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

NOTE: These FAQs discuss payment of Part A and B items and services rendered to dually eligible individuals enrolled in Original Medicare or Medicare Advantage (i.e., Medicare Part C). The FAQs do not affect or discuss Medicare Part D medication coverage and the associated Medicaid coverage rules. Please see more information here: https://www.medicare.gov/basics/costs/help/medicaid.

Section 1: Provider Enrollment and Medicaid Payment

Q1. Is a state required to pay primary for an item or service provided to a full-benefit dually eligible individual enrolled in Original Medicare by a Medicaid-enrolled provider or supplier when the provider or supplier is not also enrolled in Medicare?[1]

A1. Yes. The state would pay primary for a Medicaid-covered item or service provided by a Medicaid-enrolled provider or supplier for a full-benefit dually eligible individual when the provider or supplier is not also enrolled in Medicare.[2] Generally, providers and suppliers that are not enrolled in Medicare cannot bill Medicare, so Medicare would not be liable. Medicare would not cover items or services rendered by a provider or supplier that is not enrolled in Medicare. Therefore, the item or service is considered non-covered by Medicare and the state would pay primary for the item or 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 item or service in the State Plan); see Question 3 for more information on state processing of claims from Medicaid-only providers or suppliers without a denial from Medicare. For more information on Medicare provider enrollment, including Medicare Advantage network providers and suppliers, and how it relates to billing for items and services provided to dually eligible individuals, please see Section 3. We note that there is no federal law or requirement for Medicaid providers or suppliers to enroll in Medicare.

If the provider or supplier *is enrolled* in Medicare and provides an item or service covered by Medicare and Medicaid to a full-benefit dually eligible individual, then the provider or supplier should bill Original Medicare as the primary payer as Medicaid is generally the payer of last resort for items and services provided to full-benefit dually eligible individuals. If a balance remains after Medicare has paid the provider or supplier, or Medicare has denied payment for a

[1]Note that physicians and practitioners that are enrolled in Medicare (and have not opted out) fall into two categories: participating and non-participating physicians/practitioners. Question 9 discusses provider enrollment in Medicare in more detail.

[2] For more information on Medicaid coordination of benefits and third party liability, please see Coordination of Benefits and Third Party Liability in Medicaid (2020 COB/TPL Handbook), found here: https://www.medicaid.gov/medicaid/eligibility/coordination-of-benefits-third-party-liability/index.html.

substantive (i.e., non-procedural) reason, the provider or supplier can submit the claim to the state for payment of the balance, up to the maximum Medicaid payment amount established for the item or service in the State Plan.

Q2. Is a state required to pay primary for an item or service provided by a Medicaid-enrolled provider or supplier to a full-benefit dually eligible individual enrolled in a Medicare Advantage plan when the provider or supplier is not in the Medicare Advantage plan's network and the Medicare Advantage plan is not required to cover the service out-of-network?

A2. Only under certain circumstances would a Medicare Advantage plan pay a Medicaid-enrolled provider or supplier outside the Medicare Advantage plan's network for a Medicare-covered item or 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 or suppliers in the plan's network, unless certain exceptions apply. Some HMO plans have a point-of-service (POS) option that allows enrollees to go out-of-network for certain items or 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 or supplier, but the plan may charge higher cost-sharing for providers or suppliers outside the plan's network.[3] We note that HMO plans are required to cover services out-of-network if the HMO plan authorizes such coverage or if certain exception in the regulations requiring out-of-network coverage apply.

When the state should pay primary: The state should pay primary for Medicaid-covered items and services provided by a Medicaid-enrolled provider or supplier 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 services furnished by an out-of-network provider or supplier when the dually eligible individual is enrolled in an HMO plan that is not required to cover the services.

If the out-of-network provider or supplier 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 items or services rendered by a provider or supplier not in the plan's network. Therefore, the item or 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 item or service in the State Plan); see Question 3 for more information on state

[3] For more information on Medicare Advantage plans and network providers and suppliers, see here. With the exception of those services for which Medicare Advantage plans must pay out-of-network providers and suppliers, 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 and suppliers or may require enrollees to pay at a higher cost.

processing of claims from Medicaid-only providers or suppliers without a denial from the Medicare Advantage plan. We note that a Medicare Advantage plan is required to cover all Medicare-covered items and 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 or supplier, that item or 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 items and services rendered from out-of-network providers and suppliers (as may be the case for Medicare Advantage PPO, PFFS, or HMO-POS plans), then the out-of-network provider or supplier should bill the Medicare Advantage plan for primary payment. These Medicare Advantage plans generally will only pay an out-of-network provider or supplier when:

- the provider or supplier is already enrolled in Medicare, and
- the items or 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 item or service is not covered under Medicare Parts A and B (such as a dental service covered as a Medicare Advantage supplemental benefit),[4] and
- the Medicare Advantage plan covers the supplemental item or service out-of-network.[5]

Q3. How can the state process a claim for a dually eligible individual from a Medicaid-only provider or supplier without a Medicare denial?

A3. If the state has documented non-coverage, to denote non-coverage by a third party (including Medicare) 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 and suppliers to maintain annual documentation to substantiate third-party non-coverage when using such override codes, and the state could conduct provider and supplier audits to assure that the providers and suppliers 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 or supplier.

As a reminder, Medicare is not a liable third party for an item or service rendered to a dually eligible individual from a Medicaid-only provider or supplier, because Medicare does not cover items or services rendered by a provider or supplier not enrolled in Medicare. Providers and

[4] Medicare Advantage plans must cover all medically necessary services that Original Medicare covers and may also offer some extra benefits that Original Medicare doesn't cover; these extra benefits are referred to as "supplemental benefits".
[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 Medicare before billing the Medicare Advantage plan for items or services covered under Medicare Parts A and B. However, Medicare Advantage plans generally do not require out-of-network providers enroll in Medicare for supplemental services covered by the Medicare Advantage plan.
[6] For more information on how state may handle never-covered items and services, please see the Medicaid 2020 COB/TPL Handbook, found here: https://www.medicaid.gov/medicaid/eligibility/coordination-of-benefits-third-party-liability/index.html.

suppliers not enrolled in 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 or supplier may be unable to submit a claim to a Medicare Advantage plan and subsequently receive a denial depending on the type of plan and item or service rendered.

Section 2: Provider Enrollment and Medicaid Payment of Medicare Cost-Sharing

Q4: Do states need to enroll a Medicare-enrolled provider or supplier, including Medicare Advantage in-network providers and suppliers, in Medicaid for the state to pay for Medicare cost-sharing for a dually eligible individual?

A4: Yes. 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 item or service, the claim either automatically crosses over to the state or, in some cases, the provider or supplier 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 Medicare Advantage plan includes Medicare cost-sharing payment in the plan's payment to the provider; the provider or supplier 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 or supplier 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 or supplier. In these instances, the provider or supplier would not collect Medicaid payment of Medicare cost-sharing. See Section 3 for more discussion.

[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 2020 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

Q5: 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 and suppliers in Medicaid for the state to pay Medicare cost-sharing?

A5: No. For integrated care plans where the state capitation payment includes coverage of Medicare cost-sharing, including FIDE SNPs, the provider or supplier 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 or supplier would need to enroll with the state or Medicaid managed care plan for payment of items and services for which Medicaid is the primary payer.

Q6. Can a state deny payment of Medicare cost-sharing for items and 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?

A6: No, a state cannot deny payment of Medicare cost-sharing for a Medicare Part A- or Part B-covered item or service for dually eligible individuals enrolled in the QMB eligibility group even when the state does not cover the item or 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 for Medicare Part A or Part B items and services (see section 1905(p)(3) of the Act). As discussed above in Answer 4, 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 item or service, the claim either automatically crosses over to the state or, in some cases, the provider or supplier 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 or supplier 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 or supplier.

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 Medicare-only covered items and services unless the state opts to extend coverage of Medicare cost-sharing to these categories of dual eligibility.

[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

Section 3: Provider Enrollment and Billing a Dually Eligible Individual[10]

Q7: Can a Medicare-enrolled or in-network provider or supplier bill a dually eligible individual for Medicare cost-sharing in instances where the provider or supplier is not also enrolled in Medicaid?

A7: 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.[11] This applies regardless of provider or supplier enrollment with the state, state coverage of the item or 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 items and 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 any Medicare cost-sharing from certain dually eligible individuals. Medicare Advantage plan in-network providers and suppliers must refrain from billing QMBs enrolled in the Medicare Advantage plan for Medicare cost-sharing of Medicare Part A and Part B services.[12] These in-network provider Medicare cost-sharing provisions also apply to other non-QMB, full-benefit dually eligible individuals enrolled in the Medicare Advantage plan when the state elects to extend coverage of Medicare cost-sharing to these dual eligibility groups.[13]

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),

[10]This section discusses federal billing protections. Please also review applicable state laws for additional beneficiary protections at the state level.

[11] 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).

[12]Medicare Advantage plans are responsible for educating network providers, suppliers, and pharmacists about Medicare cost-sharing protections and billing requirements (see https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/qmbraandeobmemo04032018.pdf).

[13] 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.

Qualifying Individuals (QI), or Qualified Disabled and Working Individuals (QDWI) eligibility groups, may be responsible for any applicable Medicare cost-sharing.[14]

Q8: Can an out-of-network provider or supplier bill a dually eligible individual enrolled in a Medicare Advantage plan for a Medicare-covered item or service?

A8: Out-of-network providers and suppliers who are currently enrolled in Medicare may only bill a full-benefit dually eligible individual enrolled in a Medicare Advantage plan when:

1) the Medicare Advantage plan does not cover items or services from out-of-network providers or suppliers, *and*
2) the service is not covered by Medicaid.

As described in Question 2, there are certain circumstances when a Medicare Advantage plan would cover items or services from an out-of-network provider or supplier rendered to a dually eligible individual enrolled in that plan (excluding certain always-covered services and items).

For Medicare Advantage plans that cover Medicare Parts A or Part B items and services rendered by out-of-network providers and suppliers to a dually eligible individual, as long as the out-of-network provider or supplier is enrolled in Medicare, then the out-of-network provider or supplier bills the Medicare Advantage plan for the item or service. The out-of-network Medicare provider or supplier 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 or supplier bills the Medicare Advantage plan, the provider or supplier 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 and suppliers 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 cover items or services from out-of-network providers and suppliers, the item or service is considered non-covered by Medicare and there is no applicable Medicare cost-sharing. The QMB billing protections described in Question 7 do not apply for items and services not covered by Medicare Part A or Part B. Therefore, the requirement for states to pay for Medicare cost-sharing, as described in Section 2, does not apply for items and 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 an item or service rendered by an out-of-network provider or supplier as the individual does not

[14] 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

have full Medicaid and the Medicare Advantage plan does not cover items or services from the provider or supplier. The provider or supplier would bill the individual for payment of items or services.

- For full-benefit dually eligible individuals, the provider or supplier should confirm if there is additional coverage for the item or service as such individuals have full Medicaid. If Medicaid covers the item or service, then the provider or supplier would bill the state or Medicaid managed care plan. If Medicaid does not cover the item or service, then there is no identified coverage for the item or service and the provider or supplier would bill the individual for payment of items or services.

We encourage providers and suppliers to inform the dually eligible individual prior to rendering items or services if the provider or supplier is considered "out-of-network" for the Medicare Advantage plan.

Q9: Can a provider not enrolled in Medicare bill a dually eligible individual for a Medicare-only covered service?

A9: Yes. Excluding certain always-covered services,[15] when a physician or practitioner does not enroll in 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.[16] As discussed above, these services are non-covered by Medicare and therefore QMB billing protections and Medicaid payment of Medicare cost-sharing do not apply.

We note that physicians and practitioners that are enrolled in Medicare (and have not opted out) fall into two categories: participating and non-participating physicians/practitioners.[17] Participating physicians or practitioners agree to accept Medicare assignment for all claims. For services rendered to Medicare beneficiaries who are not dually eligible, 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 individual.[18]

If the opt-out provider is enrolled in Medicaid, then the policies described in Section 1, above, apply for services that are covered by both Medicare and Medicaid.

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[15]Medicare won't pay for items or services you get from a provider that opts out, except in emergencies. For more on what Medicare covers, see here: https://www.medicare.gov/coverage.

[16]For more on opting out of Medicare and private contracts with Medicare beneficiaries, please see the Medicare Program Integrity Manual section 10.6.12 https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c10.pdf and the Medicare Benefit Policy Manual section 40 at https://www.cms.gov/medicare/prevention/prevntiongeninfo/downloads/bp102c15.pdf.

[17]Please see more information here: https://www.medicare.gov/basics/costs/medicare-costs/provider-accept-Medicare

[18]See 1848(g)(3)(A) at https://www.ssa.gov/OP_Home/ssact/title18/1848.htm

Q10: Can a provider or supplier not enrolled in Medicaid bill a dually eligible individual for a Medicaid-only covered item or service?

A10: Full-benefit dually eligible individuals have 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 items and services.) For Medicaid-only covered items and services rendered to a full-benefit dually eligible individual by a provider or supplier not enrolled with Medicaid, (including when the provider or supplier is enrolled in Medicare or in a Medicare Advantage plan's provider network), please check with the applicable state for billing rules.

Providers and suppliers should clearly inform the full-benefit dually eligible individual prior to rendering items or services that the individual is not being accepted as a Medicaid patient and that the provider or supplier will not accept payment from Medicaid and inform the dually eligible individual of the estimated charges for care.