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Efforts take root to end illegal billing of low-income Medicaid recipients

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Advocates working with low-income older adults have for years reported that the problematic illegal billing of low-income people with Medicare (often referred to as balance billing) has been widespread and persistent. Recently, however, the Centers for Medicare & Medicaid Services (CMS) has taken important steps to correct balance billing. CMS initiatives, combined with significant advocacy by legal rights organizations, are proving successful in raising awareness about the issue, empowering consumers and their advocates, and curbing this illegal practice. More work is needed, however, including structural changes in how providers serving dual eligibles are paid.

The Negative Effects of Balance Billing

The experience of Mr. Chung, a low-income Medicare beneficiary who is also on Medicaid (a "dual eligible"), typifies the problem. Beyond relieved when he learned that a routinely scheduled colonoscopy from March 2015 showed no major problems, he was shocked when he received a bill from the hospital saying he owed more than $800 for the procedure. Because of his Medicaid status, Mr. Chung was used to paying nominal amounts, if anything, for healthcare. Faced with this large bill, he realized he would have to take away his already scarce money from housing, groceries and other necessities. Paralyzed by fear and confusion, he did nothing, and soon began receiving notices from a third-party collection agency.

The problem occurs when Medicare providers charge dual eligibles for costs that should be paid by Medicare or Medicaid. For services covered under both programs, Medicare is usually the primary payer and pays 80 percent of the Medicare rate. Medicaid covers the remaining 20 percent. Unfortunately, Medicaid pays providers little or nothing because Medi-caid programs are allowed to cap their payments at the Medicaid rate, which usually is lower than the Medicare rate. Whether or not the provider gets anything from Medicaid, dual eligibles are not financially responsible.

Despite legal protections under fed-eral law, Medicare Advantage regulations and sometimes state law, people like Mr. Chung often are billed, which causes them added stress, anxiety and worry due to relentless collection agencies and potential damage to their credit scores.

CMS Takes Action

Last year, CMS published a study that included both qualitative and quantitative data documenting the extent of the problem. In its 2017 Call Letter, CMS put Medicare Advantage plans on notice that the agency will monitor the extent to which plans educate their providers about the prohibition and enforce adherence. CMS also has been contacting physician and other provider groups, creating

FAQs and provider bulletins and working with state and national medical associations to ensure that doctors and other providers understand their obligations. Media attention, including in-depth articles in *The New York Times* (*goo.gl/f4uvpT*; *goo.gl/6BvAHv*) and the *Los Angeles Times* (*goo.gl/2XW0IA*; *goo.gl/4iiVGN*), has also helped to bring the issue forward.

Advocacy efforts also have intensified. Justice in Aging has been working with advocates across the country to ensure that dual eligibles and those who assist them know their rights and have the tools they need to stop the illegal billing.

CMS is now working to develop better mechanisms for individuals to lodge complaints, but practical issues also need to be resolved. For example, doctors and other Medicare providers frequently have no access to Medicaid systems, so they are unable to verify whether a patient is subject to the billing protections. CMS is exploring whether the Medicare records available to providers could flag those individuals who should be protected from balance billing. States also could do a much better job of identifying protected individuals via their benefit cards.

Meanwhile, Medicare Advantage plans could do a better job of tagging members who are not responsible for co-pays and other cost-sharing, by more prominently flagging their status on electronic records shared with provider offices and on member I.D. cards.

A Small, but Expensive, Fix

The root of the problem, however, needs a bigger fix. As long as doctors and other providers are paid less for treating dual eligibles compared to other Medicare patients, they are going to either try to skirt the law or drop those patients. The policy is statutory and a federal legislative fix is needed—one that will only require changing a few words in the statute, but will also require significant additional ex-penditures, which likely would be borne primarily by the federal government.

Nevertheless, the policy allowing states to shortchange these providers by limiting payment to Medicaid rates must end. Only then will dual eligibles have both the protection to which they are entitled and the access to providers that they need. ■

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