Payment for Patients Dually-Eligible for Medicare and Medicaid

Texas Medical Association

BACKGROUND
To help close a $27 billion budget deficit, the 82nd Texas legislature directed the Health and Human Services Commission to implement a multitude of new initiatives aimed at trimming Medicaid expenditures by nearly $3 billion over the next two years, including reducing benefits and services for patients and applying payment reductions for physicians and providers.

The legislature considered, but rejected a proposal to cut the physician Medicaid fee schedule by 10 percent fearing that such a deep cut would destabilize the Medicaid/CHIP physician network. Rather, the legislature instructed HHSC to eliminate Medicare Part B coinsurance and deductible payments for dually-eligible patients if the payment would result in the state paying more than the Medicaid allowable. (Texas previously implemented the same policy for Medicare Part A services). The federal Balanced Budget Act of 1997 authorized states to limit their liability for dual-eligibles to the Medicaid allowable. To date, 20 states have implemented it with more considering the change. The policy change effective January 2012 will save $475 million over two years.

TMA opposed the reduction, but given the magnitude of the savings and that only Medicaid rate reductions would achieve similar savings, the legislature included the payment scheme as a rider in the budget (House Bill 1, Article II, HHSC Special Provision 17c(3)). This legislatively directed change will affect all providers who are paid under Medicare Part B who care for dually-eligible patients, though the legislature did instruct HHSC to limit the policy change to a 5 percent reduction for nephrology (hemodialysis and renal dialysis) and renal-dialysis facilities since patients receiving those services are almost exclusively dually eligible.

Further, as a result of TMA and specialty society advocacy oncologists and psychiatrists also will get relief. No later than June 1, 2012, HHSC will increase the payment for chemotherapy drugs to the Medicare rate. Psychiatric and psychology services will be exempted from the payment reduction no later than July 1, 2012.

How will the policy effective January 2012 work?
Here are some examples. They are for illustration only. Medicare payments vary by region of the state.

Example 1: Established dual-eligible patient has not met any of the Medicare deductible and is seen during a routine office visit. Physician bills Medicare CPT code 99213. Maximum Medicare allowable is $66.90 (rest of Texas). Medicare pays 0 because deductible has not been met. Medicaid will pay $33.27, the Medicaid allowable for this code.

Example 2: Established dual-eligible patient has met $100 of $140 Medicare 2012 deductible. Patient is seen in office for routine office visit. Physician bills Medicare CPT code 99213. Medicare pays $21.52, which is 80 percent of the allowable after deductible ($66.90-$40). Medicaid will pay $11.75 ($33.27-$21.52).

Example 3: Established dual-eligible patient visits physician office for routine visit. Medicare deductible has been met. Physician bills Medicare CPT code 99213. Medicare allowable is $66.90. Medicare pays $53.52, 80 percent of the allowable. Physician bills Medicaid for the remaining 20 percent. Medicaid allowable is $33.27, so no coinsurance will be paid.

How do I know if a patient is dually-eligible?
Dual-eligible patients are known officially as “Qualified Medicare Beneficiaries (QMBs)”. To qualify for both Medicare and Medicaid, a patient must have an income at or below the federal poverty level and limited resources. If a patient is dually-eligible, the state will issue a Medicaid identification card which will say either “QMB” or “MQMB”. The latter are eligible for full Medicaid benefits in addition to help with the Medicare coinsurance and deductible payments.

Can patients who are dually-eligible be balance billed?
No. Federal law expressly prohibits physicians from billing dually-eligible patients for the Medicare coinsurance or deductible, even if the state does not pay above the Medicaid allowable. Physicians or providers who violate the prohibition are subject to sanctions.1

Can I enter into a private pay agreement with dually-eligible patients?
No. Federal law expressly prohibits physicians and providers from entering into a private pay agreement with dually-eligible patients.2

Does the change in payment policy apply to patients in Medicare fee-for-service and Medicare Advantage Plans?
Yes, the payment policy applies to both fee-for-service and Medicare Advantage.
Payment for Patients Dually-Eligible for Medicare and Medicaid
(Continued)

Some Medicare Advantage Plans, particularly Special Needs Plans designed for patients who are duals or who have chronic illnesses or conditions, do not require patients to pay a deductible; others do not require co-insurance payments, but have copayments instead. Check with the MAPs with which you contract for specific co-insurance requirements for dual-eligible patients. Unlike other Medicare patients, dual-eligibles may enroll in or switch to a Medicare Special Needs Plan (SNP) anytime.

Medicare Advantage Plans contracted with Texas Medicaid are responsible for paying the co-insurance and deductible. For a list of contracted MAPs, visit the Texas Medicaid and Healthcare Partnership (TMHP) website at www.tmhp.com. For plans not contracted with HHSC, TMHP will pay the coinsurance/deductible just as with Medicare FFS patients.

How does the change affect patients enrolled in a Medicaid STAR+PLUS HMO?
In Austin, Corpus Christi, Dallas, Ft. Worth, Galveston, Houston and San Antonio, HHSC requires patients who are full dual-eligibles to enroll in STAR+PLUS HMO for their community-based long-term care services only. Beginning on March 1, 2012, the STAR+PLUS HMO model will take effect in El Paso, Lubbock, and South Texas (in all other areas, Medicaid fee-for-service will continue to provide long term care. Full dual-eligibles receive help from Medicaid not only with their Medicare cost sharing, but also with Medicaid coverage for services not covered by Medicare. For this category of STAR+PLUS patients, Medicare continues to pay for acute care services, either via Medicare fee-for-service or a Medicare Advantage Plan (MAP). The STAR+PLUS HMO is not responsible for the co-insurance and deductible payments.

However, in order for patients to have the option of receiving their Medicare acute care services and their Medicaid long-term care services from one health plan, the STAR+PLUS HMOs also are required by the state to be licensed MAPs. Thus, a full dual eligible may be enrolled in a STAR+PLUS HMO’s MAP product for their Medicare acute care services (For example, United Health Care offers a MAP and a STAR+PLUS HMO). MAPs contracted with the state are responsible for paying co-insurance and deductibles for duals. For a list of MAPs that contract with the state, visit the Texas Medicaid claim’s payer website at www.tmhp.com and click on “Medicare dual eligibility”.

**Example 1:** A dual-eligible patient is enrolled in Medicare FFS for acute care services and has regular Medicaid for long-term care. Which payer will reimburse the co-insurance or deductible? The Texas Medicaid claims payer, TMHP.

**Example 2:** A dual-eligible patient is enrolled in Medicare FFS for acute care services and a STAR+PLUS HMO for long-term care.

Continued on page 18
Which payer will reimburse the co-insurance or deductible? The Texas Medicaid claims payer, TMHP.

Example 3: Patient enrolled in a United Health Plan’s Medicare Advantage Plan for acute care and United Health Plan’s STAR+PLUS HMO for long-term. Which payer will reimburse the co-insurance or deductible? United.

Example 4: Patient enrolled in Aetna MAP for acute care services. Aetna is not contracted with the state to pay Medicare Part C co-insurance and deductibles. Patient has Medicaid FFS for long-term services. Which payer will reimburse any co-insurance or deductible? TMHP.

Can I limit the number of dual-eligible patients I accept?
First, generally, a practice is free to manage its payor mix and physicians have no obligation to treat Medicaid patients or anyone in particular. That means that, absent an agreement that states otherwise, a physician may participate in Medicare, Medicaid, and Commercial Insurance networks while simultaneously maintaining the freedom to accept or refuse to accept new patients.

If a physician participates in a Medicare Advantage Plan(s), that physician should consult his or her contract. Medicare Advantage Plans may contractually prohibit physicians from limiting or halting acceptance of dual-eligible patients if the practice continues to accept other Medicare patients.

TMA is not aware of any federal law or rule that requires physicians to accept dual-eligible patients. However, physicians who continue to accept Medicare patients but limit or no longer accept dual-eligibles (who are a subset of the Medicare population) may be subject to legal reprisal on other grounds provided for in laws of general application. For instance, the Americans with Disabilities Act (ADA) may be applicable in certain circumstances. The ADA can affect the eligibility criteria used by public accommodations (which includes physician offices) to determine who may receive services. According to the Office of Civil Rights, “if a criterion screens out or tends to screen out individuals with disabilities, it may only be used if necessary for the provision of the services.” The activities that can trigger unlawful discrimination under the ADA can be quite subtle. “For example, requiring presentation of a driver’s license as the sole acceptable means of identification for purposes of paying by check could constitute discrimination against individuals with vision impairments...,” according to the federal government. The ADA language “tends to screen out” means that specific intent to discriminate against a disabled person is not necessary for a violation.

This does not necessarily mean that you must accept all patients and all conditions. “The ADA does not require modifications that

Continued on page 19
would fundamentally alter the nature of the services provided by the public accommodation. For example, it would not be discriminatory for a physician specialist who treats only burn patients to refer a deaf individual to another physician for treatment of a broken limb or respiratory ailment. To require a physician to accept patients outside of his or her specialty would fundamentally alter the nature of the medical practice.”

A person is eligible for ADA protections if the person “is unable to perform a major life activity that the average person in the general population can perform,” has an impairment that “significantly restricts the condition, manner or duration in which an individual can perform a particular activity as opposed to the condition, manner or duration in which the average person in the general population can perform the same activity,” or is regarded as having such impairment.6 The dually-eligible population has often been described as one with members that are very ill and who need expensive interventions.

There is also a state law of general application that can apply. Texas Health and Safety Code 311.002(c) states that a person commits an offense if the person subjects a patient needing emergency services to “arbitrary, capricious, or unreasonable discrimination based on age, sex, physical condition, or economic status.” This law provides for criminal penalties and is arguably broader than EMTALA duties as the state law addresses “emergency services” while EMTALA is concerned with “emergency medical conditions.”

Finally, there was a Texas case decided in 2008 that demonstrates there may be a risk from lawsuits alleging discrimination based on economic status. In Acosta v. Memorial Hermann Hospital Systems, the plaintiff attempted to recover by alleging that epidural anesthesia was denied based on economic status. The court denied recovery on other grounds (statute of limitations) and did not reach the merits of the allegation. It is not certain whether the allegation of discrimination based on economic status would have eventually resulted in a damage award. However, physicians will want to take note that a lawsuit has used this type of discrimination as the basis for the cause of action under various code provisions and the patient bill of rights.

This means, in short, there are real and serious legal risks should a physician consider exclusion of dually-eligible (QMB) patients from among the Medicare patients he or she is willing to treat. Unfortunately, it is not predictable how any particular case will turn out. TMA recommends that practices seek legal guidance from their own attorney before implementing any restrictions.

Can I limit the number of Medicaid patients I accept?
Physicians may limit the number of Medicaid fee-for-service patients they accept, though those limits need to be well documented in writing to avoid any accusations of discrimination (e.g. have a written policy that the practice only takes patients with Medicaid secondary or only upon referral).

For Medicaid HMO patients, please consult the HMO contract. HMO contracts often contain clauses restricting physicians’ ability to limit the number of HMO enrollees they accept without applying those same limits to all the other patients within the practice. This is contained in a provision known as a “non-discrimination clause.”

Consider the following paragraph:

“Physician shall accept and treat as patients all Enrollees without regard to the Enrollee’s race, color, religion, age, sex, lawful occupation, marital status, mental or physical disability, or any other grounds prohibited by law. Physician shall accept MCO Enrollees as patients.”

This clause requires that the physician take all enrollees who seek care from the practice and does not permit the physician with any flexibility to terminate the patient-physician relationship. He or she must accept all enrollees as patients as long as they are considered enrollees of the managed care organization.

Can I limit the number of Medicare patients I accept?
Physicians may limit the number of Medicare fee-for-service patients they accept. To ensure the policy is administered fairly, any practice limits should be clearly documented in writing (e.g. accept only patients upon referral, etc...).

For patients enrolled in a Medicare Advantage Plan, please consult the HMO contract.

4. Id.
5. Id.

NOTICE: This information is provided as a commentary on legal issues and is not intended to provide advice on any specific legal matter. This information should NOT be considered legal advice and receipt of it does not create an attorney-client relationship. The Texas Medical Association provides this information with the express understanding that 1) no attorney-client relationship exists, 2) neither TMA nor its attorneys are engaged in providing legal advice and 3) that the information is of a general character. Although TMA has attempted to present materials that are accurate and useful, some material may be outdated and TMA shall not be liable to anyone for any inaccuracy, error or omission, regardless of cause, or for any damages resulting therefrom. Any legal forms are only provided for the use of physicians in consultation with their attorneys. You should not rely on this information when dealing with personal legal matters; rather legal advice from retained legal counsel should be sought.

Updated February 24, 2012

reprinted with permission by the Texas Medical Association.