CMS Response to Public Comments Received for CMS-2019-0121

The Centers for Medicare and Medicaid Services (CMS) received several comments from the public for CMS-2019-0121. This is the reconciliation of the comment.

Comment: The Medicare Contractors require the printed name and relationship if someone other than the Medicare Beneficiary signs the CMS-R-131 Advance Beneficiary Notice of Non-coverage (ABN) form. Can that information be added to the form that is released for 2020? This would prevent a lot of ABN forms from being considered invalid by the Medicare Contractors and would make the expectations clear to the authorized representative who is signing on behalf of the Medicare Beneficiary.

Response: CMS appreciates the suggestion. At this time, we recommend that healthcare providers and suppliers utilize the Blank H (Additional Information) section to include the authorized representative's information. Also, we recommend that the term "representative" be used next to the signature of the representative so it is clear whom is signing the form.

Comment: Under Medicare, suppliers are forbidden from instructing beneficiaries on how to fill out an ABN form and the beneficiary's decision to fill out an ABN form is voluntary. Attached is the current version of the ABN form instructions that states the ABN completion process is voluntary by the beneficiaries. In addition, the DME MACs have consistently educated the supplier community to never instruct beneficiaries on how to fill out the ABN form.
This new direction in the instructions requiring suppliers to instruct dually enrolled patients to check Option 1 appears to go against Medicare ABN previous direction. AAHomecare requests CMS provide clarity and consistency on the supplier's role in the process of completing an ABN form. It would be inconsistent for supplier to 'sometimes' instruct beneficiaries on how to complete the form.

Response: Thank you for your comment. While CMS does reiterate that beneficiaries must not be instructed to select any options, this specific direction is only used for those beneficiaries who are enrolled in both Medicare and Medicaid. This instruction comes from direct statutory authority under Title 18 of the Social Security Act. CMS has also edited the language on the ABN form instructions to clarify the conflicting language.

Comment: HCA is concerned that patients receiving services from HHAs that operate in New York State (NYS) under a Third Party Liability (TPL) program may incorrectly choose Option Box One unless further guidance is included in the instructions.
Under the TPL, HHAs that believe a dual eligible patient does not meet Medicare home health eligibility criteria (i.e. is not homebound or does not require skilled care) can bill Medicaid for services without billing Medicare first. Then a third party contractor for the New York State Department of Health (DOH), Office of Medicaid Inspector General (OMIG) – the University of Massachusetts Medical School – reviews such cases

retrospectively and determines if a claim should be submitted to Medicare. If the contractor decides that a claim should be submitted, HHAs are then instructed and required to demand bill Medicare.

Historically, HHAs in NYS have relied on the following language from the Medicare Claims Processing Manual, Chapter 30 – Financial Liability Protections (page 69) and the TPL program to instruct dual eligible patients to select Option Box 2. HCA recommends that CMS incorporate some of this language from the Medicare Claims Processing Manual into the ABN instructions so that dual eligible patients are instructed to choose Option Box 2 in the affected states.

Conflicting Language

The language in the proposed instructions on page 5 which states that "Dually Eligible beneficiaries must be instructed to check **Option Box 1** on the ABN in order for a claim to be submitted for Medicare adjudication" seem to conflict with the following statement on page 6 of the proposed instructions:

The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Under no circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice.

CMS may want to consider adding language to this section of the proposed instructions on page 6 to clarify that this may not apply to dual eligible cases as explained on page 5 of the instructions.

Unclear Language

Lastly, on page 5 of the proposed instructions, the second bullet is unclear and we suggest that the word "with" be replaced with "has":
 If the beneficiary with **has** full Medicaid coverage and Medicaid denies the claim (or will not pay because the provider does not participate in Medicaid), the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy, subject to any state laws that limit beneficiary liability.

Response: Thank you for your comment. CMS is looking into your concern regarding the HHAs of NY and other TPL program states and are open to providing specific guidance to these states as needed. CMS has edited the language on the ABN form instructions to clarify the conflicting and unclear language.

Comment:
Additional Guidance for Dual Eligibles and QMBs

We welcome the additional special guidance in the form instructions for dual eligibles and commend CMS for including guidance specific to dual eligibles in this Paperwork

Reduction Act submission. We frequently hear from advocates that ABNs can be confusing for dual eligibles, particularly given the federal rules prohibiting the billing of dual eligibles for Medicare Part A and B covered services.1 This additional language helps to clarify for providers who work with dual eligibles that they cannot collect for covered services and explicitly delineates the limited circumstances under which such payment is appropriate. We also appreciate the inclusion of recognizing potential protections in state law as well. Despite increased attempts at outreach and education from CMS and advocacy organizations, we find that some Medicare providers remain confused or unaware of these billing protections, so this additional language serves as yet another important reminder to providers about the QMB billing rules.

Ensuring ABNs Are Used Appropriately

CMS has a responsibility to make clear under what situations ABNs are to be issued and to prevent providers from abusing the form. We were surprised to find that the form instructions do not remind providers that under most circumstances, ABNs are not to be issued on a routine basis as explained in the Medicare Learning Network (MLN) on Medicare Advance Written Notices of Noncoverage, ICN 006266 (October 2018). We believe this MLN contains helpful reminders about both the frequency of and prohibitions on ABN issuance that are important to include in the form instructions.

Ensuring Beneficiaries Understand the ABN

ABNs are only useful when beneficiaries truly understand their choices and the potential consequences of accepting a service that may be denied under Medicare. Accordingly, we ask CMS to ensure that ABNs, as standard documents that affect beneficiary payment responsibilities, translate the form to the 17 languages in which the Social Security Administration routinely makes materials available and include guidance to providers that reminds them of their obligation to ensure access to interpreter services when appropriate. We frequently encounter situations where ABNs are invalidated because an English ABN was given to an older adult with limited English proficiency without any interpretation.
Similarly, under the section "Completing the Notice," the instructions direct providers to use 12-point font, but in our experience, older adults find 14 and 16-point font more legible, so we encourage CMS to direct providers to use a font size that older adults will not strain to comprehend.

Response: CMS appreciates your comments regarding the additional language added for the dual eligible beneficiaries and QMBs. Thank you for your comments regarding adding language from the MLN into the ABN form instructions. CMS will consider this addition in the future. Please note that this language may already be found in the Medicare Claims Processing Manual located at:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

CMS instructs providers, suppliers, and beneficiaries to contact 1-800-Medicare or email AltFormatRequest@cms.hhs.gov for alternative formats of the form. CMS also provides our forms in large print format. These forms may be located on the ABN website:

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

Comment: We strongly encourage CMS to expand the current Medicare Fee-for-Service (FFS) ABN to Medicare Advantage (MA) to ensure beneficiaries are provided the same financial protections. Currently, when an MA beneficiary has a qualifying Out-of-Network (OON) event, but services the provider delivers are not medically necessary under FFS rules, the provider is able to bill the beneficiary directly for the cost of the service.

Response: Thank you for your comment. At this time, the statutory authority for the ABN is only applicable to Medicare FFS beneficiaries. CMS will take your comment into consideration.