
Moving Forward: A Guide to CMS Policy on Cost-Sharing for Qualified Medicare Beneficiaries

People enrolled in the Qualified Medicare Beneficiary (QMB) program are entitled to full relief from Medicare cost-sharing under the law. State Medicaid programs are required to cover some of these costs for QMBs. Yet health care providers sometimes ask QMBs to pay for Medicare charges. How can this happen when Medicare and Medicaid law, regulations, and policy manuals state that Qualified Medicare Beneficiaries (QMBs) have no cost-sharing liability in Medicare?

The main goals for this guide are: 1) to trace the protections for QMBs to sources in the Social Security Act and in the Center for Medicare & Medicaid Services' (CMS's) policy manuals and guidance and 2) to address some of the factors that lead providers in some states to bill QMBs for costs for which they are not liable. This tool also addresses some misconceptions about provider participation in Medicaid that contribute to the problems that QMBs face.

It is important for SHIP counselors to know that they are standing on firm legal ground when they help their QMB clients obtain the full benefits they are entitled to under the most comprehensive of the three Medicare Savings Programs (MSPs).

What does the law say about Qualified Medicare Beneficiaries (QMBs) and their liability for Medicare cost-sharing?

When the Balanced Budget Act (BBA) of 1997 added provisions to Section [1902\(n\)](#) of the Social Security Act, it strengthened the cost-sharing protections for Qualified Medicare Beneficiaries (QMBs) by stating, "the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in Section [1903\(m\)\(1\)\(A\)](#) [i.e., a Medicare Advantage Organization] for the service." Section [1905\(p\)\(3\)](#) of the Act defines the specific costs to be paid on behalf of QMBs to include the Part A and Part B premiums, coinsurance, and deductibles. States also have the option to pay the premiums of Medicare Advantage (MA) plans on behalf of QMBs. Section [1902\(n\)\(3\)\(B\)](#) says that "any lawful sanction may be imposed" on a provider or Medicare Advantage Organization for imposing any "excess charges" on a QMB. This means that QMBs are excused from Medicare cost-sharing in both Original Medicare and Medicare Advantage and that providers are not allowed to collect these costs from QMBs.

What does the law say about the state Medicaid agency's responsibility to reimburse providers for Medicare services that QMBs receive?

Before the BBA was enacted in 1997, the Social Security Act did not make clear if the law required state Medicaid programs to reimburse physicians and other providers for the full amount of Medicare's cost-sharing charges when they serve QMBs. Some states believed that the law expected them to pay providers the entire Part B deductible and 20 percent coinsurance amounts. Other states took the position that the law asked nothing more of them than to pay providers up to the state's Medicaid rate. They might pay a part of the coinsurance charge or nothing at all. These states took Medicare's 80 percent payment (of a higher approved amount) as their starting point. They were willing to pay more than Medicare's 80 percent payment, but only up to the state's Medicaid payment rate for the same service. If the Medicaid payment rate was lower than Medicare's 80 percent payment rate, then the state paid nothing toward Medicare's coinsurance charges.

For example, if Medicare's approved amount for a physician service is \$100, then Medicare pays 80 percent. Its payment rate is \$80. This leaves a \$20 coinsurance charge. If the Medicaid payment rate is \$90 for the same service, the state paid the difference between Medicare's \$80 rate and Medicaid's \$90 rate, or \$10. The physician receives \$80 from Medicare plus \$10 from Medicaid.

Some providers who objected to total payments that were far less than Medicare's approved amounts took their concerns to federal court. After hearing several cases, the courts were divided on the question of whether the Social Security Act required state Medicaid programs to reimburse providers the full amount of Medicare's cost-sharing charges for their services to QMBs. Congress put an end to the uncertainty in 1997 through the BBA's amendments to the Social Security Act. Section [1902\(n\)\(2\)](#) of the Act explains that the law does not require states to reimburse providers more than Medicare's actual payment rate (generally 80 percent of the approved amount for Part B services) if that amount exceeds what the state would pay on the same service for any other Medicaid enrollee. In other words, states do not have to pay anything toward Medicare's cost-sharing charges when the state's Medicaid payment falls below Medicare's 80 percent payment (and less than 80 percent for services such as mental health).

Today, some states still reimburse providers at the full Medicare rate despite the lack of a requirement to do so. Others use the Medicaid rate or some rate in between. It would seem that billing and access problems for QMBs should be less frequent in states that fully pay Medicare's cost-sharing charges. But if the current fiscal crisis for many state governments continues or intensifies, more and more states will feel pressure to reduce their reimbursement rates for providers who provide care to QMBs, and more low-income beneficiaries will be at risk.

What is the impact of the law on providers?

Shortly after the BBA was enacted in 1997, CMS seemed to anticipate the problems that some QMBs would face with providers in states whose Medicaid payment rates fell below Medicare's approved amount. Some QMBs found themselves dealing with providers who would accept assignment on Medicare claims, but who expected **someone** to pay the 20 percent coinsurance charge and who were unaware that QMBs are not liable for the bill.

CMS, then known as the Health Care Financing Administration (HCFA), sent a letter dated November 24, 1997 to the state Medicaid directors. The letter reminded them that the amount Medicare pays plus the amount that Medicaid pays (if anything), is to be considered "payment in full" for Medicare-covered services provided to QMBs, in accordance with Section [1902\(n\)\(3\)\(A\)](#) of the Social Security Act.¹ The letter also informed Medicaid directors that "these limitations apply both to Medicare providers with provider agreements and to nonparticipating Medicare physicians."² This meant that nonparticipating physicians, doctors who do not accept assignment and who reserve the right to bill their patients more than the approved amount up to the Medicare "limiting charge," could not bill QMBs for any unpaid balance after Medicare and Medicaid had paid.

CMS has regularly reminded state Medicaid agencies about these provider rules. Most recently, in February 2008, CMS sent a memo and accompanying Q & A about balance billing to state Medicaid programs.³ The Q&A further clarifies the law prohibiting provider billing of QMBs. To the question, "May a provider bill a QMB for either the balance of the Medicare rate or the provider's customary charges for Part A and B services?," CMS gave this answer:

No. QMBs are protected from liability for Part and B charges even when the amounts the provider receives from Medicare and Medicaid are less than the Medicare rate or less than the provider's customary charges. Providers who bill QMBs for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. Providers may not accept QMB patients as "private pay" in order to bill the patient directly, and providers must accept Medicare assignment for all Medicaid patients, including QMBs.

¹ Health Care Financing Administration. Letter to State Medicaid Directors, November 24, 1997. Available online at: <http://www.hapnetwork.org/assets/pdfs/letter-to-medicaid-directors-medicaid-payments-for-qmb.pdf>.

² Health Care Financing Administration. Letter to State Medicaid Directors, November 24, 1997. Available online at: <http://www.hapnetwork.org/assets/pdfs/letter-to-medicaid-directors-medicaid-payments-for-qmb.pdf>.

³ Center for Medicare & Medicaid Services. Memorandum to Associate Regional Administrators, February 27, 2008. Available online at: <http://www.hapnetwork.org/assets/pdfs/cms-memo-on-cost-sharing.pdf>.

While CMS has made clear that QMBs are not liable for Medicare's cost-sharing charges, the question of who really is liable for the balances that remain after Medicare and Medicaid have paid their share remains unresolved. It appears that CMS and many state Medicaid agencies assume that providers will write off any unpaid balances that remain for QMBs.

What does the law say about Medicaid participating providers and submitting claims to the state Medicaid program?

Some health care providers and government officials mistakenly believe that a provider must formally participate in a state's Medicaid program in order to bill Medicaid for furnishing services to QMBs. One likely source of this misconception is a provision in CMS's State Medicaid Manual that was added in a July 1991 revision, six years before the BBA amendments to the QMB law were enacted. A sentence in Manual section 3490.14, B states, "Medicaid payment of Medicare deductible and coinsurance amounts (for services furnished to QMBs) may be made only to Medicaid participating providers...."

Some have read this manual provision in light of other Medicaid billing rules and concluded that QMBs must use health care providers who have entered into written participation agreements with their Medicaid agencies. While it may be simpler for QMBs to deal with providers who formally participate in Medicaid because they are often more familiar with Medicaid claims procedures than non-participating providers, federal rules do not restrict QMBs to using them. To that point, Section 3490.14, B. goes on to say that, "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." In other words, providers who do not formally participate in Medicaid can establish provider agreements simply by submitting a claim to Medicaid for Medicare cost-sharing charges for QMBs. They effectively become "deemed" participants in the Medicaid program (though CMS does not use that term explicitly).

Despite this CMS guidance, it appears that some state Medicaid programs have not yet clearly defined their claims procedure for non-participating providers who give services to QMBs. This lack of clarity may reinforce the misconception that QMBs must only use providers who have formal participation agreements with Medicaid.

Another problem for QMBs is the misconception that providers who do not have formal participation agreements with Medicaid can bill them for all Medicare cost-sharing charges as "private pay" patients. This problem stems from another provision in Section 3490.14 where the Manual says, "Subject to State law, a provider has the right to accept

a patient ... as private pay only....” This right no longer exists. CMS’s February 2008 memo to the Associate Regional Administrators for Medicaid and Children’s Health, stated, “Although the State Medicaid manual, in a 1991 revision, refers to some circumstances in which a QMB may be balance billed, this information was later superseded by statute and corresponding policy.” The Q & A that accompanied the memo stated CMS’s policy more directly, “Providers may not accept QMB patients as ‘private pay’ in order to bill the patient directly, and providers must accept Medicare assignment for all Medicaid patients, including QMBs.”

What does the law say about Medicare cost-sharing for QMBs enrolled in Medicare Advantage (MA) plans?

As mentioned above, Section [1905\(p\)\(3\)](#) of the Social Security Act outlines the specific costs from which QMBs are excused. In a policy memo to Associate Regional Administrators for the Division of Medicaid and State Operations, dated June 30, 2000, CMS establishes that a state Medicaid agency must pay any deductibles, copayments, or coinsurance charged by an MA plan for Medicare-covered services for QMBs, up to the State’s Medicaid payment rate for the service or item.⁴ States also must pay the portion of an MA plan’s premium that covers basic Medicare benefits for QMBs. However, if an MA plan charges a monthly premium in addition to the premium that covers basic Medicare benefits, a state has the option to cover the premium for QMBs.

This memo emphasizes that state Medicaid plans must pay for the Medicare cost-sharing of QMBs enrolled in MA plans. It states, “When a Medicare M+C organization [now known as Medicare Advantage] has chosen to impose deductibles, coinsurance or copayment charges for Medicare covered services on their enrollees, (not as a premium, but as amounts charged when services are furnished), the Medicaid agency is **required** to include these costs as Medicare cost-sharing for QMBs, without regard to whether it has elected to include premiums in cost-sharing. These costs must be paid by the state in full or to a lesser extent as indicated in the Medicaid state plan.” However, in some states QMBs still are being billed by their MA plans for these copayment costs.

In a letter to state Medicaid agencies in February 2008, CMS offered additional details on how Medicaid may pay MA organizations for the Medicare cost-sharing of QMBs enrolled in MA plans.⁵ The letter indicates and further clarifies that states may choose to offer a per-enrollee payment (a “capitation” payment) to MA plans to cover the

⁴ Health Care Financing Administration. Policy Memo to Associate Regional Administrators, June 30, 2000. Available online at: <http://www.hapnetwork.org/assets/pdfs/cms-memo-on-payments-for-qmbs-in-hmos.pdf>.

⁵ Center for Medicare & Medicaid Services. Memorandum to Associate Regional Administrators, February 27, 2008. Available online at: <http://www.hapnetwork.org/assets/pdfs/cms-memo-on-cost-sharing.pdf>.

Medicare cost-sharing of QMBs enrolled in MA plans. MA plans may choose to accept the capitation payment. This arrangement between Medicaid and MA plans allows for easier billing for QMBs enrolled in MA plans with a capitation arrangement.

MA plans that do not accept capitation payments may still enroll QMBs in their plans. However, without an arrangement with the state, the MA plan's claims for payment do not "cross over" to Medicaid. Providers who see QMB patients in such MA plans must establish a mechanism to bill Medicaid directly for Medicaid's portion of the bill. This can be an involved process for providers, especially those who are not Medicaid providers. However, no provider or MA plan, including those without a capitation arrangement with states, may bill QMBs. If MA plans and their contracted providers (without capitation arrangements) wish to be reimbursed for Medicaid's portion of Medicare cost-sharing for QMBs, they must arrange for "cross over" claims with the state.

What are the state's obligations to protect QMB's access to care?

Even though states may reimburse providers at different rates, Section [1902\(a\)\(30\)\(A\)](#) of the Act requires states, "to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Because of this protection, states must ensure that the Medicaid payment rate does not adversely affect the access to care for all individuals with Medicaid, including dual eligible beneficiaries like QMBs. However, QMBs are being billed by providers in some states for copayments, which some argue does indeed deter access to care for these beneficiaries.