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New York State Medicaid Update

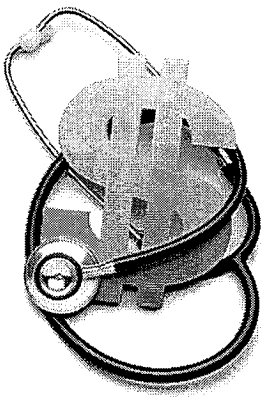
THE OFFICIAL NEWSLETTER OF THE NEW YORK MEDICAID PROGRAM

■ This is a reminder to all hospitals, free-standing clinics and individual practitioners about the requirements of the Medicaid program related to requesting compensation from Medicaid beneficiaries, including Medicaid beneficiaries who are enrolled in a Medicaid managed care or Family Health Plus (FHPlus) plan, or who have been found to be presumptively eligible for Medicaid.

Medicaid Beneficiaries Cannot Be Billed

By enrolling in the Medicaid program, a provider agrees to accept payment under the Medicaid program as payment in full for services rendered. A provider may not make a private pay agreement with a beneficiary to accept a Medicaid fee for a particular covered service and then provide a different upgraded service (usually a service that is beyond the scope of the Medicaid program) and agree to charge the beneficiary only the difference in fee between two services, in addition to billing Medicaid for the covered service. It is an unacceptable practice to knowingly demand or collect any reimbursement in addition to claims made under the Medicaid program, except where permitted by law.

ACCEPTANCE AND AGREEMENT



- *When a provider accepts a Medicaid beneficiary as a patient, the provider agrees to bill Medicaid for services provided or, in the case of a Medicaid managed care or Family Health Plus (FHPlus) enrollee, the beneficiary's managed care plan for services covered by the contract.*
- *The provider is prohibited from requesting any monetary compensation from the beneficiary, or their responsible relative, except for any applicable Medicaid co-payments.*
- *The provider is prohibited from requesting any monetary compensation from pregnant women or children who have been found to be presumptively eligible for Medicaid.*
- *A provider may charge a Medicaid beneficiary, including a Medicaid or FHPlus beneficiary enrolled in a managed care plan, only when both parties have agreed prior to the rendering of the service that the beneficiary is being seen as a private pay patient.*
- *This agreement must be mutual and voluntary.*
- *If, for example, a provider sees a beneficiary, and advises them that their Medicaid card is valid, eligibility exists for the date of service and treats the individual, the provider may not change their mind and bill the beneficiary for that service* ***or any part of that service.***

It is suggested that providers keep the beneficiary's signed consent on file so that they may be treated as a private pay patient. A provider who participates in Medicaid fee-for-service **may not bill Medicaid fee-for-service** for any services included in a beneficiary's managed care plan, with the exception of family planning services, when the provider does not provide such services under a contract with the recipient's health plan. -continued on page 3-

Medicaid Beneficiaries Cannot Be Billed -continued from cover page-

A provider who does not participate in Medicaid fee-for-service, but who has a contract with one or more managed care plans to serve Medicaid managed care or FHPlus members, **may not bill Medicaid fee-for-service** for any services. Nor may any provider bill a beneficiary for services that are covered by the beneficiary's Medicaid managed care or FHPlus contract, unless there is prior agreement with the beneficiary that they are being seen as a private pay patient as described above. The provider must inform the beneficiary that the services may be obtained at no cost from a provider that participates in the beneficiary's managed care plan.

Note: Due to the requirement that PRIOR agreement be made for reimbursement, Medicaid beneficiaries may never be charged for services rendered in an Emergency Room (except applicable Medicaid co-payments).

CLAIM SUBMISSION

The prohibition on charging a Medicaid or FHPlus recipient applies:

- *When a participating Medicaid provider or a Medicaid managed care or FHPlus participating provider fails to submit a claim to Computer Sciences Corporation (CSC) or the recipient's managed care plan within the required timeframe; or*
- *When a claim is submitted to CSC or the recipient's managed care plan, and the claim is denied for reasons other than that the patient was not eligible for Medicaid or FHPlus on the date of service.*

COLLECTIONS

A Medicaid beneficiary, including a Medicaid managed care or FHPlus enrollee, must not be referred to a collection agency for collection of unpaid medical bills or otherwise billed, *except for applicable Medicaid co-payments,* when the provider has accepted the enrollee as a Medicaid or FHPlus patient. Providers may, however, use any legal means to collect applicable unpaid Medicaid co-payments.

EMERGENCY MEDICAL CARE

A hospital that accepts a Medicaid beneficiary as a patient, including a Medicaid or FHPlus recipient enrolled in a managed care plan, accepts the responsibility for making sure that the patient receives all medically necessary care and services. *Other than for legally established co-payments,* a Medicaid or FHPlus recipient should never be required to bear any out-of-pocket expenses for:

- *Medically necessary inpatient services; or,*
- *Medically necessary services provided in a hospital- based emergency room (ER).*

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Medicaid Beneficiaries Cannot Be Billed –continued –

This policy applies regardless of whether the individual practitioner treating the beneficiary in the facility is enrolled in the Medicaid program. When reimbursing for ER services provided to Medicaid managed care or FHPlus enrollees, health plans must apply the:

- *Prudent Layperson Standard;*
- *Provisions of the Medicaid Managed Care/FHPlus Model Contract; and,*
- *Department Directives.*

CLAIMING PROBLEMS

If there is a problem with a claim submission, the provider must first contact CSC. If the claim is for a service included in the Medicaid managed care or FHPlus benefit package, the enrollee's managed care plan must be contacted.

Questions? Please call the Office of Health Insurance Programs at (518) 473-2160.