CHAPTER 4

Medicaid Coverage of Premiums and Cost Sharing for Low-Income Medicare Beneficiaries

Key Points

Medicaid Coverage of Premiums and Cost Sharing for Low-Income Medicare Beneficiaries

- For certain low-income beneficiaries, Medicaid pays for Medicare out-of-pocket costs such as premiums, coinsurance, and deductibles. Over time, Medicaid coverage of Medicare premiums and cost sharing has incrementally expanded. Today, there are four Medicare Savings Programs (MSPs), each with different income and asset level requirements:
  - qualified Medicare beneficiaries (QMBs),
  - specified low-income Medicare beneficiaries (SLMBs),
  - qualifying individuals (QIs), and
  - qualifying disabled and working individuals (QDWIs).
- In 2007, Medicaid payments for Medicare premiums totalled $10.5 billion, and Medicaid payments for acute care, which includes Medicare cost sharing and services not covered by Medicare, totalled $21.4 billion.
- Under current law, states have flexibility in how they pay providers for Medicare cost-sharing amounts. MACPAC's analysis shows that most states choose to limit their payment of Medicare deductibles and coinsurance to the lesser of the Medicare cost-sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service.
- The study finds that Medicaid payment policies for Medicare cost sharing vary both among states and among the provider types examined within individual states, including:
  - about 40 states limit their payments for Medicare cost sharing for each of the services examined,
  - about half of the states limit payments for all examined provider types, and
  - only four states pay Medicare's full deductibles and coinsurance for every provider type.
- Medicare pays certain providers (e.g., hospitals, skilled nursing facilities) for a portion of the cost sharing that cannot be collected from beneficiaries (often referred to as bad debt). The cost sharing for dual eligibles that is not paid by state Medicaid agencies as a result of lesser-of policies is included in these Medicare bad debt payments.
- These Medicaid and Medicare policies can interact to shift costs between the two programs. These interactions also raise questions about the potential impact on access to care for beneficiaries whose Medicare cost sharing is paid by Medicaid.

CHAPTER 4

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From its earliest days, Medicaid has contributed to the costs of medical care for low-income Medicare beneficiaries. Depending upon an individual's eligibility, this may include payment of Medicare premiums, coinsurance payments, and deductibles. It may also include full Medicaid coverage for services that are not covered by Medicare.

Unlike the Medicaid program, the Medicare program was originally designed to serve eligible individuals without regard to their income and included beneficiary cost-sharing requirements similar to private health insurance. While Medigap and employer-sponsored insurance plans provide supplemental coverage for many Medicare beneficiaries, low-income beneficiaries are less likely to have such coverage. Medicare's cost-sharing requirements may be a burden for people who live in poverty or have incomes just above poverty. For Medicare beneficiaries with incomes between 100 and 200 percent of the federal poverty level (FPL) in 2006, Medicare out-of-pocket spending accounted for nearly 25 percent of income (Nonnemaker and Sinclair 2011). Out of concern that low-income individuals would forgo needed care when faced with cost-sharing requirements beyond their means, the Congress made Medicaid's role in paying for these costs explicit over time through the creation of the Medicare Savings Programs (MSPs).

The MSPs, described in detail in the following sections, provided coverage for Medicare Part A and Part B cost-sharing expenses for 8.3 million out of a total of 10.2 million persons dually eligible for Medicaid and Medicare in 2011. Of these, 2.7 million Medicare beneficiaries received assistance only with cost sharing or premiums. Another 5.6 million individuals qualified for full Medicaid benefits and were also enrolled in one of the MSPs.

In 2007, Medicaid payments for Medicare premiums accounted for $10.5 billion, or 10 percent of Medicaid spending for all dual eligibles. Medicaid payments for acute

care, which includes Medicare coinsurance and deductibles as well as other services not covered by Medicare, are estimated at $21.4 billion, or 20 percent of Medicaid spending for all dual eligibles in 2007.[1]

States have a certain amount of flexibility in how they pay for Medicare's cost sharing, but information on current state policies has not been readily available at the federal level. For this report, MACPAC reviewed state policies in order to develop an up-to-date and complete picture of how states pay for these cost-sharing amounts. The review shows that, as permitted under current law, most states choose to limit their payment of Medicare deductibles and coinsurance to the lesser of the cost-sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service.[2]

The Commission is examining Medicaid coverage of Medicare premiums and cost sharing as part of its ongoing analytic agenda related to individuals who are dually eligible for Medicaid and Medicare, as well as its longstanding interest in Medicaid payment policy. It seeks to understand better the interaction between the Medicaid and Medicare programs at the state level, and, ultimately, whether such interactions affect access to services for dually eligible individuals. This chapter outlines Medicaid's coverage of Medicare premiums and cost sharing, including:

- an overview of the different programs that comprise the MSPs, including how state policies affect eligibility and enrollment of beneficiaries into these programs;
- results from a new MACPAC analysis that examines state Medicaid payment policies for Medicare cost sharing and discussion of the interaction with Medicare bad debt policy; and
- discussion of several policy questions related to Medicaid coverage of Medicare premiums and cost sharing.

Overview of Medicare Savings Programs

Since the programs' enactment in 1965, it has been possible for individuals to enroll in both Medicare and Medicaid if they are eligible for both programs, as described in Chapter 3 of this report. The Medicare program provides health insurance coverage to persons age 65 and over and persons with disabilities. Medicare Part A generally pays for institutional services such as hospital and skilled nursing facility (SNF) services, and Part B generally pays for outpatient services such as physician and laboratory services and durable medical equipment.[3] Both Part A and Part B services are subject to deductibles and coinsurance, and Part B also requires a monthly premium (Table 4-1).

Out of concern that Medicare's out-of-pocket costs could be a substantial burden for low-income Medicare beneficiaries who might not qualify for Medicaid in every state, possibly limiting access to necessary services, the Congress created programs to cover some of the costs. These programs use Medicaid as the mechanism to cover Medicare's costs, requiring states to "buy in" to the Medicare program for certain low-income Medicare beneficiaries by covering premiums and sometimes cost sharing. Medicare enrollees who meet the eligibility requirements for MSPs but have either too much income or too many assets to qualify for full Medicaid coverage in their state are often referred to as partial benefit dual eligibles.

Medicare Savings Programs

Over time, Medicaid coverage of Medicare premiums and cost sharing has incrementally

TABLE 4-1. Medicare Fee-for-Service Cost-Sharing Amounts for Part A and Part B Services, Calendar Year 2013[1]

	Part A	Part B
Premiums[2]	No premiums for most beneficiaries[3]	$104.90/month
Deductibles	Inpatient hospital: $1,184 Mental health inpatient: $1,184	$147/year
Copay/coinsurance	Durable medical equipment (DME) ▶ 20% of Medicare-approved amount for DME Inpatient hospital ▶ Days 61–90: $296/day ▶ Days 91+: $592/day for lifetime reserve days Mental health inpatient ▶ Days 61–90: $296/day ▶ Days 91+: $592/day for lifetime reserve days Nursing homes ▶ Days 21–100: $148/day ▶ Days 100+: all costs	Generally 20% of Medicare-approved amount

Notes:

1 Many of the cost-sharing amounts expressed as specific dollar amounts in this table are adjusted every year. For example, the Part B premium amounts are adjusted each year so that expected Medicare premium revenues equal 25 percent of expected Medicare Part B spending (42 U.S.C.§1395r(a)).

2 Medicare beneficiaries with incomes over $85,000 (or $170,000 for a couple) pay more for their premiums per month.

3 A Medicare beneficiary generally does not pay premiums for Medicare Part A unless the beneficiary or spouse has worked fewer than 40 quarters in his or her lifetime. For beneficiaries who do have to pay a Part A premium, it can be up to $441/month.

Source: CMS 2013b

expanded. Today, four different programs make up the MSPs, each with different qualifications based on an individual's income and assets:

- qualified Medicare beneficiaries (QMBs);
- specified low-income Medicare beneficiaries (SLMBs);
- qualifying individuals (QIs); and
- qualifying disabled and working individuals (QDWIs).

The first of the MSPs, the QMB program, was enacted in 1986 as a state option and then made mandatory in the Medicare Catastrophic Coverage Act of 1988 (MCAA, P.L. 110-360).[4] This law required states to cover all Medicare premiums and cost sharing for dual eligibles with incomes up to 100 percent FPL. The MSPs have been expanded over the years to additional low-income Medicare beneficiaries.

Table 4-2 highlights the four groups of MSP enrollees, including 2011 enrollment and 2013 eligibility and benefits. The following sections describe each group in more detail.

Qualified Medicare Beneficiary program (QMB). The QMB program is the first and most expansive of the MSPs in terms of the number of enrollees and benefits offered. (See Table 4-3 for this and other legislative milestones.) States

TABLE 4-2. Medicaid Benefits by Dual-Eligible Category

Dual Eligible Category	Medicaid Benefit Status	Enrollees in 2011 (millions)	Description	Federal Income Limits	2013 Federal Resource Limits (Individual/ Couple)	Medicaid Benefits
Medicare Savings Programs (MSPs)						
Qualified Medicare beneficiaries (QMBs)	Partial benefit (QMB only)	1.3	Qualify for Medicaid payment of all Medicare premiums and cost sharing, but are otherwise ineligible for Medicaid in their state	Up to 100% FPL	$7,080/ $10,620	Medicare Part A premiums (if needed) Medicare Part B premiums Medicare deductibles and coinsurance
	Full benefit (QMB plus)	5.3	Qualify for Medicaid payment of all Medicare premiums and cost sharing, and also meet Medicaid eligibility criteria in their state and qualify for full Medicaid benefits	Up to 100% FPL	$2,000/ $3,000	Medicare Part A premiums (if needed) Medicare Part B premiums Medicare deductibles and coinsurance Full Medicaid benefits
Specified low-income Medicare beneficiaries (SLMBs)	Partial benefit (SLMB only)	0.9	Qualify for Medicaid payment of Medicare Part B premiums and are otherwise ineligible for Medicaid in their state	Between 100 and 120% FPL	$7,080/ $10,620	Medicare Part B premiums
	Full benefit (SLMB plus)	0.3	Qualify for Medicaid payment of Medicare Part B premiums, and also meet Medicaid eligibility criteria in their state and qualify for full Medicaid benefits, which includes payment for Medicare cost sharing within the limits of the state plan. Depending on their state, they may also receive Medicaid payment of Medicare Part A premiums.	Between 100 and 120% FPL	$2,000/ $3,000	Medicare Part B premiums Medicare deductibles and coinsurance (within the limits of the state plan) Medicare Part A premiums at state option Full Medicaid benefits

TABLE 4-2, Continued

Dual Eligible Category	Medicaid Benefit Status	Enrollees in 2011 (millions)	Description	Federal Income Limits	2013 Federal Resource Limits (Individual/ Couple)	Medicaid Benefits
Qualified individuals (QIs)	Partial benefit	0.5	Qualify for Medicaid payment for Medicare Part B premiums and are otherwise ineligible for Medicaid in their state	Between 120 and 135% FPL	$7,080/ $10,620	Medicare Part B premiums
Qualified disabled and working individuals (QDWIs)	Partial benefit	Fewer than 100 individuals	Have lost their Medicare Part A benefits due to their return to work but are eligible to purchase Medicare Part A, qualify for Medicaid payment of Medicare Part A premiums, and are otherwise ineligible for Medicaid in their state.	At or below 200% FPL	$4,000/ $6,000	Medicare Part A premiums
Non-MSP						
Other full-benefit dual eligibles	Full benefit	1.9	Do not meet income or resource requirements for QMB, SLMB, or QI but meet Medicaid eligibility criteria in their state and qualify for full Medicaid benefits, which includes payment for Medicare cost sharing covered within the limits of the state plan. Depending on their state they may also receive Medicaid payment of Medicare Part A premiums.	Varies by state and Medicaid eligibility pathway	$2,000/ $3,000	Full Medicaid benefits Medicare coinsurance and deductibles (within the limits of the state plan) Medicare Part A premiums at state option

Notes: FPL is the federal poverty level. Section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are "less restrictive," enabling states to expand eligibility above these standards. Not all resources (e.g., value of house, value of one vehicle, etc.) are counted toward resource limits. Section 209(b) states may use Medicaid eligibility criteria that are more restrictive than the Supplemental Security Income program, but may not use more restrictive criteria than those in effect in the state on January 1, 1972. For information on state Medicaid income eligibility levels for persons age 65 and over and individuals with disabilities, see MACStats Table 11. Resource limits for QMB, SLMB, and QI are adjusted annually for inflation. QI expenditures are fully federally funded and total expenditures are limited by statute. Medicaid coverage of additional premiums for Medicare Advantage plans is optional for states (§1905(p)(3)(D)).

Source: Enrollees in 2011: CMS 2013a; Description and Federal Income Limits: §1902(a)(10)(E) of the Social Security Act; 2013 Federal Resource Limits: SSA 2012

are required to cover Medicare Part B premiums and all Medicare deductibles and coinsurance for Medicare beneficiaries with incomes up to 100 percent FPL ($11,490 for an individual and $4,020 for each additional family member in 2013).[5] Medicaid spending for Medicare premiums, deductibles, and coinsurance is eligible for federal financial participation (FFP).

All Medicare beneficiaries with incomes up to 100 percent FPL and assets under $7,080 for an individual in fiscal year (FY) 2013 are eligible for the QMB program, regardless of whether or not they qualify for full Medicaid benefits in their state. There are two types of QMBs. Just over 20 percent of QMBs do not otherwise qualify for full Medicaid benefits (these individuals are known as "QMB-only" dual eligibles). Medicaid coverage for QMB-only dual eligibles is limited to Medicare premiums and cost sharing. The other 80 percent consists of beneficiaries—such as Supplemental Security Income (SSI) recipients and certain medically needy individuals —who meet the QMB criteria and are also eligible for full Medicaid benefits in their state (commonly known as "QMB-plus" dual eligibles). In addition to Medicaid coverage of Medicare premiums and cost sharing, these QMB-plus individuals receive full Medicaid benefits, including some—such as long-term services and supports (LTSS), dental, and vision—that are not covered in the Medicare program.

Specified Low-income Medicare Beneficiary program (SLMB). The Omnibus Budget and Reconciliation Act of 1990 (OBRA 90, P.L. 101-508) expanded Medicaid coverage of Medicare Part B premiums to Medicare beneficiaries with incomes between 100 and 120 percent FPL (120 percent FPL is $13,788 for an individual and $4,824 for each additional family member in 2013). Medicaid payments for Part B premiums are eligible for FFP. This incremental expansion was a result of efforts by the Congress to mitigate the effect on low-income Medicare beneficiaries of provisions in OBRA 90 that increased Medicare Part B premiums (Committee on the Budget 1990).

All Medicare beneficiaries with incomes between 100 and 120 percent FPL are eligible for the SLMB program, regardless of their eligibility for full Medicaid benefits. As with QMBs, there are some SLMBs that receive full Medicaid benefits (SLMB-plus dual eligibles), generally through a medically needy eligibility pathway. There are also SLMBs who do not qualify for full Medicaid benefits in their state and who receive Medicaid coverage for only their Part B premiums (SLMB-only dual eligibles). The SLMB program, like the QMB program, is an entitlement with no caps on enrollment or spending. In 2011 there were around 900,000 dual eligibles enrolled as SLMB-only dual eligibles and around 300,000 enrolled as SLMB-plus dual eligibles.

Qualifying Individual program (QI). The Balanced Budget Act of 1997 (BBA, P.L. 105-33) further expanded Medicaid coverage of Medicare Part B premiums to Medicare beneficiaries with incomes between 120 and 135 percent FPL (QIs). Unlike the QMB and SLMB programs, the QI program is a limited entitlement that is based on a specific allotment of funds to each state. QI funds are allocated to states in one-year increments, based on congressional appropriations and periodic reauthorizations of the program.[6]

State payments for Part B premiums on behalf of QIs are fully funded by the federal government, subject to state-specific limits. If a state surpasses the amount allocated, then the state is fully responsible for the remaining expenses. Federal statute permits states to impose restrictions on enrollment policies for QIs, including limiting

the number of QIs in a given year. Enrollment in the QI program is typically on a first-come, first-served basis, and each enrollee must re-apply to the QI program every year (§1933(b) of the Social Security Act (the Act)). In 2011 there were around 500,000 dual eligibles enrolled in the QI program.

Qualifying Disabled and Working Individual program (QDWI). A fourth program to provide Medicaid coverage of Medicare Part A premiums was implemented as a result of the Omnibus Budget and Reconciliation Act of 1989 (OBRA 89, P.L. 101-239), which included changes in the Medicare law intended to help individuals with disabilities retain Medicare coverage. Before OBRA 89, many individuals with disabilities could lose their Medicare Part A and Social Security coverage (i.e., Social Security Disability Insurance) as a result of returning to work. Their relatively high need for health care services made it difficult for this group of working individuals with disabilities to purchase private health insurance. This also served as a disincentive for some employers, particularly smaller employers, to hire individuals with disabilities due to the effect they might have on the employers' group health insurance premiums.

OBRA 89 allowed persons with disabilities whose work activities caused them to lose Medicare and Social Security to purchase Medicare Part A and Part B coverage. Furthermore, the law mandated that state Medicaid programs cover the Medicare Part A premiums for individuals in this category who have incomes below 200 percent FPL and resources not in excess of twice the SSI resource levels ($4,000 for an individual and $6,000 for a couple). In 2011 there were fewer than 100 beneficiaries enrolled as QDWIs.

Non-MSP full-benefit dual eligibles. There are also individuals who are eligible for both Medicaid and Medicare but not for the MSP programs. Non-MSP full-benefit dual eligibles are generally individuals who spend down to qualify as medically needy in Medicaid, or who meet special income levels and are institutionalized or enrolled in home and community-based waivers. While these individuals receive full Medicaid benefits in accordance with each state's Medicaid state plan, there is no statutory requirement for Medicaid coverage of Medicare coinsurance and deductibles as there is for QMBs. States may choose, however, to cover these amounts as cost sharing, or as coverage of the underlying service according to their state plan. States also have the option of covering non-MSP dual eligibles' Part B premiums.[7] In 2011 there were about 2 million non-MSP full-benefit dual eligibles.

Role of States in Medicare Savings Program Eligibility and Enrollment

State Medicaid agencies administer the MSPs, and therefore play a significant role in determining eligibility and benefits, as well as other policies and procedures that can affect the rate of enrollment in the programs. While federal requirements establish a baseline for MSP eligibility, states have flexibility to increase eligibility by using different methods for determining income and resources. As a result, the number of MSP enrollees varies across states. Enrollment rates in the MSPs have generally been low, however, compared to the number of individuals who are estimated to be eligible for the programs (CBO 2004).

Eligibility

Federal standards for counting income and resources for MSP eligibility were initially based on those used by the federal SSI program. Before

TABLE 4-3. Legislative Milestones in Medicaid Coverage of Premiums and Cost Sharing for Low-Income Medicare Beneficiaries

1965 The Medicare program was enacted as Title XVIII of the Social Security Act of 1965 (P.L. 89–97) to provide health care coverage for individuals age 65 and older. The Medicaid program was enacted as Title XIX of the Social Security Act to provide health coverage for low-income individuals, including coverage for low-income Medicare beneficiaries (dual eligibles).

- For low-income individuals entitled to both Medicare and Medicaid, states were given the option to either pay for these individuals' Part B services directly as a Medicaid service (eligible for federal match) or states could pay the Medicare Part B premium and Medicare would be the primary payer of the covered services.

1967 The Social Security Amendments of 1967 (P.L. 90–248) prohibited federal financial participation for Medicaid services that could have been paid for by Medicare Part B if the recipient had been enrolled.

1986 The Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) permitted states to provide Medicaid benefits to low-income qualified Medicare beneficiaries (QMBs) with incomes at or below 100 percent of the federal poverty level (FPL). States had the option to provide either of two Medicaid benefit packages:

- Limit coverage to Medicare premiums and cost sharing or
- Provide full Medicaid benefits in addition to Medicare premiums and cost sharing.

1988 The Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100–360) enacted provisions that required states to cover QMBs but limited the Medicaid benefits to Medicare premiums and cost sharing. This was the first of the programs now commonly referred to as the Medicare Savings Programs (MSPs). Most of the MCCA was repealed in 1989, but the MSP requirements for QMB coverage remained in law.

1989 The Omnibus Budget Reconciliation Act of 1989 (P.L. 101–239)

- Established a new eligibility group for disabled and working individuals—those who previously qualified for Medicare because of disability but lost their Medicare coverage because of their return to work—who may purchase Medicare Part A and Part B coverage. States are required to pay the Medicare Part A premiums for these individuals with incomes below 200 percent FPL (known as qualified disabled and working individuals (QDWIs)). This was the second of the programs now known as MSPs.
- Prohibited providers from balance billing dual eligibles (i.e., when a provider sends the beneficiary a bill that exceeds the beneficiary share of the Medicare rate for the service).

1990 The Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508) required states to pay Medicare Part B premiums for beneficiaries with incomes between 100 and 120 percent FPL (special low-income Medicare beneficiaries (SLMBs)). This was the third MSP.

TABLE 4-3, Continued

1997 The Balanced Budget Act of 1997 (P.L. 105–33)

- Required states to pay Medicare Part B premiums for Medicare beneficiaries with incomes between 120 and 135 percent FPL (qualifying individuals (QIs)), the fourth MSP. This benefit is subject to an annual federal funding cap that limits the number of QIs served in a given year.
- Stated that state Medicaid programs may limit their payment for Medicare cost sharing for QMBs to the difference between the state's Medicaid rate and the Medicare payment amount as long as their payment policies are written in their state plan.
- Prohibited Medicare providers or Medicare managed care entities from directly charging any Medicare cost sharing directly to QMBs. They must consider the amount paid by the state for Medicare cost sharing to be payment in full for any QMBs that they serve.

2003 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173) established a voluntary outpatient prescription drug benefit for people on Medicare, known as Part D, that went into effect January 1, 2006.

- Changed prescription drug coverage for individuals dually eligible for Medicare and Medicaid from Medicaid to private Medicare Part D plans.
- Provided the low-income subsidy (LIS), an additional subsidy for beneficiaries with limited assets and income to help pay a portion of out-of-pocket prescription drug costs. Medicare beneficiaries who receive the LIS often qualify for the subsidy automatically on the basis of being Medicaid or Supplemental Security Income (SSI) recipients, or because they are enrolled in certain MSPs.

2008 The Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110–275)

- Increased the federal asset limits for MSPs (which had previously been frozen at $4,000 for an individual and $6,000 for couples) to the same level as the full Part D LIS asset limits and indexed to inflation thereafter. This change took effect January 1, 2010.
- Required the Social Security Administration to transfer information from an LIS application to the state Medicaid agency, which is required to use it to initiate an application for MSP enrollment.

2010 The Patient Protection and Affordable Care Act (P.L. 111–148)

- Created the Federal Coordinated Health Care Office (FCHCO) in the Centers for Medicare & Medicaid Services to explore methods of aligning and coordinating benefits between the Medicaid and Medicare programs more effectively and efficiently. The FCHCO is partnering with states and plans to test the alignment of service delivery and financing between the programs through the financial alignment demonstration.
- Eliminated Part D cost sharing for full-benefit dual-eligible beneficiaries receiving home and community-based services who would otherwise require institutional care (beneficiaries residing in institutional settings already had no cost sharing).
- Prohibited Medicare Advantage plans and their providers from directly charging dual eligibles for Medicare Part A and Part B cost sharing.

the passage of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), the federal resource limit for MSPs had not been raised since the QMB program was enacted in 1988 (GAO 2012). Beginning in 2010, the federal resource limits for all MSPs were uniformly tied to the resource limits of the Medicare Part D low-income subsidy (LIS) program, to be adjusted for inflation in the future. In 2013, the resource limits for the QMB, SLMB, QI, and LIS programs are $7,080 for an individual and $10,620 for a couple (SSA 2012). However, states are permitted to disregard amounts of income or resources when determining MSP eligibility, effectively increasing the number of individuals that can qualify. In 2006, 39 states used one or more methods to count income and resources that result in limits that are higher than the federal standards (Nemore 2006).

States also have flexibility in determining eligibility for full Medicaid benefits, including for full-benefit dual eligibles (see Chapter 3 and MACStats Table 11). This variability in eligibility means that Medicare beneficiaries with the same income and resources are eligible for different benefits in different states. For example, in one state, an individual may qualify as a QMB-plus dual eligible and, therefore, receive full Medicaid benefits in addition to Medicare cost sharing. In another state the same beneficiary could be eligible as a QMB-only dual eligible, entitled only to Medicaid coverage of Medicare cost sharing.

Enrollment

Historically, MSP enrollment rates among eligible Medicare beneficiaries have been low. In 2004, the Congressional Budget Office estimated that 33 percent of eligible beneficiaries were enrolled in QMB programs and only 13 percent of eligible individuals were enrolled in SLMB programs (CBO 2004).[8] A 2002 study estimated that fewer than 19 percent of eligible beneficiaries were enrolled as QIs (Summer and Friedland 2002).

Beneficiaries' lack of awareness about the programs and complex eligibility and enrollment processes are cited as primary barriers to enrollment in MSPs (Haber et al. 2003, Glaun 2002, Neumann et al. 1994). Several MIPPA provisions aimed at eliminating barriers to MSP enrollment, such as aligning resource levels with those used for LIS and additional funding for states to perform outreach for MSPs, resulted in growth in the MSP enrollment rate in each year from FY 2007 through 2011 (GAO 2012).

Enrollment rates among those eligible for MSPs have been shown to vary across states (Rosenbach and Lamphere 1999). States face conflicting incentives for increasing enrollment in their MSPs. On one hand, the programs may improve access to care for Medicare beneficiaries with low incomes. On the other hand, for QMBs, SLMBs, and QDWIs, increasing the number of beneficiaries enrolled will result in increased Medicaid expenditures. The varying rates of enrollment into the MSPs may depend on a state's eligibility and outreach activities. For example, enrollment in the QMB and SLMB programs in states that participated in the Robert Wood Johnson Foundation's State Solutions grant program increased 45 percent from 2002 to 2005, compared to a 22 percent increase nationwide during that same time period (Summer 2006). Strategies included modifying eligibility requirements, expanding outreach activities, simplifying the enrollment process, training staff and volunteers to conduct enrollment activities, and strengthening data collection.

States' Role in Determining Payment for Medicare Coinsurance and Deductibles

State flexibility in Medicaid coverage of Medicare cost sharing extends to the amounts that states pay for Medicare coinsurance and deductibles. Claims for coinsurance and deductibles are commonly referred to as crossover claims, because providers first submit a claim to the Medicare program, which pays the provider for the service, and the claim then crosses over to Medicaid for payment of cost-sharing amounts.

States are not obligated to pay the full amount of Medicare coinsurance and deductibles if total payment to the provider would exceed the state's Medicaid rate. Instead, states may limit their payment through lesser-of policies that pay the lesser of:

- the full amount of Medicare deductibles and coinsurance; or
- the difference between the Medicaid rate and the amount already paid by Medicare (Box 4-1).

The following section describes the history of lesser-of policies as well as the results of a MACPAC survey of state payment policies for Medicare cost sharing. It also describes the interaction of state payment policies and Medicare bad debt payment and limitations in data regarding Medicaid payment of Medicare cost sharing.

History of lesser-of payment policies

The origin of the lesser-of policy can be traced to the enactment of the QMB program in 1988. While the legislation required state Medicaid programs to pay for QMBs' Medicare cost sharing, it did not specify whether states were obligated to pay providers the full amount, or only up to the state Medicaid rate (§1902(a)(10)(E)(i) of the Act). In an amendment to the State Medicaid Manual, the Health Care Financing Administration (HCFA, now CMS) allowed lesser-of policies (HCFA 1991). However, providers brought lawsuits in multiple jurisdictions arguing that the HCFA guidance, and state policies implementing lesser-of policies, did not fulfill the legal requirement that a state cover Medicare's cost sharing for QMBs. Federal court decisions on this question were mixed, with four courts finding that states must pay Medicare's full cost-sharing amounts and two upholding HCFA's policy (Waxman et al. 1997).

To resolve the uncertainty, in 1997 the BBA gave states explicit authority to use lesser-of policies (§4714 of the BBA, amending §1902(n) of the Act). States were required to file an amendment to their state plan (via Supplement 1 to Attachment 4.19-B) in order to specify their policy on payment of Medicare cost sharing (HCFA 1997). The BBA also clarified that providers cannot directly bill QMBs for any Medicare cost sharing, even if Medicaid does not pay the full amount. Instead, providers must accept payment from Medicare and Medicaid as payment in full.[9]

Medicaid payment of Medicare cost sharing for non-QMB full-benefit dual eligibles is not a statutorily required benefit. The Centers for Medicare & Medicaid Services (CMS) has indicated, however, that states may choose to treat Medicare cost sharing for these individuals as either: (1) coverage of the underlying service in accordance with the Medicaid state plan, or (2) coverage of cost sharing. Under the first option, Medicaid payment to a provider is the Medicaid rate for the service according to the state plan, minus any amount paid by Medicare or other payers. Because the Medicaid payment in this case is payment for a covered service (rather than for cost sharing), any income that an enrollee may be required to contribute toward Medicaid services

BOX 4-1. Examples of Medicaid Payment for Medicare Cost Sharing

The table below illustrates Medicaid payment of cost sharing for a service with a Medicare-approved amount of $100, when the state's Medicaid-approved rate for the same service is $90. If Medicare's payment is 80 percent of the approved amount, Medicare pays the provider $80, less any remaining deductible. The remaining 20 percent (in this case, $20), plus the amount of deductible applied, is billed to Medicaid as a crossover claim.

Full-payment policy. Some states pay the Medicare cost-sharing amount in full, regardless of what their Medicaid rate is for the service. In this example, the Medicaid payment from a state with a full payment policy would bring the total provider payment to $100.

Lesser-of policy. A state with a lesser-of policy would compare the requested Medicare cost sharing to the difference between the state's Medicaid rate and the Medicare payment amount, and pay the lesser amount. In this example, the Medicaid payment would bring the total amount paid to the provider to $90 (the Medicaid-approved rate).

In instances when Medicare has already paid more than the Medicaid rate for a particular service, under a lesser-of policy, Medicaid is not required to pay anything additional. For example, if Medicare pays $80 on the $100 claim, but Medicaid's rate for the service is only $70, then Medicaid will make no additional payment, and the claim is considered paid in full.

	Full-Payment Policy		Lesser-of Policy	
	Deductible not met	After deductible is met	Deductible not met	After deductible is met
Provider charge	$125	$125	$125	$125
Medicare-approved amount	$100	$100	$100	$100
Medicaid payment rate	$ 90	$ 90	$ 90	$ 90
Beneficiary's remaining Medicare deductible	$147	$0	$147	$0
Medicare payment (e.g., for physicians, 80% of Medicare-approved amount, minus deductible)	(80% of $100) – $147 = $0	(80% of $100) – $0 = $80	(80% of $100) – $147 = $0	(80% of $100) – $0 = $80
Medicare cost sharing (billed to Medicaid as a crossover claim)	$100	$20	$100	$20
Medicaid payment to provider	$100	$20	Lesser of Medicare cost sharing ($100) or Medicaid rate minus Medicare payment ($90–$0) = $90	Lesser of Medicare cost sharing ($20) or Medicaid rate minus Medicare payment ($90–$80) = $10

would be applied.[10] Under the second option, states may choose whether to limit payment of the Medicare cost sharing in the same manner as for QMBs, and enrollee income would not be applied (CMS 2012a).

For dual eligibles that are enrolled in Medicare managed care plans, state Medicaid agencies are still responsible for payment of deductibles and coinsurance. In some cases, states opt to contract with the Medicare managed care plan to cover the cost sharing on their behalf.[11] If the state does not contract with a plan to cover cost sharing, providers must be able to submit crossover claims directly to the state Medicaid program (CMS 2012b). Similarly, when dual eligibles are enrolled in Medicaid managed care plans, states may include an amount for Medicare cost sharing in the capitation rate paid to the plan, or may require providers to bill the state directly.

Inventory of State Medicaid Payment Policies for Medicare Coinsurance and Deductibles

Because the most recent information regarding individual state payment policies for deductibles and coinsurance was over 10 years old, MACPAC undertook a study of current policies in the 50 states and the District of Columbia. The study looked at crossover payment policies for four provider types: inpatient hospitals, outpatient hospitals, SNFs, and physicians, and classified each state's policy for each provider type as one of following three options:

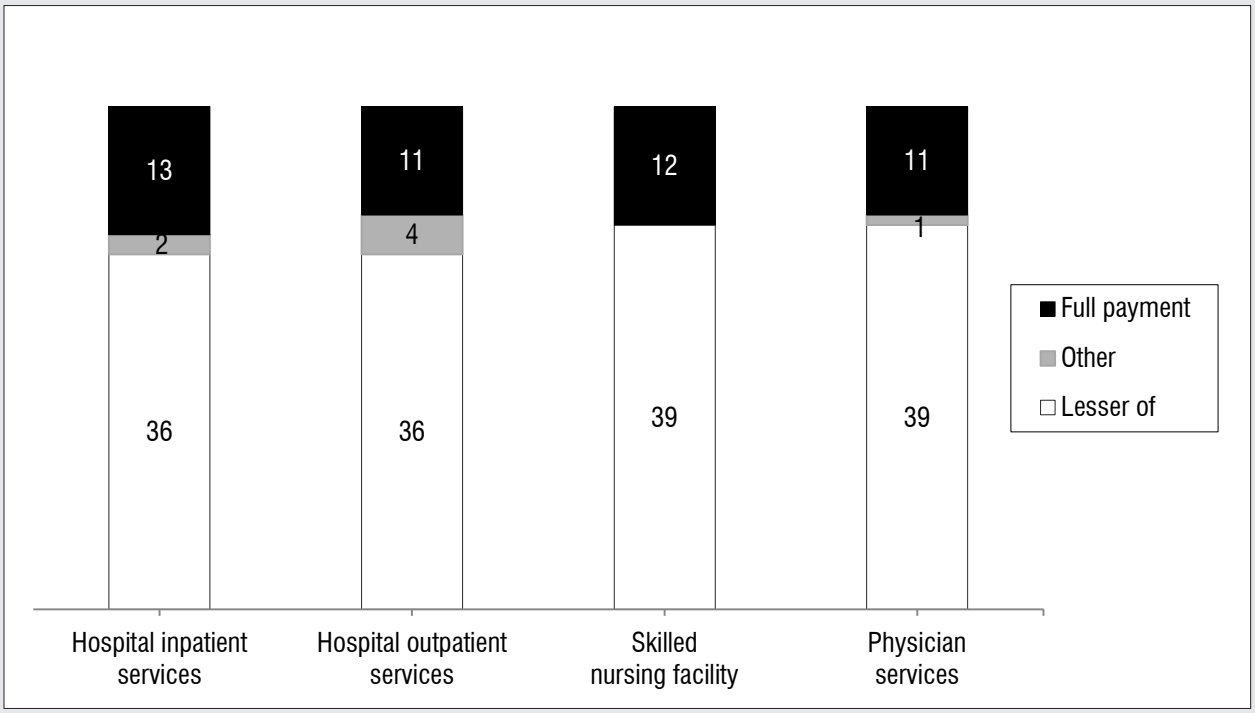
- **Full payment:** The state pays the full amount of Medicare deductibles and coinsurance, so that the provider receives the full Medicare-approved amount.
- **Lesser of:** The state pays the lesser of two amounts: (1) the full Medicare deductible and coinsurance, or (2) the difference between the Medicaid rate and the amount already paid by Medicare.
- **Other:** The state payment policy does not clearly fall into either of the above categories (e.g., the state always pays a fixed percentage of the deductible and coinsurance).

We used publicly available materials to identify crossover payment policies for most states for four categories of Medicare services, then followed up with state staff to resolve any outstanding questions. Because Medicaid state plans are not always readily available, the study team focused on state regulations and provider manuals that were believed to reflect actual current practice. This decision was reinforced by recent Office of Inspector General (OIG) reports showing that some states' crossover policies did not follow what was approved in their state plan (OIG 2012a, 2012b, 2012c). In these cases, the OIG reported that the states paid the full amount of Medicare crossover claims for dual eligibles while their state plans indicated lesser-of policies.

Results by provider type. State Medicaid programs are much more likely to use lesser-of policies than to pay the full amount of Medicare coinsurance and deductibles (Figure 4-1). In a few cases, researchers classified payment policies as "other." For example:

- **Ratio of costs to charges.** Two states that pay hospitals on the basis of a ratio of costs to charges have chosen to apply that ratio to crossover claims rather than calculating a Medicaid-allowed amount and then a lesser-of amount for each service.
- **Percentage of Medicare's cost sharing.** Several states set a specific percentage of a

FIGURE 4-1. Number of Medicaid Programs Using Lesser-of, Full-Payment, and Other Crossover Policies, 2012



Source: Data collected by NORC at the University of Chicago for MACPAC

Medicare crossover claim that they will pay, presumably as an estimate of an amount that is at least as much as they would pay under a lesser-of policy for the same type of provider.

Results within states. Crossover policies vary both among states and among provider types within individual states (Table 4-4 and Figures 4-2 to 4-5). Of the 51 Medicaid programs for which researchers collected information, about half have a lesser-of policy for all provider types. Only four states (Arkansas, Iowa, Vermont, and Wyoming) pay Medicare's full deductibles and coinsurance for every provider type that researchers investigated.

The remaining 18 states mix and match policies in almost every possible combination, with no clear patterns emerging. For example, Idaho and Montana pay the full amount for hospital inpatient and outpatient crossover claims, but use a lesser-of policy for SNFs and physicians. Hawaii does exactly the opposite, paying with a lesser-of policy for hospital-based services but paying the full amount for Medicare SNF and physician crossover claims.

Changes in crossover payment policies. From the limited information available, it appears that there has been a substantial shift toward lesser-of policies over time (Figure 4-6). Two surveys sought to track state Medicaid policies in the context of implementation of the BBA in the late 1990s. They both used a different methodology from the study conducted by MACPAC and did not differentiate among provider types. In the 1997

TABLE 4-4. Lesser-of, Full-Payment, and Other Crossover Policies, by State, 2012

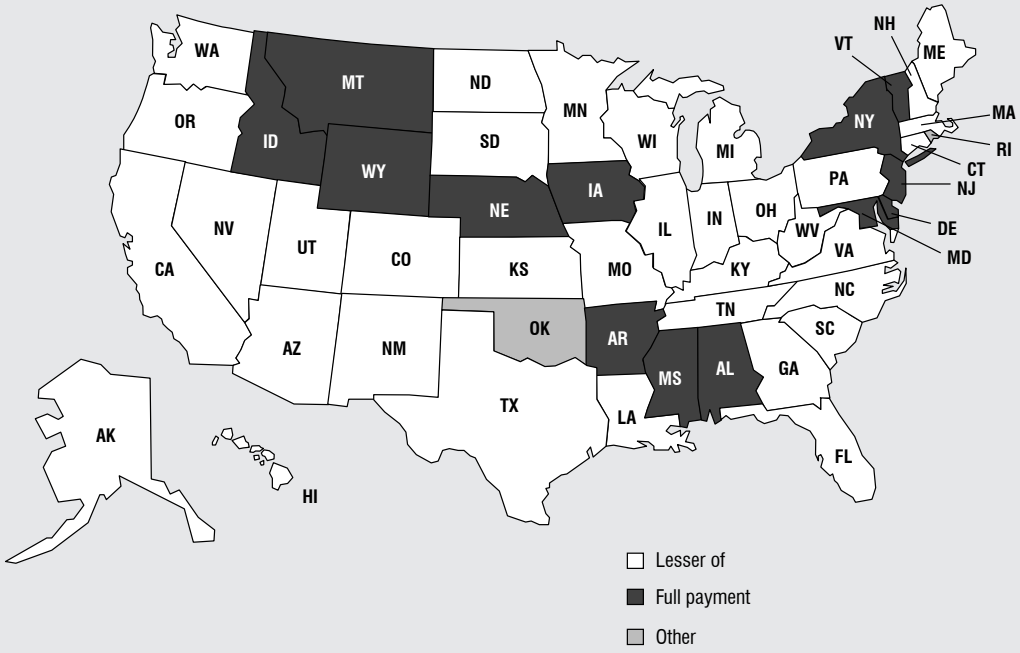
	Inpatient	Outpatient	SNF	Physician
AK	L	L	L	L
AL	F	L	F	L
AR	F	F	F	F
AZ	L	L	L	L
CA	L	L	L	L
CO	L	L	L	L
CT	L	L	L	L
DC	L	L	L	L
DE	F	L	F	L
FL	L	L	L	L
GA	L	O	L	L
HI	L	L	F	F
IA	F	F	F	F
ID	F	F	L	L
IL	L	L	L	L
IN	L	L	L	L
KS	L	L	L	L
KY	L	F	L	L
LA	L	L	L	L
MA	L	L	L	L
MD	F*	L	L	L
ME	L	L	L	F
MI	L	L	L	L
MN	L	L	L	L
MO	L	O	L	F
MS	F	F	L	F
MT	F	F	L	L
NC	L	L	L	L
ND	L	L	L	L
NE	F	F	L	F
NH	L	L	L	L
NJ	F	F	F	L
NM	L	L	L	L
NV	L	L	L	L
NY	F	L	F	O
OH	L	L	L	L
OK	O	O	L	F
OR	L	L	L	L
PA	L	L	L	L
RI	O	O	F	L
SC	L	L	L	L
SD	L	F	F	F
TN	L	L	L	L
TX	L	L	L	L
UT	L	L	L	L
VA	L	L	L	L
VT	F	F	F	F
WA	L	L	L	L
WI	L	L	F	L
WV	L	L	L	L
WY	F	F	F	F

Notes: SNF is skilled nursing facility. L is lesser of. F is full payment. O is other (i.e., not clearly lesser of nor full payment).

* Because of its all-payer waiver, Maryland's Medicaid and Medicare rates are the same for inpatient hospital services.

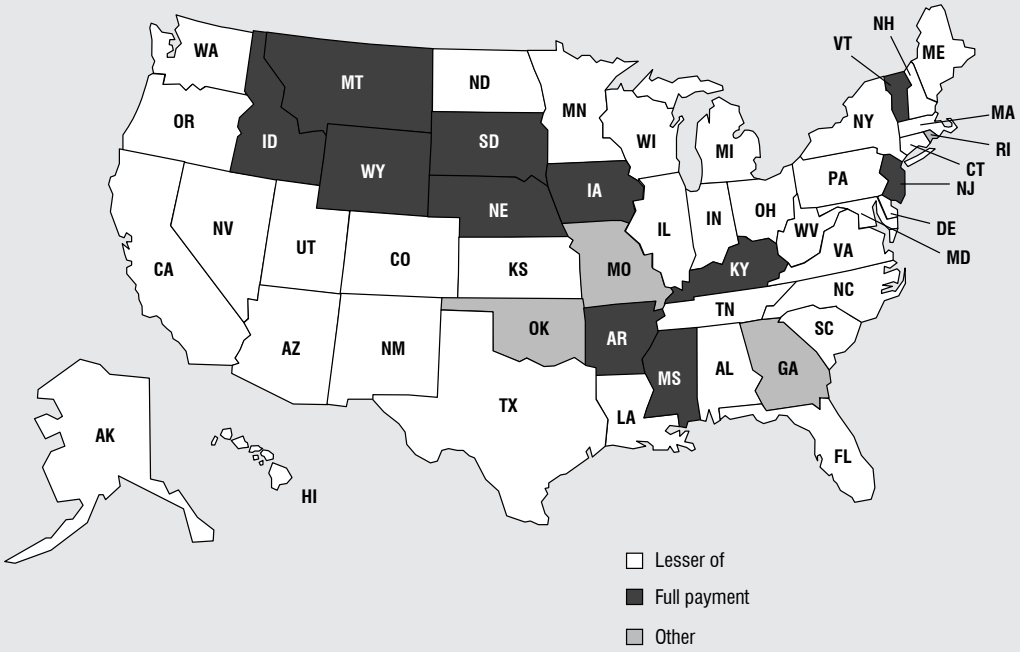
Source: Data collected by NORC at the University of Chicago for MACPAC. State-specific payment policy details and sources can be found at www.macpac.gov

FIGURE 4-2. Crossover Policies for Hospital Inpatient Services, by State, 2012



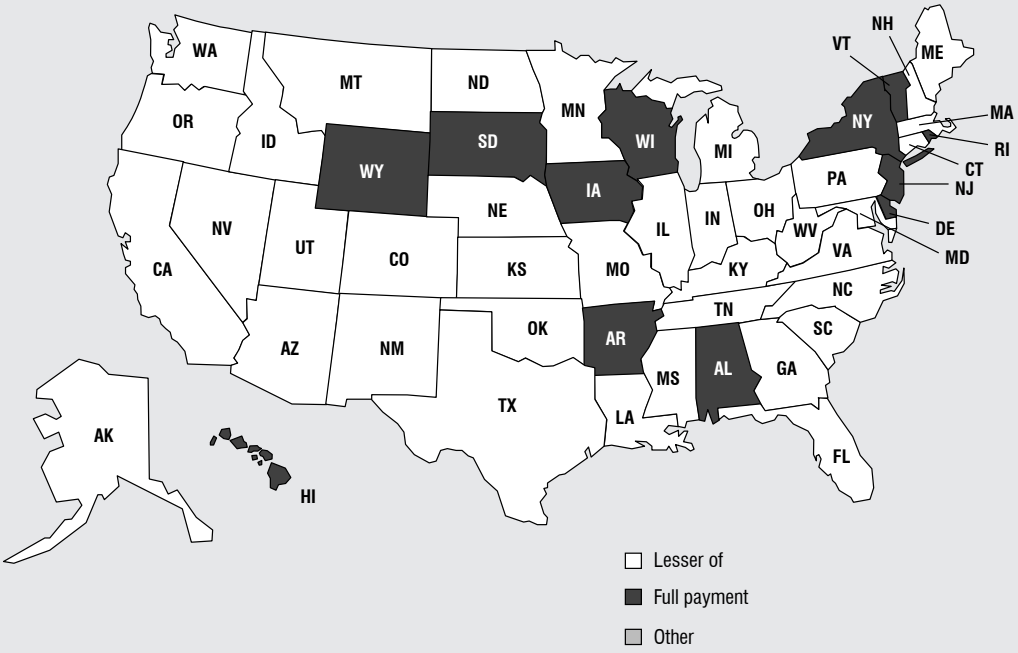
Source: Data collected by NORC at the University of Chicago for MACPAC

FIGURE 4-3. Crossover Policies for Hospital Outpatient Services, by State, 2012



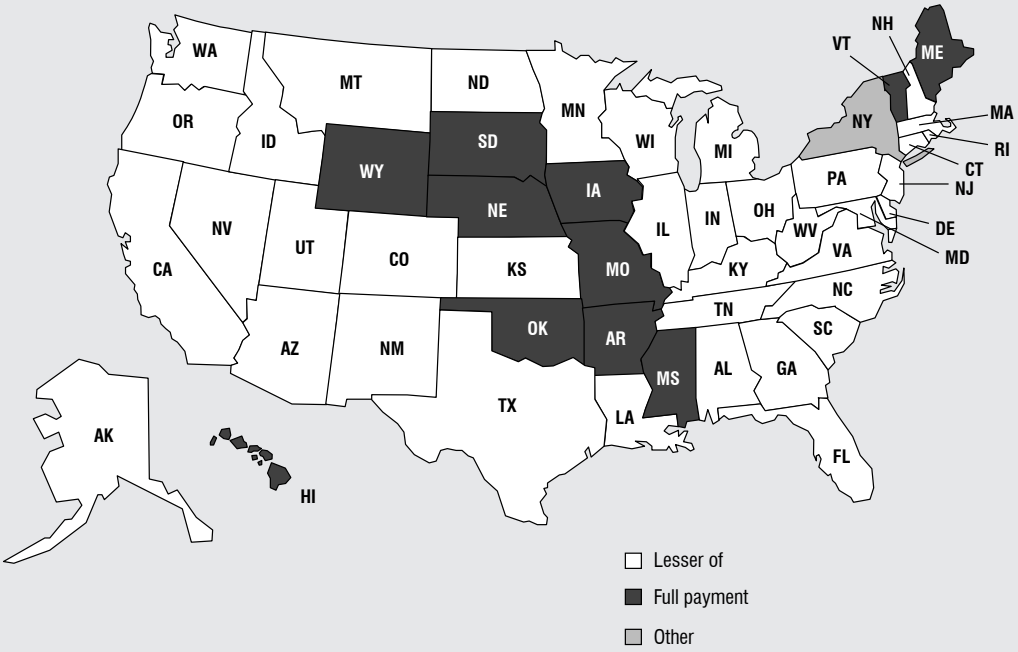
Source: Data collected by NORC at the University of Chicago for MACPAC

FIGURE 4-4. Crossover Policies for Skilled Nursing Facilities, by State, 2012



Source: Data collected by NORC at the University of Chicago for MACPAC

FIGURE 4-5. Crossover Policies for Physician Services, by State, 2012



Source: Data collected by NORC at the University of Chicago for MACPAC

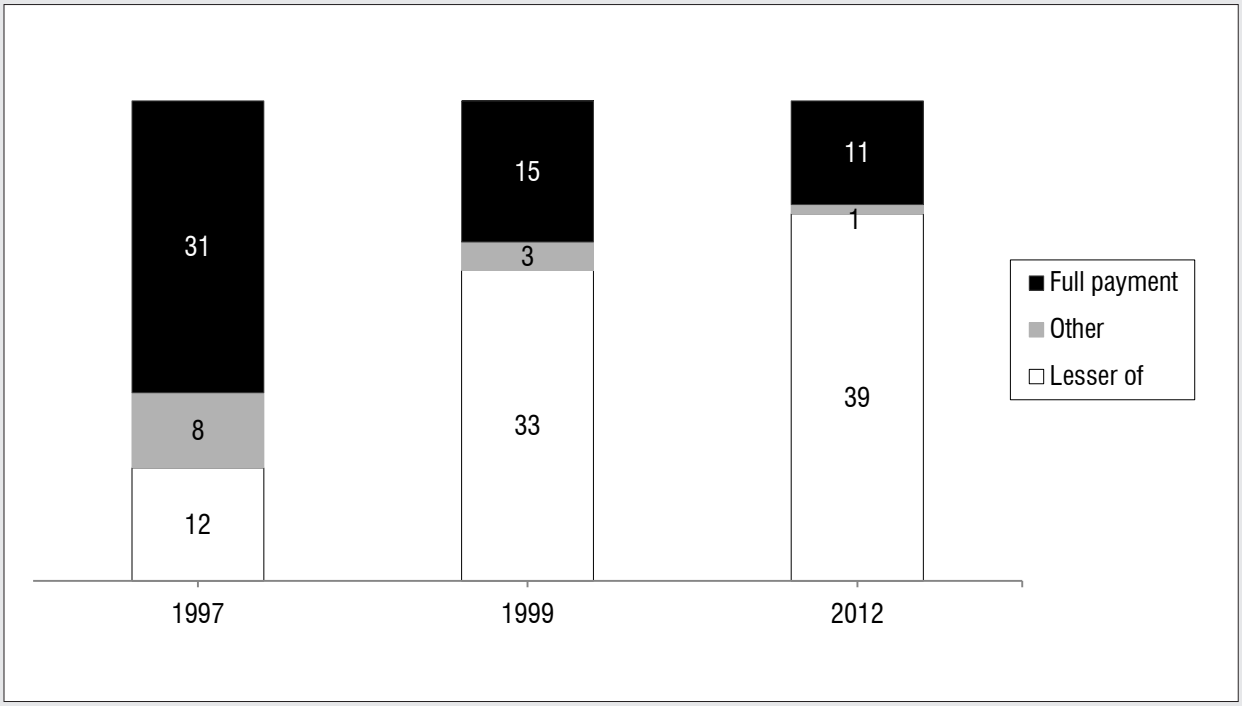
survey, 31 states reported paying the full amount of Medicare cost sharing; by 1999, the number had dropped to 15 states (Nemore 1999). Comparing these results with the results for physicians from this report, it appears that additional states have adopted lesser-of policies since 1999. However, the majority of states appear to have adopted their lesser-of policies in the two years after the BBA granted explicit statutory authority.

Medicare bad debt payment

The Medicare program reimburses certain providers (e.g., hospitals, SNFs) for a portion of the deductibles and coinsurance that cannot be collected from beneficiaries (42 CFR §413.89). These amounts, known as bad debt, include cost sharing for dual eligibles that is not paid by state Medicaid agencies as a result of lesser-of policies.[12] Providers paid based on reasonable charges or fee schedules, including physicians, are not eligible for bad debt payments (42 CFR 413.89(i)). Because the portion of cost sharing that is not paid by a state's crossover policy counts as bad debt, Medicare's bad debt policy has financial implications for providers serving individuals dually enrolled in Medicare and Medicaid.

For Medicare beneficiaries not enrolled in Medicaid, providers must make a reasonable effort to collect cost-sharing amounts before claiming them as bad debt. When an individual is also enrolled in Medicaid, however, providers are prohibited from attempting to collect Medicare's deductible or coinsurance from the enrollee. Thus, if a state does not cover Medicare's full cost sharing, the uncovered amount may be reimbursed as bad debt. As a result, providers may be able

FIGURE 4-6. State Crossover Payment Policies over Time, 1997–2012



Notes: 1997 and 1999 surveys did not specify provider type. Data shown for 2012 are for physicians.

Sources: 1997 and 1999 data are taken from surveys of State Medicaid Directors conducted by the National Senior Citizens Law Center and the Kaiser Family Foundation (Nemore 1999); 2012 data were collected by NORC at the University of Chicago for MACPAC

to recoup from Medicare a portion of the cost sharing that Medicaid programs do not pay.

Unpaid cost sharing from crossover claims may account for a substantial portion of bad debt. Nationwide, the American Hospital Association estimates that individuals dually enrolled in Medicaid and Medicare account for 20 percent of Medicare beneficiaries, but 55 percent of hospitals' Medicare bad debt (AHA 2011). The American Health Care Association estimates that dual eligibles account for nearly 94 percent of unpaid SNF copayments (AHCA 2012).

It appears that some states have considered providers' ability to recoup unpaid cost-sharing amounts through bad debt when deciding whether to implement lesser-of policies, and some make explicit mention of the availability of bad debt reimbursement from Medicare in explaining their policy. For example, Oklahoma's announcement of a change from a full-copay policy to a lesser-of policy for hospitals suggested that hospitals should look into Medicare's bad debt criteria (OHCA 2010).

Data limitations regarding Medicaid payment of Medicare coinsurance and deductibles

The total amount of Medicare cost sharing paid by the Medicaid program cannot be readily discerned from federal data sources. In some cases, cost-sharing amounts are reported on the Form CMS-64 expenditure report separately from other services, and in others it appears that cost-sharing payments are reported as payments for the underlying service (e.g., inpatient hospital, nursing facility). This may be particularly true in the case of cost sharing for non-QMB full-benefit dual eligibles. Instructions for the CMS-64 indicate that separate reporting is intended to capture cost-sharing amounts only for QMBs, but this may not be done consistently. There may also be cases where claims do not cross over automatically from the Medicare program, and providers must submit claims for cost-sharing amounts directly to the Medicaid program. In these cases, the claims may not always be reflected in federal claims data such as the Medicaid Statistical Information System.

Policy Implications

These findings raise several important issues regarding the interaction of Medicaid and Medicare payment policies, as well as the potential effects of these policies on enrollees' access to services. For one, Medicaid coverage of Medicare deductibles and coinsurance and Medicare bad debt payment result in shifting costs between the programs. For example, if states reduce their payment rates for hospitals and nursing facilities, Medicare bad debt payments increase. Conversely, if the Medicare program increases coinsurance requirements, then Medicaid spending, shared by the states and federal government, increases. Interactions are further complicated when dual eligibles are enrolled in Medicaid managed care plans or Medicare Advantage plans, in which case claims may not automatically cross over to the responsible payer.

The Medicare Payment Advisory Commission has previously raised these interactions and resultant cost shifting as issues (MedPAC 2004). At the same time, administrative resources to enroll individuals in MSP programs and process claims for premiums, deductibles, and coinsurance are also affected by state and federal coverage and payment policies.

The impact of state payment policies for Medicare cost sharing on beneficiary access to services is unclear. Both providers and beneficiary advocates contend that state Medicaid policies to limit payment of Medicare cost sharing leads to insufficient access to needed services for dual

eligibles. The ability of certain providers to recoup a portion of unpaid cost sharing through Medicare bad debt payment may mitigate the potential negative effects on access that might result from state policies that limit cost-sharing payments. However, physicians are not eligible for bad debt payment, and at least one study found that access to outpatient physician visits for dually eligible beneficiaries was reduced relative to non-dually eligible beneficiaries in states that limited their Medicare cost-sharing payment amounts (Thompson 2003).

While these findings are suggestive, a more complete understanding of the effect of state payment policies for Medicare cost sharing on access to health care services for dual eligibles would require information on the differences between Medicaid and Medicare payment rates in each state, the number of providers that serve dual eligibles, and the use of services among dual eligibles. Further research could also provide insight into the extent to which state policies to limit payment of deductibles and coinsurance affect total payments to providers. Understanding this effect would require additional information regarding the amount of unpaid cost sharing, by state and type of service.

Further, in many cases, state Medicaid payments for Medicare cost sharing will be affected by Medicaid primary care payment requirements in 2013 and 2014. Federal statute requires that, for these two years, Medicaid programs pay primary care physicians for primary care services at rates that are at least equal to Medicare (§1902(a)(13)(C) of the Act). As a result, even in the 41 states that limit their Medicare cost-sharing payments for physicians, primary care providers will receive the full amount of Medicare cost sharing for primary care services in 2013 and 2014.

The Commission will continue to explore the role that states play in assuring access to services for dual eligibles, including state enrollment policies and the effect of state Medicaid payment policies for Medicare cost sharing.

Endnotes

1 Figures are from a Mathematica Policy Research analysis of 2007 Medicare and Medicaid data for MACPAC and MACPAC analysis of CMS-64 Financial Management Report net expenditure data. The total amount of Medicare cost sharing paid by the Medicaid program can be difficult to discern from federal data sources because cost-sharing amounts are sometimes reported separately and other times reported as payments for the underlying service.

2 If the amount paid by Medicare exceeds the Medicaid rate, then these states make no additional payment for coinsurance or deductibles.

3 Medicare Part C (Medicare Advantage) is operated through Medicare-approved private insurance plans, includes all benefits and services covered under Part A and Part B, usually includes Medicare prescription drug coverage (Part D), and may include extra benefits and services. Beneficiaries enrolled in Part C plans are responsible for paying monthly Part B premiums and, depending on their chosen plan, may be responsible for a monthly premium to the Medicare plan, copayments, coinsurance, and deductibles.

4 Although much of the MCCA was repealed in the following year, the QMB program remained in law as section 1902(a)(10)(E) of the Social Security Act. Prior to the MCCA, Congress had enacted the Omnibus Budget and Reconciliation Act of 1986, which gave states the option to either offer Medicaid coverage of Medicare cost sharing or expand full Medicaid benefit coverage to low-income Medicare beneficiaries with incomes up to 100 percent FPL and resources not in excess of the SSI resource level. The option to expand full Medicaid benefits to those with incomes up to 100 percent FPL still exists, and currently, 22 states and the District of Columbia use this option (see MACStats Table 11).

5 Medicaid also pays the Part A premiums for a small number of QMBs. These are individuals who are required to pay Part A premiums because they do not have sufficient work history to quality for Social Security.

6 The QI program was most recently extended via the American Taxpayer Relief Act of 2012 (P.L. 112-240, §621) through December 2013.

7 States do not receive FFP for Part B premiums for non-MSP dual eligibles if the state elects this option (42 CFR §431.625(d)(1); see OIG 2012d). States also cannot receive FFP for covering services that could have been paid for by Medicare Part B if the eligible recipient had been enrolled in Medicare (§1903(b)(1)).

8 These estimates do not include individuals who are also eligible for full Medicaid benefits. Enrollment rates for full-benefit dual eligibles are estimated to be higher.

9 States may require QMBs to pay a small amount of cost sharing, consistent with the amounts paid by other (non-dual) Medicaid enrollees.

10 Medicaid enrollees in an institution, and certain enrollees receiving home and community-based waiver services, may be required to contribute a portion of any income to the cost of their Medicaid services. Their contribution is determined by subtracting from their income a personal needs allowance and allowances for a spouse or other dependents living in the community. Regulations regarding post-eligibility treatment of income can be found at 42 CFR 435.725–735, 435.832, and 436.832.

11 If states contract with managed care plans to cover their Medicare cost-sharing obligations, the capitation rate must take into account the payment levels specified in the Medicaid state plan and the methodology for determining the capitation rate must be part of the approved Medicaid state plan.

12 Bad debt is paid under fee-for-service Medicare only. CMS does not pay providers for the unpaid cost sharing of Medicare managed care plan members.

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