DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Financial Management & FFS Operations

[redacted]

February 4, 2010

[redacted]

Dear [redacted]

This concerns your patient, [redacted] who received a bill from you for $96.48 on December 18, 2008. [redacted] is entitled to Medicare, and is also a Medicaid recipient in the District of Columbia. You may not collect from [redacted] any amount other than the Medicare payment amount.

[redacted] is a type of dual eligible Medicare/Medicaid recipient referred to in Medicaid law as a "Qualified Medicare Beneficiary" (QMB), defined at Section 1905 (p) (1) of Title XIX of the Social Security Act. We have been contacted by the Legal Aid Society of the District of Columbia to help clarify Medicare policy concerning beneficiaries who are dual eligible under the Medicare and Medicaid programs.

Title XVIII of the Social Security Act in Section 1848 (g) (3) (A) "Limitation on Charges for Medicare Beneficiaries Eligible for Medicaid Benefits" indicates the following:

"Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in Section 1905 (p) (1) ) with respect to such services under a State plan approved under title XIX may only be made on an assignment-related basis and the provisions of Section 1902 (n) (3) (A) apply to further limit permissible charges under this section."

Section 1866 (a) (1) requires that any provider that enrolls in Medicare must not impose any charge prohibited under section 1902 (n) (3). Section 1902(n)(3) expands on Medicare cost-sharing payment limitations allowed to State Medicaid programs, as set out in Section 1902(n)(2): "A State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary."

This allows states to take the amount paid under title XVIII into account when determining what, if any, payment will be made on the Medicare cost-sharing amount. Those requirements at 1902 (n) (3) indicate that when the Medicaid payment has been reduced or eliminated (as it was for [redacted], the amount paid by Medicare and the amount paid (if any) by Medicaid shall be considered payment in full. Even though there is no Medicaid payment for [redacted] Medicare's payment is payment in full. Inappropriate attempts to collect from [redacted] amounts in excess of Medicare's payment could result in sanctions and civil monetary penalties at Title 18 Section 1842 (j) (2).

If you have questions concerning this letter, please do not hesitate to contact Mark Vogel of my staff at 215-861-4323.

Sincerely,

John David Smith
Manager, Medicare Operations Branch

Cc: Ted Gallagher, Division of Medicaid and Children's Health
Barbara Williamson, Program Management Branch