August 30, 2012

Dual Eligibles and Medicare Cost Sharing

Q: How can states and providers determine the appropriate Medicaid coverage of Medicare cost-sharing and the correct patient liability for the cost of services provided in a long-term care facility to dually eligible individuals?

A: The Medicaid coverage of the cost of a stay in a long-term care facility for individuals who are "dually eligible", i.e. eligible for both Medicare and Medicaid, will vary based on a number of factors, including the state's choice with respect to payment methodology, its choice to treat its payment of Medicare cost sharing as payments for the underlying institutional care or as the unmet cost of insurance coverage and the beneficiary's eligibility category.

Medicare Coverage of Skilled Care in a Long-Term Care Facility

Medicare covers up to 100 days of skilled care in a long-term care facility (LTCF) for individuals who are enrolled in Medicare Part A. The first 20 days are paid in full by Medicare. When the Medicare full-pay days are exhausted, the Medicare payment is subject to a Medicare co-payment amount for the remainder of the approved Medicare stay, a maximum of 80 additional days.

Post-Eligibility Treatment of Income

Medicaid beneficiaries in an LTCF generally have a liability, up to a specified amount, to contribute toward the cost of their care. In the post-eligibility process, states determine the amount of an individual's income that is available to help pay for the cost of care for Medicaid-reimbursed services in an LTCF. States determine the amount of income the individual may be required to pay by starting with the individual's total income, and subtracting from that:

An amount reserved for personal needs (at least $30 for an individual, $60 for a couple);
An amount reserved for the spouse or dependents remaining in the community, if any; and
Any incurred medical expenses not subject to payment by a third party.

The Medicaid agency reduces the Medicaid payment to the provider by the amount of the patient's income remaining after the above subtractions are made. The beneficiary's remaining income is then paid directly to the LTCF.[1]

Factors that Determine Applicability of Post-Eligibility to Medicare Co-payments

Options for Medicaid Payment of Medicare Cost Sharing

The amount of the Medicaid payment depends on the methodology the state has elected and specified in the state plan. State options with regard to payment for Medicare cost sharing, described in section 1902(n) of the Social Security Act (the Act), include the following:

1) The Medicare established cost-sharing rate; or
2) The Medicaid state plan rate.

[1] Regulations at 42 CFR 435.725, 435.733, 435.832, and 436.832 explain the post-eligibility treatment of income process in more detail.

Options for Medicaid Treatment of Medicare Cost Sharing

States may choose to treat the payment of Medicare cost sharing for an LTCF stay in one of two ways:

1) A payment for the underlying care, in this case skilled care in an LTCF, to which post-eligibility will apply; or
2) A payment for Medicare cost-sharing, to which post-eligibility will not apply.[2]

A state's choice should be reflected in its operating instructions.

QMB and QMB Plus: Medicare-Covered Services

A qualified Medicare beneficiary (QMB) is an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed a specified limit.[3] A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, co-insurance and co-pays[4] (except for items and services under Part D)[5]. QMBs who do not qualify for any additional Medicaid benefits are called "QMB Only."

A "QMB Plus" is an individual who meets all of the standards for QMB eligibility as described above, but who also meets the financial criteria for full Medicaid coverage. Such individuals are entitled to all benefits available to a QMB, as well as all benefits available under the state plan to a fully eligible Medicaid beneficiary. These individuals often qualify for full Medicaid benefits by spending down excess income to the medically needy income level, or by qualifying as an institutionalized person under a special income level.

State Medicaid programs are responsible, per section 1902(a)(10)(E)(i) of the Act, to pay for Medicare cost sharing (including deductibles, co-insurance and co-payment amounts) for all Medicare-covered services for QMBs. Individuals eligible as QMBs are entitled to payment of their Medicare cost sharing without further liability. QMB and QMB Plus beneficiaries are not required to contribute towards their cost of care for any day that is covered in full or in part by Medicare. For QMB and QMB Plus, the Medicaid program must pay the co-payment based on the payment methodology specified in the state plan and may not reduce that payment based on the post-eligibility calculation.

The LTCF may not collect any portion of the post-eligibility contribution to cost of care either for full Medicare days or for co-payment days. The LTCF may not balance bill a QMB or QMB Plus beneficiary even if the Medicare payment in addition to the state's payment (which could be zero, depending on their specified payment methodology) does not equal the full Medicare rate or the facility's charges.[6]

For individuals who are QMB Only, there are no further Medicaid payments to the LTCF after Medicare stops paying for the care (either the number of skilled days are exhausted, or Medicare no longer considers the services skilled care). Eligibility would need to be redetermined as an institutionalized person under an appropriate Medicaid eligibility group. If eligible, the individual's status would change to QMB Plus in order for Medicaid to pay the non-Medicare covered expenses in accordance with the state plan. The state's payment would then be reduced by the amount of income calculated in the post-eligibility process and the individual would be expected to contribute that portion towards the cost of care in the LTCF.

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[2] Letter from Sally K. Richardson, Director, Medicaid Bureau to Associate Regional Administrators, Division of Medicaid, Regions I – X, March 7, 1994. (Appendix B)
[3] §1905(p)(1) of the Act
[4] §1905(p)(3) of the Act
[5] §1935(d)(1)
[6] §1902(n)(3) of the Act

SLMB Plus and Medicaid Only Dual Eligible (Non-QMB) Beneficiaries

A specified low-income Medicare beneficiary (SLMB) is an individual who is entitled to Medicare Part A, has income that exceeds 100% of the FPL but is less than 120% of the FPL, and whose resources do not exceed a specified limit. The only Medicaid benefit a SLMB is eligible for is payment of Medicare Part B premiums.[7]

A "SLMB Plus" is an individual who meets the standards for SLMB eligibility, but who also meets the financial criteria for full Medicaid coverage. Such individuals are entitled to payment of Medicare Part B premiums, as well as all benefits available under the state plan to a fully eligible Medicaid recipient. These individuals often qualify for Medicaid by spending down excess income to the medically needy income level, or by qualifying as an institutionalized person under a special income level.

"Non-QMB Duals" are individuals who qualify for full Medicaid benefits, and who are also enrolled in Medicare, but whose income and/or assets exceed the limits for QMB or SLMB eligibility.

Medicaid payment of Medicare cost sharing is not a statutorily mandated benefit for SLMB Plus or Non-QMB Duals. As mentioned above, states may choose to treat Medicare cost sharing in one of two ways:

1) Medicaid may pay the co-payment as an institutional service in accordance with the state plan. In this situation, because the beneficiaries are not entitled to Medicaid payment of their Medicare cost sharing and the state considers this a payment for institutional care, the Medicaid post-eligibility treatment of income rules apply. The Medicaid payment will be reduced by the amount determined under the post-eligibility treatment of income calculation and the provider may collect from the individual the individual's liability.
2) States may choose to cover the Medicare co-payment as coverage of cost sharing, rather than as payment for a specific service. In states that make this choice, post-eligibility is not applicable.

For SLMB Plus and Non-QMB Duals, when there is no Medicare payment made towards the cost of care, either because benefits have been exhausted, or because Medicare determines that the services are not coverable, post-eligibility is always applicable.

Appendix A provides a table that summarizes the information contained in this FAQ.

We hope that this information will be helpful. If there are additional questions regarding this topic they may be directed to Anne Marie Costello, AnneMarie.Costello@cms.hhs.gov or (410) 786-5075.

[7] §1902(a)(10)(E)(iii) of the Act

DUAL ELIGIBLE CATEGORIES	DEFINITION	BENEFIT
QMB Only Qualified Medicare Beneficiaries	These individuals are entitled to Medicare Part A, have income of 100% Federal poverty level (FPL) or less, resources that do not exceed three times the limit for SSI eligibility; they are not otherwise eligible for full Medicaid under the state's plan.	Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid state plan, Medicare deductibles, co-pays and coinsurance for Medicare services provided by Medicare providers. Medicaid does not pay for services not covered by Medicare. QMB Only is not subject to post-eligibility.
QMB Plus QMB with full Medicaid	These individuals meet the eligibility for QMB as described above. They are also eligible for full Medicaid benefits under the state's plan.	Medicaid pays the Medicare premiums, co-pays, coinsurance and deductibles as described above for a QMB; Medicare covered services are not subject to post-eligibility. Medicaid also provides full Medicaid benefits, including non-Medicare covered LTC services subject to post eligibility.
SLMB Plus SLMB with full Medicaid	These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed three times the limit for SSI eligibility. They are also eligible for full Medicaid benefits under the state's plan.	Medicaid pays their Medicare Part B premiums; Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers; Medicaid will only pay for services also covered by Medicare within the limits of the state plan. States may choose to treat Medicaid payments for LTC Medicare co-pay days as payment for cost sharing, not subject to post eligibility, or as payment for LTC, subject to post eligibility. Medicaid payment of non-Medicare covered LTC services are subject to post eligibility.
Non-QMB Duals Medicaid Only Dual Eligibles	These individuals are eligible for full Medicaid benefits and are entitled to Medicare Part A and/or Part B; they are not eligible as QMB.	Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers; Payment by Medicaid of Medicare Part B premiums is a state option; Medicaid will only pay for services also covered by Medicare within the limits of the state plan. States may choose to treat Medicaid payments for LTC Medicare co-pay days as payment for cost sharing, not subject to post eligibility, or as payment for LTC, subject to post eligibility. Medicaid payment of non-Medicare covered LTC services are subject to post eligibility.