Briefing: Medicare Crossover Claims, the All-Inclusive Rate, and Dual Eligible Status

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Background

In July of 2017, Nebraska Medicaid and Long-Term Care (MLTC) amended its State Plan to update payment methodologies regarding Medicare Part A and B deductibles and cost-sharing on Medicare crossover claims for Medicaid covered services.[1] This State Plan Amendment (SPA) limited payments by MLTC to zero where the Medicare payment exceeds the Medicaid rate, and introduced a "lesser-of" methodology for payments where the Medicaid rate exceeds the Medicare rate. Since this change in payment methodology, it has introduced problems for the Tribes in Nebraska regarding reimbursement of Medicare crossover claims for Medicaid eligible beneficiaries at the All-Inclusive Rate (AIR).

Initially, MLTC's understanding was that it would be able to reimburse all Tribal Medicare crossover claims with the amended 'lesser-of' payment methodology, using the standard Medicaid rates when applicable. However, CMS advised that the applicable Medicaid rate for Tribal providers in Nebraska for Medicare crossover claims would be the All-Inclusive Rate for beneficiaries who are fully Medicaid eligible and when services rendered to these beneficiaries meets the State Plan definition of a Tribal Encounter (encounter). Additionally, MLTC is required to fully reimburse Indian Health Care Providers (IHCPs).[2] The managed care organizations (MCOs) in Nebraska have since updated their operations regarding Medicare crossover claims to reimburse Tribal providers accordingly. But issues have remained with MLTC reimbursing fee-for-service (FFS) Medicare crossover claims at the AIR. These issues stem from systems limitations, and difficulties with identifying these claims from the provider billing and agency payment standpoints.

The purpose of this briefing is to provide an overview of Medicare crossover claims guidance as it affects the Tribes in Nebraska, and to identify next steps needed by MLTC and the Tribes to ensure that FFS Medicare crossover claims are paid correctly moving forward.

Previous CMS Guidance

After initially updating it's state plan payment methodology for Medicare crossover claims in 2017, MLTC was under the assumption that it would use standard Medicaid rates for reimbursement under the new "lesser-of" payment methodology for all Medicare crossover claims. However, via email correspondence in December 2018, CMS provided clarification to

[1] *See* Nebraska SPA 17-0007

[2] According to federal regulation and NE's State Plan. See 'Federal and State Reimbursement Requirements' section below for more information.

MLTC that alternative measure would need to be taken for reimbursing Medicare crossover claims from IHCPs in Nebraska to ensure that these providers are reimbursed correctly.

The following is the text from the email Nebraska MLTC received from CMS:

> "*The state indicated the… claim was not billed as an encounter, but since it was a crossover claim, I don't believe it could have been filed as an encounter for Medicare reimbursement… We have established that if the claim is for a full dual, meaning someone with full Medicaid benefits, (not a QMB only) and the claim meets the definition of an encounter for the tribal facility rate reimbursement, that the total reimbursement the provider receives should be no less than the encounter rate. For a QMB only, the state's only obligation is for the Medicare cost sharing, so they may pay those claims according to the crossover methodology in the state plan."*

This briefing will outline the underpinning federal and state requirements regarding Medicare crossover claims, as well as how these requirements are to be thought of in the context of Nebraska Medicaid.

Dual Eligibility

It is important to understand what is meant in the above guidance when it refers to an individual as a "full dual" vs "QMB only" and why this distinction matters for the reimbursement of Medicare crossover claims from IHCPs. Individuals who are dually enrolled in Medicare and Medicaid are known as dually eligible beneficiaries, and there are several different dual eligibility categories. The different types of dual eligibility are even categorized (or referred to) differently at the federal vs state level, but the common thread for what constitutes a "full dual" vs other dually eligible beneficiaries is the same throughout.

As CMS notes in their guidance above, a full dual is "someone with full Medicaid benefits" who is also enrolled in Medicare. In order for someone to have full Medicaid benefits, they must meet all eligibility requirements (e.g. income, citizenship, age, etc.) for a Medicaid category that provides medical benefits under MLTC's state plan. In addition to these medical benefits under Medicaid, fully dual individuals are also enrolled in a Medicare Savings Program (MSP).

Medicare Savings Programs (MSPs) are programs that assist low income Medicare beneficiaries with some or all of their Medicare Part A and/or B expenses. Enrollment in MSPs is dependent on the income and resource limits of individuals already enrolled in Medicare Part A and/or B. Enrollment in Medicaid categories is dependent on eligibility criteria defined in MLTC's state plan. Some dually eligible beneficiaries may be enrolled in Medicare Part A and/or Part B, while not eligible for medical benefits under the Medicaid state plan. However, they are still considered dually eligible due to enrollment in an MSP, wherein they qualify for Medicaid to help pay for Medicare premiums and out-of-pocket medical expenses (ie. cost sharing: deductibles, coinsurance, and copayments).

In the above guidance from CMS, "QMB only" refers to one such MSP, the "Qualified Medicare Beneficiaries without other Medicaid." This is one specific dual eligibility category where the individual does not have medical benefits under Medicaid, but Medicaid helps pay for Medicare

costs. Regarding "full duals," there are two MSPs that an individual with full medical benefits under Medicaid could be enrolled in. These are the "QMBs with full-benefit Medicaid" (also known as "QMB Plus") and "SLMBs with full-benefit Medicaid" (or "SLMB Plus") categories. These categories allow the individual to be enrolled in the MSP as well as a Medicaid category that provides medical benefits at the same time. For a comprehensive list of the federal Medicare Savings Programs, and how these overlap with full dual eligibility, see the following document from CMS: Dually Eligible Individuals – Categories.[3]

Operationally in Nebraska, MLTC has its own terminology and categorization around dual eligibility which has been brought about by the Medicaid program's structure and different systems limitations. All dual eligible beneficiaries in Nebraska would fall under MLTC's Aged, Blind and Disabled (ABD), or non-MAGI programs. Resource and income limits for these individuals can be found in state regulation at Title 477 Appendix Chapter 12 (477-000-012). For specific questions about the state's categorization of dual eligility groups, please reach out to the MLTC Tribal Liaison(s).

Federal and State Reimbursement Requirements

In their guidance above, CMS notes that a Medicare crossover claim must first meet the definition of an encounter to be reimbursed at the AIR.[4] Thus it is important to note that only Medicare crossover claims for fully dual eligible beneficiaries could ever meet the definition of an encounter and be eligible for reimbursement at the AIR. Since these beneficiaries are eligible for medical benefits under Medicaid (apart from their enrollment in Medicare), services they receive could therefore also qualify as an encounter under MLTC's state plan. Medicare crossover claims for other dually eligible beneficiaries who do not qualify for medical benefits under Medicaid would therefore not be eligible for reimbursement at the AIR. Since these beneficiaries are not Medicaid-eligible apart from their enrollment in an MSP, services provided to them would not meet the definition of an encounter under MLTC's state plan.

In the guidance provided above, CMS also states that, for Medicare crossover claims which also meet the definition of an encounter, "the total reimbursement the provider receives should be no less than the encounter rate." This is a requirement found in federal regulation and echoed in MLTC's state plan. Federal regulations[5] require that, for services provided to qualifying American Indian beneficiaries, Medicaid agencies "may not reduce the payment it makes to a provider, including an Indian health care provider, by the amount of cost sharing that will otherwise be due" from the individual. This section of federal regulation and language is also mirrored in MLTC's state plan, which states that "Indian Health Care Providers will be paid in full.[6]" As such, for services billed on Medicare crossover claims which also meet the definition of an encounter under Medicaid, Medicare reimburses the provider first, and Medicaid is

[3] Additional information about federal dual eligibility categories can be found in Medicaid's Coordination of Benefits and Third Party Liability handbook, Chapter II, Section E: https://www.medicaid.gov/medicaid/eligibility/downloads/cob-tpl-handbook.pdf

[4] MLTC defines an encounter for Tribal Providers in its state plan at Attachment 4.19-B Item 2d, and in state regulation at 471 NAC 11

[5] 42 CFR 447.56(c)(2)

[6] Nebraska State Plan Attachment 4.18-A, Page 2

required to pay for the remainder of the costs, up to the AIR (if Medicare's payment is less than the AIR amount).

However, for all other Medicare crossover claims for dually eligible beneficiaries who are not eligible for medical benefits under Medicaid, these claims would not meet the definition of an encounter under Medicaid, and thus would not be eligible for reimbursement up to the AIR. In these instances, as noted in CMS's guidance above, "the state's only obligation is for the Medicare cost sharing, so they (MLTC) may pay those claims according to the crossover methodology in the state plan." This is referring to the same 'lesser-of' methodology discussed in the 'Background' section above, which is also known as a negotiated or special rate. Under this methodology, Medicaid is only required to make a payment to providers on Medicare crossover claims if the Medicaid rate for the service provided exceeds the Medicare paid amount. When this is the case, Medicaid either pays the difference between the Medicare payment and the Medicaid rate or the Medicare cost sharing amount, whichever is less. For more information about the Medicare crossover claims payment methodology in MLTC's state plan, see Supplement 1 to Attachment 4.19-B Pages 1-3.

Fee-for-service Crossover Claims Eligible for Reimbursement at the AIR

MLTC utilizes the Heritage Health managed care program, wherein physical health, behavioral health, and pharmacy benefits are combined into a single comprehensive and coordinated program for Medicaid enrollees. These programs are administered by managed care organizations (MCOs), and Medicaid members that are a part of Heritage Health enroll with one of three MCOs to receive their health care benefits. Almost all fully dual eligible beneficiaries in Nebraska are enrolled with an MCO. Crossover claims for Tribal beneficiaries enrolled in managed care are paid by the MCOs up to the AIR when applicable.

There are some individuals that receive medical benefits under Medicaid that are excluded from enrollment in the managed care program.[7] Claims, including crossover claims, for these individuals are reimbursed by MLTC on a fee-for-service (FFS) basis. Most individuals excluded from coverage in managed care are not eligible to receive, or are limited in their receipt of, medical benefits under Medicaid. As a result, services provided to these individuals often do not meet the definition of an encounter, and therefore are not able to be reimbursed up to the AIR.

Some beneficiaries with excess income or resources can still qualify for medical benefits under Medicaid on a FFS basis through Share of Cost programs. Through these programs a beneficiary's medical expenses can be counted against their income, allowing them to qualify for benefits that they otherwise would not be eligible for. Individuals enrolled in Share of Cost programs are excluded from enrollment in managed care and are covered on a FFS basis. Medicaid eligibility for these individuals is determined on a monthly basis, and dependent on whether their monthly share of cost is met.[8] Because their Medicaid eligibility varies month-to-month, individuals in Share of Cost programs are also considered to be intermittently eligible. In a month where eligibility is met for these individuals, they could receive medical benefits under Medicaid, and thus services provided to them could meet the definition of an encounter and be

[7] For a comprehensive list of these exemptions, see state regulations at 482 NAC 2.002.02

[8] See 477 NAC 27.007 and 477 NAC 25 as well as 471 Appendix sections 471-000-79 and 471-000-45 for more information around Share of Cost

reimbursed up to the AIR. This would also be true of intermittently eligible beneficiaries who are also dually eligible.

As of May 2022, FFS crossover claims from IHCPs for these intermittently eligible beneficiaries enrolled in Share of Cost programs have not been reimbursed up to the AIR by MLTC. MLTC's system for FFS reimbursement does not currently have a way to identify crossover claims to be reimbursed at the all-inclusive rate, since crossover claims are first billed to Medicare. IHCPs are unable to add the T-code modifiers (which indicate reimbursement at the AIR) to crossover claims billed to Medicare, and MLTC's FFS systems are unable to identify crossover claims that need to be paid up to the AIR since these claims are received from Medicare. As noted in CMS's guidance above, crossover claims cannot be billed by the Tribes as an encounter for Medicare reimbursement. MLTC is currently working to create a system to identify and reimburse crossover claims from IHCPs up to the AIR as required.

Determining a Beneficiary's Dual Eligibility Status

IHCPs wishing to identify and anticipate FFS reimbursement of crossover claims up to the AIR for intermittently eligible beneficiaries with a Share of Cost can utilize the Nebraska Medicaid Eligibility System (NMES line). This is a dial-up (telephone access) computer system through which enrolled Medicaid providers can obtain information regarding beneficiary Medicaid eligibility.

The NMES line can indicate whether a beneficiary is Medicaid eligible for a given month/year, enrolled in managed care, and covered under Medicare Part A or B. If an intermittently eligible beneficiary with a Share of Cost is Medicaid eligible for a given month/year, not enrolled in managed care, and also covered under Medicare, then crossover claims for these individuals for that month would be eligible for reimbursement by MLTC up to the AIR under FFS.[9] IHCP providers or staff should reach out to the MLTC Tribal Liaison for assistance with reimbursement for these claims. More information on how to utilize the NMES line can be found in state regulation at Title 471 Appendix Chapter 124 (471-000-124).

Conclusion

Reimbursement for crossover claims at the AIR from IHCPs is dependent first on the beneficiary's dual eligibility status. If the individual is fully dual eligible (meaning they are eligible to receive medical benefits under Medicaid in addition to their Medicare benefits), then crossover claims will be reimbursed up to the AIR as long as the services being billed for meet the definition of an encounter under Nebraska's State Plan. The vast majority of crossover claims eligible for reimbursement up to the AIR are for beneficiaries covered under managed care, and the MCOs in Nebraska have been paying these claims correctly since 2020.[10] Crossover claims for fully dual eligible beneficiaries not enrolled in managed care (and thus covered under FFS), are still required to be paid up to the AIR by MLTC. MLTC is currently working with the Tribes

[9] This would also be true for individuals who have received a disenrollment or waiver of enrollment from managed care. For a comprehensive list of individuals not subject to managed care, see 482 NAC 2.002.02. However, please note that some individuals receiving long-term care and waiver services aren't enrolled in managed care, but still receive medical services that are reimbursed by the MCOs.

[10] The MCOs have also reimbursed the Tribes up to the AIR for all applicable crossover claims billed prior to their 2020 system and payment updates.

to reimburse past crossover claims up to the AIR where necessary, and to update internal systems and processes to ensure proper payment of these claims going forward. The Tribes can also utilize the NMES line in order to help track and anticipate reimbursement for FFS crossover claims at the AIR.