

# Qualified Medicare Beneficiary (QMB) Protections in Medicare Advantage: Issues, Tips and Avenues for Advocacy

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## Introduction

The Qualified Medicare Beneficiary (QMB) program is a Medicaid benefit that pays Medicare premiums as well as protects individuals from coinsurance and copayment for Medicare-covered services.<sup>1</sup> The QMB program is a mandatory state Medicaid benefit available in all states.<sup>2</sup> The minimum requirements for QMB eligibility are income at or below 100% of the Federal Poverty Level (FPL), and resources below specified federal limits.<sup>3</sup> States have the option of establishing more generous income and resource limits, and some states have eliminated the asset requirement entirely.<sup>4</sup> Almost 8 million Medicare beneficiaries are QMBs.<sup>5</sup>

QMB protections apply regardless of how the beneficiary receives Medicare benefits (either through Original fee-for-service Medicare or through Medicare Advantage).<sup>6</sup> This issue brief looks specifically at how QMB protections apply to beneficiaries enrolled in Medicare Advantage plans and discusses ways to address common issues that arise for QMB beneficiaries in Medicare Advantage. It also identifies areas for advocacy to make Medicare Advantage work more smoothly for QMBs.

*A QMB-plus is an individual who qualifies both for QMB protections and for full Medicaid benefits. A QMB-only does not qualify for any other Medicaid benefits. About 80% of QMBs are QMB-plus.<sup>7</sup>*

## QMB and Medicare Advantage: The Basics

### QMB billing protections apply to Medicare-covered services

QMB protections apply to all services covered by Medicare Part A and Part B. A QMB individual who is a member of a Medicare Advantage plan must, like every other plan member, follow plan rules. If the beneficiary does not follow the rules, Medicare will not cover the service. In the context of Medicare Advantage, it is important to keep in mind the following considerations:

- QMB billing protections apply to members of all Medicare Advantage plans, not just those enrolled in Dual-Eligible Special Needs Plans (D-SNPs).<sup>8</sup>

- QMB billing protections apply whether or not a plan provider accepts Medicaid. The plan provider may not charge the member for Medicare-covered services.<sup>9</sup>
- If the QMB also is enrolled in Medicaid managed care, the Medicare Advantage provider can still serve the member even if the provider is not contracted with the Medicaid plan. QMB protections still apply.
- In a Medicare Advantage plan that is an HMO, the member must use in-network providers and must obtain any required referrals. Use of out-of-network providers must have plan approval or constitute an emergency situation.
- In a Medicare Advantage plan that is a PPO, the member may use out-of-network providers who agree to accept the plan's payment. QMB billing protections still apply. The provider may not charge the member for Medicare-covered services.
- If a plan offers supplemental services that are not covered by Part A or Part B, the QMB protection may not apply to those services and, in most cases, the member is liable for any co-insurance.<sup>10</sup> For example, a plan may offer some dental or vision coverage with co-pays. QMB billing protections may not apply to those co-pays. Note, however, that QMBs who are full dual eligibles may have Medicaid coverage for the same services. See discussion re: "Navigating supplemental benefits" on page 4 below.
- For prescription drugs, QMB billing protections apply only to those drugs covered under Part B.<sup>11</sup> Most Medicare prescription drug coverage is through Part D. For Part D drugs, all QMBs automatically qualify for the Part D Low-income Subsidy (LIS or "Extra Help"), which limits their co-insurance liability to small amounts at most.<sup>12</sup> Pharmacies may collect Part D LIS co-payment amounts from QMBs.<sup>13</sup>

*Mary and Joe, both dual eligibles and QMBs, belong to Healthy Me Medicare Advantage HMO in New Jersey. They visit Jane, their daughter, in Massachusetts. While there, Jane suggests that Mary make an appointment with Dr. Jones, Jane's dermatologist, whom Jane has been seeing for a long time, to consult on Mary's chronic skin conditions. If Mary sees Dr. Jones, she will not have QMB protections for the visit. Mary must follow her plan rules and use in-network providers unless she has received authorization from her plan. If she doesn't, Dr. Jones's services are not covered by Medicare, and Mary will have no QMB protection. She will be liable for the full charges for the visit. On the same trip, Joe has sudden chest pains and is rushed to the local hospital. Because this was an emergency, his out-of-state treatment is covered by Healthy Me, and he also has QMB protection for all deductibles and co-pays associated with the emergency. As long as Healthy Me covers the service, the fact that the provider is in Massachusetts does not affect Joe's QMB protection.*

## Medicare Advantage providers may not discriminate against QMBs

Medicare Advantage plans and their contracted providers are prohibited from discriminating against plan members on a number of bases, including "source of payment."<sup>14</sup> CMS has clarified that, under this provision, Medicare Advantage providers cannot refuse to serve QMBs.<sup>15</sup> (Note that in Original fee-for-service Medicare, providers do have the right to refuse to serve QMBs.) **If you are working with a QMB whose Medicare Advantage provider refuses to treat them because of their QMB or Medicaid status, please contact Justice in Aging.**

*Raoul, after a referral from his primary care physician and having obtained required authorization from Healthy Me, calls the office of Dr. Smith, an in-network cardiologist, for an appointment. Raoul tells the appointment staff that he is a member of Healthy Me and also has Medicaid and is a QMB. He is told that Dr. Smith doesn't take Medicaid. Raoul calls Healthy Me and asks for help. A Healthy Me representative intervenes, explaining to Dr. Smith's office that the doctor's contract with Healthy Me specifically prohibits Dr. Smith from refusing to see QMBs or dual eligibles. Raoul gets his appointment.*

**ADVOCACY TIP:** If Healthy Me is unhelpful, Raoul can contact 1-800-Medicare and file a complaint against Healthy Me, since the plan is responsible for ensuring access to in-network providers. Plans usually respond quickly to complaints filed with 1-800-Medicare.

## Several avenues are available for determining QMB status

Often the first step in getting QMB protections is providing verification to the member and the provider that the member is a QMB. Plan members should be advised to always show their plan membership card and also their QMB or Medicaid card. Sometimes plan members are unclear about their own QMB status or may just know that they “have Medicaid.” There are several ways to ensure that providers understand that a plan member is a QMB:

- Some states issue cards identifying an individual as a QMB. Others simply issue Medicaid cards. For people who are QMB-only, without full Medicaid coverage, some states do not issue any cards.
- Medicare Advantage plans know the QMB status of their members, and CMS requires plans to have mechanisms to make it easy for plan providers to verify QMB status. These mechanisms can vary. Some plans identify QMB members on the plan membership card and even show zero co-pay status on the card. Plans might also have computer or telephone verification procedures. Members can call their Medicare Advantage plan to confirm their QMB status.
- Members can call 1-800-Medicare to verify their QMB status.
- The state Medicaid program should be able to confirm QMB status.
- Plan providers can use Medicare eligibility data provided by the HIPAA Eligibility Transaction System (HETS) to verify a patient’s QMB status and exemption from cost-sharing charges. Providers usually access HETS, which includes eligibility information on both private and public health insurance, through commercially available eligibility verification programs.

**ADVOCACY TIP:** If a client is enrolled in full Medicaid but is not also a QMB, it is worth determining why. In some cases, the beneficiary may be enrolled in a Medicaid program with income limits higher than those for the QMB program. Sometimes, however, failures of either the state or the beneficiary to follow through with QMB enrollment are responsible. Because QMB billing protections extend beyond Medicaid-enrolled providers, advocates should encourage and assist any eligible client to enroll, including clients who already have full Medicaid benefits.

## Common issues and ways to address them

### Issue: Plan provider charges a co-pay to a plan member

*Dr. Marshall, Harry’s gastroenterologist, charges him Healthy Me’s usual \$30 co-pay per visit. Harry once asked whether he had to pay because he knew he was on Medicaid and thought he got services for free. Dr. Marshall’s staff told Harry that, because Dr. Marshall doesn’t take Medicaid, Harry would have to pay or Dr. Marshall would no longer see him. When talking to a SHIP counselor, Harry learned that if he is a QMB, he may not be charged any co-pays. Harry wants his money back, and because he lives in a rural community where there aren’t many gastroenterologists, he wants to keep Dr. Marshall as a provider.*

## Next Steps for Harry:

- Harry isn't sure about his QMB status, so he calls 1-800-Medicare and confirms his enrollment.
- With help from his SHIP counselor, Harry writes a letter to Dr. Marshall stating that he is a QMB and requesting a full refund of all co-payments made since he started seeing Dr. Marshall. He bases his letter on the model letters found in the [QMB billing toolkit](#)<sup>16</sup> on the Justice in Aging website.
- Harry also contacts Healthy Me and asks for assistance from the plan in getting his refund. He gets an unhelpful response, telling him that this is a problem between him and the doctor.
- Harry calls 1-800-Medicare and says he wants to file a complaint against the plan because it is not helping him with an improper billing issue. The CMS representative files his complaint in the Complaint Tracking Module (CTM) and he quickly gets a call from a more knowledgeable plan representative. Healthy Me secures his refund and explains to Dr. Marshall and her staff that Dr. Marshall may not drop Harry because he is a QMB.

## Issue: Navigating supplemental benefits

*Maria is a QMB and also a full dual eligible (QMB-plus). Her state offers broad dental benefits with zero co-pays, but it is hard to find dentists who accept Medicaid, especially in the rural area where she lives. Healthy Me offers some supplemental benefits, including free dental examinations and cleanings twice a year. Fillings are covered with a 40% co-pay. Maria goes to Dr. Scott, a Healthy Me dentist for a cleaning and also complains of a toothache. Dr. Scott is not a Medicaid provider. The cleaning is free. She is told, however, that she has a cavity that needs filling and that her 40% co-insurance would be \$125.*

### Next steps for Maria: Maria has hard choices.

- Because her Medicare dental coverage is a supplemental benefit, she may not have QMB protection. Because Dr. Scott is not a Medicaid dentist, his services are not covered by her state Medicaid benefit. If she chooses to stay with Dr. Scott, she would have to pay the 40% for the filling. Maria really likes Dr. Scott and is happy to have found care, but she cannot manage the costs of the filling.
- Maria first tries to find a dentist in the Healthy Me network who takes Medicaid but learns, after talking with Healthy Me representatives, that no Healthy Me dentist is enrolled in Medicaid. If she had found a Healthy Me dentist who also was a Medicaid provider, Medicaid would have been a secondary insurer after Medicare. As a Medicaid provider, the dentist would not have been permitted to charge Maria for the visit.
- Because using a Healthy Me dentist would cost Maria more than using Medicaid, she can bypass Healthy Me and go directly to a Medicaid dentist for her filling. However, because her check-ups and cleanings are free under Healthy Me and because Medicaid is the payer of last resort, Medicaid requires her to use her Medicare benefit first. This means that with her current coverage, the only way for Maria to get needed dental work without cost to her is to have two dentists: one to provide the services that are free under Healthy Me and one, a Medicaid provider, to provide other dental services that she needs.
- Maria is very frustrated, particularly because she gets different answers every time she calls her Medicaid program, and she can't find anyone at Healthy Me who understands her dilemma either. She is considering whether staying in Healthy Me is the best choice for her. She had joined because of its extra benefits but is finding that they do not mesh well with her Medicaid coverage. She has made an appointment with a SHIP counselor<sup>17</sup> so she can decide what is best for her.

- In the meantime, Maria still has a toothache and is having a difficult time trying to find a Medicaid dentist who takes new patients.

Maria's brother, Diego, is a QMB-only, with no other Medicaid coverage. He also is a member of Healthy Me and also needs a filling. As a QMB, he is used to not paying co-pays for services covered by Healthy Me. He hadn't understood that supplemental services are treated differently from other Medicare services and is surprised that he must pay the 40% co-insurance. He struggles to manage the payment but is glad that at least he has partial dental coverage from Healthy Me.

### Policy Advocacy Opportunity

Increasingly, supplemental benefits offered by Medicare Advantage plans overlap with Medicaid coverage. It is important that states develop and implement policies so that it is easy for Medicaid beneficiaries to access both benefits when there is coverage overlap. Dual eligible beneficiaries, state Medicaid staff, Medicare Advantage plans, and providers all need to have clear direction. This is particularly important when a Medicare supplemental benefit is limited in scope or requires payment of co-insurance. Having a Medicare supplemental benefit, particularly if it is only a partial benefit, should not impede or delay access to Medicaid benefits. To address this emerging issue, advocates can work with their state to develop protocols for ensuring timely access to Medicaid benefits and to educate beneficiaries and plans about the necessary steps to follow. Justice in Aging would be interested in learning about any such advocacy, and would be pleased to collaborate with state advocates in those efforts.

### Issue: QMBs and D-SNPs

*Duane is a QMB-only. He was in Original fee-for-service Medicare, but a broker convinced him to join Healthy Duals, a Dual-Eligible Special Needs Plan (D-SNP), saying that it is designed especially for people like Duane. After joining Healthy Duals, Duane learns that the plan does not cover two doctors that he has used for years. He also learns that the only pharmacy he can walk to is not in the plan's network. He has zero co-pays with Healthy Duals, but he never paid any co-insurance in Original Medicare either. He is unhappy and decides to return to fee-for-service as soon as he can.*

### Issue Analysis

Some Medicare Advantage plans are Dual-Eligible Special Needs Plans (D-SNPs). These plans can only enroll dual eligibles and are designed to coordinate their Medicare and Medicaid benefits. In some states, there are D-SNP plans that enroll QMB-onlys as well as full-benefit duals. Though QMB is a Medicaid program, the only benefits that Medicaid provides are payment of Medicare premiums and protection from Medicare co-insurance. Because QMB-onlys receive no Medicaid services, the "special" benefit coordination offered by D-SNPs does not apply to them. For QMB-onlys, D-SNPs function like any other Medicare Advantage plan. Yet brokers and agents often market D-SNPs aggressively to QMB-onlys as a good choice for them.

### Policy Advocacy Opportunity

In states where D-SNPs are permitted to market to QMB-onlys, advocates may want to talk with their state about whether this is good regulatory policy. States have the option to limit D-SNP enrollment to full duals and some states do. At a minimum, states should require that D-SNPs that enroll QMB-onlys demonstrate what services they offer that specifically assist this population.

## Issue: Explanations of Benefits (EOBs) and QMBs

Carl, who is a QMB-only, used to be in Original Medicare. He received a Medicare Summary Notice (MSN) quarterly, which showed that he didn't owe anything for the Part A and Part B services he used because he had QMB protections. He separately received an Explanation of Benefits (EOB) from his prescription drug plan (PDP) and the PDP EOB reflected his Low-Income Subsidy status. Carl recently enrolled in Healthy Me and started using its transportation benefit to go to doctor appointments and its vision benefit to get a new pair of glasses. In both cases, he was required to make a co-payment. Carl paid but was confused over why he had to pay for some services and not for others. Now he receives EOBs from Healthy Me for both his medical services and his drugs. He is disappointed that when his EOB arrives in the mail, it just lists the charges and does not tell him why he is charged for some but not others. He is confused because the EOB explanation of his medical services is not as clear as the MSN he used to get, and he is particularly confused about his payments for supplemental services.

### Issue Analysis

Advocates should be aware that, though EOBs look similar to MSNs, they are not subject to the same explicit requirements for explaining co-insurance protections for QMBs.<sup>18</sup> Also, for dual eligibles, plans are not required to send EOBs (other than drug EOBs) at all.<sup>19</sup> If Carl does receive an EOB for Part A and B services and supplemental services, it should accurately reflect his payment responsibilities. But it might not explain why Carl had to pay a co-pay for supplemental transportation and vision services. Justice in Aging would appreciate hearing from advocates about what they see in EOBs for QMBs. Examples of helpful and unhelpful EOBs would be particularly welcome.

## Conclusion

An increasing number of low-income beneficiaries are joining Medicare Advantage plans. About one-third of dual eligibles are in Medicare managed care. It is important that advocates understand the unique issues that QMBs face in Medicare Advantage plans. Justice in Aging is available to assist advocates in untangling Medicare Advantage issues as they arise.

For questions, contact [info@justiceinaging.org](mailto:info@justiceinaging.org).

## Additional Resources

- [42 U.S.C. § 1396a\(n\)\(3\)\(B\)](#) (Sec. 1902(n)(3)(B) of the Social Security Act)
- [42 C.F.R. § 422.504 \(g\)\(1\)\(iii\)](#)
- [Medicare Managed Care Manual, Ch. 4](#)
- [CMS Qualified Medicare Beneficiary Program webpage](#)
- [Medicare Explanation of Benefits templates](#)
- [Justice in Aging QMB billing toolkit](#)
- [Justice in Aging, Fighting Improper Billing of Dual Eligibles, New Strategies \(Feb, 2017\)](#)
- [National Council on Aging, Medicare Savings Programs \(MSPs\): Eligibility and Coverage \(2019\)](#)

# Endnotes

- 1 42 U.S.C. § 1396(p). Advocates who are not familiar with the QMB program or who could use a refresher can access Justice in Aging resources, including past trainings at [www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/](http://www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/). Also helpful is a Justice in Aging Issue Brief, Fighting Improper Billing of Dual Eligibles, New Strategies (Feb, 2017), available at [www.justiceinaging.org/wp-content/uploads/2017/02/Fighting-Improper-Billing-of-Dual-Eligibles-New-Strategies.pdf](http://www.justiceinaging.org/wp-content/uploads/2017/02/Fighting-Improper-Billing-of-Dual-Eligibles-New-Strategies.pdf). The Centers for Medicare and Medicaid Services (CMS) also has a QMB Program page that includes links to several CMS publications and documents on the program and its protections, available at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html).
- 2 42 U.S.C. § 1396a(a)(10)(E)(iii).
- 3 For 2019, the federal minimum limit is \$7,730 if single, \$11,600 if married. Asset limits are adjusted annually.
- 4 For a chart of income and asset limits in every state, see National Council on Aging, Medicare Savings Programs (MSPs): Eligibility and Coverage (2019), available at [www.ncoa.org/wp-content/uploads/medicare-savings-programs-coverage-and-eligibility.pdf](http://www.ncoa.org/wp-content/uploads/medicare-savings-programs-coverage-and-eligibility.pdf). The authority for state flexibility is found at 42 U.S.C. § 1396a(r)(2).
- 5 CMS, Qualified Medicare Beneficiary Program, available at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB).
- 6 The regulation covering Medicare Advantage plans is found at 42 C.F.R. § 422.504 (g)(1)(iii).
- 7 CMS, Qualified Medicare Beneficiary Program—FAQ on Billing Requirements (July 2018) (“QMB FAQ”), available at [www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2018-06-06-QMB-Call-FAQs.pdf](http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2018-06-06-QMB-Call-FAQs.pdf).
- 8 42 C.F.R. § 422.504(g)(1)(iii); CMS, QMB FAQ, *supra* note 7 at Q5.
- 9 QMB FAQ, *supra* note 7 at Q3 and Q4.
- 10 Although the agency has not issued explicit written guidance on the applicability of QMB protections to supplemental benefits, CMS has treated the protection as only applying to Part A and Part B benefits.
- 11 *Id.* at Q 6.
- 12 Individuals receiving home and community-based services or long-term care through Medicaid can qualify for zero dollar co-pays. See Justice in Aging, Low Income Subsidy (“Extra Help”) for Individuals Receiving Home and Community-Based Services (Aug. 2019), available at [www.justiceinaging.org/wp-content/uploads/2019/09/Updated-Part-D-HCBS-Fact-Sheet-2019.pdf](http://www.justiceinaging.org/wp-content/uploads/2019/09/Updated-Part-D-HCBS-Fact-Sheet-2019.pdf).
- 13 *Id.*
- 14 Medicare Managed Care Manual, Ch. 4 at 10.5.2, available at [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf).
- 15 *Id.*
- 16 Available at [www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/](http://www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/).
- 17 Local SHIP counseling services can be found at [www.shiptacenter.org/](http://www.shiptacenter.org/).
- 18 See CMS Approved Part C Explanation of Benefits Template HMO, Monthly EOB Version (“EOB Template”), available for download as “Part C EOB materials” from [www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial](http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial). The requirements for MSNs with respect to addressing QMB payment responsibilities are found at Medicare Learning Network, Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program (revised July, 2019), available at [www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11230.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11230.pdf).
- 19 See EOB Template, *supra*, note 19.