When *NOT* to Collect from the Patient

BY CINDY PARMAN, CPC, CPC-H, RCC

As reimbursement continues to shrink through bundling, packaging, service consolidation, and other changes to insurance payment systems, many providers are training staff to collect coinsurance, deductibles, co-payments, and other patient cost-shares at the time of service. In addition, patients today are often responsible for a more sizeable portion of their medical bills, which means that the patient's financial responsibility is the largest it has been since the implementation of healthcare coverage. For the purposes of this article, deductible is defined as the amount an insured individual is responsible for payment, generally on an annual basis, prior to receiving most medical services. Co-payment is defined as the set dollar amount paid by a patient—regardless of whether or not the deductible has been met; coinsurance is defined as the amount the patient pays for each service performed after the deductible is met, generally a percentage of the insurance payment amount.

Healthcare providers could lose significant income if patients are billed after treatment has been performed.[1] Specifically, asking patients for payment after treatment has been provided may result in additional staff time, postage, and printing costs. Collecting the patient payment amount at the time of service—while the patient is still in the office—is efficient and ensures that the total charge for the service or procedure is received.

But what if the patient is a qualified Medicare beneficiary? In 2014 there were 53.8 million Medicare beneficiaries,[2] with approximately 7 million of this total population enrolled in the Qualified Medicare Beneficiary program. (See Table 1, right, for the Qualified Medicare Beneficiary eligibility and benefits.) The 2017 Medicare Physician Fee Schedule (PFS) Final Rule published by the Centers for Medicare & Medicaid Services (CMS) provided a reminder related to this specific beneficiary group:[3]

Although we [CMS] *did not solicit comments on this statement of current law and policy, we appreciate the comments received, which included comments from national beneficiary advocacy organizations, and professional, insurance, and medical billing associations.*

Comment: Commenters concurred that confusion and improper QMB [Qualified Medicare Beneficiary] *billing problems remain pervasive and affirmed their negative toll on beneficiaries. Commenters were supportive of CMS's expanded efforts to educate providers regarding QMB billing rules to reduce the incidence of improper QMB billing. Some commenters also noted that Medicare providers encounter difficulties discerning which patients are QMBs and advised CMS to adopt strategies to help providers ascertain this information. Additionally, one commenter noted that the variation in state policies to pay providers for Medicare cost-sharing fuels confusion, frustration and compliance problems.*

Response: We continue to pursue opportunities to educate providers and welcome partnering with commenters and others in these efforts. Currently, Medicare providers must determine a patient's QMB status through information from State Medicaid agencies, including online eligibility systems and beneficiary identification cards. We are actively exploring additional mechanisms for Medicare providers to readily identify the QMB status of patients.

We are restating information to inform providers to take steps to educate themselves and their staff about QMB billing prohibitions and to exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Qualified Medicare Beneficiaries

According to *MLN Matters SE1128*, revised January 12, 2017,[4] the Qualified Medicare Beneficiary program is a state Medicaid benefit that covers Medicare deductibles, coinsurance, and co-payments, subject to state payment limits. This program was designed to ensure full access to the Medicare benefit for the lowest income enrollees by covering the deductible and other cost-sharing. Qualified Medicare Beneficiary enrollees are the largest eligibility group within the Medicare-Medicaid enrollee population. Qualified Medicare Beneficiary enrollees apply for this benefit with their state's Medicaid program, and eligibility is re-determined annually.

Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997[5] defines reimbursement and balance-billing for the Qualified Medicare Beneficiary program. This legislation clarified that a state is not

obligated to pay providers up to the full amount of Medicare cost-sharing if the total payment (including both the Medicare portion and the state's portion) would exceed the state's Medicaid rate for the service.

The vast majority of states limit Medicare cost-sharing payment levels for Qualified Medicare Beneficiary enrollees and other full-benefit dual-eligible beneficiaries at their Medicaid rates. And Medicare providers must accept assignment of the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a Qualified Medicare Beneficiary enrollee.

As a result, Medicare providers may *not* balance bill Qualified Medicare Beneficiary individuals for Medicare cost-sharing, regardless of whether the state reimburses providers for the full Medicare cost-share amounts. All original Medicare and Medicare Advantage providers (not only those who accept Medicaid) are required to follow these guidelines.

According to CMS, Qualified Medicare Beneficiary individuals retain their protection from balance billing when they cross state lines to receive care. In other words, providers cannot charge these individuals even if the patient's Qualified Medicare Beneficiary benefit is provided by a different state than the state in which the care is rendered. In addition, enrollees in the Qualified Medicare Beneficiary program cannot choose to "waive" their Qualified Medicare Beneficiary status and pay Medicare cost-share amounts. This means that providers may not accept these patients as self-pay in order to bill the patient directly; providers must accept Medicare assignment for all Medicaid patients, including those in the Qualified Medicare Beneficiary program.

NO Balance Billing

The CMS publication, "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)," dated July 2015[6] includes two studies, one of which evaluates whether Qualified Medicare Beneficiary enrollees are inappropriately balance billed. Findings that resulted from the interviews performed by the Lewin Group include:[6]

1. Providers incorrectly balance billed participants for Medicare cost-sharing; most participants paid these bills and unpaid bills were incorrectly submitted to collection agencies.
2. Participants and providers found billing processes confusing or complex.

Table 1. Qualified Medicare Beneficiary Eligibility & Benefits

DUAL ELIGIBILITY	ELIGIBILITY CRITERIA	BENEFITS
Qualified Medicare Beneficiary	• Resources cannot exceed $7,280 for a single individual or $10,930 in 2015 for an individual living with a spouse and no other dependents. • Income cannot exceed 100% of the Federal Poverty Level (FPL) +$20 ($1,001/month, Individual or $1,348/month, Couple in 2015). NOTE: These guidelines are a federal floor. Under Section 1902(r)(2) of the Social Security Act, states can effectively raise these limits above these baseline federal standards.	Medicaid pays Medicare Part A and B premiums, deductibles, coinsurance, and copays to the extent required by the state Medicaid Plan. • Exempts beneficiaries from Medicare cost-sharing charges. • The state may choose to pay the Medicare Advantage (Part C) premium.
Qualified Medicare Beneficiary Plus	Meets all of the standards for Qualified Medicare Beneficiary eligibility as described above, but also meets the financial criteria for full Medicaid coverage.	Provides all benefits available to Qualified Medicare Beneficiary enrollees, as well as all benefits available under the state plan to a fully eligible Medicaid recipient.

Overall, the study found that in spite of laws aimed at protecting beneficiaries from being billed the Medicare cost-share, this practice is still in effect. In addition, in states that adopted this "lesser-of" policy, providers ultimately may not be reimbursed the full amount for their services to Qualified Medicare Beneficiary enrollees. According to the CMS publication, "Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs," Medicare-covered services also covered by Medicaid are paid first by Medicare because Medicaid is generally the payer of last resort.[7] In general, Part B providers—including physicians and hospitals—are paid 80 percent of a service's Medicare rate by the federal program. A non-Qualified Medicare Beneficiary beneficiary would receive the bill for the 20 percent balance. However, since Qualified Medicare Beneficiary enrollees cannot be balance-billed, the provider would instead bill the balance to the state Medicaid program, which is only required by federal statute to cover a service up to its Medicaid rate. This means that when the Medicare payment exceeds the Medicaid rate, states have no obligation to pay any additional amount.

For example, if the Medicare allowable for a service is $100, and the beneficiary cost-share is 20 percent, Medicare would pay $80 and the beneficiary would pay $20. If the patient has Qualified Medicare Beneficiary status, and the state Medicaid allowed $78 for the same service, there would be no additional payment to the provider and the patient could not be balance-billed for any cost-share.

Recommendations

CMS recommends that providers and their billing staff be aware of the federal balance billing law and policies regarding Qualified Medicare Beneficiary individuals. Start by contacting the Medicaid Agency in the state(s) where Medicare beneficiaries live to learn about ways to identify Qualified Medicare Beneficiary patients. Determine what identification cards are issued to Qualified Medicare Beneficiary individuals and verify which patients have them. Find out if state systems can be queried to verify Qualified Medicare Beneficiary enrollment for the local patient population. Contact Medicare Advantage plans directly to determine how to identify the plan's Qualified Medicare Beneficiary enrollees.

All Medicare providers should ensure that their billing software and administrative staff exempt Qualified Medicare Beneficiary individuals from Medicare cost-sharing billing and related collection efforts. For example, if a claim is automatically crossed over to another payer, such as Medicaid, it is generally noted on the Medicare Remittance Advice.

On Feb. 3, 2017, CMS released *MLN Matters MM9911* stating that effective for claims processed on or after Oct. 2, 2017, a Qualified Medicare Beneficiary indicator will be included on the Provider Remittance Advice and to beneficiaries on their Medicare Summary Notice to reflect that the beneficiary is enrolled in the Qualified Medicare Beneficiary program and has no Medicare cost-sharing liability.[8] One or more of the following Remittance Advice Remark Codes will be included:

- ***N781:*** No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible, or co-payments.
- ***N782:*** No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible, or co-payments.
- ***N783:*** No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible, or co-payments.

In addition, the Medicare Administrative Contractors (MACs) will include a Claim Adjustment Reason Code of **209**:

Per regulatory or other agreement. The provider cannot collect this amount from the patient. Refund to patient if collected.

Last, the Medicare Summary Notice will be modified to inform beneficiaries that if they are enrolled in the Qualified Medicare Beneficiary program they cannot be billed for Medicare cost-sharing for covered items and services.

Provider Penalties

According to CMS, providers who inappropriately balance bill Qualified Medicare Beneficiary individuals are violating their Medicare Provider Agreement and may be subject to sanctions, such as development of a corrective action plan, monetary sanctions, and increased reporting requirements. While a provider may eventually be excluded from the federal healthcare program, exclusion is relatively rare and only occurs if the provider fails to become substantially compliant during the corrective period.[9]

These days, more insured patients owe higher deductibles, co-payments, and coinsurance amounts. In addition, it is important to make sure these patients pay their cost-share amount before walking out the door after a visit or treatment. Administrative costs and low collection rates make after-the-fact collections a losing proposition for many healthcare entities. Effective collection keeps providers in business, allows the hire of quality employees, and enables the provision of exceptional, quality-focused patient care.

However, despite federal law, CMS continues to be concerned that erroneous balance billing of Qualified Medicare Beneficiary individuals persists. Many beneficiaries are unaware of the billing restrictions, or may be concerned about undermining the provider relationship if they refuse to pay the requested amount. Others may experience undue stress

when unpaid bills are referred to collection agencies.

In addition to reviewing national CMS guidelines, providers should review local Medicare contractor information. For example, Noridian Healthcare Solutions includes not only basic information on Qualified Medicare Beneficiary individuals, but also sample beneficiary and provider compliance letters relating to balance-billing these enrollees.[10]

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