Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2018-06**
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TO: All Providers

RE: Billing Clients for Missed appointments - Reissue of PB15-05

In 2015, The Department of Social Services (DSS) issued Policy Transmittal 2015-03 (PB 2015-05) to address the topic of billing clients for missed appointments. DSS is issuing this provider bulletin to update the Transportation Broker contact information and to remind providers that federal and state policies prohibit charging Medicaid clients for broken, missed or cancelled appointments. DSS has seen an increase in client complaints about being asked to pay for missed appointments or to sign forms accepting liability for missed appointments. DSS has also received an increasing number of inquiries from providers, as they try to determine how Medicaid fits within the changing business practices related to charging for missed appointments. In addition, this policy is applicable when Medicaid is secondary to a commercial plan and /or Medicare.

Federal Statutes and Regulations

Federal statute limits client payments under Medicaid to cost sharing arrangements. Defined cost-sharing limits are strictly enforced. The Connecticut Medical Assistance Program (CMAP) has no cost-sharing arrangements. In addition, federal regulations provide that state Medicaid agencies must limit provider participation to those who will accept Medicaid as "payment in full." Federal statute also requires states to have safeguards to ensure that services are provided in the "best interests" of the client. These regulations and statutes may be found at 42 U.S.C. § 1396a (a)(14), 42 C.F.R. § 447.15, and 42 U.S.C. § 1396a(a)(19), respectively.

Federal Policy

The federal agency that administers the Medicaid program, the Centers for Medicare & Medicaid Services (CMS), has consistently advised that based on its interpretation of these federal statutes and regulations, Medicaid clients must not be charged for broken, missed or cancelled appointments. Similarly, providers cannot bill for scheduling appointments or for holding appointment blocks. This policy was articulated at least twenty years ago and reconfirmed by CMS in 2015.

Several years ago, Medicare policy changed to permit billing clients for missed appointments in certain circumstances. This includes a requirement that if the provider charges Medicare patients, they must also charge non-Medicare patients. However, this Medicare policy shift did not alter the long-standing Medicaid policy.

State Regulations and Provider Enrollment Agreement

Similar to the federal regulations referenced above, state regulations also require CMAP providers to accept DSS' rates as "payment in full." *See* Conn. Agencies Regs. § 17b-262-526(2). Paragraph 16 in the provider enrollment agreement likewise requires providers to accept DSS' payment as payment in full and to assure that they will not impose any other charges, except for any permitted cost-sharing. The intent of these provisions is to ensure that no client or family member of a client is billed in excess of the amount paid by CMAP.

The CMAP provider enrollment agreement covers all of the health benefit programs administered by DSS, including HUSKY A, B, C and D, and so the prohibition against charging for broken, missed or cancelled appointments extends to individuals covered by each of these programs.

Providers have asked whether the provider enrollment agreement provision (and comparable state regulation) allowing a provider to charge a Medicaid client for non-covered goods or services, when the client knowingly elects to receive the goods or services and enters into a written agreement for such goods or services prior to receiving them, applies to missed appointments. *See* Conn. Agencies Regs. § 17b-262-531(*l*); Provider Enrollment Agreement paragraph 16. The state regulations do not apply. The defined provisions apply only when the client wants to receive actual goods or services, and those goods or services are not covered by Medicaid. Charging a client for a missed appointment, however, is charging the client for a good or service that he or she did not receive and is therefore not permissible under those provisions.

Practical Solutions

The Department understands that missed appointments are disruptive and can have a negative financial impact on a health care provider's practice. DSS also realizes that such fees have become increasingly common in the healthcare industry. While such fees may be an effective and acceptable practice with commercially insured clients, they are not allowed for the Medicaid population. Providers may contact the relevant administrative services organization (ASO) for medical, dental, and behavioral health services to request assistance in helping clients keep their appointments. To reach CHNCT, the medical ASO, call 1-800-440-5071. To reach BeneCare, the dental ASO, call 1-866-420-2924. To reach Beacon Health Options, the behavioral health ASO, call 1-877-552-8247 and follow the prompts to be connected to the Provider Relations Department.

HUSKY A, C and D clients who do not have their own transportation and require transportation to medical, behavioral health and dental appointments may be referred to Veyo, the Medicaid/HUSKY transportation broker, at 1-855-478-7350 or the Veyo Connecticut Member Web site: https://ct.ridewithveyo.com.

Conclusion

For all of the reasons discussed above, CMAP providers may not bill Medicaid clients for missed appointments. If a provider has imposed any such charges, the provider must promptly return any amounts paid by the client to the impacted client(s).

We appreciate your participation as a Medicaid provider and welcome the opportunity to continue working with you to improve the CMAP program and the health of our shared clients.