

WHEN MEDICARE & MEDI-CAL BENEFITS ARE SEPARATE

For patients who choose to keep their Medicare and Medi-Cal separate, physicians will need to continue to bill Medicare and Medi-Cal separately. Physicians can never balance bill dual eligible patients.

- Claims for Medicare covered services will go to the Medicare Advantage plan or directly to Medicare for FFS patients.
- Claims for Medi-Cal covered services and Medicare coinsurance and copays should be sent to the Medi-Cal plan. **Physicians do not need to be part of the Medi-Cal plan's network to have these crossover claims processed and paid.**

PAYMENT FOR MEDICARE PHYSICIAN SERVICES PROVIDED TO DUAL ELIGIBLES

Physician services for dual eligibles are the responsibility of Medicare, not Medi-Cal. It is a Medicare benefit paid primarily under the Medicare fee schedule. For most physician services in Original Medicare (fee-for-service), physicians receive 80 percent of the Medicare fee schedule.

Medi-Cal is responsible for services and supports not covered under Medicare, including Medicare cost sharing, as well as some long-term care, durable medical equipment, and other services and supports. The only role Medi-Cal managed care plans have with respect to physician services for dual eligibles who remain in Original Medicare (fee-for-service) is to adjudicate the payment of crossover claims for any Medicare cost sharing owed under California state law.

WHEN MEDICARE & MEDI-CAL BENEFITS ARE COMBINED: CAL MEDICONNECT OR PACE

Cal MediConnect - Patients enrolled in Cal MediConnect generally need to receive all their physician services from providers in the Cal MediConnect plan network. Physicians who are part of a Cal MediConnect plan's network no longer need to bill Medicare or Medi-Cal for Cal MediConnect enrollees' care. They will receive all payments directly from the Cal MediConnect health plan or the plan's delegate (IPA or medical group). This simplifies billing processes for physicians. Some physicians may receive monthly capitation payments, and some may bill fee-for-service, depending on the arrangement they have with the Cal MediConnect plan or its delegate. These processes are similar to processes used by Medicare Advantage plans.

Physicians who are not part of a Cal MediConnect plan's network may, under certain circumstances and for a limited period of time, be able to continue to provide services to their patients under Cal MediConnect continuity of care guidelines. See the continuity of care fact sheet in this toolkit for more information.

PACE - Patients enrolled in a Program of All-inclusive Care for the Elderly (PACE), another option given to certain high-need persons living in areas served by a PACE program, need to receive physician services from providers in the PACE plan's network, and providers must contract with the PACE plan for all Medicare and Medi-Cal payments.

Medicare Advantage Plans or D-SNPs - Patients enrolled in a **Medicare Advantage** plan or **Medicare Advantage Dual Special Needs Plan (D-SNP)** must receive their physician services from providers who are in that plan's network of providers. For Medicare covered services, physicians may receive a capitation from the Medicare Advantage plan or its delegate (IPA or medical group) or may bill fee-for-service depending on their contract.

Medicare Fee-For-Service - Cal MediConnect, PACE and other Medicare managed care plans are voluntary. Dually eligible people may choose instead to receive their Medicare services from Original Medicare (fee-for-service). Billing and payment to Medicare for services for these patients will be the same as it has been in the past, even though dual eligible individuals now have to be enrolled in a Medi-Cal plan. Medicare should be billed and will pay 80 percent of the Medicare fee schedule. **By law, the 20 percent copay cannot be billed to dual eligible patients.**¹

Role of Medi-Cal Plans - Physicians treating dual eligible patients enrolled in a Medi-Cal plan (but not enrolled in Cal MediConnect or PACE) will need to send their "crossover claims" for the 20 percent copay to the patient's Medi-Cal plan, which will pay the physician any amount owed under state law. In some 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.**

It should be noted, however, that state law limits Medi-Cal's reimbursement on Medicare claims to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal's maximum allowed for similar services.² Essentially, this means that if the Medi-Cal rate is 80% or less of the Medicare rate for the service rendered, Medi-Cal will not reimburse anything on these crossover claims.

This is true under Fee-for-Service Medi-Cal and has been state law for over 30 years. 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.

Since Medi-Cal reimbursements are generally lower than Medicare reimbursements, there are few types of services where Medi-Cal owes any reimbursement on Medicare claims.

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."