DEPARTMENT OF HEALTH & HUMAN SERVICES
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***CMCS Informational Bulletin***

**DATE:** December 14, 2023

**FROM:** Daniel Tsai, Deputy Administrator and Director
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**SUBJECT:** Guidance to State Medicaid Agencies on Dually Eligible Beneficiaries Receiving Medicare Part B Marriage and Family Therapist Services, Mental Health Counselor Services, and Intensive Outpatient Services Effective January 1, 2024

The Center for Medicaid and CHIP Services (CMCS) is issuing this CMCS Informational Bulletin (CIB) to advise state Medicaid agencies that starting on January 1, 2024, Medicare will begin covering and making payment for the services of marriage and family therapists (MFT) and mental health counselors (MHC), and intensive outpatient program (IOP) services as authorized by Sections 4121 and 4124, respectively, of the Consolidated Appropriations Act, 2023 (CAA, 2023) (P.L. 117-328, enacted on December 29, 2022). These provisions were implemented as part of the Calendar Year (CY) 2024 Physician Fee Schedule final rule (Centers for Medicare & Medicaid Services (CMS)-1784-F, "Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2024") and the CY 2024 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) final rule (CMS-1786-F), issued on November 2, 2023.

For dually eligible beneficiaries (those enrolled in both Medicare and Medicaid) who receive Medicaid coverage of services furnished by MFTs or MHCs, or IOP services furnished by hospital outpatient departments, community mental health centers (CMHC), rural health clinics (RHC), federally qualified health centers (FQHC), or opioid treatment programs (OTP), beginning on January 1, 2024, Medicare will become the primary payer for these services provided by Medicare-enrolled practitioners or providers. CMS expects that most facilities that will begin furnishing Medicare-covered IOP services in CY 2024 will already be enrolled as providers under Medicare. However, not all MFTs and MHCs will have completed the Medicare enrollment process and be able to bill Medicare for MFT or MHC services by this date. In an effort to prevent any disruption in treatment for dually eligible beneficiaries, CMS is providing background information on the enrollment of MHCs, MFTs, and providers of IOP services and is providing clarification on options available for coordination of benefits/third party liability under Medicaid.

## Background

Typically, State Medicaid agencies may not pay claims if it is likely that a third party (such as Medicare) is liable for the claim, as Medicaid is generally the payer of last resort. For dually eligible beneficiaries, Medicare is generally liable for claims for Medicare-covered services,

including MFT services, MHC services, and IOP services furnished on or after January 1, 2024, and thus State Medicaid agencies are required to cost-avoid claims for such services, or seek reimbursement from the practitioner or provider. Currently, MFTs and MHCs provide services that can be covered as an optional state plan benefit such as services of other licensed practitioners under the Medicaid state plan. IOP services are generally covered through the optional rehabilitative services benefit under the Medicaid state plan.

MFTs and MHCs could begin submitting their Medicare enrollment applications after the CY 2024 PFS final rule was issued on November 2, 2023. The effective date of a MFT's or MHC's enrollment may be up to 30 days prior to the submission of the enrollment application to Medicare, but no earlier than January 1, 2024, which is the date the new benefits authorized by the CAA, 2023 take effect. Newly Medicare-enrolled MFTs and MHCs will not be granted an effective date earlier than January 1, 2024, and claims with dates of service prior to January 1, 2024, will not be payable by Medicare. Further, facilities that are newly enrolling in Medicare to furnish IOP services will not receive Medicare payment for IOP services for dates of service prior to January 1, 2024.

Medicaid-enrolled MFTs and MHCs, and IOP service providers interested in becoming Medicare-enrolled should follow the enrollment instructions found here. State Medicaid agencies may confirm a MFT or MHC's Medicare enrollment status and effective date of enrollment in Medicare using the Provider Enrollment Chain and Ownership System (PECOS) or PECOS extract files.

In order for State Medicaid agencies to promote continuity of care for dually eligible beneficiaries during this transition period, CMS is clarifying ways Medicaid can pay for services delivered by providers who are not yet enrolled in Medicare while upholding their responsibilities to be the payer of last resort. However, States are encouraged to reach out to their Medicaid-enrolled MFTs and MHCs, and to IOP service providers to advise them to enroll as quickly as possible in Medicare.

**Coordination of Benefits and Third-Party Liability Options for States**

While CMS anticipates that some MFTs, MHCs, and IOP service providers will become Medicare-enrolled on or around January 1, 2024, many others will not be Medicare-enrolled by that date. MFTs, MHCs, and IOP service providers cannot submit claims to Medicare or receive payment or even a denial of payment from Medicare unless they are enrolled in Medicare. Newly Medicare-enrolled MFTs, MHCs, and IOP service providers can get a retrospective billing date for up to 30 days prior to the effective date of their Medicare enrollment, but no earlier than January 1, 2024.

States must pay claims for IOP services and services provided by MFTs and MHCs delivered to dually eligible beneficiaries by Medicaid-enrolled providers who are not yet enrolled or choose not to enroll in Medicare, to the extent that the services are covered in the state plan. To prevent any disruption in IOP services and services provided by MFTs and MHCs for dually eligible beneficiaries, states have a few options during the interim until Medicare approves the practitioner's or provider's enrollment:

1) The state may choose to continue to pay MFTs, MHCs, and IOP service providers for claims for dually eligible individuals for a period in early 2024. A state may do so by not imposing systems edits to automatically reject claims at the start of 2024. Alternatively, a state may do so by suspending claims for dually eligible beneficiaries from MFTs, MHCs, and IOP service providers until it is able to manually confirm the MFT, MHC, or the IOP service provider's Medicare enrollment. Once the state verifies Medicare as a liable third party (that is, once the state verifies that the provider is enrolled in Medicare), the state must seek reimbursement within 60 days from the end of the month in which it learns of the provider's enrollment with Medicare.

Once a MFT, MHC, or IOP service provider becomes Medicare-enrolled, Medicaid must recoup ("chase") all Medicaid payments from the MFT, MHC, or IOP service provider back to the effective date of the MFT's, MHC's, or IOP provider's Medicare provider enrollment, and advise the provider to bill Medicare to receive payment for these services.

2) A state may advise MFTs, MHCs, and IOP service providers they can hold claims and bill Medicare once the provider becomes Medicare-enrolled. This process will allow Medicare to review the claim and then cross the claim to Medicaid for payment automatically.

**Managed Care**

If services provided by MFTs and MHCs, or IOP services are covered under the Medicaid state plan and delivered through a managed care delivery system that includes dually eligible enrollees, states must ensure that their managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans (referred to as "managed care plans") are notified in a timely manner of which claims processing option described above they should employ and should evaluate if the selected option impacts capitation rate development as appropriate. States must also ensure that their managed care plans can process timely and accurate claims payments to avoid any disruption or delay for enrollees in accessing these services.

States are reminded that Medicaid managed care plans may have additional obligations to ensure parity in the coverage of mental health and substance use disorder benefits compared to medical/surgical benefits, consistent with 42 CFR part 438, subpart K and 438.3(n).

**Conclusion**

As CMS implements the provisions of the CAA, 2023, our top priority is ensuring that people have better access to treatment. States are encouraged to consider the best ways to achieve that goal, especially as Medicare participation evolves over time. As always, CMS is happy to provide technical assistance to states on the information outlined in this bulletin.

For specific questions related to third party liability, you may contact Ginger Boscas, Deputy Director within the Division of Health Homes, PACE, and Coordination of Benefits/Third Party Liability at Ginger.Boscas@cms.hhs.gov.