CENTER *for* HEALTH LAW *and* POLICY INNOVATION
HARVARD LAW SCHOOL

Patient Financial Obligations in Medicare: Principal Illness Navigation, Community Health Integration, and Social Determinants of Health Risk Assessment

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This resource addresses frequently asked questions about Medicare coverage of principal illness navigation (PIN), community health integration services (CHI Services), and social determinants of health risk assessment (SDOH Risk Assessment), with a focus on patient financial obligations.

The document was developed to help Medicare providers and community-based organizations providing care incident to a Medicare provider understand considerations for implementation. The resource does not and should not be construed as providing legal advice. For specific legal questions, please consult an attorney.

Original Medicare (Medicare Parts A & B)

Is beneficiary coinsurance required?

Medicare beneficiaries enrolled in Original Medicare are responsible for a deductible.[1] After that, Medicare usually pays 80% of the fee schedule rate for Part B services; the beneficiary is responsible for the other 20%.[2] This 20% is called "coinsurance."

In the final rule creating the codes, the Centers for Medicare and Medicaid Services (CMS) clarifies that PIN, CHI Services, and SDOH Risk Assessment are Part B services subject to both the annual deductible and 20% beneficiary coinsurance. The exception is that beneficiary cost sharing is not applicable when an SDOH Risk Assessment is furnished as part of an Annual Wellness Visit.

Who is responsible for discussing coinsurance with beneficiaries?

In the final rule, CMS states that beneficiaries should be alerted to coinsurance obligations as part of the consent process for CHI Services and PIN. Consent may be obtained by the billing provider or by their auxiliary personnel (e.g., a person who contracts with the provider to deliver navigation services). For SDOH Risk Assessment, providers are encouraged to notify beneficiaries of coinsurance obligations as applicable.[3]

Do beneficiaries have to pay the coinsurance amount out of pocket?

Many beneficiaries have other, supplemental insurance that will cover the beneficiary coinsurance amount. Supplemental insurance includes:

- A private supplemental insurance policy ("Medigap"). Medigap insurance covers coinsurance amounts.[4]
- Medicaid. Medicaid covers coinsurance amounts for Qualified Medicare Beneficiaries (the majority of dually eligible beneficiaries) and may cover coinsurance amounts for non-Qualified Medicare Beneficiaries.[5]

What do coinsurance amounts look like for these services in 2024?

Based on our review of maximum prices for services under the 2024 Physician Fee Schedule, we estimate beneficiary coinsurance amounts of around $4 for an SDOH Risk Assessment (if applicable), around $15 dollars for one hour of CHI Services or PIN, and around $10 for each additional 30 minutes of CHI Services or PIN. For more information, see *Table 1*, below.

Table 1. Estimated beneficiary coinsurance amounts by code for 2024

Code	Maximum Fee Schedule Price	Estimated Beneficiary Coinsurance
G0136 (SDOH Risk Assessment)	$18.66	$3.73
G0019 (CHI Services, 60 min.)	$79.24	$15.85
G0022 (CHI Services, add 30 min.)	$49.44	$9.89
G0023 (PIN, 60 min.)	$79.24	$15.85
G0024 (PIN, add 30 min.)	$49.44	$9.89
G0140 (PIN - Peer Support, 60 min.)	$79.24	$15.85
G0146 (PIN - Peer Support, add 30 min.)	$49.44	$9.89
G0511 (Federally Qualified Health Centers & Rural Health Clinics)	$70.71	$14.14

How is the coinsurance amount collected?

Beneficiaries without supplemental insurance: When services are provided to a beneficiary without supplemental insurance, the Medicare Part B provider is responsible for attempting to collect the coinsurance amount from the beneficiary.

Beneficiaries with a Medigap policy: The Medicare Part B provider is also responsible for billing a beneficiary's Medigap policy. Unless the Medigap policy has a deductible that has not yet been met, the Medigap plan must accept a notice of Medicare payment as a claim.

Medicaid: Finally, when a Medicaid program is covering the cost, Medicare automatically "crosses over" claims to states. The provider does not need to submit a separate claim. The provider does, however, need to be enrolled as a provider in the state's Medicaid program.[6]

When Medicaid is responsible for beneficiary coinsurance, does the Medicare Part B provider collect the full amount?

As explained by CMS as part of Chronic Care Management services guidance, "most states limit payment of Medicare cost sharing to the 'lesser-of' Medicaid or Medicare rates. If the service is not covered in the State plan, states can set other reasonable payment limits, approved by CMS, for the service. The net effect of these policies is that many states pay little to none of the Medicare deductible/coinsurance, leaving practitioners to absorb the costs for Qualified Medicare Beneficiaries."[7]

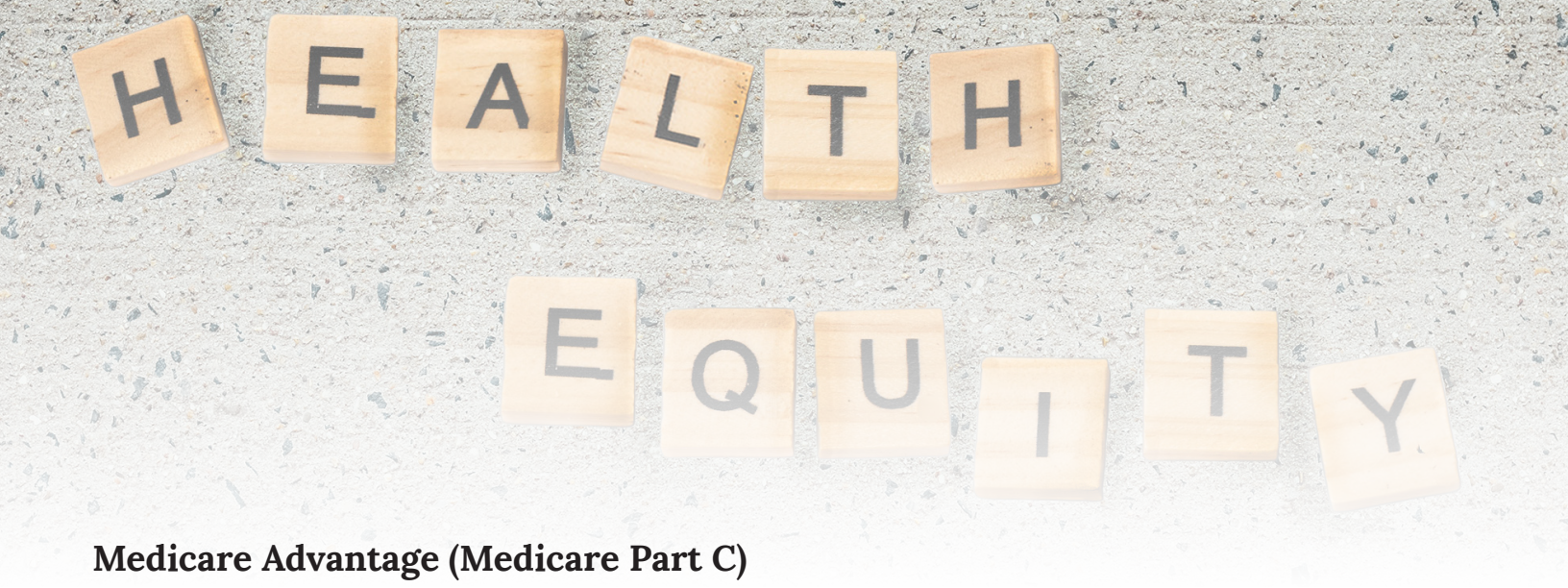
What happens if a beneficiary does not have supplemental insurance and the individual cannot pay the coinsurance amount? Can the Medicare Part B provider waive or forgive the obligation?

The waiver of Medicare beneficiary payment obligations raises concern about compliance with federal health care fraud and abuse law – especially the **routine** waiver of coinsurance amounts. Providers should consult organizational policies and/or an attorney regarding waivers, including the difference between routine waivers and individually-determined waivers of coinsurance for beneficiaries with financial hardship.

In the absence of a waiver, a beneficiary's medical record should reflect that there were normal, reasonable attempts to collect payment before the charge is written off. Providers should consult organizational policies and/or an attorney regarding when and under what circumstances they may write off the charge.[8]

Federally Qualified Health Centers (FQHCs) have sliding fee discount programs below certain income levels. How does that impact Medicare coinsurance?

An FQHC is permitted to reduce coinsurance in line with its sliding fee discount program.[9] The National Association of Community Health Centers has published guidance on this topic.



Medicare Advantage (Medicare Part C)

Are Medicare Advantage beneficiaries also responsible for a portion of the cost?

Out-of-pocket costs for Medicare Advantage beneficiaries are dependent on their Medicare Advantage plan.

Endnotes

1 Ctrs. For Medicare & Medicaid Servs., Costs, https://www.medicare.gov/basics/costs/medicare-costs (last visited Mar. 7, 2024).

2 Ctrs. For Medicare & Medicaid Servs., Costs, https://www.medicare.gov/basics/costs/medicare-costs (last visited Mar. 7, 2024).

3 *See* Ctrs. For Medicare & Medicaid Servs., Health-Related Social Needs FAQ (Mar. 2024), https://www.cms.gov/files/document/health-related-social-needs-faq.pdf.

4 Ctrs. For Medicare & Medicaid Servs., Learn What Medigap Covers, https://www.medicare.gov/health-drug-plans/medigap/basics/coverage (last visited Mar. 7, 2024).

5 Ctrs. For Medicare & Medicaid Servs., Medicare Savings Programs, https://www.medicare.gov/basics/costs/help/medicare-savings-programs (last visited Mar. 7, 2024).

6 *See* Ctrs. For Medicare & Medicaid Servs., Frequently Asked Questions about Practitioner Billing for Chronic Care Management Services (Aug. 16, 2022), https://www.cms.gov/files/document/chronic-care-management-faqs.pdf.

7 *See* Ctrs. For Medicare & Medicaid Servs., Frequently Asked Questions about Practitioner Billing for Chronic Care Management Services (Aug. 16, 2022), https://www.cms.gov/files/document/chronic-care-management-faqs.pdf.

8 U.S. Dep't of Health and Human Servs., Office of Inspector General, Fraud & Abuse Laws, https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/ (last visited Mar. 7, 2024).

9 Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Safe Harbors Under the Anti-Kickback Statute and Civil Monetary Penalty Rules Regarding Beneficiary Inducements, 81 Fed. Reg. 88368, 88372 (Dec. 7, 2016).

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