

The Physician's Role in Managed Care for Members with Special Needs (including Medicare Advantage Dual-Eligibles)

Whenever you arrange for a member's transition between care settings (e.g., from a home to a hospital, or from a hospital to hospice), there are some important steps you need to take and information you need to know.

What you need to do:

- Inform the member (or the member's representative) of the care transition process.
- Inform the member (or the member's representative) about changes to the member's health status and plan of care.
- Share your care plan with the new care setting within one business day of notifying the member or member's representative of the transition.

What you need to know:

- Federal law bars Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program. The QMB program is a dual-eligible program that exempts individuals from Medicare cost-sharing liability. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997.
- Members cannot be balance billed if they are not responsible for their Medicare Part A and Part B cost-shares.
- Further, Medicare Advantage enrollees cannot be discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Discrimination based on "source of payment" means that Medicare Advantage providers cannot refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid Program.

Members who are eligible for both Medicare and Medicaid (dual eligibles) may have certain services covered by Medicaid. To find out which benefits are covered by Medicaid, please call Provider Service at 1-877-327-1395.

