# PROVIDING FEE-FOR-SERVICE
## Medicare Services to Dual Eligibles in Medi-Cal Plans

The **Coordinated Care Initiative (CCI)** is an effort by California and the federal government to integrate the delivery of medical, behavioral, and long-term services and supports for persons eligible for both Medicare and Medi-Cal (i.e., dual eligibles). Most dual eligibles in seven counties will be eligible to enroll in a new type of coordinated plan, called a Cal MediConnect plan. These plans will be responsible for administering the benefits under both programs. Participation in Cal MediConnect is voluntary, so people can choose to join or choose to opt out and receive Medicare services as they do today. If someone is eligible for Cal MediConnect and they don't make an affirmative choice to join or not join, they will be automatically enrolled into Cal MediConnect on their coverage date, usually the first day of their birth month. They can choose to disenroll in any month.

If your patients decide not to join a Cal MediConnect plan, they can continue to see you as a Medicare Fee-for-Service (FFS) physician. However, at the same time California is requiring most dual eligibles who do not enroll in a Cal MediConnect plan to enroll in a Medi-Cal managed care plan for their Medi-Cal benefits, including long-term services and supports.

The state has received reports of a common but dangerous misunderstanding: patients who decide they want to continue in Original Medicare are being told they may not continue to see their existing physicians if they are enrolled in a Medi-Cal plan. This is plainly false. Patients remaining with Original Medicare (fee-for-service) may continue to see their current physicians even if they join a Medi-Cal plan. Medicare physicians do not need to be contracted with Medi-Cal plans to see dual eligible patients. This misunderstanding thwarts the patient's effort to be treated by the physician, and causes the physician to lose that patient, based on false information. See below for billing instructions.

## FINANCIAL RESPONSIBILITY FOR PHYSICIAN SERVICES

Physician services provided to dual eligibles are the financial responsibility of Medicare, not Medi-Cal. It is a Medicare benefit paid primarily under the Medicare fee schedule. For most physician services, the rate physicians receive is 80 percent of the Medicare fee schedule.

Medi-Cal has responsibility for services and supports not covered under Medicare, including Medicare cost sharing as well as some long-term care, durable medical equipment, incontinence supplies, and other services and supports. The only role Medi-Cal managed care plans will have with respect to physician services for dual eligibles will be to adjudicate the payment of crossover claims for any Medicare cost sharing owed under California state law.

## BILLING FOR ORIGINAL MEDICARE (FEE-FOR-SERVICE)

If dual eligible Medicare patients decline to enroll in a Cal MediConnect plan, or are excluded from joining a Cal MediConnect plan, their physicians should bill for Medicare services exactly as in the past. Even if the patient is enrolled in a Medi-Cal managed care plan, the physician should bill for Medicare services exactly as in the past. There is no change in what Original Medicare (fee-for-service) will pay for billed charges, generally 80 percent of the Medicare fee schedule.

It should be noted that **no change** is made in the rules governing the billing of the 20 percent co-pay for dual eligible patients. It continues to be **unlawful to bill dual eligible patients.**[1] Instead, that claim for the 20 percent copay should be sent to the patient's Medi-Cal plan – this is known as a "crossover claim."

## BILLING CROSSOVER CLAIMS

In most cases, providers will need to send their "crossover claims" for the 20 percent co-pay to the patient's Medi-Cal plan, which will pay the physician any amount owed under state Medi-Cal law. In some limited cases, Medicare will send these crossover claims automatically and directly to the Medi-Cal plans. **Physicians do not need to be part of the Medi-Cal plan's network to have these crossover claims processed and paid.** Please refer to the "How Medi-Cal Plans Process Crossover Claims" document in this toolkit for a chart outlining how Medi-Cal plans will process crossover claims.

It should also be noted that **no change** is made in the rules governing how much the Medi-Cal plans will pay on these claims for Medicare services to dual eligibles. Since 1982, state law has limited Medi-Cal's reimbursement on Medicare claims to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal's maximum payment for similar services.[2] Consequently, if the Medi-Cal rate is 80 percent or less than the Medicare rate for the service rendered, Medi-Cal will not reimburse anything on these crossover claims. If the Medi-Cal rate is higher, providers will receive the payment. For example, in 2014 many primary care providers received Medi-Cal reimbursement, as Medi-Cal payments for primary care services in certain circumstances have been raised to 100 percent of Medicare under the Affordable Care Act.

However, since Medi-Cal reimbursement rates are generally lower than Medicare rates (80 percent of the Medicare fee schedule), it is anticipated that **there are few types of services where Medi-Cal owes any reimbursement on Medicare claims.** Again, this is not the result of the **Coordinated Care Initiative**. This has been the rule in California for over 30 years.

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1 Welfare and Institutions Code, Section 14019.4. (a): "A provider of health care services … shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient…."

2 Welfare and Institutions Code, Section 14109.5: "Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 for all services, including, but not limited to, hospital inpatient services, shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter. For purposes of this section, effective October 1, 1992, the reimbursement rates established under this chapter for hospital inpatient services shall be no greater than the amounts paid by the Medicare program for similar services."