Medicare Demystified

A workshop for CareOregon Behavioral Health providers

careoregonadvantage.org

Questions can be submitted in the Q&A throughout the meeting.

Include your email & organization in your comments and questions

Please stay on mute, unless speaking up

During Q&A Wrap up, please raise your hand if you'd like to speak

This meeting is recorded -Feel free to keep your camera off

Thank you for joining us!

CareOregon® Advantage

Please find common Medicare acronyms, terms, and helpful resources in the handout shared in chat.

CareOregon® Advantage

Overview of CareOregon Advantage

Anna Lynch

Director, Medicare Network Performance

careoregonadvantage.org

CareOregon® Advantage

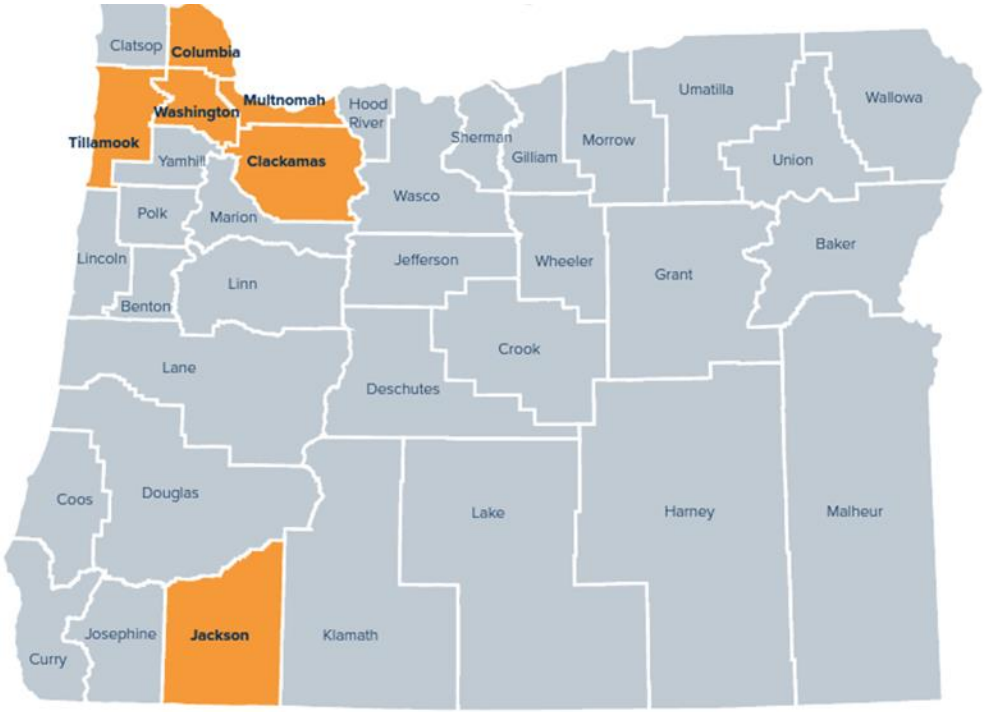
What is CareOregon Advantage?

- CareOregon Advantage (HMO-POS D-SNP) is a Medicare Advantage health insurance program for members that are Full Benefit Dual Eligible (FBDE) in both Oregon Medicaid and Medicare.
- Supplemental Medicare Benefits go beyond traditional Fee For Service Medicare.
- Plans may change their Supplemental Benefits from year to year.

CareOregon® Advantage

Who is CareOregon Advantage

- Our members are below the Federal Poverty Line (Medicaid) *AND* are either 65 years-old or older, OR disabled (Medicare).
- CareOregon Advantage operates in Multnomah, Washington, Clackamas, Columbia, Tillamook, and Jackson Counties. (HSO, JCC, CPCCO).
- We have just over 17,500 members

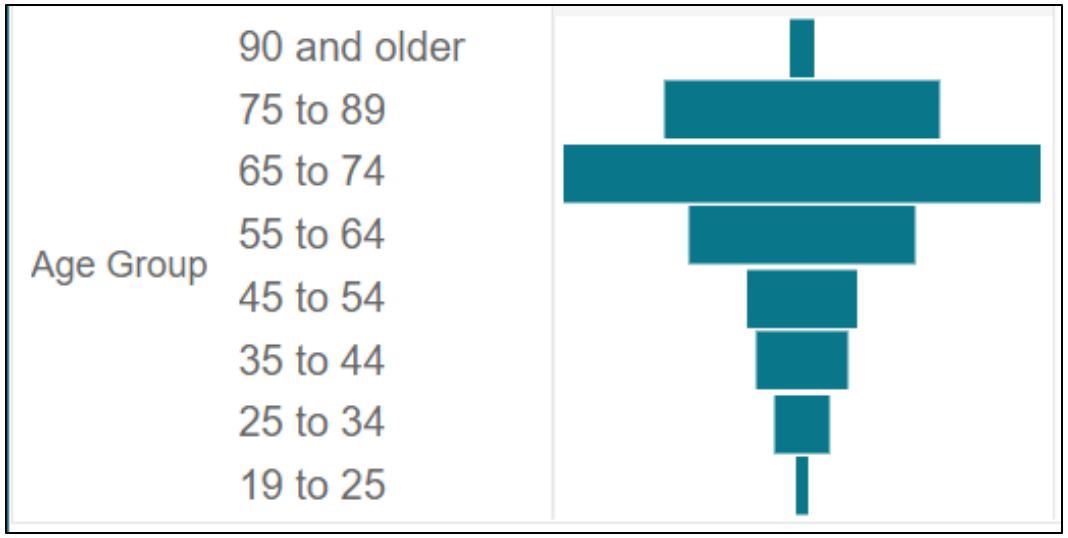


CareOregon Advantage Plus Service Area

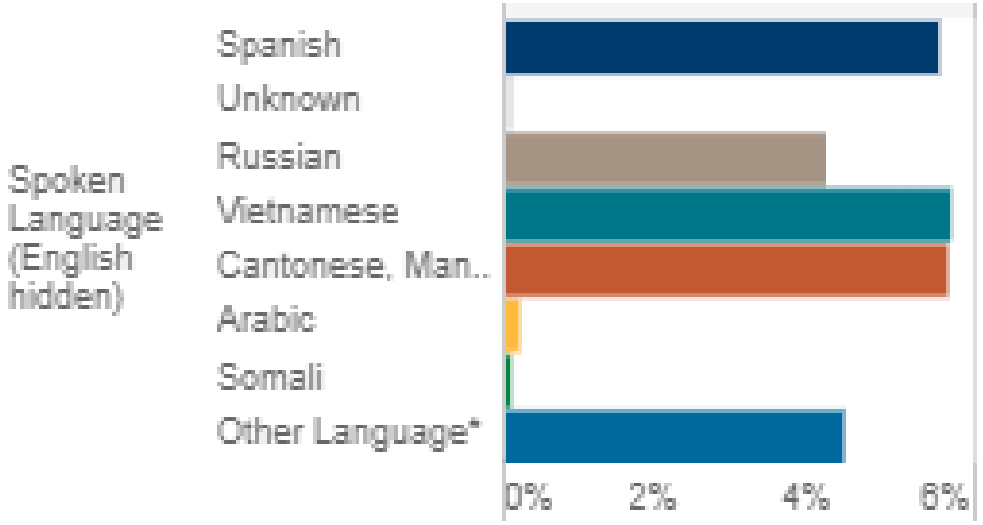
CareOregon Advantage

Who are CareOregon Advantage Members

Age Profile



Languages Spoken Other than English



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Who are CareOregon Advantage Members

BH Diagnoses Profile

Disease/Condition	Precent of CareOregon Medicaid Member	Percent of CareOregon Advantage members
Bipolar	1.9	5.6
Depression	16.8	39.1
Schizophrenia	1.7	8.3
Substance use disorder	7.8	11.8

CareOregon Advantage

2024 Benefits (above and beyond FFS MA)

CareOregon Advantage Plus HMO-POS SNP

- $0 Monthly Premium
- $0 copays on Medicare covered services
- Part-D included with reduced cost-sharing
- $405 per quarter

Medicare's Behavioral Health Benefit

Matthew Hatch

Behavioral Health Planning & Operations Manager

careoregonadvantage.org

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BH and Medicare

History 1960-Present

- Mental Health services have been part of Medicare benefits since its inception in the 1960's.
- However, between its inception and 2024 provider types were limited to mostly: LCSW, Psychologists, and LMP (PMHNP and MD)
  - This left a large gap for individuals needing services.
    - E.g, those with Medicare only needing community mental health supports.
  - Caused possible confusion in organizations with multiple provider types

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BH and Medicare

History 1960-Present

- In 2023 CMS issued changes to it rule set to allow for Licensed Marriage and Family and Licensed Professional Counselors.
  - According to CMS this is an added 400,000 providers now eligible to serve Medicare members.

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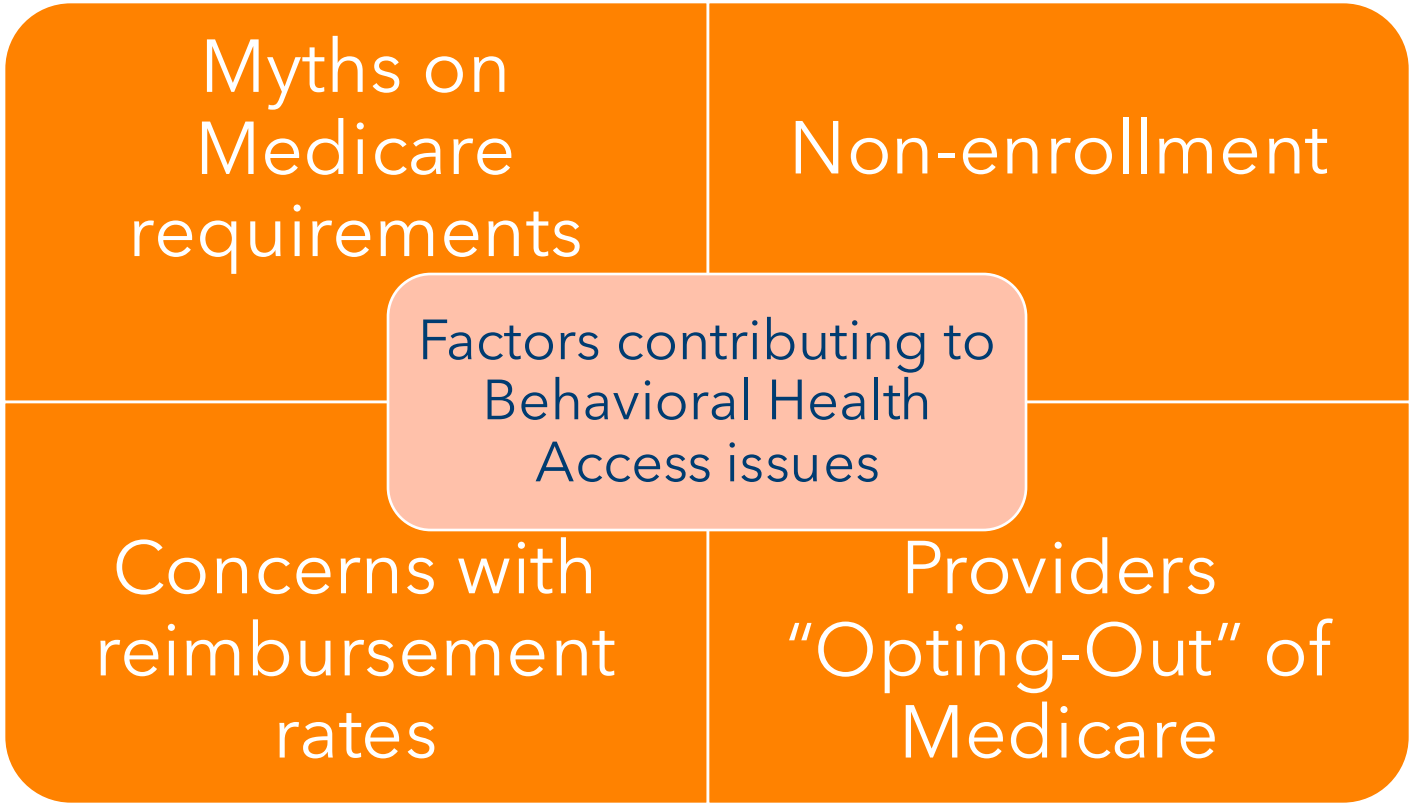
BH and Medicare

Despite the allowance of LMFT and LPC, we are still seeing gaps in BH coverage.



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Medicare Enrollment

Maig Tinnin

Behavioral Health

Provider Relations Supervisor

careoregonadvantage.org

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Medicare Enrollment Basics

- Medicare enrollment allows healthcare providers to receive payment from Medicare
- Enrollment (PTAN) is necessary for both traditional Medicare and Medicare Advantage plans
- Institutional facilities have a Medicare enrollment process that is facility-specific (Medicare Enrollment Guide for Institutional Providers)
- Organizational enrollment is required for organizational (Group NPI) billing

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Medicare- eligible providers currently billing CareOregon for Medicaid services are expected to enroll in Medicare

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Medicare Enrollment Basics

BH provider types eligible to enroll

- Physicians with eligible specialty type
- Clinical Social Worker (CSW)
- Marriage and Family Therapist (LMFT)
- Mental Health Counselors (LPC)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Psychologists

BH provider types NOT eligible to enroll

- Registered Associates including:
  - Registered Counselor Associate
  - Registered Social Work Associate
- CADC
- Peer Support Specialist

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Application

- Complete the Medicare Enrollment Application – may take 60-90 days
- Online Application: pecos.cms.hhs.gov/pecos
- Paper Application – CMS.gov/medicare/enrollment-renewal
- Select a Specialty Designation

Approval

- Once approved, providers will receive an enrollment letter from the MAC (Noridian for Oregon providers) that includes an effective date and PTAN

Update CareOregon

- Email BHProviderDataUpdates@careoregon.org **with copy of enrollment letter**
- Once received, CareOregon will update the provider profile within 30 days and reprocess claims based on effective date in letter

Helpful Resources

CMS FAQ on enrollment for LPCs/LMFTs

- Marriage and Family Therapists and Mental Health Counselors FAQs (cms.gov)

Oregon Part B providers can get enrollment support through Noridian

- Enroll in Medicare - JF Part B - Noridian (noridianmedicare.com)

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TRUE or FALSE?

"Opting out" of Medicare with CMS allows providers to be paid by Medicaid benefit for services to dual-enrolled members.

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CMS "Opt-Out" Process and Implications

Jonique Dietzen CPC

Director, Payment Integrity

careoregonadvantage.org

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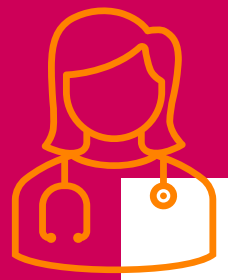
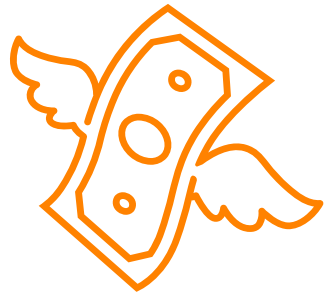
What is CMS Opt-Out?



Physicians and practitioners who do not wish to enroll in the Medicare program may "opt-out" of Medicare.

This means that neither the physician, nor the beneficiary submits the bill to Medicare for services rendered.



Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare.

Note: Exceptions to pay Opt-Out providers can be made for urgent and emergent situations

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Specifics on the CMS Opt-Out process

Physicians and practitioners must submit a signed affidavit to their Medicare Administrative Contractor (MAC) expressing his/her decision to opt-out of the Medicare program.

Opt-out periods last for two years and cannot be terminated early unless you are opting out for the very first time and you terminate your opt-out no later than 90 days after the effective date of your first opt-out period.

Only certain provider-types allowed to Opt Out.

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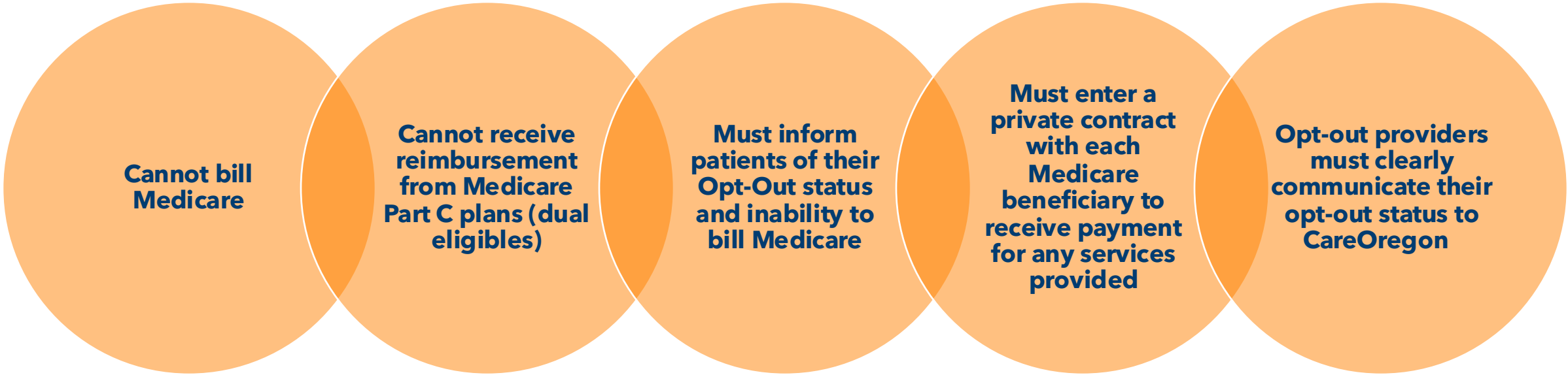
Responsibilities of Opt-Out providers



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Opt-Out private pay agreements are not allowed for OHP covered services provided to dual-enrolled members

Oregon Health Authority

OHP Client Agreement to Pay for Health Services

Oregon HEALTH PLAN

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000. The client agrees to pay for service(s) not covered by the Oregon Health Plan (OHP), the Oregon Health Authority (OHA) or OHA-contracted managed care entities (MCEs).

Provider section

① Provider completing this form is *(check one)*:

☐ Rendering provider *(the person providing the service)* ☐ Prescribing provider

☐ Hospital ☐ Pharmacy ☐ Ancillary *(other)* provider:

② Services requested. These include, but are not limited to, treatment, equipment, supplies and medications.

Service codes *(CDT/CPT/HCPCS/NDC)*:

OAR 410-120-1280

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Implications of CMS Opt-Out

Providers should NOT opt-out if they intend to furnish services covered by traditional Medicare fee-for- service (Part B) or Medicare Advantage.

Not enrolling in Medicare and 'opting out' of Medicare via affidavit are two different things

Providers will be unable to serve existing clients that become Medicare eligible during the opt-out period

Contributes to access barriers Medicare beneficiaries experience

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Medicare Billing

Jane Speyer

Director, Operations

careoregonadvantage.org

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TRUE or FALSE?

If a provider is not contracted with CareOregon Advantage, they can still provide Behavioral Health Services to COA members.

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Medicare Claim Submission

If billing for members with CareOregon Advantage primary coverage: bill CareOregon and a secondary Medicaid claim will be created automatically after the COA benefit processes.

If billing for members with Noridian FFS Medicare, CareOregon will receive a crossover claim automatically

If billing for members enrolled in an external Medicare Advantage plan: bill the primary benefit plan first and then submit secondary claim to CareOregon with the EOB included.

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CareOregon Advantage Claims Processing

CareOregon Advantage and CareOregon have the same payer ID

CareOregon's claims processing system is designed to process all claims through the CareOregon Advantage Medicare benefit first.

Next, a secondary claim for Medicaid is created the day after the Medicare claim pays.

For CareOregon Advantage members, there is no way for providers to designate that a claim is billed only to the member's Medicaid benefit.

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When are EOBS required for payment?

-

EOB Required

Medicare-eligible provider type rendering a Medicare covered service

EOB Not Required

Medicare ineligible provider type rendering a Medicare covered service

(Ex: Registered associate billing for psychotherapy codes)

OR

Services not covered by Medicare

(Ex: H codes)

CareOregon Advantage

Medicare Rates & Fee Schedules

Out of Network

Behavioral Health is an out-of-network benefit for Medicare members.

However, eligible provider types must be enrolled with Medicare to receive payment.

Out of Network

If providers are billing out-of-network, claims will process at rates outlined in the CMS Fee Schedule.

Found online at : **Search the Physician Fee Schedule | CMS**

COA Contracted

Providers contracted with CareOregon Advantage should reference their contract and fee schedule for rate information

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REMINDER

As of July 1st, 2024 CareOregon requires EOBs for Medicare covered services provided by LPCs & LMFTs.

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Common points of confusion

- **Medicaid is the payer of last resort.** If a provider is eligible to enroll in Medicare, CareOregon expects enrollment and billing to Medicare first. Medicaid pays secondary to Medicare.

- Medicare denial letters are sent to members when the service is not covered by Medicare. Even if the provider didn't realize the claim would be processed by CareOregon Advantage.
  - CO is required to mail denial letters to members when CareOregon Advantage denies claims.

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Coding and Documentation Differences

Between Medicare and Medicaid services

Medicare pays higher when the POS is office vs. facility setting	• CMS Place of Service Codes information
H codes & T codes (and some others) aren't covered by Medicare	• H-codes, T-codes, 90882, 90882 HN, G0176, G0176 GO, G0176 HQ, G0177, G0177 HQ, and S9480
Higher likelihood of chart note requests for Medicare services	• Noridian resources on Mental Health Documentation Requirements

CareOregon Advantage

Prior Authorizations for Medicare

Maig Tinnin

Behavioral Health

Provider Relations Supervisor

careoregonadvantage.org

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Services Requiring Prior Authorization

For services requiring prior authorization, the auth numbers must be submitted on the claim form for claims to process and pay correctly.

If a member has Non-CareOregon Medicare (e.g. Medicare AB) and OHP secondary with CareOregon, an authorization is **not** required

- The provider can submit claims for secondary costs along with an Explanation of Benefits (EOB) directly to CareOregon without requesting an authorization.

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Services Requiring Prior Authorization continued . . .

If Non-CareOregon Medicare denies payment of services or does not cover a service, and member has secondary OHP with CareOregon, the provider can request that CareOregon pay primary & secondary costs that were not covered by Medicare.

- If it is a service that requires clinical review, the provider will need to submit an authorization request to CareOregon.
- A Behavioral Health Clinician will review the request. If the request is approved, then payment will be rendered.
- Provider will be required to submit an EOB with their claims

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Contracting with CareOregon Advantage

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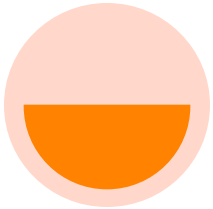
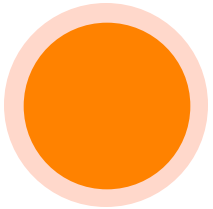
Contracting with CareOregon Advantage

COA contracted providers receive higher rates for BH services than out of network providers. To request a contract, follow these steps:



If you are already contracted with CareOregon for Medicaid BH Services but not CareOregon Advantage >

Email: contractmanager@careoregon.org with your request to add CareOregon Advantage to your existing BH contract



If you are not yet contracted with CareOregon for BH Medicaid services OR CareOregon Advantage>

Email: MetroBHPRS@careoregon.org to request a CareOregon Advantage BH contract

CareOregon Advantage

TRUE or FALSE?

Providers that contract with CareOregon Advantage are mandated to serve any and all Medicare beneficiaries who request their services.

CareOregon® Advantage

Misconceptions and common myths have kept providers from enrolling and contracting with Medicare.

CareOregon Advantage contracted providers are not required to provide services to any/all Medicare beneficiaries.

Just like Medicaid contracted groups, providers can make business decisions on who they are able to serve.

CareOregon Advantage is a

D-SNP Medicare Advantage plan, meaning all members qualify for both Medicare and Medicaid benefits.

Our members do not pay premiums.

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Resources and Pathways for Support

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Questions

Provider Customer Service

Real-time issue support: Benefits, Eligibility, Auth and Claims questions that can't be answered in Connect Portal

Connect Portal

***NEW* Secure Messaging and Forms**, *Eligibility, Claim Status, Claim payment info, Remits, Auth status, Auth submission*

CareOregon Website

Provider resources and forms, BHSI FAQ, QDP details and instructions

Provider Relations

Training requests

Issues impacting a large number of claims and/or large dollar amounts

Contracting questions

Metro Bh Provider Relations: MetroBHPRS@careoregon.org

Phone Numbers & more!

Provider Customer Service: *800.224.4840 (option 3)*
Metro BH provider Relations *email: MetroBHPRS@careoregon.org*

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QUESTIONS?

We value your input!

Providers can submit more complex or provider-specific questions to our team of experts here 24/7:

Online Question Intake Form

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Thank you!

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