



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Health Care Financing Administration  
Center for Medicaid and State Operations

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MEMORANDUM

**DATE:** June 30, 2000

**FROM:** Director  
Disabled and Elderly Health Programs Group

**SUBJECT:** Policy Memorandum on Medicaid Obligations to Pay Medicare  
Cost-sharing Expenses for Qualified Medicare Beneficiaries in Medicare  
Health Maintenance Organizations or Competitive Medical Plans or  
Medicare Plus Choice Organizations--INFORMATION

**TO:** Associate Regional Administrators  
Division of Medicaid and State Operations  
Regions I - X

This policy memorandum provides clarification about State Medicaid agency obligations to pay Medicare cost-sharing expenses for Qualified Medicare Beneficiaries (QMBs) enrolled in Medicare Health Maintenance Organizations (HMOs) or Competitive Medical Plans (CMPs) or in Medicare Plus Choice (M+C) plans through M+C organizations.

**Qualified Medicare Beneficiaries (QMBs)**

QMBs are individuals who meet the definition in §1905(p)(1) of the Social Security Act (the Act) (further described at §3490.2 of the State Medicaid Manual (SMM)). All QMBs are Medicare beneficiaries, entitled to the full range of **Medicare covered services and Medicare provider options, without regard to whether those services are covered under the Medicaid State Plan**, and eligible for **Medicaid payment** of their Medicare cost-sharing expenses. QMBs include both:

- **QMB** - Medicare beneficiaries who are eligible for Medicaid under the QMB definition and only receive Medicare services. Medicaid pays for their Medicare cost-sharing expenses.
- **QMB Plus** - Medicare beneficiaries who are eligible for Medicaid under the QMB definition and also are eligible under another Medicaid eligibility group and, in

addition to the above, receive Medicaid services. Medicaid pays for their Medicare **Medicare Cost-sharing**

Section 3490.12 of the SMM defines the Medicare cost-sharing expenses that Medicaid must pay for a QMB as including:

- Medicare Part A and Part B deductibles and coinsurance, including deductibles and coinsurance that HMOs and Competitive Medical Plans (CMPs) charge their Medicare enrollees in lieu of the Medicare deductibles and coinsurance that the beneficiaries would pay if they were not enrolled in an HMO or CMP; and
- At the State's option, premiums for enrollment with an HMO or CMP under §1876 of the Social Security Act (the Act).

This language interprets §1905(p)(3) of the Act, which clearly states that Medicare cost-sharing expenses include, subject to §1902(n)(2) of the Act, Medicare deductibles and coinsurance, and may include, at the option of the State, premiums for enrollment of QMBs with an eligible organization under §1876 of the Act. §1902(n)(2) of the Act provides that a State is not required to provide any payment for deductibles, coinsurance, or **copayments** for Medicare cost-sharing to the extent that payment under Medicare for the service would exceed the payment amount that otherwise would be made under the Medicaid State plan for such service if provided to an eligible recipient other than a Medicare beneficiary. Clearly, the Medicaid State plan (Supplement 1 to Attachment 4.19-B) is controlling as to the amount (the Medicare rate, the State plan rate, or somewhere in between) Medicaid must pay for Medicare cost-sharing.

### **Medicare Plus Choice (M+C) Options**

The Balanced Budget Act of 1997 (BBA) introduced a new Part C to title XVIII of the Act, the M+C program. M+C provides Medicare beneficiaries with some new options for receiving Medicare benefits through private health plans, including provision for provider sponsored organizations (PSO), preferred provider organization (PPO) plans, private fee-for-service plans, and a medical savings account (MSA) option that currently is not available because no private insurer has chosen to participate.

Most organizations that previously contracted on a risk basis under §1876 as HMOs and CMPs now contract with Medicare as M+C organizations under Part C. Only a limited number of grandfathered cost-reimbursed HMOs or CMPs still contract under §1876. Although Medicare cost-sharing under §1905(p)(3) of the Act does not expressly provide for States to include premiums for M+C organizations, we believe that Congress intended to permit States to include premiums under Medicare contracts with private health plans, and that §1905(p)(3) should thus be read to permit M+C premiums for M+C plans to be included, at State option, in cost-sharing under the same terms as §1876 contracts. For

ease of reference, references to M+C organizations will include any remaining cost-contracting HMOs or CMPs under §1876 of the Act.

### **Monthly Premiums in M+C Organizations**

Monthly premiums are fixed monthly amounts that an M+C organization can charge its enrollees. If the M+C organization charges monthly premiums, the premiums generally cover the basic package of Medicare covered benefits, but may include additional premium amounts for supplemental benefits, which are not otherwise covered under Medicare. Medicaid is liable for payment of monthly premium amounts for QMBs and QMB Plus categories for the basic package of Medicare covered benefits only, if so elected in the Medicaid State plan (page 29, 3.2(a)(1)(i)). In addition, since QMB Plus is also eligible for full Medicaid benefits, Medicaid may also pay premiums for supplemental benefits not covered by Medicare, but which are covered by Medicaid, if so elected in the Medicaid State plan (page 29b, 3.2(a)(2)).

### **Medicare Cost-sharing**

Deductibles are fixed dollar amounts that an individual must pay out-of-pocket before the costs of services are covered by the M+C organization. Coinsurance charges are a percentage of costs for services. Copayments are fixed dollar amounts that a beneficiary must pay when he or she uses a particular service. For purposes of the provisions discussed in this memorandum, coinsurance includes the copayments that M+C organizations charge when beneficiaries use services. Medicaid is liable for these Medicare cost-sharing expenses for Medicare covered services to the payment amount specified in the Medicaid State plan (Supplement 1 to Attachment 4.19-B). If the payment amount is not specified, or the payment amount is the State plan payment rate and Medicaid does not cover the service so there is no State plan payment rate, Medicaid will be liable for the full Medicare cost-sharing.

### **State Options and Responsibilities**

It is **optional** for State Medicaid agencies to include as "cost-sharing" under §1905(p)(3) of the Act, premium charges imposed by M+C organizations for enrollment. When the State Medicaid agency has opted to include the premium charges as cost-sharing and is paying the premium as described above, the QMB is relieved of liability for such premiums. In this case, when the State is paying for the charges in the basic benefit package attributable to Medicare covered services, the QMB would be entitled to the full range of Medicare covered services. When the State has opted to pay M+C organization premiums, it must treat all M+C organizations the same.

For individuals eligible as **QMB Plus**, the Medicaid agency must pay for any services in their Medicaid State plan provided by a Medicaid provider, whether within the M+C organization or outside the M+C organization. If some of these services are included in the group of supplemental benefits that are part of the M+C organization's benefits package, the State may find it cost-effective to choose to pay for the portion of the premium attributable to the supplemental benefits. However, since these supplemental benefits are non-Medicare covered services, when they are offered on an optional basis, they may never be included in Medicare cost-sharing under §1905(p)(3).

When a Medicare M+C organization 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 those 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.

If an individual eligible as a **QMB Plus** is enrolled in an M+C organization, and uses out-of-plan Medicaid providers for M+C covered Medicaid services under non-emergency conditions, Medicaid can deny payment for the services that should have been provided through the M+C organization, **if the service is available at no cost to the individual**. If the State has opted to pay premiums for enrollment of a such an individual in an M+C organization, and is paying deductibles and coinsurance/copayments, that M+C organization coverage is available to the recipient at no cost. In this case, the M+C organization can be considered a third party resource which the State must take into account in determining the extent of medical assistance payment. The State can deny payment for the individual's Medicaid coverage in an amount corresponding to the value of this available resource. Where both the M+C organization and the State Medicaid agency appropriately deny payment, a provider may seek payment from the QMB Plus as a Medicaid recipient.

Please forward the information in this memorandum to the State agencies in your region. Questions on Medicaid policy in this area can be directed to Robert Nakielny at (410) 786-4466 or by E-mail at Rnakielny @ hcfa.gov.

/s/

Thomas E. Hamilton

Attachment

**Attachment**

**State Liability for QMB Payments**

<b><u>Summary</u></b>	<b><u>QMB</u></b>	<b><u>QMB Plus</u></b>
<b>Part B Premiums</b>	<b>Required</b>	<b>Required</b>
<b>Part A Premiums, when necessary</b>	<b>Required</b>	<b>Required</b>
<b>Deductibles</b>	<b>Required</b>	<b>Required</b>
<b>Coinsurance</b>	<b>Required</b>	<b>Required</b>
<b>Copayments</b>	<b>Required</b>	<b>Required</b>
<b>Enrollment Premiums</b>	<b>Optional</b>	<b>Optional</b>
<b>Other M+C Premiums (non basic Medicare)</b>	<b>None</b>	<b>Optional</b>