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Improving the Qualified Medicare Benefit Program for Dual Eligibles

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Foreword

This paper provides recommendations on changes to improve delivery of the Qualified Medicare Beneficiary (QMB) program so that it can more fully serve the purposes for which the program was established. It is the last in a series of four papers that highlight pressing issues facing dual eligibles and provide recommendations to the federal Medicare-Medicaid Coordination Office (MMCO), state Medicaid agencies and other interested policymakers and stakeholders on how to address them. The first paper discussed consumer protections needed in delivery system models that integrate Medicare and Medicaid. The second paper addressed differences in Medicare and Medicaid program rules and

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This paper is supported by a grant from The SCAN Foundation, dedicated to creating a society in which seniors receive medical treatment and human services that are integrated in the setting most appropriate to their needs. For more information, please visit www.TheSCANFoundation.org.

coverage standards. The third paper discussed ideas for integrating the appeals systems of the two programs.[1]

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This report is also available online at *www.justiceinaging.org*.

Executive Summary

The Qualified Medicare Beneficiary (QMB) program is a Medicaid program designed to give low-income Medicare beneficiaries full access to their Medicare benefit.[2] The QMB program covers Medicare premiums, deductibles and copayments.[3] It also includes protection from payment liability for all cost sharing and from liability for any charge above the Medicare-approved amount ("balance billing") to Medicare providers.[4] If the program worked as it should, anyone who qualifies as a QMB would have full Medicare Part A and B coverage without any premium liability and would have the same access to Medicare providers (primary care physicians, specialists, mental health providers, physical therapists, skilled nursing facilities, etc.) as any other Medicare beneficiary. Medicare would pay the Medicare-covered portion, Medicaid would then process the provider's bill to cover of the remainder of the Medicare-approved amount and the beneficiary would be shielded from any charges.

In practice, the program does not fulfill its promise. States are permitted by statute to cap their contribution to Medicare copayments at Medicaid rates, which usually are significantly lower than the Medicare-approved rate for the same service. This policy renders the copayment benefit largely illusory. Medicare providers usually only receive small copayments—and often no copayments at all—when they submit charges for QMBs and, as a result, many providers refuse to accept QMBs as patients. Advocates report that QMBs frequently go without needed care because they cannot find specialists, mental health professionals, and other providers willing to serve them.

Besides payment levels, payment procedures create another barrier that discourages provider participation. Many states, despite guidance to the contrary from the Centers for Medicare and Medicaid Services (CMS), require Medicare providers seeking copayments to go through

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[1] The series is available at *www.nsclc.org/index.php/health/dual-eligibles/*.

[2] The shortened name for the program, QMB, is pronounced, Quimby.

[3] For QMBs enrolled in Medicare Part C (private plans), the benefit covers copayments. States have the option of covering Part C premiums. Note that CMS sometimes draws a distinction between copayment responsibility (set amounts, e.g., a $20 copayment for an office visit) and co-insurance responsibility (percents, e.g., 20 percent of the allowed charge). Because these distinctions are not relevant to the issues discussed in this paper, we will use the more common term, copayment, throughout.

[4] For purposes of the balance billing discussion in this paper, the term "copayment" comprises both cost-sharing and amounts above the Medicare approved amount.

cumbersome application procedures and often reject reimbursement requests outright if providers are not also enrolled in the state Medicaid program.

Beneficiaries also face challenges in accessing the protection against balance billing that is part of the QMB program. QMB who are able to find Medicare providers may face demands for copayments that they do not owe. Protections against balance billing are not well understood by providers. Though both state and federal authorities have enforcement remedies available, they are rarely used.

The practical impact of these many deficiencies is that QMBs find that when they need to use their Medicare benefit, it is largely unavailable to them.

This paper examines what the QMB program should offer, where it currently fails, and why. The paper identifies access to Medicare providers as the biggest challenge facing QMBs and suggests that a fundamental overhaul of provider reimbursement is needed. The paper proposes three alternative provider payment structures:

- Payment rates equal to the full Medicare-approved rate in all provider categories.
- Payment rates equal to the full Medicare rate in those categories in which problems of provider access are most critical.
- Payment rates that are less than the full Medicare rate but that are, across-the-board, higher than current Medicaid rates.

The paper also recommends administrative and procedural improvements in the benefit including:

- Simpler and smoother payment processes for providers serving QMBs.
- More information and more active enforcement around the protections against balance billing of QMBs by providers.
- Better identification cards for QMBs with clearer instructions to providers on rules for serving QMBs.

Finally, the paper examines three possible models for redesigning delivery of the QMB benefit:

- A continuation of the current state-operated model, but with an increased federal match (Federal Medical Assistance Percentage or FMAP) of up to 100 percent to allow states to increase payments to providers.
- A partially federalized program in which states continue to pay Medicare premiums for QMBs, but the Medicare program handles all provider payments.
- A fully federalized QMB program operated by CMS without participation by the states that would offer maximum administrative efficiencies.

Introduction

For those aged 65 and older and people with disabilities, the Medicare program provides health insurance coverage for physician visits, hospital stays, and post-acute care and equipment, as well as for prescription drugs. For those who qualify, the Medicaid program provides coverage for additional services, particularly long-term services and supports, both in the community and in institutions.

Medicare coverage requires beneficiaries to contribute to the cost of their care in the form of premiums and copayments for services. Because of these cost-sharing requirements, people with low incomes would not be able to use their Medicare benefits without additional assistance. The primary vehicle for that additional assistance is the Qualified Medicare Beneficiary (QMB) program, a state Medicaid program that is intended to cover premiums and copayments for low-income Medicare beneficiaries. The program is meant to ensure that low-income Medicare beneficiaries do not forego critical health care services due to the cost-sharing requirements of the Medicare program. Through QMB coverage, low-income Medicare beneficiaries should be able

to participate fully in the Medicare program, with the same access to Medicare doctors and facilities afforded to middle and higher income Medicare beneficiaries.

Despite its promise, the QMB program does not work as it should. Policies that limit the amounts that states are required to reimburse providers leave QMBs without full access to Medicare. Administrative hurdles and cumbersome rules for providers add to the access problem. Advocates report that finding Medicare specialists, mental health professionals, and primary care providers who accept QMBs is a challenge. The dearth of willing providers creates serious problems in access to care, problems that have the greatest impact on the many low-income Medicare beneficiaries who have complex and chronic conditions.

This paper looks at the QMB program and how it currently works. The paper focuses on areas in which program structure and administration interfere with the program's ability to deliver full Medicare benefits. The paper starts with a description of program basics. It then focuses on four aspects of program implementation where current deficiencies create the greatest barriers to QMBs fully using their Medicare benefits: provider payment levels, provider payment procedures, balance billing protections, and information for beneficiaries and providers. For each deficiency, the paper recommends changes that would improve delivery of the program's benefit. In this paper, we also propose that policymakers consider undertaking a more comprehensive redesign of the QMB program and we identify three options for policymakers to consider.

QMB Basics

What is the QMB program?

The QMB program is one of four Medicare Savings Programs (MSPs) created in 1988 by the Medicare Catastrophic Coverage Act.[5] Although all MSPs offer assistance with Medicare premiums, the QMB program is the only one that also assists with Medicare deductibles and copayments. The QMB program is a required part of state Medicaid plans and thus is offered in every state.[6] Under current federal law, the benefit must be available to individuals enrolled in Medicare Part A with incomes at or below 100 percent of the federal poverty level (currently $903/mo for an individual and $1,215/mo for a couple) and assets at or below the asset level to qualify for the Medicare Part D Low Income Subsidy (currently $6,680 for an individual and $10,020 for a couple).[7] States have the option to set more generous limits; nine states have chosen to eliminate the asset limit entirely and several others have increased the income and/or asset limits.[8]

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[5] The other Medicare Savings Programs are: Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual (QI), and Qualified Disabled Working Individual (QDWI). These programs will not be discussed in this paper. For a description of all Medicare Savings Programs, see Ctr. for Medicare Advocacy, "Medicare Savings Programs" available at *www.medicareadvocacy.org/Print/FAQ_MedicareSavingsPrograms.htm*.

[6] 42 U.S.C. § 1396a (a)(10)(E). A less robust version of the QMB program was included in law in 1986 as an option for states. As noted above, the current program, enacted in 1988, is a required benefit in state Medicaid programs.

[7] 42 U.S.C. § 1396d(p)(1).

[8] See Kaiser State Health Facts at *www.statehealthfacts.org/comparereport.jsp?rep=61&cat=6&gsa=2* for a chart of state income and asset requirements for QMB eligibility.

What Does the QMB Program Provide?

The QMB program pays:

- The full monthly Medicare Part B premium (for 2012, the Part B premium is $99.90/mo[9]).
- Part A premiums (the full Part A premium is $451/mo[10]) for individuals who do not qualify for premium-free Medicare Part A coverage.
- Deductibles and copayments for Medicare Part A and Part B services (with limitations discussed below).

In addition, Medicare providers are prohibited from billing Qualified Medicare Beneficiaries (QMBs) for any amount beyond what they are paid by Medicare and Medicaid, a practice known as "balance billing." QMBs also automatically qualify for the Medicare Part D Low Income Subsidy, which provides extra help with Medicare prescription drug premiums, deductibles and copayments.

The QMB program differs from full-scope Medicaid in that QMB eligibility and benefits cannot be retroactive and benefits are not subject to Medicaid estate recovery.[11]

Who are Qualified Medicare Beneficiaries (QMBs)?

There are two categories of QMBs, often referred to as "QMB-plus" and "QMB-only." QMB-plus individuals are those who qualify for both full scope Medicaid benefits (full benefit dual eligibles) and for the QMB benefit. Although exact statistics are unavailable, roughly half of the 6.9 million full benefit dual eligibles are QMB-plus.[12] Most of those full benefit dual eligibles who are not QMBs are dual eligibles who are "medically needy," that is, people with incomes above the Medicaid limits but with high medical expenses. They must "spend down" to qualify for Medicaid. Medically needy dual eligibles do not qualify for the QMB benefit if their incomes before medical expense deductions are above the QMB income limits.[13]

"QMB-onlys" have incomes or assets low enough to qualify for the QMB program, but too high to qualify for full Medicaid benefits.[14] They are also referred to as "partial duals."[15]

Given the overlap between QMBs and full dual eligibles, the problems that dual eligibles face in using their Medicare benefits—problems that the QMB program is meant to solve but does not—must be addressed as part of any analysis of how to improve the delivery system for dual eligibles.

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[9] 76 Fed. Reg. 67572 (Nov. 1, 2011).

[10] 76 Fed. Reg. 67570 (Nov. 1, 2011).

[11] 42 U.S.C. § 1396P(b)(1)(B)(ii).

[12] CMS does not publish statistics on how many full-benefit dual eligibles are QMBs. Estimates are based on information in a monthly enrollment report compiled by CMS, "Part A and Part B Buy-ins by State and Selected Eligibility Categories" (Nov. 2011)(copy available from the authors), and statistics on dual eligibles compiled by Kaiser Family Foundation at *www.kff.org/medicaid/upload/4091-08.pdf*.

[13] According to Kaiser Family Foundation statistics, about 3.4 million dual eligibles qualify for Medicaid coverage because they are medically needy (2003 statistics). See *www.statehealthfacts.org/comparemaptable.jsp?ind=209&cat=4*.

[14] Income and asset limits for full-scope Medicaid benefits vary by state. About half the states set limits below $700 for an individual. The asset limit in most states is $2000 for an individual. See Kaiser Family Found., State Health Facts, available at *www.statehealthfacts.org/comparereport.jsp?rep=59&cat=4*.

[15] The term "partial duals" is also used for participants in the other MSP programs.

Program Deficiencies

Low or No Copayment for QMBs

Advocates report that the greatest challenge for QMBs is that many Medicare providers refuse to accept them as patients. Provider payments are at the core of the problem. The Medicare program, in general, covers 80 percent of Medicare-approved charges. Medicare beneficiaries are required to pay the remaining 20 percent of the Medicare-approved fee for the service. For QMBs, providers must look to state Medicaid programs for the remaining 20 percent and may not charge QMBs directly. However, the statute authorizing the QMB program does not require states to pay the 20 percent. States are considered to have fulfilled their duty under the QMB program if they cover the difference between the 80 percent Medicare pays and the amount Medicaid would have paid for the same service.[16] The Medicaid rate often is below 80 percent of the Medicare rate, meaning that providers receive nothing from the state.

An example from California demonstrates how QMB payments work in practice. California limits QMB copayment amounts to Medicaid rates.[17] For a new patient outpatient office visit, procedure code 99205, the Medicare approved rate for Santa Clara County is $225.45, of which Medicare pays $180.36 (80 percent of the Medicare rate), leaving the provider with an outstanding balance of $45.09 (20 percent of the Medicare rate).[18] The California Medicaid rate for the same service code is $82.70.[19] Because the Medicaid rate is (significantly) lower than 80 percent of the Medicare rate, the state has no obligation to pay anything and the Medicare provider in this example receives nothing more from the QMB program. The provider is prohibited from billing the beneficiary and has no other source of payment for the 20 percent that California does not contribute.

Advocates report that, because of these payment gaps, many Medicare providers refuse to serve QMBs.[20] A 2003 study commissioned by CMS confirmed the problem of provider access, particularly with primary care providers and mental health professionals.[21]

Copayment levels have been an issue from the very start of the QMB program. After the QMB program was established, CMS (then the Health Care Finance Administration) provided guidance telling the states that they could limit their copayments to Medicaid levels. Litigation followed, in which beneficiaries argued that the limitation was contrary to the intent of the program. The litigation resulted in conflicting court rulings.[22] With the Balanced Budget Act of 1997 (BBA), Congress resolved the question

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[16] 42 U.S.C. § 1396a(n). Most states exercise this option. See Patricia B. Nemore, "Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries—a 1999 Update" (December 1999) (hereinafter, "Variations in State Medicaid"), available at *www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13351.*

[17] Cal. Welfare and Institutions Code, § 14109.5.

[18] *www.cms.gov/apps/physician-fee-schedule/.*

[19] *http://files.medi-cal.ca.gov/pubsdoco/rates/rates_information.asp?num=22&first=94799&last=99499.*

[20] For example, several complaints about provider access, particularly in rural areas, were raised by advocates at a listening session hosted by the MMCO in San Francisco in June 2011.

[21] See Janet B. Mitchell and Susan G. Haber, "State Payment Limitations on Medicare Cost-Sharing Impacts on Dually Eligible Beneficiaries and Their Providers " (July 2003), available at *www.rti.org/abstract.cfm?pid=1203.* Although the study proposed that CMS continue to monitor provider access, no later studies were commissioned.

[22] See, e.g., Rehabilitation Ass'n of Va. v. Kozlowski, 42 F.3d 1444 (4th Cir. 1944)(state must pay Medicare rates); Beverly Cmty. Hosp. Ass'n v. Belshe, 132 F.3d 1259 (9th Cir. 1997) (state allowed to pay Medicaid rates).

by incorporating into the statute a provision that explicitly permits states to limit copayments to Medicaid rates.[23]

The BBA permitted, but did not require, states to cap payments at Medicaid rates. States also have the option to cover copayments up to full Medicare rates or to set QMB rates that are higher than Medicaid rates but lower than full Medicare rates. However, most states set QMB payment levels at Medicaid rates.[24] For Medicare services that are not also covered by Medicaid and thus do not have a comparable Medicaid payment rate, CMS guidance directs states to develop "reasonable" rates, which may be below full Medicare rates and are subject to prior CMS approval.[25]

Some partial measures address this payment gap and the resulting problem of access to providers.

Two partial solutions to the problem of payment gaps and provider access are available. However, as currently designed, neither is sufficient to give beneficiaries the access they need.

Perhaps more important from the point of view of the beneficiary is a provision in the Affordable Care Act (ACA) requiring that, for 2013 and 2014, Medicaid programs must pay primary care providers at Medicare rates.[26] So that states can afford these increased payments, the federal matching rate or FMAP for such services will be 100 percent. This provision, though limited to only two years, will provide some improvements in access for QMBs since even states that cap QMB coverage at Medicaid rates will now be providing coverage up to the full Medicare payment rate.[27]

The ACA provision, however, is narrowly drawn. The requirement for Medicare rates is limited to physicians "with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine." Many dual eligibles with chronic conditions rely on specialists as their primary care providers and it is unclear whether primary care services offered by those specialists could be encompassed by the provision. Moreover, the provision clearly excludes care other than primary care so the more general problem with access to treatment by specialists, mental health professionals and other types of providers remains. If expanded to encompass more providers, however, the ACA provision could be a springboard for more extensive QMB reform.

An additional payment mechanism, the Medicare "bad debt" recovery process, is a method of compensating providers for the failure of states to pay them full Medicare rates. Under the bad debt procedure, certain Part A providers may submit claims to the Medicare program for any uncollectible payments due from Medicare beneficiaries.[28] The bad debt recovery program encompasses all uncollectible Medicare copayments and is not specifically

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[23] 42 U.S.C. § 1396a(n). See also Health Care Fin. Adm., State Medicaid Dir. Letter (Nov. 24, 1997), available at *www.cms.gov/smdl/downloads/SMD112497.pdf*.

[24] A 1999 survey found that only 16 states paid the Medicare rate. See Nemore, "Variations in State Medicaid" supra note 16. Although there is no recent survey data about payment levels set by states for their QMB programs, advocates have reported a trend of additional states moving to Medicaid rates.

[25] CMS State Medicaid Manual, Ch. 3 at 3490.14(A)(2).

[26] 42 U.S.C. § 1396a(a)(13)(C). This section was inserted by Section 1202 of the Affordable Care Act (ACA).

[27] A pre-ACA statutory provision also requires that Medicaid rates for hospice services be equal to Medicare rates. However, because Medicare pays 100 percent of Medicare approved amounts for hospice with no required copayment, this provision is not relevant to the QMB copayment issue. 42 U.S.C. § 1396a(a)(13)(B).

[28] Bad debt recovery is available to hospitals, skilled nursing facilities, home health agencies, outpatient rehabilitation facilities, end-stage renal dialysis facilities, outpatient physical therapy facilities and organ procurement agencies.

designed to address gaps caused by Medicaid program decisions to not cover the full Medicare cost-sharing liability of QMBs. However, CMS categorizes copayments for QMBs that are not fully paid by state Medicaid agencies as "uncollectable" for purposes of the bad debt recovery program.[29]

The bad debt program allows institutions to submit all Medicare bad debt claims to a Medicare fiscal intermediary. After review for accuracy, submitting institutions receive payment from Medicare to cover a portion of their Medicare "debt." Disputes are resolved by a Provider Reimbursement Review Board and ultimately are appealable to federal court. The reimbursement rate for these bad debt claims has varied over the life of the program; currently Medicare pays providers 70 percent of approved bad debt amounts. For QMBs who are members of Medicare Advantage (MA) organizations, Part A providers must look to the MA plan for coverage of bad debts. MA plans are required to set out their bad debt reimbursement policy in their contracts with providers.[30]

The Medicare bad debt program, although offering some partial payment relief to a subclass of providers, is neither comprehensive nor effective in solving the access issues facing QMBs. The accounting and reporting procedures are complicated and particularly burdensome for smaller providers with fewer resources to navigate the system.[31] Providers serving QMBs who use the process go through three steps: submitting claims to Medicare, then claims review by Medicaid for the amounts remaining after Medicare has paid its portion of the Medicare-approved amount, then combining unpaid claims and resubmitting them once more to Medicare. This complex process does not serve the broader ACA goal of streamlining health benefit systems. Moreover, it is not available to Part B providers, including the primary care doctors, specialists and others providers that QMBs have the most difficulties seeing.

The history of the bad debt program shows further weaknesses, making the bad debt recovery program a poor vehicle on which to build future QMB reforms. Audits by the Office of Inspector General (OIG) of the Department of Health and Human Services in the 1990's found significant error rates in provider submissions and the OIG, as recently as March of this year, has recommended elimination or reduction of the program.[32] A proposal to eliminate the bad debt program was also included in the President's 2008 and 2009 budgets.[33] Although the program continues to operate, this history of vulnerability, when combined with its complexity, suggests a limited role for the bad debt program in future solutions to QMB access problems.

Recommendations

To put QMBs on the same footing as other Medicare beneficiaries, the current payment process that allows states to limit copayments for QMBs to Medicaid rates must be changed. When providers receive lower reimbursement for serving QMBs than they receive for serving other Medicare beneficiaries, those providers have little incentive to accept QMBs as patients. To ensure that QMBs have

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[29] See 42 C.F.R. § 413.89 and CMS, Provider Reimbursement Manual, Ch. 3, available at *www.cms.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021929&intNumPerPage=10.*

[30] See *www.cms.gov/privatefeeforserviceplans/downloads/pffs_conf_followup2.pdf* at Q9.

[31] See CMS, Provider Reimbursement Manual, Ch. 3 for reimbursement procedures.

[32] See HHS Off. of Inspector Gen., "Compendium of Unimplemented Recommendations" (March 2011), Pt. 1, pp. 9-10 and reports cited therein. Available at *http://oig.hhs.gov/publications/docs/compendium/2011/CMP-March2011-Final.pdf.*

[33] Id.

full access to Medicare providers, QMB reimbursement rates should equal the full authorized Medicare amount for all Medicare-covered services.

If an across-the-board conversion to Medicare rates is not possible, targeted partial approaches to improving payment would bring some benefit. One such approach would be to target those provider categories where access has been most constricted and require that QMB reimbursement be at Medicare levels for those categories. This approach could build on the ACA provision requiring that Medicaid rates match full Medicare rates for primary care physicians, and add more categories. Effective targeting would necessitate an analysis of which categories of services are least accessible to beneficiaries (which may differ by state or region within a state).

An alternative approach could be an across-the-board requirement that QMB programs pay at least a set percent of Medicare copayments. This approach, though similar to the Medicare bad debt reimbursement of 70 percent of unpaid Medicare-approved amounts, would be more direct and administratively efficient. Nevertheless, any across-the-board partial payment system would offer little guarantee that the amount chosen would be adequate to ensure access to different types of providers and services.

Ensuring that providers are compensated at or near Medicare rates would involve additional governmental outlays. In the current budgetary climate, it is unlikely that states would be able to absorb those costs without a significant federal contribution, such as the 100 percent FMAP accompanying the ACA requirement to raise Medicaid primary provider rates. Financial participation by the Medicare program would likely be necessary but those costs would be partially offset by the drop in Medicare bad debt payments to Part A providers.

There would be other systemic benefits as well. Reforming the QMB payment system would have a disproportionately positive effect on providers who primarily serve low-income communities, many of whom currently treat QMBs but do not get reimbursed up to full Medicare rates. Paying these providers full Medicare rates for services provided to QMBs is an equitable and easily administered mechanism for directing dollars to these clinics, primary care physicians, and hospitals and of helping them to achieve the financial security they need to continue to serve underserved communities.

Provider Payment Procedures

CMS policy guidance tells states that a provider need not be enrolled in the state Medicaid program in order to receive copayments for Medicare services provided to a QMB. Claims submission alone should be enough for a Medicare provider to receive any QMB copayments for which the state is liable.[34] Yet many states impose onerous enrollment requirements on providers seeking copayment coverage. Kansas and the District of Columbia, for example, require a full Medicaid provider application; Virginia's QMB application is 17 pages in length.[35] Advocates also report that

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[34] The CMS State Medicaid Manual provides that participation in Medicaid for the purpose of furnishing services to a QMB can be "executed through the submission of a claim to the Medicaid agency requesting Medicaid payment for Medicare deductibles and coinsurance for QMBs." State Medicaid Manual, Ch. 3 at 3490.14(B). Unfortunately, the Manual has some confusing and contradictory language, also saying the payments may be made only to "Medicaid participating providers" then defining that participation, for purposes of QMB, as merely submitting a claim for services to the QMB beneficiary.

[35] See Kansas Medical Assistance Program, QMB Application Checklist, available at *www.kmap-state-ks.us/Documents/Content/Checklists/QMB.pdf;* District of Columbia "Qualified Medicare Beneficiary Program," available at *www.dc-medicaid.com/dcwebportal/docs/providerenrollment/crossover_enrollment_application.pdf.* Virginia's form is available at *www.dmas.virginia.gov/downloads/forms/pe-qmb.pdf.*

many states routinely reject claims from providers who are not enrolled in Medicaid without consideration of whether the claim is for a QMB copayment. Many state publications say unequivocally that only providers who participate in Medicaid can be used by QMBs. For example, a Fact Sheet titled "Medicare Savings Programs in Alabama—February 2011" created by the Alabama Medicaid agency tells QMBs to "Make sure your doctor or hospital takes Medicaid."[36] These state policies and procedures further discourage providers from accepting QMB patients.

Providers serving QMB-onlys (those without full scope Medicaid coverage) encounter an additional obstacle. They often must separately bill Medicare and Medicaid, without bills automatically being forwarded. Although Medicare routinely forwards claims to Medicaid for full-benefit dual eligibles (just as it forwards claims to insurers for people with MediGap coverage), the process frequently breaks down for QMB-onlys, adding administrative cost and creating another disincentive to serving QMBs.

Recommendations

States should put procedures in place so that Medicare providers serving QMBs can easily request payment without having to enroll as Medicaid providers. CMS should establish best practices for states to adopt. Providers should be able to submit a properly identified claim without having to complete any further application or registration forms. These procedures should be well publicized among providers in the states and easily accessible on state Web sites. CMS also should coordinate with the states so that all QMB claims are automatically forwarded from Medicare to Medicaid. A claim should be processed through the Medicare and Medicaid systems without the need for any additional action by the provider.

Balance Billing Protections

The Medicaid statute explicitly prohibits providers from billing or collecting from any QMB amounts above those received from Medicare and Medicaid, even if the state Medicaid agency pays nothing toward the Medicare copayment.[37] Both Medicaid and Medicare sanctions may be imposed on providers who violate this prohibition against balance billing.[38] CMS has further interpreted the statute to prohibit providers from accepting QMB patients as "private pay" in order to bill the patient directly.[39]

Advocates report, however, that despite these prohibitions, they see repeated instances in which Medicare providers bill QMBs for Medicare copayments, sometimes requiring copayment at the time of service, sometimes initiating collection actions against QMBs who are unable to pay.[40] Providers often either misunderstand or ignore this protection against balance billing.

Information for providers about the QMB benefit and the balance billing prohibition often

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[36] Available at *http://medicaid.alabama.gov/documents/3.0_Apply/3.2_Qualifying_Medicaid/3.2_Medicare_Savings_Programs.pdf*.

[37] 42 U.S.C. § 1396a (n)(3).

[38] Id.

[39] CMS, Memorandum to Associate Regional Administrators (Feb. 27, 2008), available at *www.Hapnetwork.org/assets/pdfs/cms-memo-on-cost-sharing.pdf*. CMS, "Balance Billing of Qualified Medicare Beneficiaries Q&A" (2008), available at *www.medicareadvocacy.org/InfoByTopic/MedicareSavingsPrograms/MedSavProg_08_04.24.ARABalanceBilling.pdf*. See also CMS, "Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) at a Glance" (Dec. 2010), available at *www.cms.gov/mlnproducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf*.

[40] One source of advocate comments on this and other problems with the QMB program is a series of advocate calls about QMB organized by the Health Assistance Partnership, archived at *www.hapnetwork.org/troubleshooting-medicare/qmb/*.

is extremely difficult to find on state Web sites. On the federal side, CMS has recently been more aggressive in provider outreach. In October, 2011, the agency sent a notice to all Medicare fee-for-service providers alerting them specifically to the prohibition on balance billing and to the potential for sanctions against violators.[41]

The CMS State Medicaid Manual, however, includes contradictory statements that specifically allow providers to accept QMBs as private pay patients. Those Manual provisions, which reflect the law prior to the enactment of balance billing protections, have yet to be updated.[42] The out-of-date provisions are confusing and also could be used by providers to justify balance billing violations.

Further, although the recent CMS notice stresses that providers who balance bill QMBs are subject to sanctions, advocates have seen little enforcement by either CMS or state Medicaid agencies.[43]

Recommendations

Additional state and federal outreach to providers is needed, including provider education and fact sheets on the balanced billing policies. The recent CMS communication to providers is a good step. States also should have better and more accessible information for providers on their Web sites. In addition to education, both CMS and the states should impose sanctions against providers who violate the balance billing prohibition. Finally, CMS should amend its State Medicaid Manual to reflect current law and policy and communicate the change to all relevant stakeholders.

Identifying QMBs

Advocates report that many QMBs do not know they have access to QMB or understand its protections. Although state identification cards vary, in many states the cards for QMB-onlys, QMB-plus beneficiaries, and Medicaid-only beneficiaries look the same with no notification of QMB status visible on the card. Sometimes with electronic "swipe" cards, the QMB information is scrambled in the coding strip. In many cases, both beneficiaries and providers assume that only providers who participate in Medicaid are eligible for reimbursement.

Recommendations

Simple solutions such as a prominent QMB designator on a dual eligible's Medicaid card would be helpful. Including on the card both a toll-free number and Web site with clear, provider-oriented information on how to handle QMB billing and a notice that providers may not balance bill would also help alleviate the most common problems.

Options For Redesign Of The QMB Program

As discussed above, making the QMB program work effectively for beneficiaries and providers requires a combination of payment reform and administrative improvements. Both to create savings to offset payment costs and to create a more streamlined and efficient experience for beneficiaries and providers, policymakers should consider whether structural changes in the delivery system for QMBs would improve the benefit.

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[41] Available at *www.cms.gov/MLNMattersArticles/downloads/SE1128.pdf*.

[42] CMS, State Medicaid Manual, Ch. 3 at 3490.14(B), available at *www.cms.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927*. Note that while the outdated State Medicaid Manual provision is accessible on the CMS Web site, the memorandum overruling its provisions could not be found there. The balance billing protections were added as part of the BBA of 1997.

[43] Two warning letters were issued to providers by CMS Region III, both in 2010. Letters of Feb. 4, 2010 from John D. Smith, Manager, Medicare Operations Branch, Region III, CMS (names of recipients redacted), referenced in Judith Stein and Alfred Chiplin, Jr., 2011 Medicare Handbook (Wolters Kluwer, 2011) at § 10.06(B), n. 120. We are unaware of any other warning letters or of any cases where sanctions were imposed.

As currently structured, the QMB program is awkward. It is a state-operated Medicaid program for the purpose of improving access to the federal Medicare program. Its structure requires state Medicaid programs to deal with providers who otherwise are not enrolled in the Medicaid system, leading to confusion for all involved. For providers, especially those using the bad debt recovery process, it requires bouncing back and forth between agencies, wasting resources and increasing chances for error. Despite the resources expended, beneficiaries receive much less from the program than they are entitled to.

In this paper, we consider three delivery model options for the operation of the QMB program.

OPTION 1: A State-administered QMB Program with Increased FMAP.

In this option, the QMB program would remain a state Medicaid program but states would be required to reimburse providers at the full Medicare rate (or alternate rates higher than currently paid as discussed above). In light of state budgetary pressures, new requirements on the states would likely need to be accompanied by a significantly higher federal match in funds, as with the 100 percent FMAP that accompanies the new ACA requirement that Medicaid pay Medicare rates to primary care providers. This option would have the advantage of not requiring major restructuring of the program. The states with more generous asset and income requirements for QMB eligibility also could easily retain these beneficiary-friendly provisions. If the states were required to pay full Medicare rates, beneficiary access would certainly improve, though states would still need to address processing bottlenecks such as application forms for providers. A disadvantage of this approach is that it would not simplify provider payment procedures.

OPTION 2: A Federal/State Hybrid

Using a hybrid approach, states would continue to pay Part B and, where applicable, Part A premiums for QMBs. However, all Medicare copayments and deductibles would be considered a federal responsibility and paid at the full Medicare rate. This approach would simplify provider payments. Providers would submit their charges to CMS Medicare contractors as they currently do. For QMBs, Medicare would simply pay 100 percent of the Medicare-approved amount with no need for bills to be forwarded to Medicaid for payment. Data transmission needs would be simplified, providers would be paid more quickly and the process would be seamless for the QMB. There would be no need for Part A providers to use the bad debt recovery procedure for QMB costs.

This option would increase efficiency and relieve states of some, but not all payment responsibilities.

OPTION 3: A Federalized QMB Program

The most comprehensive option would assign to the Medicare program the full responsibility for the QMB program. Under this option, providers would be reimbursed up to the full Medicare-approved amounts and states would not be responsible for premium payments.[44] Complete federalization, in addition to the streamlined provider payments in the hybrid model, would provide additional administrative efficiencies as there would be no need for transfer of state Medicaid funds to Medicare to cover Part A and Part B premiums.

[44] Federalizing QMB is a proposal that has been discussed almost since the inception of the program. See, e.g., Marilyn Moon et al, "Protecting Low Income Beneficiaries" (Dec. 1998), available at *www.commonwealthfund.org/usr_doc/moon_growth_318.pdf?section=4039.*

Allocating financial responsibility for a fully or partially federalized program would be a key issue. Would funding be entirely federal or would there continue to be a state Medicaid contribution?[45] Would that contribution be in the form of a "clawback"—a repayment from the state reflecting its reduced fiscal responsibilities—as was included in Medicare Part D, which took over Medicaid's responsibility for prescription drug coverage for dual eligibles?[46] These are key policy questions that would need to be clarified. However, from a beneficiary perspective, the mechanism chosen is not important. What is important is that funding be stable and sufficient to finance a strengthened QMB program.

If Medicare accepted responsibility for paying QMB cost sharing and deductibles, it may be appropriate to federalize the QMB eligibility and enrollment process as well. Several issues would need to be addressed if this path were considered. The first involves eligibility criteria. Uniform eligibility requirements set at the current federal minimums would disadvantage beneficiaries in the 11 states that have higher income cut-offs and/or asset allowances.[47] Although current beneficiaries could be grandfathered into a federal system, the question of whether and how to continue to permit state flexibility would be a difficult one in a fully federalized program.

Administration of eligibility determinations, enrollment and redeterminations would also need to be worked out. One important question would be whether to handle enrollment through state Medicaid offices, the Social Security Administration (SSA), which currently handles enrollment in Medicare and in the Part D Low Income Subsidy, or both.[48] Currently, state Medicaid agencies must screen QMB applicants for full-scope Medicaid. Any federalized delivery of the benefit would need to include that protection for applicants. Further, regardless of how the benefit is delivered, applying for QMB should be a consumer-friendly "no wrong door" process.

A direct SSA role in QMB enrollment could address some of the enrollment problems currently facing the program (see accompanying box). Adding enrollment responsibilities to SSA, however, should only happen if those activities are fully funded and staffed so that resources are not diverted from other programs in this already understaffed agency. Moreover, SSA would need to address current inadequacies and delays in its appeals processes in order to ensure due process rights for QMBs.

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[45] For an analysis (in 1996 dollars) of various cost-shifting scenarios, see Moon, supra note 44, pp. 10-13.

[46] For a description of how "clawback" works in Medicare Part D, see Andy Schneider, "The "Clawback: State Financing of Medicare Drug Coverage" (June 2004), available at *www.kff.org/medicaid/upload/The-Clawback-State-Financing-of-Medicare-Drug-Coverage.pdf*.

[47] See Kaiser State Health Facts at *www.statehealthfacts.org/comparereport.jsp?rep=61&cat=6&gsa=2* for a chart of state income and asset requirements for QMB eligibility. Note that states that increase income limits do so by setting higher income disregards.

[48] Note that in Medicare Part D, the statute permits both the states and SSA to enroll beneficiaries in the Low Income Subsidy. In practice, the states have declined to undertake enrollment responsibilities and refer applicants to SSA.

QMB Gaps and Integrated Care for Dual Eligibles

As the MMCO works with states on new models for integrating care for dual eligibles, it is important that both managed care and fee-for-service integration models address the access problems facing QMBs. To ensure a "best of both worlds" design for a combined Medicare/Medicaid benefit, dual eligibles need access to robust provider networks. Creating such networks, particularly for those services typically covered by Medicare, will require following the recommendations in this paper for fixing the QMB benefit.

Integration models that utilize managed care plans to integrate program rules, benefits and funding will be able to offer the administrative simplicity of a single payment representing Medicare and Medicaid reimbursement to providers serving QMBs. To ensure adequate access, these payments must be based on Medicare payment rates.

Models that retain a fee-for-service system, but create opportunities for Medicare, Medicaid and providers to share savings resulting from improved care coordination can also take steps to address current access problems for QMBs. Medicaid systems could be redesigned to ease the administrative burden of submitting claims for serving QMBs. Furthermore, the potential for sharing in savings that would normally only accrue to the Medicare program should incentivize states to pay a larger amount of the Medicare copayments and deductible for co-payments.

Conclusion

As state and federal policymakers wrestle with how to improve the interaction of Medicare and Medicaid for low-income people who qualify for both programs, an important element they need to consider is how well the Medicare benefit currently functions for this group. Central to that consideration is an examination of the QMB program, the primary vehicle for allowing low-income individuals to access their Medicare benefits.

On paper, the QMB program provides a rich benefit that gives many dual eligibles the opportunity to participate fully in Medicare without having to pay premiums and copayments they cannot afford. In practice, the QMB program delivers much less. This paper has looked at some of the ways in which the QMB program fails to achieve its goals and provides recommended improvements, some small and easily achievable, some more ambitious and far reaching.

There would be challenges, both fiscal and administrative, to improving the QMB program significantly. Nevertheless, change is needed so that this benefit, a lynchpin for robust delivery of health care to dual eligibles, can allow QMBs to be full participants in the Medicare program.

QMB Enrollment: A Continuing Challenge

Barriers to enrollment in Medicare Savings Programs, including the QMB program, deserve continuing policy attention. Under-enrollment has been a persistent problem, with estimates that less than half of those eligible have enrolled.[49] Federalizing the program could address most of the current problems but shorter term improvements also are needed. As states upgrade their enrollment systems to respond to the requirements of health reform, they should use the opportunity to address QMB enrollment challenges as well. Current problems include:

Part A Enrollment: Although most Medicare-eligible individuals qualify for premium-free Part A coverage, some with limited work history, including many older immigrants, can only receive the benefit if they pay steep premiums. QMB covers Part A premiums but, to get QMB, an individual must first be enrolled in Medicare Part A. The Part A enrollment period each year extends only from January 1 to March 31 and coverage does not begin until July 1. This limited enrollment period can create gaps and costs for individuals who are not enrolled in Part A when they apply for QMB.

To address these issues, most states have entered into Part A "buy-in" agreements with CMS that allow an individual who otherwise qualifies for the QMB benefit to enroll in Part A at any time with no late enrollment penalty. Fifteen states, however, do not have buy-in agreements and beneficiaries in these states can face delays of as long as 15 months for their QMB benefit to begin.[50]

MSP Coordination with the Low-Income Subsidy: When Medicare beneficiaries apply for the Low Income Subsidy, the Social Security Administration automatically forwards the applications to the states for additional review for MSP eligibility. States may accept all income and asset information that has been verified by SSA.[51] Advocates report seeing a variety of problems in the states: delay or outright failure in processing applications, requirements that beneficiaries resubmit information that has already been verified by SSA, confusing notices to beneficiaries and more.

Part B Premiums: After qualifying for the QMB program, many beneficiaries wait months before they see their Part B premium covered by their state Medicaid agency. These delays, a function of poor data exchange and slow processing by the states, cause considerable hardship for beneficiaries.

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[49] See, e.g., the 2009 estimate by MedPac that only 33 percent of individuals eligible for the QMB benefit are enrolled. MedPac, "Context for Medicare Payment Policy" (Mar. 2009) p. 21, available at *www.medpac.gov/chapters/Mar09_ch01.pdf*.

[50] For a discussion of the conditional enrollment procedure, which provides limited relief to individuals in non-buy-in states, see Ctr. For Medicare Advocacy, "Can You Be A 'Qualified Medicare Beneficiary' If You Don't Have Medicare Part A," (Oct. 2009), available at *www.medicareadvocacy.org/Projects/AdvocatesAlliance/IssueBriefs/09_10.19.QMBsWithoutPartA.pdf*. For a thorough description of steps that New York State has taken to streamline Part A buy-in procedures, see Medicare Rights Ctr., "Streamlining Medicare and QMB Enrollment for New Yorkers," (Feb. 2011), available at *www.medicarerights.org/pdf/Part-A-Buy-In-Analysis.pdf*.

[51] This procedure was introduced by the Medicare Improvements for Patients and Providers Act (MIPPA).

QMB Enrollment: A Continuing Challenge *(Continued)*

Data problems can also hamper access to the Medicare Part A premium benefit offered by the QMB program.

Need for Outreach: Many states have done a poor job of publicizing MSP programs. Advocates also report that state Medicaid offices often do not screen applicants for the benefit. Yet, where states make a focused effort to improve enrollment, the results can be significant.[52]

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[52] For a discussion of effective outreach efforts in Maine, see MedPac, "Increasing Participation in the Medicare Savings Program and the Low Income Subsidy"(March 2008), pp. 315-317, available at *www.medpac.gov/chapters/Mar08_Ch05.pdf*.

Resources

NSCLC has produced four issue briefs as part of a series of reports on how best to align Medicare and Medicaid for dual eligibles.

Building an Integrated Appeals System for Dual Eligibles. This paper provides recommendations for building an integrated appeals process for individuals that qualify for Medicare and Medicaid (dual eligibles).

Medicare and Medicaid Alignment: Challenges and Opportunities for Serving Dual Eligibles. In another Justice in Aging brief, simple fixes are suggested to several problems dual eligibles experience from not getting essential medical equipment to gaps in prescription drug coverage.

Ensuring Consumer Protection for Dual Eligibles in Integrated Models. In the first of a series of issue briefs, Justice in Aging says it is essential to have consumer protections in place before new models are implemented.

The briefs as well as background papers, Webinar transcripts and a recording of a policy forum hosted by Justice in Aging at the Kaiser Family Foundation in July 2011 can be found at *justiceinaging.org* under Health Care/Dual Eligibles.

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