Washington State Health Care Authority

Apple Health Medicare Connect behavioral health billing guidance

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This guidance document is intended to educate providers and Managed Care Organizations (MCOs) on submitting encounters and claims for individuals on Medicaid, Medicare, and Apple Health Medicare Connect beneficiaries.

Updated 2/24

Behavioral health billing guidance

Background

Individuals who have both Medicare and Apple Health (Medicaid) coverage are dual-eligible, or 'duals and are enrolled in Apple Health Medicare Connect coverage. These individuals have two tiers of coverage, with Medicare considered primary and Apple Health secondary. The Health Care Authority (HCA) enrolls eligible clients with both Apple Health and Medicare into an Apple Health Behavioral Health Services Only (BHSO) plan for behavioral health services. Learn more about Apple Health Medicare Connect.

Medicare Parts A, B, C, and D

Part A: In-patient hospital insurance

- 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: Out-patient medical insurance

- HCA Medicaid policy requires clients to enroll in Part B as soon as they are eligible. Medicare enrollees need to follow Medicare guidelines and policy in enrolling in Part B services. Apple Health clients have their Medicare Part B premium covered through their Apple Health coverage and will generally always have Part A and Part B.

Part C: Medicare Advantage

- Medicare Advantage (MA) health plans, or Part C, are private companies who contract with Medicare to provide Managed Medicare. They contract with the Centers for Medicare and Medicaid services (CMS) and combine Part A and Part B benefits. A client must already have Medicare Parts A & B to be eligible for an MA plan.
    - Part C plans provide all Part A and Part B coverage and follow the same federal rules for benefit design and cost sharing but may offer more as supplemental benefits as approved by CMS.
    - Part C Dual-Special Needs Plans (D-SNP) are a subset of Medicare Part C designed for dual eligible individuals and will often contain a Part D benefit.
    - A client with a D-SNP will appear under the Managed Care Information field when verifying information. Any other Medicare part C and Part D plan will be found in the Coordination of Benefits segments.

Part D: Prescription drug coverage

- Part D ss a pharmacy benefit Medicare clients enroll in through a variety of different managed care plans. This coverage replaces their Apple Health prescription drug coverage. When a client has Part D, drugs are usually covered by the plan's formulary, but Apple Health may cover drugs that Medicare will not.
- If a beneficiary enrolls in a Medicare Advantage (Part C) plan that offers Part D coverage such as a 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 HCA offers Medicare Savings Programs, which can pay the cost-sharing amount for dual-eligible clients, and in some cases provide no out-of-pocket expenses. Providers may not bill a full benefit 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 full benefit dual-eligible patients as private pay in order to bill them directly and must accept Medicare assignment. If a client participates in a D-SNP, providers will need to work with that plan for any payments and client responsibility.

QMB plus and SLMB plus

Eligible clients who qualify for a Qualified Medicare Beneficiary (QMB) plus or Specified Low-Income Medicare Beneficiary (SLMB) plus are also enrolled in an Apple Health Behavioral Health Services Only (BHSO) plan.

Qualified Medicare Beneficiary (QMB)

QMB dual-eligible individuals will have:

- QMB-plus program, or as seen in ProviderOne, CNP-QMB, also called full-duals. The CNP represents Apple Health's full scope-of-care (Medicaid and QMB), 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.

Specified Low-Income Medicare Beneficiary (SLMB)

SLMB only pays for Medicare Part B premiums – no other cost sharing such as deductible and copay. Similar to QMB plus, SLMB plus clients are considered full-dual eligible and have all Apple Health benefits. HCA pays cost sharing through Apple Health and Part B premiums through SLMB.

Verification of client eligibility can be seen on the ProviderOne benefit inquiry screen under the client eligibility spans shown in the below image.

Clients on SLMB Plus may 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 incurring or paying for services out-of-pocket, SLMB Plus coverage begins and the client becomes enrolled with a BHSO managed care plan until their next spenddown period. Moving between being a full-dual (SLMB Plus) and a partial dual (SLMB only) makes it difficult to determine who pays for a clients crisis services.

- The Behavioral Health – Administrative Services Organization (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 a BHSO on the managed care screen, they have not met their spenddown and are not eligible for full Apple Health benefits.

- The managed care plan that 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 Apple Health benefits.

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

ProviderOne and Medicare should always have the same information for what Medicare coverage a client has. 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 crossover claim takes place when the services are payable by both Medicare and Apple Health. Crossover claims can be processed in two ways:

- Transmitted electronically from Medicare to 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).

Learn more about the recent expansion of covered provider types in the CMCS Informational Bulletin.

Claims are not considered crossover claims if Medicare denies the entire claim and the provider then bills Apple Health. These are 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 not covered by Medicare, but by Apple Health, can be billed directly to the appropriate Apple Health 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 for them to be payable by Apple Health.

View the Provider billing guides and fee schedules for more information and guidance.

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 to bill Medicare as primary to obtain an EOMB showing why the service was not covered (e.g., the service limit was met). Claims that Medicare never covers are the only claims that do not require an. 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. These are not always the same provider types Apple Health allows. Medicare has a limited set of mental health and substance use disorder providers that are allowed to provide behavioral health services 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. Providers should contact the responsible managed care plan to see if additional documentation is 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. No further inpatient psychiatric benefits are available to individuals after the maximum is met. If the client is enrolled in a Medicare Advantage plan, they need to follow the directions of their plan.

Before the limit is met, hospitals do not need prior authorization from Apple Health to admit the individual. Prior Authorization is required for Apple Health to cover these services after the limit is met. If the client meets the limit during a hospital stay, the hospital must request prior authorization from Apple Health for the expected remaining days.

Opioid Treatment Programs

Medicare is the primary payer for dual-eligible individuals currently receiving Opioid Treatment services (OTP. 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. OTP providers are advised to enroll with Medicare to receive payment for services and avoid disruption to services.

View the Substance Abuse and Mental Health Services Administration's (SAMHSA) guidance form providers to learn more.

Pharmacy services

Apple Health Medicare Connect clients must enroll in a Part D plan once they are dual-eligible. Part D supplements Apple Health prescription drug coverage. Apple Health does not pay co-pays. View the Part D coverage for Dual-Eligibles guide to learn more.

For details on what drugs are covered view the Apple Health covered drugs for part D dual-eligibles fact sheet. View the Provider billing guides and fee schedules to learn more.

More information

- Medicare Learning Network - Free educational materials for health care professionals on CMS programs, policies, and initiatives.
    - The Medicare and Medicaid basics is a good resource to start with.
- Internet Only Manuals – CMS resource that includes the Medicare Claims Processing Manual and the Medicare Secondary Payer Manual.
- WAC 182-502-0110 – Details about the general conditions of payment for Medicare coinsurance, copayments, and deductibles, including statutory authority references.
- Medicare and You booklet- helpful information for dual-eligible clients.
- CMS Fee Schedules – View specific procedure codes covered by Medicare.
- 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. This provides a way for non-Medicare providers to learn when Medicare is going to start covering their services.