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Balance Billing Protections

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National Senior Citizens Law Center

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at www.NSCLC.org.

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JUSTICE IN AGING

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What is Balance Billing of Duals?

- Balance billing is the practice in which providers, particularly physicians, seek to bill:
  - (1) dual eligibles for charges not entirely covered by either Medicare or Medi-Cal; or
  - (2) Medi-Cal only SPDs any amount for a Medi-Cal covered service.

Payment of Medicare Services for Dual Eligibles

Medicare pays 80 percent of the Medicare rate.

Medi-Cal covers the remaining 20 percent.*

Balance Billing is Illegal

Balance billing violates both federal and California law.

Federal law protects "qualified Medicare beneficiaries."

State law protects all Medi-Cal beneficiaries.

Balance Billing is Illegal

Federal Law

Providers cannot bill qualified Medicare beneficiaries. Any payment (if any) made by the State Medicaid plan shall be considered payment in full. Provider will be subject to sanctions.

Federal law: 42 U.S.C. 1396a § 1902(n)(3)(B)

Balance Billing is Illegal

State Law

A provider of health care services who obtains proof of Medi-Cal eligibility cannot seek reimbursement nor attempt to obtain payment for the cost of those covered health care services. The provider will be subject to sanctions.

State law: Cal. Welf. & Inst. Code §14019.4

Balance Billing is Illegal

These laws apply to Medicare providers regardless of whether the Medicare plan accepts Medi-Cal.

CCI Case Example: Ms. Smith

- Ms. Smith is a dual eligible and lives in a CCI county. She opts out of Cal MediConnect and picks a Medi-Cal managed care plan. She visits her Medicare fee-for-service doctor for a regularly scheduled office visit. Although the doctor typically bills Medicare and Medi-Cal for her visits, he does not have a contract with Ms. Smith's new Medi-Cal plan. He bills her for the charges that Medicare did not pay.

Under no circumstances may the doctor bill Ms. Smith. Even if he does not have a contract with the Medi-Cal plan, he can still bill that plan for the Medicare coinsurance.

What Should Advocates Do?

- Instruct beneficiaries to call You (HICAP) to report the issue.
- Work with beneficiaries and:
  - explain to them their legal rights;
  - encourage them not to pay; and
  - make sure providers know about their Medi-Cal enrollment.
- Contact NSCLC.

Physician Toolkit

Providing Fee-For-Service Medicare Services to Dual Eligibles in Medi-Cal Plans

The Coordinated Care Initiative (CCI) is an effort by California and the federal government to integrate the delivery of medical, behavioral, and long-term services and supports for persons eligible for both Medicare and Medi-Cal (i.e., dual eligibles). Most dual eligibles in eight counties will be eligible to enroll in a new type of coordinated plan, called a Cal MediConnect plan. These plans will be responsible for administering the benefits under both programs. Participation in Cal MediConnect is voluntary, so people can choose to join or choose to opt out and receive Medicare services as they do today. If someone is eligible for Cal MediConnect and they don't make an affirmative choice to join or not join, they will be automatically enrolled into Cal MediConnect on their coverage date, usually the first day of their birth month. They can choose to disenroll in any month.

If your patients decide not to join a Cal MediConnect plan, they can continue to see you as a Medicare Fee-for-Service (FFS) physician. However, at the same time California is requiring most dual eligibles who do not enroll in a Cal MediConnect plan to enroll in a Medi-Cal managed care plan for their Medi-Cal benefits, including long-term services and supports.

The state has received reports of a common but dangerous misunderstanding: patients who decide they want to continue in Original Medicare are being told they may not continue to see their existing physicians if they are enrolled in a Medi-Cal plan. This is plainly false. Patients remaining with Original Medicare may continue to see their current physicians even if they join a Medi-Cal plan. Medicare physicians do not need to be contracted with Medi-Cal plans to see dual eligible patients. This misunderstanding thwarts the patient's effort to be treated by the physician, and causes the physician to lose that patient, based on false information. See below for billing instructions.

Financial Responsibility for Physician Services

Physician services provided to dual eligibles are the financial responsibility of Medicare, not Medi-Cal. It is a Medicare benefit paid primarily under the Medicare fee schedule. For most physician services, the rate physicians receive is 80 percent of the Medicare fee schedule.

Medi-Cal has responsibility for services and supports not covered under Medicare, including Medicare cost sharing as well as some long-term care, durable medical equipment, incontinence supplies, and other services and supports. The only role Medi-Cal managed care plans will have with respect to physician services for dual eligibles will be to adjudicate the payment of crossover claims for any Medicare cost sharing owed under California state law.

Billing for Fee-for-Service Original Medicare

If dual eligible Medicare patients decline to enroll in a Cal MediConnect plan, or are excluded from joining a Cal MediConnect plan, their physicians should bill for Medicare services exactly as in the past. Even if the patient is enrolled in a Medi-Cal managed care plan, the physician should bill for Medicare services exactly as in the past. There is no change in what Medicare Fee-For-Service will pay for billed charges, generally 80 percent of the Medicare fee schedule.

It should be noted that **no change** is made in the rules governing the billing of the 20 percent co-pay for dual eligible patients. It continues to be **unlawful to bill dual eligible patients**.[1] Instead, that claim for the 20 percent copay should be sent to the patient's Medi-Cal plan – this is known as a "crossover claim."

Billing Crossover Claims

In most cases, providers will need to send their "crossover claims" for the 20 percent co-pay to the patient's Medi-Cal plan, which will pay the physician any amount owed under state Medi-Cal law. In some limited cases, Medicare will send these crossover claims automatically and directly to the Medi-Cal plans. **Physicians do not need to be part of the Medi-Cal plan's network to have these crossover claims processed and paid.** Please refer to the "How Medi-Cal Plans Process Crossover Claims" document in this toolkit for a chart outlining how Medi-Cal plans will process crossover claims.

It should also be noted that **no change** is made in the rules governing how much the Medi-Cal plans will pay on these claims for Medicare services to dual eligibles. Since 1982, state law has limited Medi-Cal's reimbursement on Medicare claims to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal's maximum payment for similar services.[2] Consequently, if the Medi-Cal rate is 80 percent or less than the Medicare rate for the service rendered, Medi-Cal will not reimburse anything on these crossover claims. If the Medi-Cal rate is higher, providers will receive the payment. For example, in 2014 many primary care providers will receive Medi-Cal reimbursement, as Medi-Cal payments for primary care services in certain circumstances have been raised to 100 percent of Medicare under the Affordable Care Act.

However, since Medi-Cal reimbursement rates are generally lower than Medicare rates (80 percent of the Medicare fee schedule), it is anticipated that **there are few types of services where Medi-Cal owes any reimbursement on Medicare claims**. Again, this is not the result of the Coordinated Care Initiative. This has been the rule in California for over 30 years.

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[1] Welfare and Institutions Code, Section 14019.4. (a): "A provider of health care services … shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient…."

[2] Welfare and Institutions Code, Section 14109.5: "Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 for all services, including, but not limited to, hospital inpatient services, shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter. For purposes of this section, effective October 1, 1992, the reimbursement rates established under this chapter for hospital inpatient services shall be no greater than the amounts paid by the Medicare program for similar services."

California's Coordinated Care Initiative | www.CalDuals.org | info@calduals.org

http://www.calduals.org/wp-content/uploads/2014/09/PhysToolkit_FFS-Medicare-for-Duals-in-Medi-Cal-Plans_09.18.14.pdf

Fact Sheet

NSCLC National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS.

What Should California Advocates Do If Their Clients are Balance Billed?

Balance billing is the practice in which providers, particularly physicians, seek to bill (1) dual eligible beneficiaries (those with both Medicare and Medi-Cal) for charges not covered by either Medicare or Medi-Cal; or (2) Medi-Cal only seniors and persons with disabilities any amount for a Medi-Cal covered service.

Balance billing violates both federal and state law.[1] State law protects any Medi-Cal beneficiary against balance billing.[2] A provider must accept as payment in full whatever amount the provider receives from Medicare, other insurance (if any), and Medi-Cal. Private pay agreements or other waivers of the balance billing protection are unlawful.

Note that the state law balance billing protection applies to Medi-Cal share of cost beneficiaries when the share of cost has been met for the month during which services were rendered.

Providers, however, are often confused about their obligations under law and that confusion can affect both dual eligibles and SPDs. Providers who balance bill beneficiaries are subject to penalties under both federal and state law. If a provider has erroneously billed a beneficiary, upon proof of Medi-Cal enrollment, the provider must call off any collection efforts that have begun, and if the bill has been sent a debt collection agency, the agency also must correct any erroneous information sent to credit reporting agencies.

As dual eligible beneficiaries transition from fee-for-service to managed care, advocates may begin to see increased instances of balance billing during the implementation of the Coordinated Care Initiative (CCI) due to provider confusion and misunderstanding.

Case Example #1

Ms. Jones is a dual eligible who resides in a CCI county. After opting-out of Cal MediConnect and picking a Medi-Cal managed care plan, she visits her Medicare fee-for-service doctor for a regularly scheduled office visit. Although the doctor typically bills Medicare and Medi-Cal for her visits, he does not have a contract with Ms. Jones's new Medi-Cal plan so he instead sends her a bill for the charges that Medicare did not pay.

RULE: Under no circumstances may the doctor bill Ms. Jones. Even if he does not have a contract with Ms. Jones's Medi-Cal plan, the doctor can still bill her plan for the Medicare coinsurance.

Case Example #2

Mr. Lee is a dual eligible who resides in a CCI county but is not eligible for Cal MediConnect. He signs up for a Medi-Cal plan and visits his Medicare fee-for-service doctor. The doctor tells him that he cannot see Mr. Lee unless he agrees to pay the 20 percent co-insurance.

RULE: Under no circumstances may the doctor bill Mr. Lee. Even if he does not have a contract with Mr. Lee's Medi-Cal plan, the doctor can still bill her plan for the Medicare coinsurance.

Case Example #3

Ms. Garcia is a dual eligible with a Medi-Cal share of cost of $100 and lives in a CCI county. She opts out of Cal MediConnect and picks a Medi-Cal plan. In February, she sees her Medicare fee-for-service doctor, and she receives a bill from him for $50, which is 20 percent of the Medicare-approved amount for the service.

RULE: If Ms. Garcia has not yet met her share of cost for February, she can pay the $50 bill and have it count toward her share of cost. If she has already met her share of cost for February prior to this visit, balance billing protections are in effect, and she should not pay the bill.

What Should Advocates Do If Their Clients Are Balance Billed?

- **Beneficiaries should be instructed to contact the local Health Insurance Counseling and Advocacy Program (HICAP) agency (1-800-434-0222) to report the issue.**
- **Advocates should work with beneficiaries to make sure their balance billing provider knows of the beneficiary's Medi-Cal enrollment, inform beneficiaries of their legal rights, and encourage them not to pay the bill.**
- **Please tell NSCLC if you see balance billing issues so we can monitor the issue. NSCLC also is available to provide technical assistance to advocates. Contact Georgia Burke, gburke@nsclc.org.**

1 Federal law provides that all Medicare providers who serve qualified Medicare beneficiaries ("QMBs") cannot bill them for Medicare cost-sharing. 42 U.S.C. 1396a § 1902(n)(3)(B). The state law covers all Medi-Cal beneficiaries, whether or not they are QMBs. Cal. Welf. & Inst. Code § 14019.4.

2 Cal. Welf. & Inst. Code § 14019.4. See also the All Plan Letter on Coordination of Benefits: Medicare and Medi-Cal guidance (January 3, 2013), available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-001.pdf.

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1330 Broadway, Suite 525 | Oakland, CA 94612 | (510) 663-1055 | (510) 663-1051 Fax

http://dualsdemoadvocacy.org/wp-content/uploads/2014/10/Balance-Billing-in-California-2.pdf

CalMediConnect

Get the Facts: Balance Billing

What should I know about balance billing?

If you have both Medicare and Medi-Cal coverage (meaning you are a dual eligible beneficiary), health care providers (like a doctor or hospital) cannot charge you for any part of your health care costs. This means that you cannot be charged for co-pays, co-insurance or deductibles. If a health care provider does charge you, this is called "balance billing" and it is against the law.

This applies to both your Medicare and Medi-Cal providers. This applies even if you are in a health plan for your Medicare or Medi-Cal benefits. This does not apply to all prescription drugs. This also does not apply to dual eligible beneficiaries who pay a share of their Medi-Cal cost every month.

Balance billing is **illegal** under both federal and state law[1]. Dual eligible benecifiaries should **never** be charged any amount for services covered under Medicare or Medi-Cal.

What should I do if I am billed by one of health care providers?

If you have been billed by a health care provider for a Medi-Cal or Medicare covered service, do not pay the bill. Contact your health plan immediately to resolve the issue. Phone numbers for Cal MediConnect and Medi-Cal plans can be found here: http://www.calduals.org/all-health-plan-info/

You should also contact your health care provider and tell them that you should not have been billed because you receive Medi-Cal. Providers must take immediate actions to fix the issue once they know that you have Medi-Cal. They must stop the bill collection process and they must work with credit reporting agencies to correct any issues caused by billing you.

If you or your health care provider want to understand more about balance billing or have questions about what actions to take, you can also call the Cal MediConnect Ombudsman at (855) 501-3077.

For more information on Cal MediConnect, dual eligibility or balance billing, please visit www.calduals.org.

[1] Billing dual eligible beneficiaries violates Federal law as outlined in Section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997. This section of the Act is available at: http://www.ssa.gov/OP_Home/ssact/title19/1902.htm

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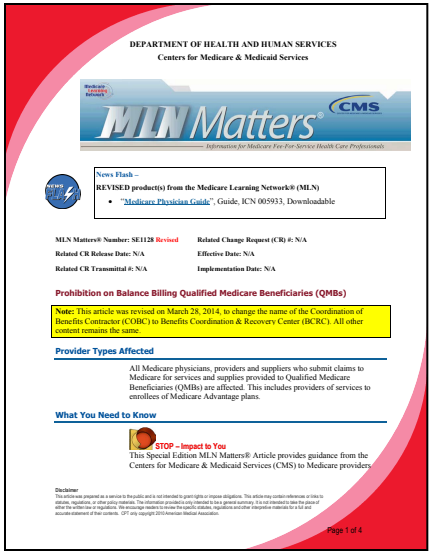
http://www.calduals.org/wp-content/uploads/2014/11/Balance-Billing_11.7.14.pdf



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

MLN Matters®
Information for Medicare Fee-For-Service Health Care Professionals

News Flash –
REVISED product(s) from the Medicare Learning Network® (MLN)
- "Medicare Physician Guide", Guide, ICN 005933, Downloadable

MLN Matters® Number: SE1128 Revised | Related Change Request (CR) #: N/A
Related CR Release Date: N/A | Effective Date: N/A
Related CR Transmittal #: N/A | Implementation Date: N/A

Prohibition on Balance Billing Qualified Medicare Beneficiaries (QMBs)

Note: This article was revised on March 28, 2014, to change the name of the Coordination of Benefits Contractor (COBC) to Benefits Coordination & Recovery Center (BCRC). All other content remains the same.

Provider Types Affected

All Medicare physicians, providers and suppliers who submit claims to Medicare for services and supplies provided to Qualified Medicare Beneficiaries (QMBs) are affected. This includes providers of services to enrollees of Medicare Advantage plans.

What You Need to Know

STOP – Impact to You

This Special Edition MLN Matters® Article provides guidance from the Centers for Medicare & Medicaid Services (CMS) to Medicare providers

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serving QMBs. **All Medicare providers are reminded that they may not bill QMBs for Medicare cost-sharing.**

CAUTION – What You Need to Know

All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs must be aware that they may not bill QMBs for Medicare cost-sharing. This includes deductible, coinsurance, and copayments, known as "balance billing." **Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing.** QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who inappropriately bill QMBs for Medicare cost-sharing are subject to sanctions.

GO – What You Need to Do

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staffs are aware of the current balance billing law and policies regarding QMBs. Visit the State Medicaid Agency websites of the states in which you practice to learn how to submit claims if you are not currently submitting claims to a state.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductible, coinsurance, and copayments. This is known as "balance billing."

Balance Billing of QMBs Is Prohibited by Federal Law

Under current law, Medicare providers cannot balance bill a QMB. **Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing.** (Please note, this section of the Act is available at http://www.ssa.gov/OP_Home/ssact/title19/1902.htm on the Internet.)

Specifically, the statute provides that the Medicare payment and any Medicaid payment are considered payment in full to the provider for services rendered to a QMB.

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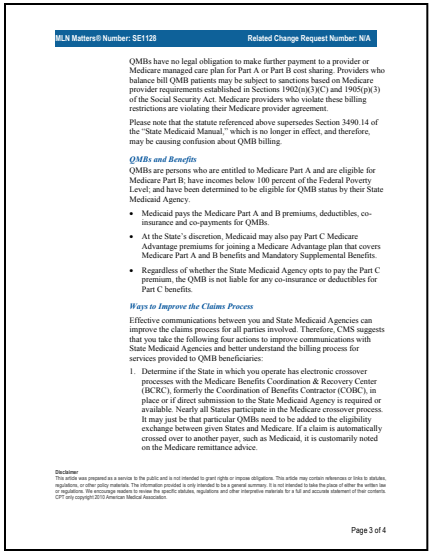

QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who balance bill QMB patients may be subject to sanctions based on Medicare provider requirements established in Sections 1902(n)(3)(C) and 1905(p)(3) of the Social Security Act. Medicare providers who violate these billing restrictions are violating their Medicare provider agreement.

Please note that the statute referenced above supersedes Section 3490.14 of the "State Medicaid Manual," which is no longer in effect, and therefore, may be causing confusion about QMB billing.

QMBs and Benefits

QMBs are persons who are entitled to Medicare Part A and are eligible for Medicare Part B; have incomes below 100 percent of the Federal Poverty Level; and have been determined to be eligible for QMB status by their State Medicaid Agency.

- Medicaid pays the Medicare Part A and B premiums, deductibles, co-insurance and co-payments for QMBs.
- At the State's discretion, Medicaid may also pay Part C Medicare Advantage premiums for joining a Medicare Advantage plan that covers Medicare Part A and B benefits and Mandatory Supplemental Benefits.
- Regardless of whether the State Medicaid Agency opts to pay the Part C premium, the QMB is not liable for any co-insurance or deductibles for Part C benefits.

Ways to Improve the Claims Process

Effective communications between you and State Medicaid Agencies can improve the claims process for all parties involved. Therefore, CMS suggests that you take the following four actions to improve communications with State Medicaid Agencies and better understand the billing process for services provided to QMB beneficiaries:

1. Determine if the State in which you operate has electronic crossover processes with the Medicare Benefits Coordination & Recovery Center (BCRC), formerly the Coordination of Benefits Contractor (COBC), in place or if direct submission to the State Medicaid Agency is required or available. Nearly all States participate in the Medicare crossover process. It may just be that particular QMBs need to be added to the eligibility exchange between given States and Medicare. If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare remittance advice.

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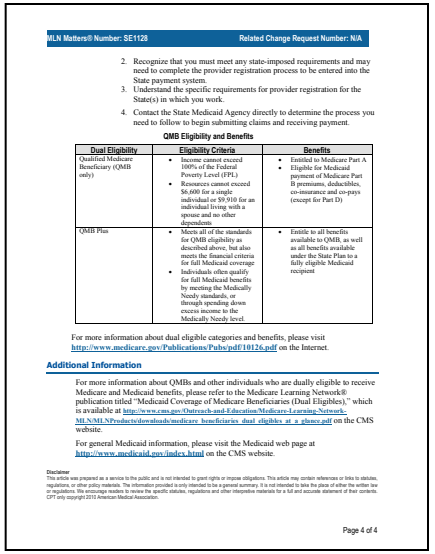

2. Recognize that you must meet any state-imposed requirements and may need to complete the provider registration process to be entered into the State payment system.
3. Understand the specific requirements for provider registration for the State(s) in which you work.
4. Contact the State Medicaid Agency directly to determine the process you need to follow to begin submitting claims and receiving payment.

QMB Eligibility and Benefits

Dual Eligibility	Eligibility Criteria	Benefits
Qualified Medicare Beneficiary (QMB only)	• Income cannot exceed 100% of the Federal Poverty Level (FPL) • Resources cannot exceed $6,600 for a single individual or $9,910 for an individual living with a spouse and no other dependents	• Entitled to Medicare Part A • Eligible for Medicaid payment of Medicare Part B premiums, deductibles, co-insurance and co-pays (except for Part D)
QMB Plus	• Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage • Individuals often qualify for full Medicaid benefits by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy level.	• Entitle to all benefits available to QMB, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient

For more information about dual eligible categories and benefits, please visit http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf on the Internet.

Additional Information

For more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the Medicare Learning Network® publication titled "Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles)," which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf on the CMS website.

For general Medicaid information, please visit the Medicaid web page at http://www.medicaid.gov/index.html on the CMS website.

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http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf

Want to know more?

- NSCLC Duals Website http://dualsdemoadvocacy.org
- Contact us:
  - Denny Chan – dchan@nsclc.org; 213-375-3559
  - Amber Cutler – acutler@nsclc.org