payment of Medicare cost-sharing as the state system does not recognize the provider. In these instances, the provider would not collect Medicaid payment of Medicare cost-sharing. See Section 4 for more discussion.

Q7: For a dually eligible individual who is enrolled in an integrated care plan, such as a fully integrated dual eligible special needs plan (FIDE SNP), does a state need to enroll in-network providers in Medicaid for the state to pay Medicare cost-sharing?

A7: No. For integrated care plans, including FIDE SNPs, the provider does not need to enroll in the affiliated Medicaid managed care plan solely for the purpose of billing for payment of Medicare cost-sharing.[9] However, the provider would need to enroll with the state or Medicaid managed care plan for payment of services for which Medicaid is the primary payer.

Q8. Can a state deny payment of Medicare cost-sharing for services provided to dually eligible individuals enrolled in the Qualified Medicare Beneficiary (QMB) eligibility group if the state does not cover the service and/or provider-type in the State Plan?

A8: No, a state cannot deny payment of Medicare cost-sharing for a Medicare-covered service for dually eligible individuals enrolled in the QMB eligibility group even when the state does not cover the service or enroll the provider-type in the State Plan. States have a statutory obligation to adjudicate claims for payment of Medicare cost-sharing for QMBs (see section 1905(p)(3) of the Act). In accordance with 42 CFR 455.410(d), states must have a mechanism to allow enrollment of all Medicare-enrolled providers and suppliers that serve certain dually eligible individuals for purposes of processing claims for Medicare cost-sharing. Once Medicare adjudicates a claim for a Medicare-covered service, the claim either automatically crosses over to the state or, in some cases, the provider then submits the claim to the state and the state adjudicates the claim for payment of Medicare cost-sharing. This statutory obligation applies for QMBs in Original Medicare or in a Medicare Advantage plan.

In instances where a provider declines to enroll with the state, the state's system would reject (not deny) the claim for payment of Medicare cost-sharing as the state system does not recognize the provider.

[9] For more information, see: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MedicaidProviderEnrollmentProvisionsByIntegratedD-SNPsandMMPs.pdf

For other full-benefit dually eligible individuals who are not in the QMB eligibility group, the state does not pay for Medicare cost-sharing of a Medicare-only covered services unless the state opts to extend coverage of Medicare cost-sharing to these categories of dual eligibility.

Section 4: Provider Enrollment and Billing a Dually Eligible Individual

Q9: Can a Medicare-enrolled or in-network provider bill a dually eligible individual for Medicare cost-sharing in instances where the provider is not also enrolled in Medicaid?

A9: Federal law forbids Medicare providers and suppliers, including pharmacies, from billing QMBs for Medicare cost-sharing. QMBs have no legal obligation to pay Medicare deductibles, coinsurance, or copays for any Medicare Part A or Part B covered items and services.[10] This applies regardless of provider enrollment with the state, state coverage of the service, or state coverage of the provider type. For more information on the QMB eligibility group and billing protections, please see: https://www.cms.gov/medicare/medicaid-coordination/qualified-medicare-beneficiary-program.

Federal regulation at 42 CFR 422.504(g)(1)(iii) further addresses Medicare cost-sharing protections for dually eligible individuals enrolled in a Medicare Advantage plan and requires Medicare Advantage plan contracts for in-network providers to reflect these Medicare cost-sharing protections for Medicare Part A and B services. The Medicare Advantage plan provider contract requires that in-network providers accept the plan's payment and any Medicaid payment of Medicare cost-sharing (whether paid by the Medicare Advantage plan or billed to the state or appropriate Medicaid managed care plan) as payment in full and prohibits in-network providers and suppliers from collecting from a dually eligible enrollee any Medicare cost-sharing. These in-network provider Medicare cost-sharing provisions must also apply to other non-QMB, full-benefit dually eligible individuals enrolled in the Medicare Advantage plan.[11]

States also do not pay for Medicare cost-sharing for partial-benefit dually eligible individuals (those who have Medicare and whose only Medicaid benefit consists of coverage of Medicare premiums) who are not also in the QMB eligibility group. These beneficiaries, such as those in the Specified Low-Income Medicare Beneficiaries without other Medicaid (SLMB-only), Qualifying Individuals (QI), or Qualified Disabled and Working Individuals (QDWI) eligibility groups, may be responsible for any applicable Medicare cost-sharing.[12]

[10] However, states may apply a nominal Medicaid copay to care for QMBs that Medicare and Medicaid cover in accordance with section 1916(a) of the Social Security Act (SSA).

[11] 42 CFR 422.504(g)(1)(iii) also limits the Medicare cost-sharing amounts that Medicare Advantage plans can impose on dually eligible individuals. For more information, see 74 FR 1494-1499. For specific information regarding D-SNP requirements and Medicare zero-dollar cost-sharing, please see the Medicare Managed Care Manual Chapter 16b.

[12] Please see more information on dual status categories and Medicaid coverage here: https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/medicaremedicaidenrolleecategories.pdf

Q10: Can an out-of-network provider bill a dually eligible individual enrolled in a Medicare Advantage plan for a Medicare-covered service?

A10: As described in Question 4, there are certain circumstances when an out-of-network provider may bill the Medicare Advantage plan and certain circumstances when an out-of-network provider may not bill the plan (excluding certain always-covered services). See below for more information on each circumstance.

For Medicare Advantage plans that allow out-of-network providers to bill for Medicare Parts A or B services to a dually eligible individual, as long as the out-of-network provider is enrolled in Original Medicare, then the out-of-network provider bills the Medicare Advantage plan for the service. The out-of-network Medicare provider not enrolled in Medicaid may not bill a QMB for Medicare cost-sharing, and states may elect to extend these Medicare cost-sharing protections to additional categories of full-benefit dually eligible individuals. Therefore, after an out-of-network provider bills the Medicare Advantage plan, the provider would bill the state or Medicaid managed care plan for any remaining payment of Medicare cost-sharing for QMBs and, when states elect to extend Medicare cost-sharing protections to additional categories, for other full-benefit dually eligible individuals. However, as explained above, providers would bill partial-benefit dually eligible individuals who are not in the QMB eligibility group for payment of Medicare cost-sharing.

For Medicare Advantage plans that do not accept claims from out-of-network providers, the service is considered non-covered by Medicare and there is no applicable Medicare cost-sharing. The QMB billing protections described in Question 9 do not apply for services not covered by Medicare. Therefore, the requirement for states to enroll providers and pay for Medicare cost-sharing, as described in Section 3, do not apply for services not covered by Medicare. In these cases, the following should occur, depending on the dual status category:

- For partial-benefit dually eligible individuals, there is no identified coverage for a service rendered by an out-of-network provider as the individual does not have full Medicaid and the Medicare Advantage plan does not cover services from the provider. The provider would bill the individual for payment of services.
- For full-benefit dually eligible individuals, the provider should confirm if there is additional coverage for the service as such individuals have full Medicaid. If Medicaid covers the service, then the provider would bill the state or Medicaid managed care plan. If Medicaid does not cover the service, then there is no identified coverage for the service and the provider would bill the individual for payment of services.

Q11: Can a provider not enrolled in Original Medicare bill a dually eligible individual for a Medicare-only covered service?

A11: Yes. Excluding certain always-covered services, when a physician or practitioner does not enroll in Original Medicare and "opts out," the physician or practitioner must enter into a private contract with a Medicare beneficiary, including a dually eligible individual, for any

payment of services. As discussed above, these services are non-covered by Medicare and therefore QMB billing protections and payment of Medicare cost-sharing do not apply.

We note that physicians and practitioners that are enrolled in Original Medicare (and have not opted out) fall into two categories: participating and non-participating physicians/practitioners.[13] Participating physicians or practitioners agree to accept Medicare assignment for all claims. Non-participating physicians and practitioners can, on a claim-by-claim basis, choose whether to accept assignment and be paid at the Medicare-approved amount for services. If they do not accept assignment, they may balance bill the patient for charges above the Medicare-approved amount up to the statutory limiting charge. However, per federal law, a non-participating Medicare physician or practitioner must accept assignment for physicians' services provided to a dually eligible beneficiary.[14]

However, if the opt-out provider is enrolled in Medicaid, then the policies described in Section 2, above, apply for services that are covered by both Medicare and Medicaid.

Q12: Can a provider not enrolled in Medicaid bill a dually eligible individual for a Medicaid-only covered service?

A12: Full-benefit dually eligible individuals have full Medicare and full Medicaid. Medicaid covers additional services not also covered by Medicare. (Note: partial-benefit dually eligible individuals do not have full Medicaid benefits and therefore do not have Medicaid coverage of Medicaid-only services.) For Medicaid-only covered services rendered to a full-benefit dually eligible individual by a provider not enrolled with Medicaid, please check with the applicable state for billing instructions. Providers should clearly inform the full-benefit dually eligible individual that the individual is not being accepted as a Medicaid patient and that the provider will not accept payment from Medicaid and inform the dually eligible individual of the estimated charges for care.

[13]Please see more information here: https://www.medicare.gov/basics/costs/medicare-costs/provider-accept-Medicare
[14]See 1848(g)(3)(A) at https://www.ssa.gov/OP_Home/ssact/title18/1848.htm