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MEDICARE AND MEDICAID

The U.S. government sponsors several programs designed to provide health insurance for people who meet specific criteria. Medicare provides coverage for medical expenses for people age sixty-five and over and for younger people who qualify for Social Security because of a disability. Medicaid provides benefits for low-income individuals.

Although these programs serve different populations and are funded by different mechanisms, they are both subject to complex federal rules and regulations, which cover everything from who is eligible to receive services to how much physicians can charge for those services. Working with these programs is complicated by the fact that the government does not administer them directly. Rather, it contracts them out to state governments, third-party administrators, and large insurance companies. These administrative arrangements result in a great deal of variation in how specific program policies are interpreted and implemented.

The following presents a brief overview of the Medicare and Medicaid programs and provides tips for achieving compliance with each. It is extremely important to remember that different administrators may have different interpretations of program rules, and that rules may change frequently. If you have specific questions about a program, contact the program administrator in your area directly for assistance.

MEDICARE

Medicare was created in 1965 as part of the Social Security Act. The program was divided into two parts. Part A is hospital insurance and helps to pay for care provided in a hospital, skilled nursing facility, nursing home, or hospice. It covers the room, board, and ancillary charges billed directly by the facility. The covered portion of expenses is based on the number of days the patient has received care. Part A was previously administered within each state by insurers that were designated as *Fiscal Intermediaries* (FIs). In all but a few states, Part A and Part B are now both administered by one entity called a Medicare Administrative Contractor, or MAC, and the country has been divided into 15 regions that are overseen by the MACs. (See Appendix X).

Part B covers the professional services of physicians and nonphysician healthcare providers and a variety of outpatient services including x-rays, laboratory work, and durable medical equipment. As a psychiatrist, you will almost always be working with Part B. Part A coverage is automatic upon reaching age sixty-five. Part B coverage is voluntary, and beneficiaries are

required to pay a monthly premium for coverage. Medicare generally covers 80 percent of allowed medical charges, and the patient is responsible for paying the remaining 20 percent.

Many Medicare beneficiaries now receive their Medicare coverage through commercial insurers who operate Medicare Advantage plans. If you are in-network for one of these insurers, you should be reimbursed for seeing the Medicare Advantage patients according to your negotiated fee schedule. If you are a Medicare provider who is not in-network and the Advantage plan authorizes your service, the plan is obligated to pay you the Medicare mandated fee for that service. Claims for Medicare Advantage patients are sent directly to the Advantage plan for reimbursement; MACs will return any claims sent to them for these patients.

In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) created Medicare Part D, Medicare's outpatient prescription drug benefit, which was implemented on January 1, 2006. The MMA mandated that Part D be managed by private prescription drug plans (PDPs), which would negotiate their own contracts with pharmaceutical companies for medications. Medicare beneficiaries must choose between the many plans offered in their states. With the advent of Medicare Part D, dual eligible beneficiaries, who have both Medicare and Medicaid, had their drug coverage automatically switched from Medicaid to Part D.

Key Medicare Part B Information

- Every procedure (designated by a CPT code) covered by Medicare has a value attached to it that can be found by referring to your MAC's website (see Appendix AA). A Physician Fee Schedule is released each fall for the next year.
- If a patient has a Medigap policy (supplemental insurance to Medicare), that insurance may pick up the patient's entire copay or some part of it, depending on the particular policy.
- Claims for care provided to Medicare patients who are part of Advantage plans must be sent to the Advantage plan rather than to your MAC.
- Physicians may choose to be either *participating* or *nonparticipating* Medicare providers. Participating providers must "accept assignment," which means they are responsible for filing the claims for treatment provided to Medicare patients and are paid the Medicare-allowed fee (minus the patient copay) directly by their MAC. Nonparticipating providers can choose to accept assignment on a case-by-case basis or can choose to be paid the Medicare-allowed limiting fee (about 9% higher than the regular Medicare fee) by their

patients, *but the physician is still responsible for filing the claims with the MAC* so the patient will be reimbursed. When nonparticipating providers do accept assignment they are paid 5 percent less than the Medicare-allowed amount.

- You can only "opt out" of Medicare by filing an affidavit with your MAC that states you will not see *any* patients under Medicare for a period of two years. Once you have opted out, Medicare allows for private contracting between a physician and a Medicare beneficiary. See below for details.
- Although private contracting is allowed for physicians who opt out of Medicare entirely, a physician who sees any patients under Medicare cannot negotiate fees above the Medicare allowed amount. (Beneficiaries can request that you not file their claims with Medicare, but, as a Medicare provider, you are still limited to charging the Medicare allowed amount for your services.)
- The best way to keep on top of the changes in the Medicare program is to pay attention to the emails you are sent by your MAC. MACs are required to notify physicians of all changes to program rules, coverage guidelines, and fees. A list of MACs (and the few remaining Carriers) is provided in Appendix X.
- If you encounter a problem with Medicare that you are unable to resolve, contact the APA's Practice Management HelpLine (800-343-4671 or hsf@psych.org). They maintain working relationships with many MAC administrators and often are able to facilitate resolutions.

Opting Out and Private Contracting Under Medicare

Since January 1, 1998, federal law has permitted a physician to opt out of Medicare altogether and enter into private contracts with Medicare patients that allow the provision of physician services entirely outside of Medicare. Payment for these services is to be negotiated between the physician and patient and is not limited by the Medicare fee schedule.

A nonparticipating physician may opt out of Medicare at any time. A participating physician may opt out if he/she terminates the Medicare part B participation agreement by submitting the required affidavit to the Medicare carrier at least thirty days before the first day of the next calendar quarter. The affidavit must show an effective date of the first of that quarter. See Appendix W for opt out affidavit and private contract templates. More complete information about opting out can be found on the APA website, www.psych.org.

The law requires that the private contract with the patient stipulate that the patient agrees in writing that she will not submit any claims to Medicare and will not ask the physician to submit any claims. The patient also: acknowledges that Medigap plans (and possibly other supplemental plans as well) will not make

payments for services rendered by the contracting physician; agrees to be fully responsible for payment to the contracting physician for services rendered; and acknowledges that Medicare's fee schedule amounts and charge limits do not apply to the contracting physician. Physicians must use a contract that meets Centers for Medicare and Medicaid Services (CMS) regulatory requirements and have it signed by the patient or his legal representative. (The contract provided in Appendix W meets these requirements.)

Although a patient may agree to a private contract with one or more physicians, a physician who opts out of Medicare may not see *any* Medicare patients except under private contracts for two years.

State law may affect private contracts and physicians should check with their insurance commissioner, APA district branch, and/or a local attorney.

The templates in Appendix W meet current CMS requirements according to a review by the APA's legal counsel. Currently most MACs have affidavits available on their websites that may be even easier to use.

MEDICAID

Like Medicare, the Medicaid program was created under the Social Security Act of 1965. Medicaid, however, is a joint federal-state program, with funding coming from both sources. Medicaid is an entitlement program that provides medical assistance to families and certain individuals with low incomes. The federal government sets broad guidelines for the Medicaid program, but each state determines its own eligibility standards, scope of services, and payment rates. Under the Accountable Care Act (ACA or Obamacare), Medicaid was expanded to cover many more people, most of whom were previously uninsured.
Today, many states operate their Medicaid programs through managed care plans, and reimbursement rates for participating providers have become more attractive than they were previously. These managed Medicaid plans may sometimes carve-out the behavioral health benefit to another administrator.

Signing a contract to participate in a managed Medicaid program should be approached with the same caution as signing any other contract with an insurer. One thing psychiatrists want to be aware of if they contract to provide care under a managed Medicaid plan is that they may be signing on to be in-network with all the plan administrator's various healthcare products. If you don't want to be in-network for other plans you must be sure that you don't sign a contract that specifies it applies for all products. See Chapter 28 for information about contracting.

Key Medicaid Information

- Because the program covers low-income individuals, Medicaid recipients typically have nominal, if any, copayments for services.
- Prescription drugs are not a required Medicaid benefit but are covered under most programs. Medicaid beneficiaries who also have Medicare, dual eligibles, receive their drugs through Medicare Part D.
- For dual eligibles, Medicare is the primary insurer and should be billed first.
- Due to the extreme variance inherent in the program structure, specific questions about program services and fees should be directed to the Medical Assistance office in your state.