

Frequently Asked Questions: Dual Eligible Older Adults

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If an individual has full-scope Medicaid, why would they also enroll in QMB?

Very simple: enrollment into the QMB (Qualified Medicare Beneficiary) program offers important protections and assistance beyond what Medicaid alone provides. The QMB program is targeted to the lowest income individuals (100% FPL) and therefore offers the most comprehensive benefit. As a QMB enrollee, Part A and B premiums are paid for, as well as all Medicare deductibles, co-pays, and co-insurance. **In addition, Medicare providers cannot charge QMBs for any amounts beyond what Medicare and Medicaid pay; QMBs are protected from improper billing under federal law.**¹ For many low-income seniors who have multiple chronic conditions, the QMB program protects them from being liable for hundreds of dollars of co-insurance each month that would otherwise be impossible to pay. Importantly, QMB also qualifies the individual for “Extra Help,” or the **“Low-Income Subsidy” to help pay for Medicare Part D’s prescription drug costs.** Practitioners should take care to ensure all Medicare beneficiaries who meet the Medicare Savings Program (MSP) eligibility criteria, especially SSI recipients, apply for MSP with the State Medicaid agency. Many individuals mistakenly believe they are enrolled in an MSP because Medicaid is paying for their premiums. Practitioners should verify enrollment with the State Medicaid agency or through 1-800-MEDICARE.

Is the quarterly enrollment change only applicable for Medicare? (i.e. someone can’t change their Medicaid managed care plan quarterly as well)?

Correct. The quarterly enrollment change is only related to the Medicare Advantage or Part D prescription drug plan. It does not affect how frequently someone can change Medicaid plans, which varies state to state.

Can you clarify about the dual protections and providers refusing treatment? My understanding was that if they have Medicare and the provider accepts that Medicare, then they cannot deny the patient despite Medicaid?

A dual eligible client likely has federal and/or state protections against treatment refusal. Three things to consider:

- *Is the client enrolled in Original Medicare, also known as fee for service Medicare?* For individuals enrolled in Fee-for-Service, with freedom of contract protections, Medicare providers have a right to see whatever beneficiaries they want to see (provided they are not discriminating), just like Medicare beneficiaries can see whatever provider they want to.
- *Is the client enrolled in a Medicare Advantage plan?* Federal law requires providers contracted with a Medicare Advantage plan to treat dual eligibles. **There is a Medicare Advantage rule which says**

¹ 42 U.S.C. sec. 1396a(n)(3)(B). Federal regulations apply this protection to Medicare Advantage enrollees. 42 C.F.R. sec. 422.504(g)(1)(iii).

providers cannot discriminate on a number of bases, including method of payment.² This explicitly includes Medicaid. A Medicare Advantage provider cannot refuse to treat a Medicare beneficiary simply because of their Medicaid status. If this is happening to a client, the client has a right to file a grievance with the Medicare Advantage plan. We suggest [reaching out to a local SHIP program](#) and working with them to file a complaint in the complaint tracking module.

- *Does your state Medicaid law protect against stopping treatment?* If the the above protections do not apply, the client may still be protected by state laws, either in the code governing the professional conduct of physicians or elsewhere. Many state laws prohibit medical providers from dropping beneficiaries during a course of treatment. Check your state protections.

What transportation services does Medicaid offer that Medicare does not?

Medicare does not generally offer transportation to get routine health care. The Medicare transportation benefit is limited to emergency transport or in circumstances in which non-emergency travel is required by ambulance because of a health condition. Some Medicare Advantage plans (Medicare Part C) may offer additional services or expanded transportation coverage. On the other hand, federal regulations require state Medicaid plans to ensure necessary transportation for recipients to and from providers and to describe the methods that the state Medicaid agency will use to meet this requirement.³ Further regulations require that transportation include expenses for transportation and other related travel expenses determined to be necessary by the state Medicaid agency to secure medical examinations and treatments for a Medicaid beneficiary.⁴ States are required to provide transportation to and from services for individuals who receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.⁵ Please see the [Medicaid and Transportation for Older Adults](#) Chapter Summary for more information.

What protections does a dual eligible have against improper billing?

Any QMB individual should never be charged for services covered under Medicare Part A or B. This is true even if the beneficiary receives services in a Medicare Advantage plan. Duals who are not enrolled in QMB may also be protected from billing for covered services under state law. Justice in Aging's [Improper Billing Toolkit](#) has a full bank of resources to help clients who are being improperly billed. Please see the toolkit for Model Letters to send to providers and guidance from the Centers for Medicare and Medicaid Services to inform providers of their responsibility.

How do we know if a client qualifies for QMB?

You can call 1-800-MEDICARE with the client. 1-800-MEDICARE's customer service representatives can check whether a Medicare beneficiary is enrolled in the QMB program. Also, if the client is in Original Medicare, ask the client to bring in their latest Medicare Summary Notice (MSN), documents sent every quarter outlining Medicare costs for the period. MSNs for QMBs now include language advising the individual of their QMB status and related billing protections. Providers, too, have ways to find out if the beneficiary is in the QMB program. In the [HIPAA Eligibility Traction System \(HETS\)](#), CMS has included a QMB indicator which allows Medicare providers, when they are checking Medicare eligibility, to also see the person is enrolled in the QMB program.

2 Medicare Managed Care Manual, Ch. 4, Sec. 10.5.2.

3 42 C.F.R. sec. 431.53.

4 42 C.F.R. sec. 440.170(a).

5 42 C.F.R. sec. 441.56(a).

I don't understand the difference between D SNP and MMP, could you explain?

A D-SNP is a type of Medicare Advantage (MA) plan that only is available for enrollment to dual eligibles. D-SNPs can define exactly what types of dual eligibles are allowed to enroll. A D-SNP has to meet certain requirements that traditional MA plans do not; for example, they must have a contract with the state Medicaid agency. Additional regulations have recently been released that clarify a D-SNP's responsibility to coordinate with Medicaid. However, if a state Medicaid agency requires enrollment in Medicaid managed care, duals who enroll in a D-SNP still must enroll in a separate Medicaid plan.

In those states where it is available, a Medicare-Medicaid Plan (MMP) combines both Medicare and Medicaid benefits under one health plan and is supposed to offer care coordination across the continuum of care. By virtue of its benefit package, only full benefit dual eligibles can enroll into a MMP. Enrolling into one plan that handles all healthcare benefits in theory should allow the plan to more easily deliver appropriate, person-centered care. MMPs only operate in California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas.

Can you be enrolled in Medicare, QMB, and Medicaid at the same time?

Yes. Medicare and Medicaid are separate health insurance programs with separate benefit packages. When a benefit is covered by both, Medicare is primary and Medicaid only pays after Medicare pays. QMB is a Medicare Savings Program that helps low-income Medicare beneficiaries with incomes at or below 100% FPL and who meet the qualifying resources limits by paying for Medicare cost-sharing and protecting the individual from being billed for that cost-sharing.