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CMCS – MMCO – CM Informational Bulletin

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Subject: **Payment of Medicare Cost Sharing for Qualified Medicare Beneficiaries (QMBs)**

This Informational Bulletin provides information for state Medicaid agencies and other interested parties regarding the treatment of claims for Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs). The Bulletin also reminds states of the statutory requirement to process Medicare cost-sharing claims for QMBs from Medicare-certified providers, and to be able to document proper processing of such claims. This Informational Bulletin is provided as a companion to communications on this topic to Medicare providers in the form of a Medicare Learning Network Matters article, and a CMCS Informational Bulletin published in 2012, which are available at: http://www.cms.gov/MLNMattersArticles/Downloads/SE1128.pdf; and http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf.

State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost sharing that is due for QMBs according to the state's CMS-approved Medicare cost-sharing payment methodology. State Medicaid Management Information Systems (MMIS) must process all Medicare "crossover" claims (claims that include primary payment from Medicare) for QMBs, including Medicare-adjusted claims that are submitted by Medicaid-enrolled providers, even if a service or provider category is not currently recognized in the Medicaid State Plan. States must furnish all Medicare-enrolled providers, including out-of-state providers, with a means by which they can enroll in the Medicaid program for purposes of having such claims processed.

Statutory Authority for Payment of QMB Cost-Sharing Amounts

Section 1902(a)(10)(E) of the Social Security Act (*hereinafter* "the Act") directs state Medicaid agencies to reimburse providers for QMB cost-sharing amounts [as defined in §1905(p)(3)], *"without regard to whether the costs incurred were for items and services for which medical*

assistance is otherwise available under the plan." (emphasis added). Section 1902(n)(2) of the Act does permit the state to limit payment for QMB cost sharing to the amount necessary to provide a total payment to the provider (including Medicare, Medicaid, required nominal Medicaid copayments, and third party payments) equal to the amount a state would have paid for the service under the State Plan. When the crossover claim is for Medicare-covered services that are not included in the Medicaid State Plan, the state is still liable to pay the crossover claim, but may establish reasonable payment limits, approved by CMS, for the service.

The actual crossover payment made to a provider by Medicaid (plus the QMB's personal liability for any nominal copayments under Medicaid, if applicable) is considered payment-in-full for Medicare deductibles and coinsurance.

Impermissible Balance Billing of QMBs

Providers are strictly prohibited under §1902(n)(3) of the Act from seeking to collect any additional amount from a QMB for Medicare deductibles or coinsurance (other than nominal Medicaid copayments, as mentioned above), even if the Medicaid program's payment is less than the total amount of the Medicare deductibles and coinsurance.

Possible Causes of Impermissible Balance Billing of QMBs

CMS believes that some instances of impermissible balance billing of beneficiaries occur when Medicare-certified providers are unable to obtain reimbursement or an 835 Health Care Payment and Remittance Advice (RA) for QMB cost-sharing claims from the state Medicaid program.

Repeated reports of QMB crossover claims not being processed in state MMIS systems prompt us to remind states of their claim processing obligations under federal law. We are aware of situations typically occurring when:

- the Medicare-certified provider submitting the claim is not enrolled with the state Medicaid agency; or
- the MMIS does not recognize the provider identifier; or
- the service is covered by Medicare, but not included in the Medicaid State Plan; or
- the provider type is recognized by Medicare, but not by the state Medicaid program; or
- the service is provided by an out-of-state provider.

For each of the situations listed above, CMS has received reports that Medicare-certified providers may not be receiving adjudication of their claim for Medicaid liability, or may not be receiving subsequent notification through the standard RA, as required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). There may be isolated instances of a state MMIS rejecting a QMB crossover claim because the individual provider has been suspended from participation in the Medicaid program, but continues as a Medicare-certified provider. Even in this circumstance, the state is required to permit the provider to enroll for the

limited purpose of obtaining adjudication of the QMB cost-sharing amount.

State Medicaid Programs' Claims Processing Obligations

All states maintaining a federally-certified MMIS funded under §1903(a)(3) of the Act are required–*as an express condition of receiving enhanced federal matching funds for the design, development, installation and administration of their MMIS systems*—to process Medicare crossover claims, including QMB cost sharing, for adjudication of Medicaid cost-sharing amounts, including deductibles and coinsurance for Medicare services, and to furnish the provider with an RA that explains the state's liability or lack thereof.

Specifically, §1903(a)(3)(A)(i) of the Act requires MMIS systems to demonstrate full compatibility with the claims processing and information retrieval systems utilized in administration of the Medicare program. Instructions contained in CMS's State Medicaid Manual (SMM), Part 11, §11325 reinforce the requirement of the MMIS system to (1) record Medicare deductibles and coinsurance paid by the Medicaid program on crossover claims, (2) provide a prompt response to all inquiries regarding the status of the crossover claim, and (3) issue remittance statements to providers detailing claims and services covered by a given payment at the same time as payment, including remittance statements for zero payment amounts. The state must be able to document that it has properly processed all claims for cost-sharing liability from Medicare-certified providers to demonstrate compliance with §§1902(a)(10)(E) and 1902(n)(1) & (2) of the Act.

Services Not Covered by the Medicaid State Plan

As noted earlier in this Informational Bulletin, a Medicaid agency's obligation to adjudicate and reimburse providers for QMB cost sharing exists even if the service or item is not covered by Medicaid, irrespective of whether the provider type is recognized in the State Plan and whether or not the QMB is eligible for coverage of Medicaid state plan services. For Full Benefit Dual Eligibles who are not eligible as QMBs, a state may elect to limit coverage of Medicare cost sharing to only those services also covered in the Medicaid State Plan.

Provider Enrollment

The state may require Medicare-certified providers to execute a Medicaid provider agreement and enroll in the state's Medicaid program in order to submit claims for reimbursement of QMB cost sharing, but the state should have a mechanism to ensure that providers who enroll only for that purpose are not included in lists of providers available to other beneficiaries. Alternately, a state may utilize a simplified, limited-purpose enrollment process for Medicare providers seeking to enroll in Medicaid for the sole purpose of claiming Medicare cost-sharing reimbursement while in compliance with the provider screening and enrollment requirements included in the CMCS Informational Bulletin issued December 23, 2011 (http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf). As noted above, however, regardless of the specific enrollment mechanism chosen, states must enable all Medicare-enrolled providers, including those who are out-of-state, some mechanism by which they can get the state to process their Medicare crossover claims, including claims for QMB cost sharing.

Summary

Therefore, in circumstances where a provider has submitted a claim to Medicaid for processing in accordance with the timely filing provisions of 42 CFR §424.44; and the provider has executed the necessary provider agreement according to a state's procedures for provider enrollment, the state *must* process the claim in accordance with the timely claims processing provisions of 42 CFR §447.45 and must issue the provider an RA for those claims as required by the SMM.

CMS Technical Assistance Is Available

CMS will provide technical assistance to states in:

- understanding state Medicaid agency liability for Medicare cost sharing;
- modifying or enhancing the MMIS to permit proper processing of QMB crossover claims; and
- enrolling providers for the limited purpose of processing Medicare cost-sharing crossover information, or developing alternative methods to identify these Medicare providers in the MMIS.

States should contact the CMS Regional Office to request technical assistance.

For further information concerning state Medicaid agency liability for Medicare cost sharing, please contact Nancy Dieter, Technical Director for Coordination of Benefits and Third Party Liability, Division of Integrated Health Systems, at 410-786-7219 or Nancy.Dieter@cms.hhs.gov. For further information concerning MMIS requirements, please contact your CMS Regional Office or George Patterson, Health Insurance Specialist, Division of State Systems, at 410-786-4609 or George.Patterson@cms.hhs.gov.