

# Preventing Improper Billing of Medicare-Medicaid Enrollees in Managed Care: Strategies for States and Dual Eligible Special Needs Plans

By Claire Postman and James Verdier, Mathematica Policy Research

**SUMMARY:** Medicaid provides some degree of coverage for Medicare deductibles, copayments, and coinsurance amounts for about 85 percent of dually eligible beneficiaries. The vast majority of these Medicare-Medicaid enrollees are Qualified Medicare Beneficiaries and are protected from billing by any providers for unpaid Medicare Parts A and B cost-sharing. Although providers are prohibited from billing these protected beneficiaries for cost-sharing, improper billing continues to be an issue. The complexity of processing Medicare claims for cost-sharing, state policies concerning Medicare cost-sharing payments, and lack of provider awareness about billing prohibitions may contribute to the persistence of this issue. This brief explores strategies that states and Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) can use to streamline claims processing and communicate with providers and members in order to prevent instances of improper billing.

Approaches to prevent improper billing include:

- **States can make capitated payments to D-SNPs for Medicare cost-sharing to enable seamless payment of cost-sharing** to providers by the D-SNP. This allows D-SNPs to directly pay the provider for any cost-sharing amounts and eliminates the need for providers to submit separate cost-sharing claims to Medicaid because the D-SNP payment constitutes payment in full.
- **States can require D-SNP members to be enrolled in a Medicaid managed care plan offered by the same organization** to facilitate the organization's handling of cost-sharing payments to providers.
- **States can limit D-SNP enrollment to Medicare-Medicaid enrollees with zero cost-sharing** to provide a clear and uniform benefit to D-SNP members and simplify communication with plan providers regarding the absence of cost-sharing.
- **D-SNPs can include clear and prominent language on health plan provider portals, member identification cards, and Explanation of Payment documents (remittance advice notices)** to enable providers to readily identify when no cost-sharing applies to the D-SNP member.
- **D-SNPs can create outreach materials and recurring trainings for providers** to help them understand the billing prohibitions and identify which beneficiaries are protected from cost-sharing.
- **D-SNPs can provide outreach materials for members** to assist them in understanding their benefits, communicating their eligibility status to providers, and identifying instances when they are being improperly billed.

## Overview

For dually eligible beneficiaries, Medicaid plays a crucial role in assisting with Medicare out-of-pocket costs. Approximately 85 percent of dually eligible beneficiaries receive coverage of Medicare cost-sharing (deductibles, co-payments, and co-insurance) from their state Medicaid programs. In 2012, about 64 percent of dually eligible beneficiaries nationwide were enrolled in the Qualified Medicare Beneficiary (QMB) program, a Medicaid program that pays Medicare premiums and cost-sharing. Another 21 percent were classified as other Full Benefit Dual Eligibles (FBDEs) for whom states provide full Medicaid benefits and coverage of Medicare beneficiary cost-sharing.<sup>1</sup> See Exhibit A.1 in the Appendix for more detail on the dual eligible benefit categories.

By federal statute, QMBs cannot be billed by any Medicare provider for Medicare Parts A and B cost-sharing.<sup>2</sup> Federal regulations extend this prohibition to other FBDEs in Medicare Advantage managed care plans for whom states cover Medicare cost-sharing.<sup>3</sup> Despite this prohibition, improper billing – the practice of billing protected dually eligible beneficiaries for Medicare cost-sharing – continues to be an issue in several states and plans. This technical assistance brief outlines some of the causes of this problem and describes steps states and health plans can take to address it.

## **What State Medicaid Programs Will Cover**

Medicare is the primary payer for services to dually eligible beneficiaries. For Parts A and B services covered by both Medicare and Medicaid, states pay Medicare cost-sharing amounts once Medicare has paid its share.

State Medicaid programs can take one of three approaches to paying dually eligible beneficiaries' Medicare deductibles, co-payments, and co-insurance. They may choose to: (1) pay the full amount; (2) use a "lesser-of" payment policy; or (3) pay a negotiated rate that allows the state to pay an amount approved by the Centers for Medicare & Medicaid Services (CMS) to prevent access to care concerns. The state has the option to establish a different payment method for each group of dually eligible beneficiaries and can establish different payment methods for Part A deductibles, Part A coinsurance, Part B deductibles, and Part B coinsurance within each group. The state may use a combination of the optional payment methods as it chooses, as long as the state can assure CMS that the selected payment methods will not adversely affect access to care for the beneficiary.

Authorized in the 1997 Balanced Budget Act, the "lesser-of" rule allows state Medicaid programs to pay less than the full Medicare cost-sharing amount if the Medicare-approved amount (Medicare rate) for the service exceeds the Medicaid rate. Under this rule, Medicaid pays the lesser of the full Medicare cost-sharing amount or the difference between the Medicaid rate and the Medicare paid amount. In cases where the Medicaid rate for a service is less than the Medicare paid amount, this could result in a cost-sharing payment of zero to the provider. An example of the lesser-of calculation is shown in Exhibit A.2 in the Appendix. States that have adopted the "lesser-of" rate often end up eliminating or reducing Medicare cost-sharing payments to providers. Even if the state does not pay the full or any amount of the Medicare cost-sharing, Medicare providers – even those who do not participate in Medicaid – may not bill individuals enrolled in the QMB program for Medicare cost-sharing.

## **Claims Processing**

In traditional fee-for-service Medicare (i.e., Original Medicare), Coordination of Benefits Agreements (COBAs) in most states allow Medicare to send "crossover" claims for Medicare beneficiary cost-sharing directly to the Medicaid agency.<sup>4</sup> To the extent that states delegate coordination of benefits to Medicaid managed care plans for dually eligible beneficiaries in Original Medicare, the Medicaid managed care plan must enter into a coordination of benefits agreement with Medicare.<sup>5</sup> States can only pay Medicare cost-sharing to providers who are enrolled in Medicaid.<sup>6</sup>

Claims processing in Medicare managed care settings varies by state and plan. In less streamlined managed care settings, providers may be responsible for submitting the Medicare cost-sharing claim to Medicaid, which requires knowledge of the beneficiary's Medicaid status and the state claims process. However, D-SNPs can streamline this process by internally handling Medicaid payment of Medicare cost-sharing and ensuring providers are informed when no cost-sharing is due from D-SNP members.

D-SNPs are Medicare Advantage plans that specifically enroll dually eligible beneficiaries and are required to provide or arrange for Medicaid benefits. D-SNPs are prohibited from imposing cost-sharing in excess of amounts permitted under the Medicaid state plan for individuals not enrolled in the D-SNP.

Through their D-SNP contracts and payments, states have opportunities to improve coordination of claims processing to prevent improper billing of members for cost-sharing they do not owe. States and D-SNPs both have opportunities to improve provider and member communication around this issue.

### Causes of Improper Billing

Some practices that may lead to continued inappropriate billing of D-SNP members include:

- Providers may not understand or be aware of the prohibition on billing of QMBs or other FBDEs.
- Many states apply the “lesser-of” rule to eliminate or reduce cost-sharing payments to providers, leading providers to improperly bill the beneficiary for remaining balances when the full Medicare cost-sharing amount is not paid.
- D-SNP remittance advice notices to providers or Explanations of Payment documents for beneficiaries may not clearly show that the beneficiary is not responsible for cost-sharing and may indicate inaccurate cost-sharing amounts.
- Providers may not be adequately informed that they need to collect cost-sharing payments from the state when payment is not the responsibility of the managed care organization. Some providers may not know how to submit bills to the state or may not be able to obtain reimbursement if they are not registered in the state Medicaid system.
- For D-SNPs enrolling dually eligible beneficiaries with varying levels of cost-sharing (Non-Zero Cost-Sharing D-SNPs), providers may have difficulty discerning what Medicare cost-sharing charges should or should not apply if they are not aware of a beneficiary’s dual eligible coverage category. Plans may lack timely access to state information on dual eligible status to determine which beneficiaries are not responsible for cost-sharing, and plans may not provide real-time access (through portals or other systems) to providers to enable them to determine member cost-sharing liability at the time care is delivered or prior to submission of claims.
- Plans struggle to monitor the incidence of balance billing outside of complaints from members.
- Non-contracted providers may bill patients for out-of-network emergency and urgent care even though billing protections apply to such care.

### Best Practices for Streamlining Payment Mechanisms

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The following practices – identified through interviews with states and D-SNPs – streamline claims processing in a way that shifts the burden away from the provider for determining what, if any, cost-sharing is due and for obtaining any Medicaid payment of cost-sharing.<sup>7</sup> These strategies reduce the need for providers to determine the dual status of the member and submit Medicare cost-sharing claims, which may eliminate some of the confusion and administrative barriers that can lead to improper billing.

- **The most effective way to eliminate improper billing is for states to enable seamless payment by making capitated payments to D-SNPs for Medicare cost-sharing.** D-SNPs in states that provide capitated payments for Medicare cost-sharing said that they observe fewer instances of improper billing than D-SNPs in states that require providers to bill the state for Medicare cost-sharing on a claim-by-claim basis. When states make capitated payments for cost-sharing, D-SNPs can directly pay the provider for the cost-sharing amount, rather than requiring the provider to bill the state for cost-sharing. This capitated payment is generally based on what the state would pay in the fee-for-service system, which typically follows the “lesser-of” methodology. States that make capitated payments to D-SNPs for Medicare cost-sharing should include language in their D-SNP contracts noting the federal requirement that plan providers must accept the D-SNP’s payment as payment in full when the plan pays the full amount that the state would pay if the beneficiary were enrolled in fee-for-service Medicare and Medicaid. Arizona’s D-SNP contract provides an example.<sup>8</sup>

- **Through their contracts, states can limit D-SNPs to enrolling only those categories of dually eligible beneficiaries who do not owe Medicare cost-sharing.** This enables D-SNPs to provide clear and uniform communication to providers and plan members that no cost-sharing for Medicare services is owed under the plan.
- **States that do not pay capitated amounts to plans for cost-sharing can require D-SNPs to bill Medicaid for Medicare cost-sharing on the provider's behalf.** D-SNPs may be able to automatically bill the state Medicaid agency or Medicaid managed care plan. The Medicaid managed care plan or agency then directly pays the provider for the cost-sharing portion of the amount, again removing the provider from needing to bill the state directly. States can encourage these automatic payments in the following ways:
  - **Organizational alignment of Medicaid MCOs and D-SNPs can make the billing process more efficient.** In the instance where a Medicaid managed care organization and its companion D-SNP fall under the same parent organization, billing often happens internally, without the claim going back to the provider.
  - **States can require D-SNPs to submit cost-sharing claims directly to the state Medicaid agency.** For example, Tennessee handles cost-sharing payments through its fee-for-service system, but the state eases the burden on the provider by contractually requiring its D-SNPs to submit Medicare cost-sharing claims directly to the state Medicaid agency, rather than requiring the provider to submit a claim.<sup>9</sup> Tennessee requires the providers in D-SNPs' networks to register as Medicaid providers so that the D-SNP can submit Medicare cost-sharing claims to the state.<sup>10</sup>

## Best Practices for Provider and Member Communication

In addition to structuring claims processing in a way that reduces improper billing, states and D-SNPs are conducting provider and member outreach to increase awareness around billing restrictions:

- **D-SNPs can use online eligibility platforms to readily notify providers about beneficiary Medicaid eligibility and reinforce billing restrictions.** One plan noted that immediately upon accessing the D-SNP's provider portal, providers are informed of billing restrictions. As noted above, D-SNP communication regarding cost-sharing can be greatly simplified if states limit D-SNP enrollment only to beneficiaries who do not owe Medicare cost-sharing. However, if plans do charge cost-sharing to some members, it is important for their online platforms to clearly indicate Medicaid eligibility information as well as appropriate charges, so that providers can readily determine which members are responsible for cost-sharing and which members are protected.<sup>11</sup>
- **D-SNPs can include language about the billing prohibition on Explanation of Payment documents (remittance advice) and member identification cards.** Plans can prevent instances of improper billing by including language about the billing restrictions directly on the Explanations of Payment document that they send to providers and on member identification cards. If plans have zero cost-sharing, it is clearest for plans to simply say that the member cost should be zero. See *Example Language from an Explanation of Payment* and *Example Language from a Member Identification Card*.<sup>12</sup>

### Example Language from an Explanation of Payment

"Members shall not be billed or charged for any Medicare covered benefits provided to Member by Provider."

## Example Language from a Member Identification Card

### MEMBER CANNOT BE CHARGED

Cost Sharing/Copays: \$0 for doctor visits and hospital stays

- **D-SNPs can educate providers about billing prohibitions in outreach materials.** Most plans cover billing restrictions in their initial provider training modules, as well as in follow-up notices and annual trainings. Plans should use clear language that explains the restriction to providers who may not be familiar with Medicaid. Plans may also include language that encourages D-SNP providers to register with Medicaid in order to be reimbursed for cost-sharing. See *Illustrative D-SNP Provider Outreach Materials* for examples of language used in D-SNPs' provider outreach materials.

## Illustrative D-SNP Provider Outreach Materials

**Example language from D-SNP provider communications about recognizing an identification card for a protected beneficiary (includes a picture of the ID card):** "[Plan] is a single-payer, fully integrated Dual Eligible Special Needs Plan (D-SNP)...for beneficiaries who have Medicare and Medicaid coverage. It's a health insurance plan designed for individuals who don't have any cost-sharing responsibility. [Plan] members should not be balance billed for any covered benefit."<sup>13</sup>

**Example language from a D-SNP provider outreach bulletin:** "Even if a provider is providing only Medicare-covered Part A or Part B services to D-SNP members, we recommend that the provider attain a Medicaid ID, as the state Medicaid agency may require them to submit a claim for the Medicare Cost Share. Providers cannot bill D-SNP members for services not reimbursed by Medicaid or [D-SNP name] plan. D-SNP members are protected from all balance-billing."<sup>14</sup>

- **States can also play a role in educating providers about billing prohibitions, especially for providers who may be out-of-network for the D-SNP.** Oregon has provided particularly clear guidance to providers on how to identify QMBs and how to handle Medicare cost-sharing claims.<sup>15</sup> To encourage Medicaid enrollment, states can also offer a modified registration process that allows Medicare providers to enroll in Medicaid for the exclusive task of billing for cost-sharing.<sup>16</sup>
- **D-SNPs can send provider representatives into the field to educate billing staff about billing restrictions.** D-SNPs explained that their provider representatives conduct on-site visits with billing staff to walk them through restrictions and provide in-person trainings around billing prohibitions.
- **D-SNPs can provide member, family, or caregiver education around billing prohibitions.** D-SNPs are limited in their ability to learn about instances of improper billing. Member complaints and grievances are the primary way that D-SNPs learn that improper billing has occurred;<sup>17</sup> therefore, plans noted that making sure that members understand their benefits and (lack of) cost-sharing responsibilities was a key component in identifying and reducing instances of improper billing. D-SNPs have raised the topic of improper billing in a variety of settings, across member literature, welcome calls, and advisory board meetings with members. Plans may also consider educating the member's family or caregivers, as many D-SNP members have cognitive impairments. See *Example Language from D-SNP Member Outreach Materials* for an example of language in a member outreach notice.<sup>18</sup>



### Example Language from D-SNP Member Outreach Materials

“Deductibles, coinsurance, or copayments are known as cost-sharing amounts. When you get a bill for these amounts it is known as balance billing. Please be advised that it is unlawful for providers to “balance bill” any patient who is a member of [Plan name] for any covered services.

If you think you are being balance billed, do not pay the bill. Call Member Services first at [phone number]...Please have the bill ready when you call.”

- **States and plans can educate beneficiaries on their Medicaid eligibility and cost-sharing status and advise them on how to communicate that information to providers.** Providing eligibility information to providers at the point of service helps to alleviate confusion and close gaps in information around Medicaid eligibility status. See *Example Language from District of Columbia Website* for how the District of Columbia advises QMBs to show their member identification card at the point of service. This language and other examples of state guidance to beneficiaries are provided in a recent issue brief from Justice in Aging.<sup>19</sup>

### Example Language from District of Columbia Website

“When you get health services, remember to always show your QMB card whenever you show your Medicare card. This card is proof of your QMB status and means that your health care provider cannot bill you for Medicare co-pays or deductibles.”<sup>20</sup>

- **D-SNPs can be actively involved in re-educating providers who are improperly billing.** Some strategies D-SNPs have adopted when providers have improperly billed are:
  - Following up with and retraining providers who have improperly billed, including through one-on-one engagement and site visits with provider representatives.
  - Sending letters to providers informing them of the restrictions on billing. Justice in Aging provides plain language model letters to send to providers who are improperly billing.<sup>21</sup>
  - Following up with the member to ensure that improper billing has ceased.

## Conclusion

States and D-SNPs can work together to help providers and beneficiaries better understand the protections against improper billing by communicating the prohibition at both the point of service and the point of payment and by expanding education and technical assistance efforts. At a structural level, states and D-SNPs can facilitate cost-sharing payments to providers and reduce complexity by streamlining or eliminating the need for providers to separately bill Medicaid for cost-sharing claims. Online eligibility platforms, Explanations of Payments, and other communications to providers and Member ID cards should clearly indicate that no cost-sharing is due for Medicare services.

### ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the **Integrated Care Resource Center** are coordinated by [Mathematica Policy Research](#) and the [Center for Health Care Strategies](#). For more information, visit [www.integratedcareresourcecenter.com](http://www.integratedcareresourcecenter.com).

## Appendix

### Exhibit A.1. Dual Eligible Enrollment by Benefit Category

Benefit Category	Percentage of Dually Eligible Beneficiaries in 2012	Medicaid Benefit*
<b>Full-benefit dual eligibles</b>	<b>72%</b>	
Qualified Medicare Beneficiary (QMB) plus	51%	Medicare Parts A and B premiums, Medicare Parts A and B cost-sharing, other Medicaid benefits
Specified Low-Income Medicare Beneficiary (SLMB) plus	3%	Medicare Part B premiums, Medicare Part B cost-sharing, other Medicaid benefits
Other FBDE	18%	Medicare Parts A and B premiums, Medicare Parts A and B cost-sharing, other Medicaid benefits
<b>Partial-benefit dual eligibles</b>	<b>28%</b>	
QMB only	13%	Medicare Parts A and B premiums, Medicare Parts A and B cost-sharing
SLMB only	9%	Medicare Part B premiums
Qualifying Individual (QI)	5%	Medicare Part B premiums
Qualified Disabled and Working Individuals (QDWI)	<1%	Medicare Part A premiums

\*State Medicaid agencies may choose to cover services in addition to those listed.

SOURCES: MedPAC and MACPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid: Data Book." Exhibit 2, p. 28. January 2017; and Center for Medicaid and CHIP Services. "Coordination of Benefits and Third Party Liability (COB/TPL) in Medicaid." p. 42. 2016. <https://www.medicaid.gov/medicaid/eligibility/downloads/tpl-cob/training-and-handbook.pdf>.

### Exhibit A.2. "Lesser-of" Calculation Example

Physician visit*	Full Payment Policy	Lesser-of Policy
Provider charge	\$125	\$125
Medicare-approved amount (Medicare rate)	\$100	\$100
Medicaid payment rate	\$90	\$90
Medicare payment (e.g., 80% Medicare rate less deductible)	(80% of \$100) – \$0 = \$80	(80% of \$100) – \$0 = \$80
Medicare cost-sharing (billed to Medicaid as a crossover claim)	\$20	\$20
Medicaid payment to provider	\$20	Lesser of Medicare cost-sharing, (\$20) OR Medicaid rate minus Medicare payment (\$90 – \$80 = \$10)
Total provider payment	\$100	\$90

\*Example assumes full Medicare deductible has been met.

## Endnotes

- <sup>1</sup> MedPAC and MACPAC. “Beneficiaries Dually Eligible for Medicare and Medicaid: Data Book.” Exhibit 2, p. 28. January 2017. There are three smaller categories – SLMB-only, QI, and QDWI – for whom Medicaid pays only Medicare premiums, which accounted for approximately 15 percent of dually eligible beneficiaries in 2012. See Table 1 on pp. 4-5 for details on all categories of dually eligible beneficiaries. For more information about the categories, see pgs.43-44 at: <https://www.medicaid.gov/medicaid/eligibility/downloads/tpl-cob/training-and-handbook.pdf>.
- <sup>2</sup> Medicare Part D copayments are not covered by this prohibition on improper billing.
- <sup>3</sup> Further details on the evolution of this requirement are in Chapter 6 in MACPAC’s March 2015 Report to Congress. For billing prohibition for QMBs, see Sec. 1902(n)(3)(B) of the Social Security Act. For billing prohibition for non-QMB FBDEs in Medicare Advantage plans, see 42 CFR Sec. 422.504(g)(1)(iii).
- <sup>4</sup> The Coordination of Benefits Agreement (COBA) facilitates coordination of crossover claims between Medicare claims processors and their state Medicaid partners. Under the COBA, state Medicaid agencies or Medicaid managed care plans are designated as trading partners with Medicare. This allows CMS to cross over paid Medicare claims to Medicaid entities to process any remaining benefits for dually eligible beneficiaries. For more information about coordination of benefits for dually eligible beneficiaries, see Coordination of Benefits and Third Party Liability in Medicaid (COB/TPL) 2016, Section E. at <https://www.medicaid.gov/medicaid/eligibility/downloads/tpl-cob/training-and-handbook.pdf>.
- <sup>5</sup> 42 CFR Section 438.3(t).
- <sup>6</sup> CMS has received reports indicating that these crossover claims may not always be fully processed in state systems, particularly if the provider has not completed a state registration process or entered into the state payment system. See: CMS–MMCO–CM Informational Bulletin, “Payment of Medicare Cost Sharing for Qualified Medicare Beneficiaries (QMBs),” June 7, 2013. Available at: <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-06-07-2013.pdf>; Coordination of Benefits and Third Party Liability in Medicaid (COB/TPL) 2016. Available at: <https://www.medicaid.gov/medicaid/eligibility/downloads/tpl-cob/training-and-handbook.pdf> pages 46-47.
- <sup>7</sup> ICRC collected information through interviews and email exchanges with states and D-SNPs to learn about the strategies they are using to prevent improper billing. Many of the D-SNPs also had companion Medicaid managed care plans under the same parent organization.
- <sup>8</sup> Arizona D-SNP Contract, 2017, Sec. 2.3. “MA [Medicare Advantage] D SNP Health Plan providers shall not impose Medicare cost-sharing on dual eligible members for services covered by both Medicare and Medicaid. MA D SNP Health Plan providers agree to accept MA D SNP Health Plan payment as payment in full for services covered by both Medicare and Medicaid.... Section 1902(n)(3)(B) of the Social Security Act prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments.”
- <sup>9</sup> Tennessee D-SNP contract, Sec. A.2.h. “The Contractor shall transmit crossover or claims for Medicare co-pays or deductibles electronically to TennCare by January 1, 2013 in a compliant format approved by TennCare.”
- <sup>10</sup> Tennessee D-SNP contract, Sec. A.3.a. “Any of the Contractor’s subcontractors or providers who attempt to file claims for co-payments or coinsurance allowed by law shall be required to become registered TennCare providers, according to the procedures developed by TennCare.”
- <sup>11</sup> State contracts with D-SNPs must describe how the D-SNP will receive access to real-time information verifying eligibility of dually eligible members from the state Medicaid agency. See State Contract Requirements for D-SNPs in the Medicare Managed Care Manual, Chapter 16B at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf>. In addition, CMS provides all Medicare Advantage organizations with access to data files that enable the ready identification of QMB enrollees. See HPMS memo “Qualified Medicare Beneficiary Program Enrollee Status Resources” at: [http://www.integratedcareresourcecenter.net/pdfs/Identification\\_of\\_QMBs\\_6-21-17-PDF%20LMC%20OK.PDF](http://www.integratedcareresourcecenter.net/pdfs/Identification_of_QMBs_6-21-17-PDF%20LMC%20OK.PDF).
- <sup>12</sup> Example language comes from provider and member communication materials we received from health plans we interviewed.
- <sup>13</sup> UnitedHealthCare Community Plan. “Frequently Asked Questions for Care Providers and Practice Managers.” Undated. Available at: [https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/NJ-Provider-Information/NJ\\_Dual\\_Complete\\_ONE\\_FAQs\\_for\\_Providers\\_Practice\\_Managers.pdf](https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/NJ-Provider-Information/NJ_Dual_Complete_ONE_FAQs_for_Providers_Practice_Managers.pdf).
- <sup>14</sup> Anthem Blue Cross Blue Shield. “Dual Eligible Special Needs Plans New for 2015.” October 2015. Available at: [https://www11.anthem.com/shared/noapplication/f2/s2/t1/pw\\_e232004.pdf?refer=ahpmember&state=oh](https://www11.anthem.com/shared/noapplication/f2/s2/t1/pw_e232004.pdf?refer=ahpmember&state=oh).
- <sup>15</sup> Oregon Health Authority. “Reminders about Billing for Services to Qualified Medicare Beneficiaries (QMBs).” Memo to Oregon Health Plan Providers. September 12, 2014. Available at: [https://www.oregon.gov/oha/healthplan/Announcements/Reminders%20about%20billing%20for%20services%20to%20Qualified%20Medicare%20Beneficiaries%20\(QMBs\).pdf](https://www.oregon.gov/oha/healthplan/Announcements/Reminders%20about%20billing%20for%20services%20to%20Qualified%20Medicare%20Beneficiaries%20(QMBs).pdf).
- <sup>16</sup> Many states offer this type of “crossover-only” provider enrollment. California’s website provides an example of FAQs for Medicare providers interested in registering as crossover only providers. See: California Department of Health Care Services. “Crossover Only Enrollment FAQs” Available at: <http://www.dhcs.ca.gov/provgovpart/Pages/CrossoverOnlyEnrollment.aspx>.
- <sup>17</sup> Starting in March 2017, the Complaints Tracking Module (CTM) began distinguishing complaints received from QMBs from other complaints. When appropriate, CMS encourages MA plans to use this source of information, alongside grievance and plan call center data, to identify further opportunities to strengthen provider education activities, improve internal call center messaging, and reduce future CTM complaints. See 2017 Final Call Letter at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtSpecRateStats/Downloads/Announcement2017.pdf> and HPMS memo “Qualified Medicare Beneficiary Program Enrollee Status Resources.” at: [http://www.integratedcareresourcecenter.net/pdfs/Identification\\_of\\_QMBs\\_6-21-17-](http://www.integratedcareresourcecenter.net/pdfs/Identification_of_QMBs_6-21-17-)



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<sup>18</sup> Example language comes from member communication materials we received from a health plan we interviewed.

<sup>19</sup> P. Travitsky. "QMB Identification Practices: A Survey of State Advocates." Justice in Aging. March 2017. Available at: [http://www.justiceinaging.org/wp-content/uploads/2017/03/QMB-Identification-Practices\\_A-Survey-of-State-Advocates.pdf](http://www.justiceinaging.org/wp-content/uploads/2017/03/QMB-Identification-Practices_A-Survey-of-State-Advocates.pdf).

<sup>20</sup> District of Columbia Department of Health Care Finance. "Qualified Medicare Beneficiary (QMB)." Available at: <https://dhcf.dc.gov/service/qualified-Medicare-beneficiary-qmb>.

<sup>21</sup> Justice in Aging. "Improper Billing of Duals." Available at: <http://www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/>.