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Center for Medicaid and State Operations  
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**FROM:** Gale P. Arden, Director *gpa*  
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**SUBJECT:** Medicaid Obligations for Cost-Sharing in Medicare Part C Plans

**TO:** All Associate Regional Administrators  
Division of Medicaid and Children's Health

Many questions have been raised by States, providers and Medicare Part C plans regarding Medicaid's obligation to pay cost-sharing for individuals who are eligible for both Medicare and Medicaid (dual eligibles) and who are enrolled in Medicare Part C, i.e. Medicare Advantage (MA) plans. Over the years CMS has issued guidance on various aspects of this question; however there has been no single document that brings this guidance together. The purpose of this memorandum is to provide a compilation of pertinent information found in statute, regulation and guidance in a concise format.

Dual eligibles are individuals enrolled in Medicare and eligible for Medicaid coverage, whether that Medicaid coverage is limited to certain costs, such as Medicare premiums, or the full benefits covered under the State Plan. Dual eligibles whose benefits are limited include Qualified Medicare Beneficiaries (QMB), Specified Low-income Medicare Beneficiaries (SLMB), Qualifying Individuals (QI), and Qualified Disabled Working Individuals (QDWI). Those eligible for full Medicaid benefits are called Full Benefit Dual Eligibles (FBDE). At times individuals may qualify for both limited coverage of Medicare cost sharing as well as full Medicaid benefits.

MA plans are health plan options approved by Medicare and run by private companies. These plans must provide all Part A and Part B services, and may offer additional services including Part D drug coverage. MA plans include Medicare Preferred Provider Organizations (PPO), Medicare Health Maintenance Organizations (HMO), Medicare Private Fee-for-Service (PFFS) plans, Medicare Medical Savings Account (MSA) plans and Medicare Special Needs Plans (SNP).

Medicare cost-sharing includes Part A and B premiums and Part C premiums for those enrolled in an MA plan. Medicare cost sharing also includes deductibles, co-insurance and, for MA plans, may include co-pays. Deductibles are fixed dollar amounts that an individual must pay out-of-pocket before the costs of services are covered. Co-insurance is a percentage of the cost of services. Co-payments are fixed dollar amounts that an individual must pay each time a service is received.

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Several factors determine whether or not Medicaid is liable for coverage of cost-sharing in MA plans. These factors include the dual eligible's coverage category, the type of cost-sharing, the options elected by the State, and payment limitations specified in the State Plan. The attached chart is intended to clarify how these factors affect whether or not the State Medicaid program has a liability for cost-sharing for dual eligibles in MA plans.

The information presented in this policy clarification is not intended to address all issues related to Part C cost-sharing for dual eligibles. This clarification is limited to State Medicaid program cost-sharing obligations, and does not address issues related to provider billing practices or beneficiary obligations.

Please share this information with the States in your regions. If you have any questions regarding this memorandum, please contact Christine Gerhardt at 410-786-0693, or [christine.gerhardt@cms.hhs.gov](mailto:christine.gerhardt@cms.hhs.gov).

Attachment

## Cost Sharing for Medicare Advantage Plans

Questions have been raised by States, providers and Medicare Advantage plans regarding the obligations of State Medicaid programs, and the availability of Federal Financial Participation (FFP), for dual-eligibles enrolled in Medicare Advantage plans.<sup>1</sup> In the past, guidance has been issued in the State Medicaid Manual, letters to CMS Associate Regional Administrators and other correspondence that addressed various aspects of this issue. To properly determine Medicaid liability for Part C cost sharing for a dual-eligible it is necessary to determine the individual's Medicaid coverage group and the type of Part C cost-sharing. Below is a description of the various coverage groups in which a dual-eligible could be certified. The chart that follows identifies the Medicaid liability by coverage group and type of Part C cost-sharing. The purpose of the chart is to clarify existing Centers for Medicare and Medicaid Services (CMS) policy by combining material from previously issued guidance, statute and regulation into a concise format, addressing all categories of dual-eligibles and all forms of Medicare Part C cost-sharing.

### Description of Coverage Groups

#### **Qualified Medicare Beneficiary (QMB Only)**

A "QMB" is an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, co-insurance and co-pays (except for Part D). QMBs who do not qualify for any additional Medicaid Benefits are called "QMB Only."

#### **QMB Plus**

A "QMB Plus" is an individual who meets all of the standards for QMB eligibility as described above, but who also meets the financial criteria for full Medicaid coverage. Such individuals are entitled to all benefits available to a QMB, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient. These individuals often qualify for full Medicaid benefits by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy level.

#### **Specified Low-income Medicare Beneficiary (SLMB Only)**

A "SLMB" is an individual who is entitled to Medicare Part A, has income that exceeds 100% FPL but is less than 120% FPL, and whose resources do not exceed twice the SSI limit. The only Medicaid benefit a SLMB is eligible for is payment of Medicare Part B premiums. SLMBs who do not qualify for any additional Medicaid benefits are called "SLMB Only".

<sup>1</sup> Sec. 201 of P. L. 108-173 established the Medicare Advantage program, consisting of the program under part C of Medicare. Any references to part C or "Medicare + Choice" were deemed to be references to "Medicare Advantage" or "MA". Thus, any references in past policy documents to "Medicare + Choice" plans are applicable to Medicare Advantage plans.

### **SLMB Plus**

A "SLMB Plus" is an individual who meets the standards for SLMB eligibility, but who also meets the financial criteria for full Medicaid coverage. Such individuals are entitled to payment of Medicare Part B premiums, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient. These individuals often qualify for Medicaid by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy level.

### **Qualifying Individual (QI)**

A "QI" is an individual who is entitled to Part A, has income that is at least 120% FPL but less than 135% FPL, resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid. A QI is similar to a SLMB, in that the only benefit available is Medicaid payment of the Medicare Part B premium, however expenditures for QIs are 100% federally funded and the total expenditures are limited by statute.

### **Other Full Benefit Dual Eligibles (FBDE)**

An individual who is eligible for Medicaid either categorically or through optional coverage groups such as medically needy or special income levels for institutionalized or home and community-based waivers, but who does not meet the income or resource criteria for QMB or SLMB.

### **Qualified Disabled and Working Individual (QDWI)**

A QDWI is an individual who lost Medicare Part A benefits due to returning to work, but who is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. QDWIs are eligible only for Medicaid payment of Part A premiums.

## Description of Medicare Part C Benefits

### **Mandatory Supplemental Benefits**

Mandatory supplemental benefits are non-drug benefits that are not covered by Medicare, but are covered by the plan for every enrollee of the plan. Mandatory supplemental benefits are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums, cost sharing or through application of rebate dollars.

### **Optional Supplemental Benefits**

Optional supplemental benefits are non-drug benefits that are not covered by Medicare. However, plan enrollees may choose whether to elect and pay for optional supplemental benefits. These services may be grouped or offered individually.

### **Deductibles, Coinsurance and Co-payments**

Deductibles are fixed dollar amounts that an individual must pay out-of-pocket before the cost of services are covered by the MA organization. Coinsurance charges are a percentage of the costs for services. Co-payments are fixed dollar amounts that a beneficiary must pay when he or she uses a particular service. For purposes of this memorandum, co-payments charged by a Part C plan are considered to be coinsurance.

**Medicare Part C Cost Sharing Chart**

	<b>Part C Premium for Basic Medicare Part A and Part B Benefits and Mandatory Supplemental Benefits</b>	<b>Part C Premium for Optional Supplemental Benefits</b>	<b>Medicare Deductibles, Coinsurance &amp; Co-pays* (except Part D) **</b>
<b>QMB Only</b>	Optional 1	Not allowed 2	Required 3
<b>QMB Plus</b>	Optional 4	Optional 5	Required 6
<b>SLMB Only</b>	Not allowed 7	Not allowed 8	Not allowed 9
<b>SLMB Plus</b>	Not allowed 10	Optional 11	Conditional 12
<b>QI</b>	Not allowed 13	Not allowed 14	Not allowed 15
<b>Other FBDEs</b>	Not allowed 16	Optional 17	Conditional 18
<b>QDWI</b>	Not allowed 19	Not allowed 20	Not allowed 21

\*Section 1902(n)(2) of the Social Security Act provides that a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or co-payment for Medicare cost-sharing to the extent that payment under Medicare for the service would exceed the payment amount that otherwise would be made under the State Medicaid plan. In any case where Medicare deductibles, coinsurance or co-payments are required to be paid or may be paid conditionally, the State may limit Medicaid payment as specified in Supplement 1 to Attachment 4.19-B of the State Plan, including nominal cost sharing amounts as permitted under Section 1916 of the Social Security Act and specified in attachment 4.18 of the State Plan. These payment limitations may result in a Medicaid payment of zero.

\*\* Section 1935(d)(1) of the Social Security Act specifies that FFP is not available for the coverage of Part D drugs for Part D eligible individuals.

### Notes to Cost Sharing Chart

1. Section 1905(p)(3) of the Social Security Act (the Act) provides that the State may opt to cover premiums for enrollment of QMBs in organizations under §1876. In a June 30, 2000 Policy Memorandum, from the Director of the Disabled and Elderly Health Programs Group, Thomas E. Hamilton, to Associate Regional Administrators (Hamilton Memo), CMS affirmed that §1905(p)(3) may be read to permit Medicare + Choice (now known as Medicare Advantage) to be included, at State option, under the same terms as §1876 contracts. States may make this election on page 29, 3.2(a)(1) of their Medicaid State Plan.
2. Section 1902(a)(10)(E)(i) specifies that QMB coverage is limited to the cost sharing described in §1905(p)(3) of the Act, and does not include coverage of additional services.
3. Coverage of Medicare deductibles and coinsurance are required for QMBs under §1902(a)(10)(E)(i) and §1905(p)(3) of the Act. Hamilton Memo, page 3, Medicare Cost Sharing, "... coinsurance includes the co-payments that M+C organizations charge when beneficiaries use services."
4. See note #1.
5. Section 1905(a) of the Act permits coverage of health insurance premiums, other than Medicare Part B, for medical or remedial care, except for individuals who could be enrolled in Part B but are not. Hamilton Memo, page 3, Monthly premiums in Medicare +Choice Organizations, "...since QMB Plus is also eligible for full Medicaid benefits, Medicaid may also pay premiums for supplemental benefits not covered by Medicare, but which are covered by Medicaid, if so elected in the State Plan (page 29b, 3.2(a)(2))."
6. See note #3.
7. Section 1902(a)(10)(E)(iii) and §1905(p)(3)(A)(ii) limit SLMB coverage to Part B premiums.
8. See note #7.
9. See note #7.
10. See note #7. For non-QMB dual-eligibles, FFP is not available for Medicaid coverage of Medicare Advantage premiums for basic Medicare services.
11. Section 1905(a) of the Act permits payment of health insurance premiums, other than Medicare Part B, for coverage of medical or remedial services, except for individuals who could be enrolled in Part B but are not. States may elect this option in their State Plan, page 29b, 3.2(a)(2).

12. For non-QMB eligibles, there is no Medicaid liability for cost sharing in a Medicare Advantage plan, however, States are liable for payment for Medicaid covered services rendered by Medicaid providers to Medicaid eligible individuals in excess of any third party (including Medicare Part C) liability. When the following conditions are met, there may be a liability for a specific service received through a Medicare Advantage plan:

- The Medicare service is also a covered service under the State Plan;
- The Medicare provider is also a Medicaid provider; and
- The amount specified in the State plan is greater than the Medicare payment amount.

13. Sections 1902(a)(10)(E)(iv) and §1905(p)(3)(A)(ii) of the Act limit QI coverage to Part B premiums.

14. See note #13.

15. See note #13.

16. For non-QMB dual-eligibles, there is no FFP available for Medicaid coverage of Medicare Advantage premiums for basic Medicare services.

17. See note #11.

18. See note #12.

19. Section 1902(a)(10)(E)(ii) and §1905(p)(3)(A)(i) limit QDWI coverage to Part A premiums.

20. See note #19.

21. See note #19.