

## **Key Terms: QMB and Medicare Cost-Sharing**

This glossary provides standard definitions for common terms and concepts frequently used in the Qualified Medicare Beneficiary (QMB) program and Medicare cost-sharing discussion. Use this glossary as a reference for HAP's Moving Forward: A Guide to CMS Policy on Cost-Sharing for Qualified Medicare Beneficiaries.

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**Balance Billing:** Refers to the charging, or billing, of a beneficiary by a non-participating Medicare provider for a service above Medicare's approved amount.

Medicare participating providers must accept assignment which means they agree to accept Medicare's approved amount for a given service as payment in full (i.e., up to 100 percent). If a provider chooses not to participate in Medicare, he may on a case-by-case basis choose to accept assignment. A non-participating provider who chooses to accept assignment can, in most states, bill the beneficiary up to 15 percent above the Medicare approved amount (i.e., 115 percent). Non-participating providers who choose not to accept assignment can bill only up to 115 percent and also ask for the full payment up front. QMBs are exempt by law from any balance bill amounts, and therefore, providers must accept assignment if providing Medicare services to QMBs.

**Cost-Sharing:** Cost-sharing refers to the amount a beneficiary may be responsible to pay upon receipt of health care services. Cost-sharing consists of copayments, coinsurance, deductibles, and, in some cases, the costs associated with balance billing.

**Dual-Eligible (Duals):** Common term that refers to a beneficiary enrolled in both Medicare and Medicaid. Dual eligibles are either "full" or "partial" depending on the level of Medicaid benefits they qualify for.

**Full-dual eligibles:** Medicare beneficiaries who are enrolled in a Medicaid program that provides Medicaid health coverage, as well as assistance in paying the beneficiaries' Medicare premiums and cost-sharing. Medicaid programs that offer "full" Medicaid benefits include the SSI eligibility category and the low-income or medically-needy elderly or disabled.

**Partial-dual eligibles:** Medicare beneficiaries who are enrolled in a Medicaid program that does not offer Medicaid health coverage, but does provide assistance in paying Medicare premiums and other out-of-pocket costs. Medicaid programs that provide "partial" Medicaid benefits include Medicare Savings Programs (MSPs).

**Mechanism:** A system set-up between a provider and the state Medicaid agency that allows for billing claims. It may require a complicated process at first, such as validating

a provider's license and background checks, with the goal of assigning the provider a Medicaid identification number to allow for billing and coding.

**Medicare Savings Programs (MSPs):** Medicare Savings Programs (MSPs) are Medicaid-administered programs available to Medicare and Medicaid eligible beneficiaries with limited income and resources to help beneficiaries with Medicare cost-sharing. There are four MSP programs:

**Qualified Medicare Beneficiary (QMB) program:** Under the QMB program, Medicaid pays the Medicare Part A and Part B premiums, Medicare deductibles, and coinsurances or copayments on behalf of the QMB enrolled individual. To qualify for QMB in 2009, an individual may have income up to 100 percent of the federal poverty level (or \$923 per month) and in most states less than \$4,000 in resources. (Note that states have authority to increase or all together eliminate the resources test.)

Beneficiaries enrolled in the QMB program are commonly referred to as QMBs, QMB clients, QMB-enrolled, or QMB recipients.

**Specified Low-Income Medicare Beneficiary (SLMB) program:** SLMB is a federally funded program that covers the Medicare Part B monthly premium for beneficiaries whose income is between 100 percent and 120 percent of the federal poverty level.

Countable resources for SLMB are the same as for QMB – up to \$4,000 for one person and up to \$6,000 for a married couple\*, with some states using higher resource limits, or eliminating the resource test entirely. SLMB differs from QMB is that it does not cover Medicare's deductibles, copayments, and coinsurance charges.

**Qualified Individual (QI, or QI-1) program:** QI-1 program, provided as a block grant to states by Congress, covers the Medicare Part B monthly premium for persons whose income is between 120 percent and 135 percent of the federal poverty level. It is like the SLMB program in that it does not cover the Medicare deductibles, copayments, and coinsurance charges.

Countable resources for QI-1 are the same as for QMB and SLMB: up to \$4,000 for one person, and up to \$6,000 or for a married couple.\* As with QMB and SLMB, some states use higher resource limits or eliminate the resource test entirely.

**QDWI (Qualified Disabled and Working Individual) program:** Less common of the MSPs, this program is available to individuals who were entitled to Medicare benefits because of a disability, but lost Medicare coverage because of

employment. QDWI pays for the cost of the Part A premium. Individuals must have income at or below 200 percent of federal poverty level and cannot otherwise eligible for full Medicaid to be eligible for QDWI.

**Provider (Contracted provider):** A provider is defined as any individual, (e.g., physician, pharmacist, therapist) or facility (e.g., hospital) that provides health care services or items to a patient.

According to the State Medicaid Manual, Chapter 3 - Eligibility, Section 3490.14, a contracted provider (for purposes of billing for QMBs) is defined as "A provider agreement necessary for participation for this purpose (e.g., for furnishing the services to the individual as a QMB) may be executed through the submission of a claim to the Medicaid agency requesting Medicaid payment for Medicare deductibles and coinsurance for QMBs."

**Rate:** A set fee, or amount, for a given health care service. In most states the Medicare rate is a higher amount than the Medicaid rate.

Example: Medicare's approved amount for a doctor's visit is \$100. A beneficiary visits his doctor, who charges \$100 for his services. Medicare payment rate is 80 percent of the \$100 approved amount (or \$80); the beneficiary would be responsible for the remaining 20 percent (or \$20).

\* Note the resource limits for the MSP programs will increase beginning in 2010 to match the asset limits of the full low-income subsidy (LIS) program.