Frequently Asked Questions (FAQs) on Duals Billing

August 2022

Please note: the responses below apply to individuals enrolled in Medicare who also receive full Medicaid benefits. These responses are not applicable for Medicare enrollees partially eligible for Medicaid through the Medicare Savings Program, which provides assistance with Medicare premiums and cost-sharing. For more information about the Medicare and Medicaid dual eligible categories, please refer to Dually Eligible Individuals - Categories (cms.gov).

Q1. If a recipient is dually enrolled in Medicare and Medicaid, do providers get the full Medicaid/APG rate?

Answer:

The answer to this question depends on the service the person receives and the individual's specific Medicaid and Medicare enrollment status. Some services such as Assertive Community Treatment (ACT) and the non-clinic portion of Personalized Recovery Oriented Services (PROS) are not Medicare reimbursable, so Medicaid pays the service at the full Medicaid rate:

Several reimbursement scenarios for OMH clinic services are explained below.

a. Recipient is enrolled in Medicare Fee-for-Service (traditional Part B) and Medicaid Fee-for-Service (FFS), the service was delivered by a Medicare enrollable[1] professional, and the service is reimbursable by Medicare:

> Medicare FFS pays according to the appropriate Medicare fee schedule[2], and Medicaid FFS pays the clinic provider up to the Medicaid government rate (APGs), even if it is more than the Medicare approved amount. This is the so-called "higher of", which is the government rate for these services.

b. Recipient is enrolled in Medicare FFS and Medicaid FFS, and the service was delivered by a non-Medicare enrollable professional:

[1] BH agencies must ensure Medicare eligible professionals enroll in Medicare.

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Medicaid FFS pays the full Medicaid amount. Providers should follow the 0FILL process, see answer to Q3 for details.

c. Recipient is enrolled in Medicare FFS and Medicaid Managed Care[3], the service was delivered by a Medicare enrollable professional, and the service is reimbursable by Medicare:

Medicare FFS pays according to the appropriate Medicare fee schedule and the Medicaid Managed Care plan pays the clinic provider up to the government rate (APGs), even if it is more than the Medicare approved amount. This is the so-called "higher of," which is the government rate for these services.

d. Recipient is enrolled in Medicare FFS and Medicaid Managed Care, the service was delivered by a non-Medicare enrollable professional:

Medicaid Managed Care pays the full Medicaid amount. Providers should follow the 0FILL process, see answer to Q3 for details.

e. Recipient is enrolled in a Medicare Advantage HMO (Part C plan) and Medicaid FFS and the provider is NOT a Medicare HMO in-network provider:

If an individual receives a Medicaid covered service from a Medicaid enrolled provider who does not participate in the recipient's Medicare Advantage HMO network, Medicaid FFS will cover the service at the Medicaid rate, per New York State Health Department guidance, "Medicare Advantage Plans and Medicaid Advantage Plans" issued in 2009 by the Department of Health.

f. Recipient is enrolled in integrated Medicare and Medicaid coverage through a Medicare Advantage HMO (Part C plan) aligned with a Medicaid Advantage Plus (MAP) Plan (which covers Medicare and most Medicaid services) and the provider is in network:

Medicaid Advantage Plus Plans reimburse services at a negotiated rate and pay 100 percent of Medicare copays, coinsurance, and deductibles per the Medicaid Advantage Plus Model Contract. Beginning January

[3] Medicaid Managed Care Includes Mainstream Medicaid Managed Care Plans, Health and Recovery Plans (HARPs), and HIV Special Needs Plans (HIV SNPs).

1, 2023, MAP Plans will be required to pay at least 100 percent of the mandated Medicaid government rate for Medicaid-only covered procedures delivered to MAP Plan enrollees when the service is provided by an OASAS or OMH licensed, certified, or designated ambulatory program. Additionally, OASAS Part 820 Residential Treatment should also be paid at least 100 percent of the mandated Medicaid government rate.

Q2. Please clarify, if a service provided to a dually eligible recipient is not reimbursable by Medicare because it was provided by a clinician who cannot enroll in Medicare and does not provide Medicare covered services (e.g., psychotherapy provided by professionals other than psychologists or clinical social workers), can providers use the 0FILL process regardless of the secondary insurer (e.g., Medicaid Mainstream, HARP, Commercial plan)?

Answer:

The Medicaid Managed Care Billing Guidance for Dual Eligible Enrollees issued by the State in 2017 covers the scenario in which Medicare is the primary insurer and Medicaid FFS or Medicaid Managed Care (Mainstream, HARP or HIV SNP) is the secondary insurer.

If an individual has other third-party health insurance, the provider must comply with Medicaid coordination of benefits rules including confirming plan enrollment information and seeking and reporting payments from such payers on their claims.

While providers may not simply 0FILL these claims, Federal and New York State laws prohibit liable third parties from denying Medicaid third party liability claims for administrative or procedural reasons, including but not limited to: filing limits, claim format, failure to present card at point of service, retrospective reviews, or for failure to obtain prior authorization. OMH encourages providers to review this guidance and pursue appeals for inappropriate denials accordingly before such claims are submitted to Medicaid: https://www.health.ny.gov/health_care/medicaid/program/update/2020/no15_2020-10.htm#tpl.

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Q3. Medicaid Managed Care requires an Explanation of Benefits (EOB) from Medicare denying payment before Medicaid will pay. However, if a provider is not Medicare enrollable and cannot bill Medicare, the claim is not processed by Medicare and no EOB is provided. What should providers do in this scenario?

Answer:

According to New York's Medicaid Managed Care Billing Guidance for Dual Eligible Enrollees (2017), which applies to both Medicaid FFS and Medicaid Managed Care:

"If a professional delivers a service not billable to Medicare, agencies will bill using the "0FILL." The literal "0FILL" is no longer used, rather to indicate a "0FILL" the total Claim Charge Amount (CLM02) must be reported in the non-Covered Amount Field (Loop 2320 – AMT02) for the applicable payer (NOTE: "0FILL" is only to be reported when the prior payer has NOT adjudicated the claim since the payer does not cover the services). The Medicaid Managed Care Plan will then process the claim as per contract guidelines."

If providers run into any issues with Medicaid Managed Care plans accepting the "0FILL" process, please contact OMH at omh-managed-care@omh.ny.gov.

Q4. When a client becomes eligible for Medicare, can they remain enrolled in a Medicaid Managed Care plan as their secondary insurer, or do they need to have traditional Medicaid FFS for the secondary insurer? For example, a PROS client has Medicare FFS as the primary insurer and Medicaid Managed Care as the secondary insurer. Should providers use the 0FILL process with the Medicare primary information on the claim and send it to the Medicaid MCO because PROS services are never covered by Medicare?

Answer:

During the federal public health emergency, the State has suspended regular plan disenrollment rules for dual eligible enrollees.

When the individual is enrolled in a Medicaid Managed Care plan and Medicare FFS, the Medicaid plan is required to pay OMH licensed clinics up to the Medicaid government rate. Since PROS is not a Medicare covered service, with the exception of PROS clinic, the Medicaid Managed Care plan must reimburse for the service if it is medically necessary.

According to New York's Medicaid Managed Care Billing Guidance for Dual Eligible Enrollees (2017) which applies to both Medicaid FFS and Medicaid Managed Care:

"If a professional delivers a service not billable to Medicare, agencies will bill using the "0FILL". The literal "0FILL" is no longer used, rather to indicate a "0FILL" the total Claim Charge Amount (CLM02) must be reported in the non-Covered Amount Field (Loop 2320 – AMT02) for the applicable payer (NOTE: "0FILL" is only to be reported when the prior payer has NOT adjudicated the claim since the payer does not cover the services). The Medicaid Managed Care Plan will then process the claim as per contract guidelines."

If providers run into any issues with Medicaid Managed Care plans complying with the "0FILL" process, please contact OMH at omh-managed-care@omh.ny.gov.

Q5. The COVID-19 federal public health emergency has prevented Medicaid Managed Care enrollees who become dually eligible for Medicare from being disenrolled from their Medicaid Managed Care Plan (MMCP). How does dual eligibility for Medicare and Medicaid impact behavioral health provider reimbursement in this scenario?

Enrollees who become eligible for Medicare have remained in their MMCP during the public health emergency, unless opting to change their enrollment. Some of these enrollees have enrolled in their MMCP's aligned Medicare D-SNP and remained in their MMCP through the Integrated Benefits for Dually Eligible Enrollees program.

This is a reminder that Chapter 57 of 2019 of the Laws of New York and Section 21.19 (f) of the Medicaid Managed Care/HIV Special Needs Plans/Health and Recovery Plan Model Contract requires that MMCPs reimburse hospital-based and free-standing behavioral health clinics at an amount equivalent to the payments established for such services under New York State's Medicaid ambulatory patient group (APG) rate-setting methodology. Therefore, when processing claims for dual eligibles for services provided by behavioral health clinics:

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1) MMCPs are required to coordinate benefits with Medicare primary coverage when applicable, and

2) MMCPs are to ensure reimbursement to such behavioral health clinics is configured to pay up to the higher of the Medicaid APG payment amount or the Medicare rate.

This represents total reimbursement to the provider; members in MMCPs should not experience Medicare cost sharing responsibility outside of the pharmacy benefit.

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Reference Table: Medicaid and Medicare Payment Responsibility

The following table provides a visual representation of the scenarios outlined in Question 1 above. At this time, the State is finalizing guidance for Medicaid and Medicare payment responsibility for individuals enrolled in Medicare Part C (Medicare Advantage) and Medicaid FFS. This guidance will be forthcoming.

#	Medicare Enrollment (Primary)	Medicaid Enrollment (Secondary)	OMH Clinic Payment	MH Specialty Service Payment (e.g., ACT, PH, PROS, CDT, and DT)	Authority/References
1	Medicare Fee-for-Service (Original Medicare)	Medicaid Fee-for Service	OMH clinic reimbursed at **full Medicaid government rate:** • Medicare FFS pays according to the appropriate Medicare fee schedule. • Claim crosses over to Medicaid FFS[4], Medicaid FFS pays "higher of" rate (government rate) to clinic provider. Other Payment Considerations: • Medicaid FFS pays full Medicaid amount for services rendered by non-Medicare reimbursable providers (i.e., LMSW) (0FILL process).	• Services covered by Medicare Part B (Medicare FFS) are reimbursed at the Medicare rate. • Medicaid will pay the copayment and deductible for qualified dual beneficiaries. ○ "Higher of" provision is applicable only to ambulatory patient group (APG), Partial Hospitalization, Continuing Day Treatment and Day Treatment for Children. • Services covered only by the Medicaid benefit package are reimbursed at the Medicaid FFS rate (e.g., ACT).	• Medicaid State Plan Amendment Supplement 1 to Attachment 4.19-B (Medicaid payment of Medicare copayments and deductibles) • Medicaid Managed Care Billing Guidance for Dual Eligible Enrollees (2017) • NYS statute- Chapter 57 of the laws of 2019 (BH government rates)

[4] Some claims cross over automatically, others do not.

#	Medicare Enrollment (Primary)	Medicaid Enrollment (Secondary)	OMH Clinic Payment	MH Specialty Service Payment (e.g., ACT, PH, PROS, CDT, and DT)	Authority/References
2	Medicare Advantage D-SNP aligned with Medicaid Plan (Part C)	Medicaid Managed Care (including Mainstream and HARP)	• **Medicare Advantage Plan-** pays 100 percent of Medicare Advantage Plan negotiated rate for Medicare reimbursable procedure codes, less enrollee's coinsurance/ copayment, if any. • **Medicaid Managed Care Plan[5]-** ○ Pays 100 percent of enrollee's Medicare coinsurance/copayment. ○ Must reimburse OMH licensed clinics at an amount equivalent to the payments established for such services under New York State's Medicaid ambulatory patient group (APG) rate-setting methodology. MMCPs are to ensure reimbursement to such behavioral health clinics is configured to pay up to the higher	• Services covered by the Medicare Advantage Plan (Part C Plan) are reimbursed at the negotiated Medicare Advantage Plan rate. ○ Medicare Part C plans may elect not to impose cost-sharing requirements. ○ Medicaid Managed Care Plans will pay the copayment and deductible for qualified dual beneficiaries. • Services covered only by the Medicaid Managed Care benefit package are reimbursed at no less than the Medicaid FFS rate, per NYS law.	• Duals Reimbursement in MMC (2021)

[5] Due to the federal public health emergency, Medicaid Managed Care enrollees may stay in their plan when they become dually eligible for Medicare. They may be dually enrolled in a MMCP and either Original Medicare (Fee-for-Service), a Medicare Advantage (Part C) plan, which includes a Medicare Advantage D- SNP aligned with their MMCP. For items or services that are statutorily not covered by the Medicare program, providers may bill the Medicaid Managed Care Plan directly without receiving a denial from Medicare. Providers can receive Medicare EOBs for non-covered services. Medicare will not provide EOBs for claims with non-Medicare eligible professionals. In this scenario providers must use the "0FILL" process outlined above.

#	Medicare Enrollment (Primary)	Medicaid Enrollment (Secondary)	OMH Clinic Payment	MH Specialty Service Payment (e.g., ACT, PH, PROS, CDT, and DT)	Authority/References
			of the Medicaid APG payment amount or the Medicare rate.		
3	Medicare Advantage D-SNP Plan aligned with Medicaid Plan (Part C)	IB-Dual Medicaid Advantage Plus	OMH clinic reimbursed 100 percent of Medicare D-SNP negotiated rate. • **Medicare Advantage Plan**- pays 100 percent of Medicare Advantage Plan negotiated rate, less enrollee's coinsurance/ copayment. • **Medicaid Advantage Plus**- pays 100 percent of enrollee's coinsurance/copayment.[6]	• Services covered by the Medicare D-SNP (Part C Plan) are reimbursed at the negotiated Medicare Plan rate. ○ Medicare Part C plans may elect not to impose cost-sharing requirements. ○ Medicaid FFS will pay the copayment and deductible for qualified dual beneficiaries. • Services covered only by the Medicaid benefit package are currently reimbursed by Medicaid FFS at the **Medicaid FFS rate**.	• Medicaid Advantage Plus Model Contract (Appendix K-1, Benefit Package; pg. 177[7])

[6] MAP Plan reimbursement for behavioral health services benefits will change when specialty behavioral health services carve into the MAP benefit package on January 1, 2023. Please reference the MAP BH Billing and Coding Manual for the payment responsibility effective 1/1/2023.
[7] Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Dual Eligibles