

**Balance Billing
of Qualified Medicare Beneficiaries (QMB)
Q & A**

Question

May a provider bill a QMB for either the balance of the Medicare rate* or the provider's customary charges for Part A or B services?

Response

No. QMBs are protected from liability for Part A and B charges even when the amounts the provider receives from Medicare and Medicaid are less than the Medicare rate or less than the provider's customary charges. Providers who bill QMBs for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. Providers may not accept QMB patients as "private pay" in order to bill the patient directly, and providers must accept Medicare assignment for all Medicaid patients, including QMBs.

Explanation

State Options for Rate Setting

For QMBs Medicaid is responsible for deductibles, coinsurance and co-payments for Medicare Part A and B covered services, however §1902(n) of the Social Security Act (the Act) provides States with the option to set payment rates for these services that are the same as their Medicaid rates, the same as the Medicare rates, or to utilize a methodology that places the payment rate somewhere between the Medicaid and Medicare rates. States that opt for use of the Medicaid rates or a special methodology must identify their option in their State plan. §1902(n) of the Act specifies that the State rate, regardless of the methodology used by the State, is considered payment in full for the service.

Often, when States elect to use the Medicaid rate, that rate is lower than the Medicare rate. For deductibles in States that elect this option Medicaid would pay the claim at the Medicaid rate. For coinsurance and co-payments, in States that elect this option and where the Medicaid rate is less than the Medicare rate, this option means that the State will actually make no payment, since the amount received from Medicare exceeds the State payment rate.

This means that when a provider renders a service to a QMB, the only payment he receives may be the Medicare payment, calculated as the Medicare rate less the coinsurance/co-payment. If, for example, the Medicare rate were \$100, Medicare would pay \$80 (\$100 less \$20 coinsurance). After Medicare pays their share of the cost, the claim crosses over to Medicaid, and Medicaid compares their rate (based on the methodology specified in their State plan) to the amount already paid by Medicare. If the Medicaid rate is less, no payment is made to the provider.

Provider Billing Limitations

The State Medicaid Manual (SMM) at Section 3490.14, in a revision issued in 1991, states that a physician may advise a patient that he is accepting the patient as "private pay only" or "QMB only" and that a physician who does not accept Medicare assignment may, in certain circumstances, bill the QMB directly for the difference between his charges and the Medicare rate.

Section 4714 of the Balanced Budget Act of 1997 (BBA) clarified the protection against payment liability for QMBs by amending §1902(n) of the Act to specify that the Medicare payment, and the Medicaid payment, if any, is considered payment in full, and that the QMB has no legal liability to make a payment to a provider or Medicare managed care plan (Medicare Advantage plan) for Part A or B cost sharing. The BBA also specified that providers who violate these provisions are subject to penalties.

In addition to these changes to title XIX (Medicaid), the BBA made changes to title XVIII (Medicare) by amending §1848(g)(3)(A) of the Act to require that a physician treating an individual who is eligible for Medical Assistance, including QMB, accept Medicare assignment. There is no option for treating a QMB or other Medicaid recipient as a private pay patient. The BBA also amended §1866(a)(1)(A) to require Medicare providers to comply with §1902(n).

The changes made by the BBA are discussed in a letter to State Medicaid Directors dated November 24, 1997. This may be found at the following link:
<http://www.cms.hhs.gov/smdl/downloads/SMD112497.pdf>.

The changes in statute made by the BBA and the above referenced letter *make obsolete the policy related to providers' options to accept patients as "private pay only" or "QMB only"* found in the SMM section 3490.14. (Note that other policies found in SMM section 3490.14 are still in force.)

- * "Rate" means a fixed amount for a specific service which is the basis for the program payment. For example, a physician charges \$120 for an office visit, but the Medicare rate for the service is \$100, and the Medicare payment is calculated at 80% of the rate, i.e. \$80 ($.80 \times \$100 = \80).