How do states and health assistance programs handle billing disputes for Medicaid beneficiaries?

Many Medicaid health assistance programs spend a great deal of time resolving health care billing disputes for Medicaid beneficiaries. Although Medicaid is supposed to pay for their care, beneficiaries often get billed. Sometimes, straightening out this problem is just a matter of notifying a provider that a patient had Medicaid coverage, but other times, disputes are more complicated - the provider is out-of-state or outside a Medicaid managed care plan, the bill has gone to an outside collection agency, or the Medicaid beneficiary has signed a form accepting financial responsibility for a bill that should have been paid by Medicaid.

Information about Federal Requirements

Medicaid regulation:
42 CFR §447.15: Acceptance of State payment as payment in full

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or co-payment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan in accordance with §431.55(g) or §447.53. The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge.

Question: What about out-of-state hospital or emergency room bills--can the provider bill the beneficiary?

Answer: "[A] Medicaid participating hospital, even if out-of-state, must accept an out-of-state payment and not bill the beneficiary if the host state is willing to pay based on a reciprocity standard (431.52 and 447.15). An out-of-network hospital must accept the state's Medicaid rate, usually based on a fixed state fee schedule. It cannot bill the beneficiary if the state or MCO is willing to pay because it becomes a mandatory covered service. Only if the MCO or state denies the claim can a hospital bill the beneficiary." (Tim Roe, Center for Medicaid and State Operations, CMS in correspondence to the Health Assistance Partnership of Families USA, May 2002)

"The citations Tim provided support the policy. That is, a recipient temporarily absent from his state of residence is entitled to receive care from providers in another state and have such care paid by his home
state. Further, as a condition of being a Medicaid provider, the provider must accept as payment in full the amounts determined by the state for the care in question, even when the payment is zero." (Robert Tomlinson, Center for Medicaid and State Operations, CMS, in correspondence to the Health Assistance Partnership of Families USA, May 2002)

Question: Who can enforce the obligation of out-of-state providers?

Answer: "I'd contact the CMS regional office that is responsible for covering the state that contains the hospital in question. The regions are the enforcers of our rules and contracts." (Tim Roe, CMS)

The mechanics: How can health assistance programs help consumers through billing problems?

1) Educate consumers to handle bills:

Oregon sends a notice to Medicaid consumers every six months, "What to do if you get a bill for health care services." See (www.omap.hr.state.or.us/clientinfo/clientnotices/billing_0701.html).

2) Ask collection agents to stop collection action:

The Kentucky Ombudsman (located in Kentucky's Cabinet for Health Services) sends consumers letters from the state telling them they are not responsible for the bill, and consumers can use this with collection agencies.

3) Work with Attorneys General's offices to enforce Fair Debt Collection Laws:

See "Fair Debt Collection" on the Federal Trade Commission's Web site (www.ftc.gov/bcp/online/pubs/credit/fdc.htm) for a summary of the Fair Debt Collection Practices Act. This act mostly pertains to bills that have gone to collection. One provision of the act states that if consumers send collection agencies letters within 30 days of receiving written notice stating that they do not owe money, the collector may not contact the consumer unless the consumer is first sent proof of the debt. Another provision states that debt collectors may not give false information to a credit bureau. On a state level, attorneys general enforce the Fair Debt Collection Practices Act. State laws may contain additional provisions about debt collection that are helpful to consumers. Some Medicaid health assistance programs have asked Attorneys General to write letters to Medicaid providers or debt collectors who attempt to collect from Medicaid beneficiaries. The implied threat of the Attorney General's letter sometimes gets a provider or debt collector to be more careful about billing practices. For example, the Maryland Attorney General's Office sometimes sends letter to providers telling them that it is illegal to bill patients for covered services. In Oregon, the Attorney General helps if the Medicaid agency first documents that there is an overt intention to defraud the Medicaid agency.

The Health Assistance Partnership may be able to help Medicaid consumer assistance programs make
connections with Attorney General. Programs should contact Cheryl Fish-Parcham at 202-737-6340 if interested.

4) What procedures have health assistance programs used to resolve quickly the many billing complaints that come their way?

No programs said that their procedures quickly resolved cases, but Connecticut Children's Health Project (CC) shared their protocols:

CC gathers basic information about the bill and whether it has gone to a collection agency, verifies Medicaid eligibility on the date of service, and then calls the provider to be sure the provider has correct insurance information.

If the client was on fee-for-service, CC asks the provider to bill and then refers the client to both the Department of Social Services and Legal Aid if bills do not stop.

If the client was in a managed care plan and was treated by a participating provider, CC calls member services and asks the Plan for any record or reason why the bill was not paid. If the billing issue cannot be resolved at the Plan level, CC calls the Department of Social Services liaison and refers the client to Legal Aid.

If the client was in a managed care plan but was treated by a non-participating provider, CC calls member services at the Plan in which the client was enrolled to determine whether the Plan will approve the out-of-network provider. If the CC cannot resolve the billing issue at the Plan level, the Department of Social Services liaison for the Plan is called, and the client is referred to Legal Aid.

If the client did not have Medicaid/SCHIP coverage at the time of billing and the bill was incurred within the three months prior to a signed application for coverage, CC calls the Department of Social Services to see whether eligibility can be retroactively granted. Once eligibility is granted, CC or the client notifies the provider of updated insurance information, and then the protocols for a fee-for-service bill are followed.

The Health Rights Hotline and other health assistance programs in California give beneficiaries letters to take to providers on the front-end before they have been billed.

5) How do advocates make sure a billing issue has really been resolved?

Some programs mentioned problems in getting collectors to confirm in writing that they are no longer holding a patient responsible for a bill. California advocates mentioned success in getting providers to send letters to beneficiaries saying that the beneficiaries are no longer responsible and that the provider is notifying the collection agency to stop the billing. Collection agencies that do not cooperate can be referred to their regulator (in California, the Department of Consumer Affairs).
California advocates reported that disputes about emergency care payment are usually handled through a provider appeals process and do not become problems for patients. Urgent and routine hospital care cause more billing problems for patients.

The broader issues: What can be done to prevent Medicaid beneficiaries from getting bills?

What language have states put in managed care contracts or policy guidelines to protect consumers from wrongful billing by contracted providers? Has this language been effective in the eyes of health assistance programs?

See Rosenbaum, et al. "Negotiating the New Health System: A Nationwide Survey of Medicaid Managed Care Contracts" (Center for Health Services Research and Policy, George Washington University, 1999) (www.gwu.edu/~chsrp/) for a compilation of language from state Medicaid managed care contracts. Table 7 addresses payment terms, and Table 6 addresses plan sanctions. Language in Kentucky and Texas Medicaid managed care contracts allows the withholding of capitation payments for wrongful denials of covered services or failure to pay bills. However, the Kentucky ombudsman reports that Kentucky has never acted to withhold payment using this clause.

California health assistance programs (both those within and outside state government) discussed their billing problems. California contracts contain useful language (and required language for a managed care plan's subcontractors), but with so many layers of care in California, it is hard to prevent individual providers from billing inappropriately. There is a huge amount of delegation to medical groups and no regulation of medical groups. Additionally, patients may present Medi-Cal information in a hospital emergency room, but the hospital may not inform its ancillary providers of the coverage.

In Oregon, some Client Advocacy Services Unit staff members specialize in billing problems. For services that are not covered by Oregon's Medicaid program, Oregon has developed a waiver form that has been approved by CMS. Providers must tell patients in advance that a service will not be covered by Medicaid, and they must get the patient to sign the waiver form for that specific service. If a provider does not have a signed waiver form on file, the provider cannot bill the patient. When Client Advocacy Services Unit finds that a patient was inappropriately billed, the patient is sent a letter saying that as of this date, your account balance with x provider is zero; call us if you get another bill.

For emergency care in Oregon, Medicaid will cover all diagnostic services. At the point when a diagnosis has been determined, if treatment will not be covered, the provider must still get a signed waiver if the patient is going to be responsible for the bill.

What systemic issues should be brought to the attention of national policymakers?

The group noted a number of systemic problems:

1) Medicaid beneficiaries are often required to sign agreements from providers accepting financial responsibility if their insurance does not pay a bill.
2) Administrative hurdles prevent out-of-state providers from participating in another state’s Medicaid program.

3) People transitioning from fee-for-service to managed care or vice versa have particular problems.

1) Financial responsibility agreements

Health assistance programs mentioned problems in California and Washington, DC with Medicaid patients being asked to sign forms saying they would be responsible for health care bills that their managed care plan did not pay. People felt that this was inappropriate for most Medicaid beneficiaries, given the rules that providers accept Medicaid as payment in full. Only if the beneficiary was on spend-down and had to pay a share of cost should there be any financial responsibility. In California, people dually eligible for Medicare and Medicaid have frequent problems with pharmacy bills; some consumer assistance programs have developed notices for dually eligible consumers to take to pharmacies explaining why they cannot be required to pay for services.

Consumers Union and Health Access are proposing legislation in California that would require hospitals to offer charity care, require hospitals to offer patients an opportunity to apply for Medicaid/SCHIP before they bill for service, and require hospitals to bill uninsured patients at a lower rate than they currently bill self-pay patients.

The Health Assistance Partnership has asked CMS to examine financial responsibility issues further, perhaps in upcoming audits or investigations. Health assistance programs can provide information to CMS about when people are now being asked to sign financial agreements—e.g., for emergency services or elective admissions—and what those agreements say. (If you wish to send information to Cheryl Fish-Parcham, (cparcham@healthassistancepartnership.org), we will pass it on to CMS.)

2) Out-of-state providers

Health assistance programs in California, Maryland, and Connecticut noted that they have problems getting out-of-state providers (often emergency care providers) to accept in-state Medicaid for people who were traveling at the time of their illness. Those states require the providers to get an in-state Medicaid provider number, a process that can take a year. Ms. Fish-Parcham will talk with CMS about this problem to see whether any easier administrative procedures can be adopted.

3) Transition between fee-for-service and managed care

In some states, such as Connecticut, some providers participate only in Medicaid managed care, not in fee-for-service. Medicaid beneficiaries start their certification periods in fee-for-service and then enroll in a managed care plan. They have problems with coverage of bills from managed care providers during their initial fee-for-service period.

The information in this fact sheet came from background materials and a conference call of health assistance programs sponsored by the Health Assistance Partnership of Families USA on May 17, 2002.