

# Medicare and Medicaid

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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. Both programs are administered by the Centers for Medicare and Medicaid Services (CMS), although Medicaid is a joint federal and state program and many decisions are made at a state level.

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. The APA posts any national Medicare changes on its [website](#) at [www.psychiatry.org/medicare](http://www.psychiatry.org/medicare) as they become public. If you have specific questions about a program, contact the program administrator for your [Medicare Contractor](#) in your area directly for assistance. You can access this information via the CMS website, by downloading a copy from the APA's website (previous link) or contacting the APA's Practice Management HelpLine at 800.343.5671 or [hsf@psych.org](mailto:hsf@psych.org).

### **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 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 free upon reaching age sixty-five. Part B coverage is voluntary, and beneficiaries are required to pay a monthly premium for coverage. For those patients who are still employed and choose to participate in Part B, their employee insurance will be primary and Medicare will be the secondary payer.

Although in the past Part A was administered within each state by insurers designated as Fiscal Intermediaries (FIs) and Part B was administered by Medicare Carriers, currently CMS has almost entirely transitioned Medicare administration to regional Medicare Administrative Contractors (MACs), which administer both Parts A and B.

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 negotiate their own contracts with pharmaceutical companies for medications. Medicare beneficiaries must choose between the many plans offered in their states.

Many Medicare beneficiaries now receive all their benefits through private Medicare Advantage plans. If a physician is in-network for one of these plans, she will be paid for her services according to her contract with the plan. If the Advantage plan agrees to cover care from an out-of-network physician, the physician is entitled to the same reimbursement he would receive under Medicare, although the billing is done to the Advantage plan rather than to the Medicare contractor. If the Advantage plan denies coverage, the physician may charge his usual and customary fee, although if coverage is granted upon appeal by the patient, the Medicare fee schedule will apply.

### **Key Medicare Part B Information**

- For outpatient mental health care (unless it's a diagnostic service, or treatment for a patient with Alzheimer's or an Alzheimer's-like dementia) Medicare currently pays 60 percent of the allowed fee (with the patient responsible for the rest); in 2013 it will pay 65 percent; and, finally, in 2014 outpatient mental health services will be paid at the same rate as other medical services, 80 percent. (The Medicare payment for inpatient mental health care has always been 80 percent of the fee-schedule amount.)
- 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.
- Physicians may choose to be either *participating* or *nonparticipating* Medicare providers. Participating (par) providers must "accept assignment," which means they are responsible for filing the claims for treatment to Medicare patients and are paid the Medicare-allowed fee (minus the patient's copay) directly by their Medicare Carrier or MAC. Nonparticipating (nonpar) providers may charge slightly more than participating providers, up to a limiting charge that is about 9% higher than the participating provider fee. Nonpar providers still must file claims with Medicare, but the patient pays the entire fee up front, and is then reimbursed by Medicare for the appropriate amount.
- You can only "opt out" of Medicare by filing an affidavit with your Medicare Carrier or MAC that states you will not see *any* patients under Medicare for a period of at least 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 permitted for physicians who have opted out of Medicare entirely, a physician who has not opted out may not negotiate fees with Medicare patients above the Medicare allowed amount. (Beneficiaries may request that you not file their claims with Medicare, but you are still limited to charging the Medicare allowed amount for your services.)
- If you are not enrolled as a Medicare provider, it is illegal for you to bill Medicare patients for your services (unless you have officially opted out and have a signed contract with them).
- The best way to keep on top of the changes in the Medicare program is to contact your local MAC and request that you be placed on its mailing list. Medicare Contractors are required to notify physicians of all changes to program rules, coverage guidelines, and fees.

- If you have specific questions, and feel the response you receive from your Contractor's customer service department is not adequate, or seems questionable, contact the APA's Practice Management Help Line for assistance (800-343-4671, hsf@psych.org).

### **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 and submits 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. More complete information about opting out can be found on the APA website at [www.psychiatry.org/medicare](http://www.psychiatry.org/medicare).

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 on the APA website 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.

### **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.

#### **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. Medicaid may or may not pay up to the beneficiary's copay. This varies from state to state.
- Medicaid reimbursement rates are typically significantly lower than usual and customary fees, and are often lower than managed care and Medicare fees.
- 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.