Fighting Improper Billing of Dual Eligibles: New Strategies

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Improper billing of dual eligible Medicare beneficiaries and Qualified Medicare Beneficiaries ("QMBs"), sometimes referred to as a form of "balance billing," has been a persistent problem, but some significant progress is being made. Dual eligibles across the country report receiving improper bills from their medical providers for covered services,[1] and the problem has captured the sustained attention of federal officials at the Centers for Medicare and Medicaid Services (CMS), who, in addition to releasing a detailed report (the "CMS Study") on this commonplace practice, have ramped up outreach and education to providers and consumers.[2]

Due in large part to CMS efforts and the efforts of aging advocacy organizations to draw attention to the issue, there are several major positive developments to report. This Justice in Aging issue brief offers an overview on the problem of improper billing and focuses on new ways that advocates can take action. These changes and improvements can help mitigate the problem by arming advocates and consumers with tools to fight improper billing.

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This brief starts by reviewing the basic problem of improper billing, including recent developments and advocacy tips. It then examines (1) how billing protections are applied in managed care, (2) how the challenge of identifying QMBs makes improper billing more common, and finally (3) how the "lesser-of" payment rule underlies the entire improper billing problem. In each instance, this brief reports on new developments and includes advocacy tips on how to assist beneficiaries in fighting illegal bills.

1 Robert Pear,"Doctors Are Improperly Billing Some on Medicare, U.S. Says", *New York Times*, July 30, 2016, available at nytimes.com/2016/07/31/us/politics/doctors-are-improperly-billing-some-on-medicare-us-says.html?_r=0.

2 Center for Medicare &Medicaid Services, *Access to Care Issues Among Qualified Medicare Beneficiaries (QMB),* (July 2015), available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

Ms. Mock,[3] a 72 year old senior with multiple chronic conditions, felt increasingly frustrated and helpless. She had seen the same primary care doctor for many years, and her doctor knew she had both Medicare and Medicaid coverage (a dual eligible). However, the new receptionist at the doctor's office told her that because the office did not accept Medicaid, Ms. Mock must pay the 20% co-insurance that Medicare did not cover. Ms. Mock lived on a fixed income that barely covered rising rent and groceries. She worried about the onslaught of future bills and feared being hounded by a collection agency. Her case manager at the local senior center told Ms. Mock that she should not have to pay for covered medical procedures, and helped her write a letter telling them not to bill her. However, the doctor's office persisted in sending bills, and soon Ms. Mock began to dread visits to her doctor, as the office repeatedly reminded her about the growing, unpaid balance on her account.

Ms. Mock's situation is, unfortunately, all too common. But advocates now have more tools to help people like her fight the bills she should not be paying, and help her access the health care she needs despite her limited budget.

Improper Billing: The Basic Issue

Federal law, 42 U.S.C. § 1396a(n)(3)(B), provides that no Medicare-enrolled provider may require payment directly from a Qualified Medicare Beneficiary (QMB) for Medicare-covered services. The statute subjects Medicare providers to federal sanctions, including disenrollment from the Medicare program, for violating this provision.

Qualified Medicare Beneficiaries (QMB) are individuals with Medicare, who receive help from the Medicaid program to pay for their Medicare premiums, deductibles, co-payments, and coinsurance. The QMB program is a Medicare Savings Program administered by state Medicaid agencies. At a minimum, the QMB program covers individuals with incomes at or below 100% of the federal poverty level and assets at or below $7,280 for an individual, or $10,930 for a couple, although some states have set more generous standards.

Most QMBs (79%), known as QMB-plus, also are full-benefit dual eligibles who qualify for full Medicaid coverage under their state laws. Likewise, most dual eligibles with full Medicare and Medicaid benefits also are QMBs. QMB-only beneficiaries (21%) receive help paying Medicare premiums, deductibles, copayments and co-insurance, but do not qualify for other Medicaid services. [4]

In addition to federal statutory protections, state laws and additional authorities may also protect dual eligibles from being charged for covered medical services. Some states, like California, protect all Medicaid enrollees, including dual eligibles who may not be QMBs, from being billed for covered services by any health care provider.[5] In other states, the protections may only apply if a provider is enrolled in the state Medicaid program. Since these protections vary from state to state, advocates need to review their specific state laws. As an initial resource for advocates, Justice in Aging has compiled a list of state authorities on improper billing, which is appended to this issue brief and available as a separate document here.[6]

3 Ms. Mock's situation is based on the stories that advocates have reported when helping dual eligibles with this problem.

4 For more on the QMB program, see the Medicare.gov page explaining Medicare Savings Programs at: medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html.

5 See, e.g., Cal. Welf. & Inst. Code § 14019.4.

6 This compilation is intended to be a starting point for state-based protections, and advocates should check for possible changes before asserting the protections on behalf of consumers.

Improper billing persists despite these legal prohibitions. Many QMBs report that their doctors and other providers bill them for Medicare deductibles and co-insurance, often referring unpaid bills to collections, as documented in the CMS Study.[7] Advocates continue to struggle to help their clients fight improper bills. Until recently, advocates have not known how to report violations to CMS when violations occur.

Progress Update

CMS recently instituted procedures to take action when improper billing occurs. Beneficiaries and their advocates can contact 1-800-MEDICARE if they believe improper billing has taken place. The Customer Service Representatives (CSRs) now can verify QMB status in their database and will instruct beneficiaries to tell their provider that they may not be billed. (For model letters that a beneficiary or advocate can send to a provider, see the Justice in Aging improper billing toolkit). If a beneficiary does not successfully resolve the billing problem with the provider, the CSRs will refer the issue to the Medicare Administrative Contractor (MAC) for the region where the beneficiary lives. The Medicare contractor will send a letter to the provider instructing the provider to return any payments received from the QMB and to cease any current billing or collection effort. Importantly, the MAC will also send a letter to the beneficiary with a copy of the provider communication and with instructions not to pay the bill. A provider bulletin explains the process and includes the model letters that are used.[8]

For 2017, the Medicare & You Handbook (p. 99) for the first time includes a discussion of payment protections and directs beneficiaries to contact 1-800-MEDICARE to report problems.[9] "What to do if you're wrongfully billed for Medicare costs," a consumer advisory authored by the Consumer Financial Protection Bureau and the Medicare-Medicaid Coordination Office (MMCO) within CMS, also tells consumers in simple straightforward language the steps they should take if they experience improper billing.[10] The consumer advisory also tells beneficiaries whose bills have been sent to collection that, in addition to calling 1-800-MEDICARE, they can file a complaint with the CFPB. The consumer advisory is available on-line and also as a two-page handout. Information about QMB billing protections was also included in the new MOON notices, which are beneficiary notices given to individuals in hospital settings to explain observation status and the financial consequences for Medicare beneficiaries.[11] Some state Medicaid agencies also have publications, such as this one created for New Jersey consumers, that explain billing protections.[12]

National and state provider associations have also issued bulletins to their members about their billing responsibilities, such as this one by the California Medical Association.[13] Advocacy organizations have created simple, consumer-facing flyers like this one to educate clients on their rights and how to take action.[14]

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7 See Note 2, *supra*.

8 MLN Matters, *Issuing Compliance Letters to Specific Providers and Suppliers Regarding Inappropriate Billing of Qualified Medicare Beneficiaries (QMBs) for Medicare Cost-Sharing* (Nov. 18, 2016), available at cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf.

9 *Medicare & You 2017*, available at medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf.

10 Available at consumerfinance.gov/about-us/blog/what-do-if-youre-wrongfully-billed-medicare-costs/. See also The Medicare Blog 01.18.17, available at blog.medicare.gov/2017/01/18/qualified-medicare-beneficiary-program/.

11 MOON Notices and instructions are available at cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

12 N.J. Dep't of Health Serv., *When You Have Medicaid and Other Insurance* (Jan. 2016), available at nj.gov/humanservices/dmahs/home/Medicaid_TPL_Coverage_Guide.pdf.

13 Cal. Med. Assn, *CMS auditing physicians who inappropriately bill Medi-Medi patients* (Dec. 2016), available at cmanet.org/news/detail/?article=cms-auditing-physicians-who-inappropriately.

14 Justice in Aging and Health Consumer Alliance, *Do You Have Free Medi-Cal? Have You Been Billed?,* available at calduals.org/wp-content/uploads/2016/11/Balance-Billing-JiA-flyer-2016.pdf.

Advocacy Tips

- Use the new system of reporting complaints to 1-800-MEDICARE. Please contact Justice in Aging with feedback on how well it is working and on any difficulties encountered. Also note that because CSRs can check on QMB status, calling 1-800-MEDICARE is a way to verify a beneficiary's coverage.
- Use the Justice in Aging toolkit and model letters and new CMS provider bulletins to educate providers when they improperly bill beneficiaries.[15]
- Work with your local and state medical associations and other provider associations to educate providers about their responsibilities to protect their patients from improper billing.
- Educate and empower your clients with trainings and flyers. Use the consumer resources discussed above or create your own.
- Use the attached list of state authorities as a starting point and determine what additional levers, if any, are available through state law, and under what circumstances they may be appropriate.
- Tell Justice in Aging about the cases you are seeing and how you are addressing these issues. We created a simple form to make it easy. Your reports and stories will help us in our advocacy.

Special Issues with Managed Care

As more and more beneficiaries find themselves in a managed care plan for Medicare, Medicaid, or both, low-income older adults and people with disabilities may have increased challenges and additional protections related to improper billing.

Issues in Medicare Advantage

Across the country, an estimated three million dual eligibles, or about three out of ten, are enrolled in the Medicare Advantage (MA) program.[16] CMS regulations require that Medicare Advantage plans, in their contracts, ensure that all MA plan providers accept the capitated rate from the plan as payment in full; providers cannot charge QMBs for Medicare cost-sharing.[17]

Medicare Advantage plans are managed care plans operated by private insurers. They offer all Medicare Part A and Part B services and, in most cases, also provide Medicare prescription drug coverage.

Many dual eligibles and QMBs in Medicare managed care are enrolled in Dual Eligible Special Needs Plans (D-SNPs), plans that are targeted toward dual eligibles and help them coordinate Medicare and Medicaid benefits. Other dual eligibles are enrolled in Medicare-Medicaid plans (MMPs) that combine both benefits. Because these plans focus on the dual population, the issue of improper billing rarely arises for dual eligibles who are enrolled in D-SNPs and MMPs.

15 See Note 9, *supra*.

16 See, e.g., Kaiser Family Found., *Medicare Fact Sheet* (May 2016), available at http://kff.org/medicare/fact-sheet/medicare-advantage/.

17 42 C.F.R. § 422.504(g)(1)(iii). Note that the Medicare Advantage regulation covers all dual eligibles and all QMBs. In contrast, the federal statute excludes those dual eligibles—a minority—who do not also qualify under the QMB eligibility rules.

However, for dual eligibles who are enrolled in a traditional Medicare Advantage plan (one that is not tailored to low-income seniors), improper billing is more likely. That is because these traditional Medicare Advantage plans, and their contracted providers, may treat their dual eligible members like their Medicare-only members, who typically must pay co-pays at each visit. Furthermore, written materials from such Medicare Advantage plans may not distinguish dual eligibles from Medicare-only beneficiaries, so duals may even receive member cards from their Medicare Advantage plan listing a co-payment amount. The Medicare Advantage plan's computer systems may also not identify these dual eligibles as exempt from paying the co-payment and other cost-sharing, so staff at contracted provider offices may prompt these members for payment, contravening rules against the improper billing of dual eligibles. Unfortunately, as these co-payments can sometimes be relatively small amounts, improperly billed dual eligibles are less likely to report them to advocates. Instead, many duals simply make the payments as a condition of receiving services.

Mr. Ramirez is a QMB enrolled in Health-Is-Good Medicare Advantage Plan. Mr. Ramirez is 86 years old and has congestive heart failure. This requires him to see a cardiologist on a frequent basis. Every time he visits his Health-Is-Good cardiologist, he shows his MA plan card, and the office charges him the standard $25 co-payment before he enters the exam room. How can Mr. Ramirez get these payments to stop?

Progress Update

In its 2017 Call Letter, CMS stressed to Medicare Advantage contractors that federal regulations, specifically 42 C.F.R. § 422.504 (g)(1)(iii), require that provider contracts must prohibit collection of deductibles and co-payments from dual eligibles and QMBs.[18] In the Call Letter and also in later-issued clarifying guidance in the Medicare Managed Care Manual, Ch. 4, Sec. 10.5.2, CMS also told plans that refusal of in-network providers to serve enrollees based on their QMB status/Medicaid eligibility constitutes prohibited discrimination.[19] CMS has followed up with education and technical assistance to plans and provided strong encouragement to plans to take measures to ensure that their providers understand the rules and also that they are in compliance.

As a result of these CMS actions, plan attention to improper billing issues has increased. Some managed care plans, in partnership with advocates, have implemented creative and effective tools that educate members on their rights and curb the practice among providers. Many plans already conduct routine training of in-network providers, office staff, and agents, reminding all of the obligations under the law. Two examples of provider fact sheets created by plans are found here and here.[20] Some plans have partnered with local legal services providers and other aging advocates to conduct trainings for their staff. Trainings are particularly important as new physician groups join the managed care plan's network. Plans have also created tailored on-hold messaging for members over the phone when members are waiting to speak with a customer service representative, explaining to dual eligibles and QMBs that if they get billed, they should seek assistance from the plan. As a complement, some plans have changed the on-hold messaging for their contracted providers as well, so they too are reminded of the rules when they call their plan's provider information hotline. Plans have also sent out special mailers and other written communications to beneficiaries that briefly remind them that they cannot be billed and prompt them to call the plan with any billing issues.

18 Relevant portions of the Call Letter are available at justiceinaging.org/wp-content/uploads/2016/04/Call-Letter-Balance-Billing.pdf.

19 Available at cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.

20 A factsheet created by United Healthcare is available at uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/UHC-BalanceBillingReminder.pdf and one by Superior Healthplan is available at superiorhealthplan.com/content/dam/centene/Superior/Provider/PDFs/SHP_20163630D-MMP-Balance-Billing-QRG-P-01122017.pdf.

Advocacy Tips

- If a Medicare Advantage plan member experiences illegal billing, and the provider insists on continuing the improper billing, ask the plan to intervene. Plans, just like their contracted providers, have a duty to ensure that the billing stops and that improper payments be returned.
- If you learn that a plan employee is giving providers or beneficiaries incorrect information on billing protections, go up the chain of command with the plan. In most cases, supervisory personnel are more familiar with CMS requirements. Justice in Aging can assist if these efforts are unsuccessful.
- If a provider refuses to serve a plan member because of QMB status or dual eligibility, enlist assistance from the plan. Plans have a duty to ensure that all members, including dual eligibles and QMBs, have the same access to in-network providers.
- Reach out to Medicare Advantage plans in your area to partner in educating providers and beneficiaries about billing protections. Share the best practices identified above, and consider joint presentations to provider groups or other initiatives.

Issues in Medicaid Managed Care

Over 3.8 million dual eligibles are enrolled in some form of Medicaid managed care, and the number is growing.[21] As more states transition to either optional, partial, or mandatory Medicaid managed care for dual eligibles, implications for potential improper billing are significant.

Billing in Medicaid managed care can generate confusion among providers, just as Ms. Mock's doctor was confused about billing because the doctor did not accept Medicaid. In one situation, the provider may actually be contracted with Medicaid, but not specifically with the dual eligible beneficiary's Medicaid plan. Fortunately, providers do not have to be contracted with the specific Medicaid plan – or the state Medicaid agency – to collect the appropriate cost-sharing from the Medicaid program. They may, instead, enroll as Medicaid crossover-only providers in order to receive payment. Many states have developed simple forms to facilitate that enrollment.[22]

Progress Update

Recent changes to the Medicaid managed care regulations make it easier for providers to receive any amounts that they are owed from Medicaid managed care plans. The regulations now require that any Medicaid managed care plan that has any dual eligible enrollees and that has delegated authority from the state to pay Medicare co-payments must sign a Coordination of Benefits Agreement and participate in the automated crossover billing process administered by Medicare. [23] This means that after Medicare renders payment, the balance is automatically sent to the Medicaid plan to pay, if any amount is owed. Providers do not have to take the additional step of separately billing the Medicaid plan after Medicare has rendered payment. The result is that providers are paid whatever cost-sharing they are owed from the Medicaid plan, just like they would be in fee-for-service Medicaid.

Some promising practices for provider education have developed as well. California's Department of Healthcare

21 Kaiser Family Found., *Dual Eligible Enrollment in Medicaid Managed Care, by Plan Type*, available at kff.org/medicaid/state-indicator/dual-eligible-enrollment-in-medicaid-managed-care-by-plan-type/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D.

22 For example, California has developed this form: dhcs.ca.gov/provgovpart/Pages/MedicareCrossoverOnlyProviderAuthorization.aspx.

23 42 C.F.R. § 438.3(t).

Services, for example, has created a fact sheet as part of a Physician Toolkit.[24] The fact sheet discusses billing rules for dual eligibles and emphasizes that the shift to Medicaid managed care does not change physician rights to payment.

Advocacy Tips

- Work with your state Medicaid program, local Medicaid managed care plans, and provider organizations to ensure that providers understand that their patient's enrollment in a Medicaid managed care plan has no effect on whether the provider gets payment for Medicare-covered services. Payments that providers receive will be exactly the same whether or not the provider has any affiliation with a beneficiary's Medicaid plan. Develop informational materials for physicians.
- Find out if your local Medicaid managed care plans have complied with the new managed care regulation and are accepting crossover billing. If they have not, work with your Medicaid agency and plans to get them into compliance.[25]
- Ensure that communications to beneficiaries and providers from Medicaid plans and from your state Medicaid agency include clear and consistent messages about Original (fee-for-service) Medicare beneficiaries' right to use any Medicare provider for Medicare-covered services.

Helping Providers Identify QMBs

Although all QMBs are protected under the federal statute, some practical considerations exist that make it difficult for QMBs to receive these protections. Not all QMBs may know that they are enrolled in this specific Medicare Savings Program and therefore may not understand that the protection applies to them. State Medicaid cards rarely indicate whether a full-benefit dual eligible is also a QMB. Beneficiaries who are QMB-only often either receive a Medicaid card that looks the same as the card issued to a full-benefit dual eligible or receive no card at all. A recent informal survey of advocates found only four jurisdictions that provided cards identifying beneficiaries as QMBs, despite the CMS State Medicaid Manual requiring so.[26] Further, state computer systems that identify individuals enrolled in Medicaid programs, including QMBs, generally are accessible only to providers who are enrolled in the state Medicaid program. Thus, Medicare-only providers who opt not to enroll in Medicaid have been unable to check an individual's status.

Progress Update

The new protocols at 1-800-MEDICARE, discussed above, permit a CSR to pull up an individual's QMB status.[27] More recently, CMS has started to initiate changes to its systems with hopes of further stemming inappropriate QMB billing. To this end, starting in October 2017, FFS systems will notify providers that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability.[28] This will enhance providers' ability to identify QMBs and reduce improper billing. The system will also inform beneficiaries about QMB protections through the Medicare Summary Notice. In its 2017 Call Letter, CMS also impressed on

24 *Providing Fee-for-Service Medicare Services to Dual Eligibles in Medi-Cal Plans*, available at calduals.org/wp-content/uploads/2015/03/010_PhysToolkit_FFS_Physician_Payments-R4.pdf.

25 Note that, in commentary, CMS acknowledged that managed care plans will need "some time" to enter into Coordination of Benefits Agreements. 81 Fed. Reg. 27498, 27555 (May 6, 2016).

26 Medicare State Medicaid Manual, Ch. 3, § 3490.11, available at cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

27 See Note 9, *supra*.

28 CMS Manual System, Pub 100-04 Medicare Claims Processing (Feb. 3, 2017), available at: www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3715CP.pdf.

Medicare Advantage plans their obligation to ensure that network providers protect dual eligibles and QMBs, identifying the files that plans can consult to establish an enrollee's status.[29]

Advocacy Tips

- Talk to your state about issuing cards that clearly identify both QMB-only beneficiaries and those who are QMB-plus, meaning that they are eligible for both full-scope Medicaid and QMB. QMB identification on cards would both help providers and also be a useful tool in educating beneficiaries about their status and their rights.
- Use the new 1-800-MEDICARE capability to determine your client's QMB status.
- Talk to the Medicare Advantage plans in your area about what they are doing to identify QMBs and dual eligibles to their in-network providers.

The Lesser-Of Rule

Although improper billing of dual eligibles arises from a variety of reasons, including provider negligence and confusion, the underlying source of the problem stems from a provision of the Medicaid statute that explicitly allows states to limit payment to the Medicare cost-sharing amount or the state's Medicaid rate for the same service, whichever is smaller.[30] Known as the "lesser-of" rule, this policy, given generally low Medicaid rates, often leads to providers not being entitled to any additional payments. In other words, instead of receiving the full 20 percent balance typically owed for a Medicare service, the provider can only collect up to the Medicaid rate.

Mrs. Li, who has QMB and is dually eligible for Medicare and Medicaid, goes to see Dr. Care, her primary care doctor. Dr. Care's office visit is valued as $100 on the Medicare fee schedule. Medicare is the primary payor and Medicaid the payor of last resort. So, Medicare pays 80 percent ($80) to Dr. Care. In Mrs. Li's state, the Medicaid rate for this office visit is lower than the Medicare rate, and it is only $70. Mrs. Li's state has adopted the "lesser-of" rule for all primary care, so Dr. Care is only entitled to $70 under the Medicaid rules. Since Dr. Care has already been paid $80, Dr. Care receives no additional payment from the state Medicaid program. Dr. Care is prohibited from billing Mrs. Li for any balance.

This "lesser-of" policy causes some providers to seek to bill dual eligibles for the balance after receiving payment from Medicare, despite clear prohibitions against doing so. Other providers, knowing they cannot collect the full Medicare amount, decide not to serve dual eligibles at all. Even when the Medicaid rate is higher than the Medicare rate for the same service, it may only be slightly higher, such that any additional payment the provider receives is a nominal amount. Low Medicaid rates and the likely reality that they will receive little, if any, reimbursement from Medicaid prompt many Medicare providers to not enroll as Medicaid providers, even when they serve dual eligibles.

Progress Update

The CMS study provided important quantitative and qualitative analysis of the negative impact that the lesser-of policy has on access to Medicare providers and is a good starting point for advocacy to change the lesser-of policy. Nevertheless, the route to change may be a long one. A solution requiring either states or the federal government to

29 See Note 19, *supra*.

30 The 1997 Balanced Budget Act allowed "lesser of" Medicaid payment policies. For a discussion see CMS Report, Note 2, *supra*.

pay up to the full 100% of the Medicare rate seems unlikely in the current political climate, but would be critical to ensuring duals have full access to care without being pressured to make payments they simply can't afford. State and federal policymakers need to be educated further on the implications of the lesser-of policy for access to care. This education is an important step in ultimately fixing the core problem.

Advocacy Tips

- Collect stories of dual eligible beneficiaries who lose access to doctors because of state payment rates.
- Continue to raise with your state Medicaid program and state legislators the corrosive impact of the lesser-of policy on beneficiary access to care.[31]

Conclusion

Many new tools have been added to the arsenal to protect older adults and people with disabilities who are QMBs or dual eligibles from improper billing. Beneficiaries and their advocates now have new ways to report and combat illegal billing. Promising practices are emerging for increased education of beneficiaries, providers, plans, advocates, and state policymakers. By using these new tools effectively, advocates can continue to make inroads to attack the persistent problem of improper billing, which wreaks havoc on the limited budgets of the lowest-income Medicare beneficiaries and imperils their access to care.

31 Advocates can find summaries of their state's current Medicare policies for paying Medicare cost sharing, arranged by state and type of service, in a state policy compendium prepared by the Medicaid and CHIP Payment and Access Commission (MACPAC), available at macpac.gov/publication/state-medicaid-payment-policies-for-medicare-cost-sharing-2016/.

Resources on Improper Billing of QMBs and Dual Eligibles

General Background

New York Times, "Doctors Are Improperly Billing Some on Medicare, U.S. Says," July 30, 2016, available at: nytimes.com/2016/07/31/us/politics/doctors-are-improperly-billing-some-on-medicare-us-says.html?_r=1

Centers for Medicare & Medicaid Services, "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)", July 2015, available at: cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf

For Consumers and Advocates

Medicare and You 2017 Handbook, available at: medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf

Consumer Financial Protection Bureau Consumer Advisory, available at: consumerfinance.gov/about-us/blog/what-do-if-youre-wrongfully-billed-medicare-costs/

Justice in Aging and the Health Consumer Alliance, Do You Have Free Medi-Cal? Have You Been Billed?: calduals.org/wp-content/uploads/2016/11/Balance-Billing-JiA-flyer-2016.pdf

Justice in Aging, What Should California Advocates Do if Their Clients are Balance Billed?, available at: justiceinaging.org/wp-content/uploads/2015/11/FINALBalance-Billing-in-California.pdf

Justice in Aging Model Letters, available at: justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/

For Providers

MLN Matters, Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program, Feb. 4, 2016, available at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf

MLN Matters, Issuing Compliance Letters to Specific Providers and Suppliers Regarding Inappropriate Billing of Qualified Medicare Beneficiaries (QMBs) for Medicare Cost-Sharing, Nov. 18, 2016, available at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf

California Medical Association, CMS auditing physicians who inappropriately bill Medi-Medi patients, December 2016, available at: cmanet.org/news/detail/?article=cms-auditing-physicians-who-inappropriately