"Qualified Medicare Beneficiaries" (QMB) - Protections against "Balance Billing"

THE PROBLEM: Meet Joe, whose Doctor has Billed him for the Medicare Coinsurance

Joe Client is disabled and has SSD, Medicaid and Qualified Medicare Beneficiary (QMB). His health care is covered by Medicare, and Medicaid and the QMB program pick up his Medicare cost-sharing obligations. Under Medicare Part B, his co-insurance is 20% of the Medicare-approved charge for most outpatient services. He went to the doctor recently and, as with any other Medicare beneficiary, the doctor handed him a bill for his co-pay. Now Joe has a bill that he can't pay. Read below to find out --

1. May the provider bill consumer and does consumer have to pay?
2. How can consumer show a provider that they are a QMB
3. What can you or the consumer do if consumer is balance billed?
4. If consumer has QMB, how does the provider bill for the coinsurance?

    - 4a. How much will Medicaid pay for QMB coinsurance? - click here.

SHORT ANSWER:

QMB or Medicaid will pay the Medicare coinsurance only in limited situations. First, the provider must be a Medicaid provider. Second, even if the provider accepts Medicaid, under recent legislation in New York enacted in 2015 and 2016, QMB or Medicaid may pay only part of the coinsurance, or none at all. This depends in part on whether the beneficiary has Original Medicare or is in a Medicare Advantage plan, and in part on the type of service. However, **the bottom line is that the provider is barred from "balance billing" a QMB beneficiary for the Medicare coinsurance**. Unfortunately, this creates tension between an individual and her doctors, pharmacies dispensing Part B medications, and other providers. Providers may not know they are not allowed to bill a QMB beneficiary for Medicare coinsurance, since they bill other Medicare beneficiaries. Even those who know may pressure their patients to pay, or simply decline to serve them. These rights and the ramifications of these QMB rules are explained in this article.

CMS is doing more education about QMB Rights. The Medicare Handbook, since 2017, gives information about QMB Protections. Download the 2020 Medicare Handbook here. See pp. 53, 86.

1. May the Provider 'Balance Bill" a QMB Benficiary for the Coinsurance if Provider Does Not Accept Medicaid, or if Neither the

Patient or Medicaid/QMB pays any coinsurance?

No. Balance billing is banned by the Balanced Budget Act of 1997. 42 U.S.C. Â§ 1396a(n)(3)(A).

In a Medicare Learning Network Fact Sheet titled "*Prohibition on Billing Qualified Medicare Beneficiaries*" (MLN7936176, previously No. SE1128) updated in October 2024, the federal Medicaid agency CMS repeated the longstanding rule:

All Medicare providers and suppliers, including pharmacies, must not bill Medicare beneficiaries in the
Qualified Medicare Beneficiary (QMB) eligibility group for Medicare Part A or Part B cost-sharing. This
includes Medicare Part A and Part B deductibles, coinsurance, and copayments.

This rule was previously stated many times -- see Informational Bulletin issued January 6, 2012. Even if the provider is not registered as a Medicaid provider, or if Medicaid fails to pay all or part of the deductible or coinsurance, they still may not bill a QMB beneficiary. If the provider wants Medicaid to pay the coinsurance, then the provider must register as a Medicaid provider under the state rules. This is a change in policy in implementing Section 1902(n)(3)(B) of the Social Security Act (the Act), as modified by section 4714 of the Balanced Budget Act of 1997, which prohibits Medicare providers from balance-billing QMBs for Medicare cost-sharing.

The 2024 CMS MLN Fact Sheet makes a few important points (which are not new but gathered in one place):

- The same protections apply to QMB beneficiaries who are in **Medicare Advantage** plans. The provider may not bill them for cost-sharing including the standard plan copayment.
- The provider "may be subject to **sanctions** if you don't follow QMB billing prohibitions (even
  when Medicaid pays nothing)."
- The fact sheet explains **how a provider can determine if a patient is a QMB** (page 2 under "How to Ensure Compliance." See more below on how to show one is a QMB.
- The provider must "Recall any bills for QMB Medicare cost-sharing or bills you turned over to collections" and "Refund any collected QMB cost-sharing money to the QMB."

Traveling out of state - Not mentioned in the 2024 bulletin, but the 2018 version of MLN Bulletin No. SE1128 states rights when travel out of state --"Individuals enrolled in the QMB program keep their protection from billing when they cross State lines to receive care. Providers and suppliers cannot charge individuals. enrolled in QMB even if their QMB benefit is from a different State than the State where they get care."

See also CMS Medicare Learning Network MLN 006977 -- Fact Sheet - Beneficiaries Dually Eligible for Medicare and Medicaid (rev. June 2024)

See more info at New Federal Resources to Address Improper Billing of Low-Income Medicare Enrollees -National Center on Laaw and Elder Rights

2. How do QMB Beneficiaries Show a Provider that they have QMB and cannot be Billed for the Coinsurance?

CMS had updated its systems to make it easier for a provider to identify QMB status. Different methods for identifying QMB status are listed in the October 2024 Medicare Learning Network Fact Sheet titled "*Prohibition on Billing Qualified Medicare Beneficiaries*" (MLN7936176):

- Using the HETS 270/271 system. Ask your third party eligibility-verification vendors how their products reflect the QMB information from HETS. See also Pub 100-04 Medicare Claims Processing. (April 2017).
- Accessing the Medicare Administrative Contractor (MAC) Online Provider Portal and MAC Interactive Voice Response (IVR) System. Each MAC offers its own online provider portal and IVR. Find your MAC's website to register for their portal or for more information on using their IVR.
- Reviewing the provider **Medicare Remittance Advice (RA)** notices and beneficiary **Medicare Summary Notices (MSNs)** - both of which now indicate QMB status and tell provider they may not bill. CMS MLN Matters No. MM 11230 (rev. July 9, 2019) - *Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the QMB Program;* CMS MLN Matters Number 10433 (PDF) - *Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims (rev. July 2, 2018)(*
- Using automated **Medicaid eligibility-verification systems in the state** where the person lives.

    - ♦ NYS NOTE: Info for providers checking Medicaid eligibiluity system (GIS 16 MA/005 - Changes to eMedNY for Certain Medicaid Recipient Coverage Codes (PDF)
    - ♦ Recipient Coverage Code "09" is defined as "Medicare Savings Program only" (MSP) and is used along with an eMedNY Buy-in span and MSP code of "P" to define a Qualified Medicare Beneficiary (QMB).
    - ♦ Providers will receive the following eligibility messages when verifying coverage on EMEVS and ePaces:

      "Medicare coinsurance and deductible only" for individuals with Coverage Code 06 and an MSP code of P. *Code 06 is "provisional Medicaid coverage" for Medicaid recipients found provisionally eligible for Medicaid, subject to meeting the spend-down. See more about provisional coverage here.

"Family Planning Benefit and Medicare Coinsurance and Ded" for individuals with Coverage Code 18 and an MSP code of P. "Code 18" is for Medicare beneficiaries who are enrolled in the Family Planning Benefit Program (FPBP), who are also income eligible for QMB.

- PHARMACIES -

    - ♦ Using the Medicare Eligibility Verification transaction (E1 transaction) for pharmacies.
    - ♦ Pharmacy providers may submit request E1 transactions and receive a real-time response that includes Medicare Part A, B and D enrollment information.
- Asking individuals for other proof, like their Medicaid identification card, Medicare Summary Notice, or other QMB status documentation.

    - ♦ **NYLAG note re Medicaid cards in NYS:** Unfortunately, the Medicaid ID card does not indicate QMB status. THe same card is used for Medicaid and QMB - so a provider can't tell QMB status from the card. However, Medicare Summary Notices should have this indicator, and you should have received a Notice from your local Medicaid agency approving QMB.
    - ♦ Advocates have asked NYS and NYC Medicaid agencies for a special QMB card, or a notation on the Medicaid card to show that the individual has QMB. See this Report - a National Survey on QMB Identification Practices published by Justice in Aging, authored by Peter Travitsky, NYLAG EFLRP staff attorney. The Report, published in March 2017, documents how QMB beneficiaries could be better identified in order to ensure providers do not bill them improperly.
- Contacting the Medicare Advantage (MA) Plan, if you're an MA provider or supplier, to learn the best way to identify the QMB status of plan members both before and after claims submission.

Also -- Consumers can now call 1-800-MEDICARE to verify their QMB Status and report a billing issue. If a consumer reports a balance billng problem to this number, the Customer Service Rep can escalate the complaint to the Medicare Administrative Contractor (MAC), which will send a compliance letter to the provider with a copy to the consumer. See CMS Medicare Learning Network Bulletin effective Dec. 16, 2016.

Read more about QMB Balance Billing protections iat webpage of National Center on Law & Elder Rights --New Federal Resources to Address Improper Billing of Low-Income Medicare Enrollees (2024)

3. If you are Billed -â Strategies and More Info

- **Consumers may call 1-800-MEDICARE** (TTY users can call 1-877-486-2048). **to report a billing issue.** If a consumer reports a balance billng problem to this number, the Customer Service Rep can escalate the complaint to the Medicare

Administrative Contractor (MAC), which will send a compliance letter to the provider with a copy to the consumer. See CMS Medicare Learning Network Bulletin effective Dec. 16, 2016.

- **Send a letter to the provider,** using the Justice In Aging Model model letters to providers to explain QMB rights.â â â both for Original Medicare (Letters 1-2) and Medicare Advantage (Letters 3-5) - see Overview of model letters . Include a link to the CMS Medicare Learning Network Notice: Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program (revised June 26. 2018)
- **File a complaint with the federal Consumer Finance Protection Bureau (CFPB)**, which issued this guide to QMB billing (2017(A consumer who has **a problem with debt collection,** may submit a complaint online or call the CFPB at 1-855-411-2372. TTY/TDD users can call 1-855-729-2372.

    - ♦ See a joint statement from CMS and CFPB that reminds **debt collectors** that debt resulting from improper billing should not be collected and should not be used to tarnish an individual's credit scores, according to federal law.
- **Medicare Advantage members** should complain to their Medicare Advantage plan. In its 2017 Call Letter, CMS stressed to Medicare Advantage contractors that federal regulations at 42 C.F.R. Â§ 422.504 (g)(1)(iii), require that provider contracts must prohibit collection of deductibles and co-payments from dual eligibles and QMBs.
- â â In July 2015, CMS issued a report, "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB's)" documenting how pervasive illegal attempts to bill QMBs for the Medicare coinsurance, including those who are members of managed care plans.
- Justice in Aging, a national advocacy organization, part of the National Center on Law & Elder Rights, webpage New Federal Resources to Address Improper Billing of Low-Income Medicare Enrollees (2024). to educate beneficiaries about balance billing and to advocate for stronger protections for QMBs.
- The Medicare and You Handbook 2025 has, since 2017, included information about QMB Protections. See pp. 59, 91.

4. How Does a Provider that DOES accept Medicaid Bill for a QMB Beneficiary?

In order to bill Medicaid for coinsurance, "Providers must enroll as Medicaid providers in order to bill Medicaid for the Medicare coinsurance." CMS Informational Bulletin issued January 6, 2012, titled "*Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs).* The CMS bulletin states, "If the provider wants Medicaid to pay the coinsurance, then the provider must register as a Medicaid provider under the state rules." If the provider chooses not to enroll as a Medicaid provider, they still may not "balance bill" the QMB recipient for the coinsurance.

If beneficiary has Original Medicare --

The provider bills Medicaid - even if the QMB Beneficiary does not also have Medicaid. Medicaid is required to pay the provider for all Medicare Part A and B cost-sharing charges for a QMB beneficiary, even if the service is normally not covered by Medicaid (ie, chiropractic, podiatry and clinical social work care). Whatever reimbursement Medicaid pays the provider constitutes by law payment in full, and the provider cannot bill the beneficiary for any difference remaining. 42 U.S.C. Â§ 1396a(n)(3)(A), NYS DOH 2000-ADM-7

- See CMS Medicare Learning Network (MLN) Article: "Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles): At a Glance" (2020)

If the QMB beneficiary is in a Medicare Advantage plan -

The provider bills the Medicare Advantage plan, then bills Medicaid for the balance using a "16" code to get paid. The provider must include the amount it received from Medicare Advantage plan.

- NYS Provider questions about QMB billing and eligibility should be directed to the Computer Science Corporation 1-800-343-9000

4a. For a Provider who accepts Medicaid, How Much of the Medicare Coinsurance will be Paid for a QMB or Medicaid Beneficiary in NYS?

The answer to this question has changed by laws enacted in 2015 and 2016. In the proposed 2019 State Budget, Gov. Cuomo has proposed to reduce how much Medicaid pays for the Medicare costs even further. The amount Medicaid pays is different depending on whether the individual has Original Medicare or is a Medicare Advantage plan, with better payment for those in Medicare Advantage plans. The answer also differs based on the type of service.

1. **Part A Deductibles and Coinsurance** - Medicaid pays the full Part A hospital deductible ($1,408 in 2020) and Skilled Nursing Facility coinsurance ($176/day) for days 20 - 100 of a rehab stay. Full payment is made for QMB beneficiaries and Medicaid recipients who have no spend-down. Payments are reduced if the beneficiary has a Medicaid spend-down. For in-patient hospital deductible, Medicaid will pay only if six times the monthly spend-down has been met. For example, if Mary has a $200/month spend down which has not been met otherwise, Medicaid will pay only $164 of the hospital deductible (the amount exceeding 6 x $200). See more on spend-down here.
2. **Medicare Part B** -

    1. **Deductible** - Currently, Medicaid pays the full Medicare approved charges until the beneficiary has met the annual deductible, which is $198 in 2020. For example, Dr. John charges $500 for a visit, for which the Medicare approved charge is $198. Medicaid pays the entire $198, meeting the

deductible. If the beneficiary has a spend-down, then the Medicaid payment would be subject to the spend-down.

◊ In the 2019 proposed state budget, Gov. Cuomo proposed to reduce the amount Medicaid pays toward the deductible to the same amount paid for coinsurance during the year, described below. This proposal was REJECTED by the state legislature.

2. **Co-Insurance -** The amount medicaid pays in NYS is different for Original Medicare and Medicare Advantage.

◊ **If individual has Original Medicare**, QMB/Medicaid will pay the 20% Part B coinsurance only to the extent the total combined payment the provider receives from Medicare and Medicaid is the lesser of the Medicaid or Medicare rate for the service. For example, if the Medicare rate for a service is $100, the coinsurance is $20. If the Medicaid rate for the same service is only $80 or less, Medicaid would pay nothing, as it would consider the doctor fully paid = the provider has received the full Medicaid rate, which is lesser than the Medicare rate.

Exceptions - Medicaid/QMB wil pay the full coinsurance for the following services, regardless of the Medicaid rate:

- ambulance and psychologists - The Gov's 2019 proposal to eliminate these exceptions was rejected.
- hospital outpatient clinic, certain facilities operating under certificates issued under the Mental Hygiene Law for people with developmental disabilities, psychiatric disability, and chemical dependence (Mental Hygiene Law Articles 16, 31 or 32).

SSL 367-a, subd. 1(d)(iii)-(v) , as amended 2015

- **If individual is in a Medicare Advantage plan, 85% of the copayment** will be paid to the provider (must be a Medicaid provider), regardless of how low the Medicaid rate is. This limit was enacted in the 2016 State Budget, and is better than what the Governor proposed - which was the same rule used in Original Medicare -- NONE of the copayment or coinsurance would be paid if the Medicaid rate was lower than the Medicare rate for the service, which is usually the case. This would have deterred doctors and other providers from being willing to treat them. SSL 367-a, subd. 1(d)(iv), added 2016.

EXCEPTIONS: The Medicare Advantage plan must pay the full coinsurance for the following services, regardless of the Medicaid rate:

- ambulance)
- psychologist) The Gov's proposal in the 2019 budget to eliminate these exceptions was rejected by the legislature

Example to illustrate the current rules. **T**he Medicare rate for Mary's specialist visit is $185. The Medicaid rate for the same service is $120.

- **Current rules (since 2016)**:
  - **Medicare Advantage -**- Medicare Advantage plan pays $135 and Mary is charged a copayment of $50 (amount varies by plan). Medicaid pays the specialist 85% of the $50 copayment, which is $42.50. The doctor is prohibited by federal law from "balance billing" QMB beneficiaries for the balance of that copayment. Since provider is getting $177.50 of the $185 approved rate, provider will hopefully not be deterred from serving Mary or other QMBs/Medicaid recipients.
  - **Original Medicare** - The 20% coinsurance is $37. Medicaid pays none of the coinsurance because the Medicaid rate ($120) is lower than the amount the provider already received from Medicare ($148).
  - For both Medicare Advantage and Original Medicare, if the bill was for a **ambulance or psychologist**, Medicaid would pay the full 20% coinsurance regardless of the Medicaid rate. The proposal to eliminate this exception was rejected by the legislature in 2019 budget. .

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