COMMISSIONS, BOARDS AND INSTITUTIONS: ADMINISTRATIVE PROCESS ACT.

Effective date—July 1, 1998—of change in reimbursement policy for Medicare cost sharing for QMBs is consistent with Administrative Process Act and 1998 Appropriation Act. Interpretation by Department of Medical Assistance Services that changes made by federal Balanced Budget Act of 1997 apply to QMBs, as currently defined, is consistent with position of Health Care Financing Administration. Department was authorized to change state policy allowing use of Medicaid rates to determine its payment responsibility for deductibles and coinsurance for QMBs.

The Honorable Jane H. Woods

Member, Senate of Virginia

January 18, 1999

You ask several questions regarding a June 30, 1998, memorandum from the acting director of the Department of Medical Assistance Services (the "Department") to participating providers billing Medicare for Parts A and B ("Medicaid memo" or "memorandum"). The Medicaid memo announces a change to the Virginia Medicaid Policy. Your questions relate primarily to the basis for the determination of the effective date of the changes and for the inclusion of certain recipients in the changes.

The purpose of the Medicaid memo is to inform providers of changes in the way Medicaid will reimburse coinsurance, effective for services on and after July 1, 1998, for dual eligibles and qualified Medicare beneficiaries. "Dual eligibles" are those persons who are eligible for both Medicare and Medicaid coverage. "Qualified Medicare beneficiaries" ("QMBs"), as originally defined, "included persons eligible for Medicare and who met certain statutory requirements of poverty, but who did not meet a state’s eligibility requirement for Medicaid." As discussed below, the definition of QMBs has changed to include both QMBs as originally defined and dual eligibles.

The Medicaid memo provides that, for nursing facilities, the Department will limit its coinsurance payments to the Medicaid, instead of the Medicare, maximum payment allowed and that the combined Medicare and Medicaid payments will not exceed the Medicaid per diem rate for the nursing facility in which the Medicare/Medicaid recipient resides. In addition, nursing facilities cannot collect more than the Medicaid per diem payment and must return any excess patient pay to the recipient. The memorandum further provides that, for Part B services, Medicaid payment for Medicare coinsurance will be limited to the difference between Medicaid’s maximum fee for a procedure and 80 percent of Medicare’s allowance.

You ask first what regulatory basis supports the determination stated in the memorandum that the change in reimbursement policy for Medicare cost sharing for QMBs is on July 1, 1998. July 1, 1998, is the date on which emergency regulations that changed the Department’s reimbursement policy regarding QMBs and dual eligibles became effective. The effective date is consistent with the provisions of the Administrative Process Act. Under § 9-6.14:9(B) of the Code of Virginia, a portion of the Administrative Process Act, an emergency regulation filed in accordance with § 9-6.14:4.1(C)(5) of the Act "become[s] operative upon its adoption and filing with the Registrar of Regulations, unless a later date is specified." Section 9-6.14:4.1(C)(5) provides that a regulation which an agency finds necessitated by an "emergency situation" is excluded from the public participation and other procedural requirements of Article 2 of the Act. Section 9-6.14:4.1(C)(5) defines "emergency situation" to include "a situation in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation shall be effective in 280 days or less from enactment of the law or the appropriation act."
The emergency regulations were enacted under a mandate by the General Assembly included in the 1998 Appropriation Act as Item 335. Item 335(O) provides:

As authorized by section 4714 of the Balanced Budget Act of 1997 and section 1902 (a) (10) of the Social Security Act, or other applicable federal law, payments for Medicare Part A and Part B coinsurance for Medicaid covered services for all dual eligibles, including but not limited to Qualified Medicare Beneficiaries, shall be calculated based on the Medicaid rate. The State Plan and all necessary regulations shall be amended accordingly and shall be effective within 280 days of enactment of this provision.

The effective date of the change in the reimbursement policy is thus consistent with the Administrative Process Act and with the General Assembly mandate included in the 1998 Appropriation Act.

You ask also what basis the Department used in determining that dual eligibles are included in the proposed policy and whether this determination is in accordance with federal and state regulatory provisions. On August 5, 1997, the Balanced Budget Act of 1997 was signed into law by the President of the United States. Section 4714(a)(2) of the Balanced Budget Act states:

"In carrying out paragraph (1), 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 [subchapter] XVIII [of this chapter] for the service would exceed the payment amount that otherwise would be made under the State plan under this [subchapter] for such service if provided to an eligible recipient other than a Medicare beneficiary."

In addition, § 4714(a)(3) refers to "case[s] in which a State's payment for Medicare cost-sharing for a qualified Medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)."

In a letter to all state Medicaid directors, dated November 24, 1997, the Health Care Financing Administration ("HCFA") advised that the changes made by § 4714 apply to both categories of QMBs: QMBs without other Medicaid, or pure QMBs, and to QMBs with Medicaid, also known as dual eligibles. Thus, the Department interpretation that the changes made by § 4714 of the 1997 Balanced Budget Act applies to both pure QMBs and dual eligibles is consistent with the position of the HCFA.

Court decisions discussing QMBs also recognize that the designation embraces two sets of individuals: "Medicare eligibles who are also eligible for Medicaid benefits (i.e., dual eligibles) and Medicare eligibles who are not eligible for Medicaid benefits but who meet certain criteria of poverty (i.e., pure QMBs)." In the case of Paramount Health Systems, Inc. v. Wright, the Seventh Circuit discussed QMBs or "quimbies" in the context of § 4714 of the Balanced Budget Act. The court explained:

Quimbies are elderly or disabled persons who qualify for Medicare and who, in addition, either qualify by reason of their poverty for Medicaid as well, in which event they are called "dual eligibles," or, though not poor enough to qualify for Medicaid, cannot easily afford to pay the Medicare Part B premiums,
deductible, and copayments; these quimbies are called "pure quimbies."[20]

The court in *Paramount Health Systems* recognized that § 4714 was applicable to both "dual eligibles" and "pure quimbies" and also determined that § 4714 was retroactively applicable to claims of QMBs arising before passage of the Balanced Budget Act. The court held that § 4714 was a "clarification" of congressional intent and was effective as to claims arising before its passage that were the subject of the litigation.[21]

Based on these case decisions and the HCFA letter to state Medicaid directors, it is my opinion that § 4714 is applicable to both "dual eligibles" and "pure QMBs," and that the Department was authorized to change its regulation allowing the use of Medicaid rates to determine its payment responsibility for deductibles and coinsurance for both of the groups. The Department thus has conducted itself within both the letter and spirit of the applicable laws and regulations with respect to the policy change.[22]


2You include with your request a copy of the Medicaid memo, the subject of which is "Changes to the Virginia Medicaid Policy for Dually Eligible Medicaid/Medicare Recipients and Qualified Medicare Beneficiaries."


4See Rehabilitation Ass’n of Va. v. Kozlowski, 42 F.3d 1444, 1447 (4th Cir. 1994).

5Id.

6See id.

7The Medicaid memo explains "Medicaid per diem" as the Medicare payment plus the patient pay amount.

8The Medicaid memo provides the following example. If Medicare allows $10 for a procedure, 80% of the allowance is $8. If Medicaid allows $9 for the same procedure, Medicaid’s payment of the coinsurance would be limited to $1, the difference between the Medicaid allowance of $9 and the 80% amount of $8. In any event, the combined payment is not to exceed the Medicare or Medicaid allowance for the procedure, whichever is less.

Emergency regulations are effective for no more than 12 months. Section 9-6.14:4.1(C)(5). If the agency wishes to continue regulating the subject matter beyond this period, it is to promulgate a permanent regulation to replace the emergency regulation in accordance with the procedures set out in Article 2 of the Administrative Process Act. See id. The Department has initiated procedures under Article 2 to promulgate permanent final regulations to replace the emergency regulations.


State Plan Amendment 98-07, effective July 1, 1998, regarding the change in reimbursement, was approved on September 30, 1998. See letter from Claudette V. Campbell, Associate Regional Administrator, Division of Medicaid and State Operations, Region III Health Care Financing Administration, Department of Health & Human Services, to Mr. Dennis G. Smith, Director, Department of Medical Assistance Services, and enclosed Transmittal and Notice of Approval of State Plan Material.


You also question an apparent error of the Department in the processing of claims for payments made during the first 20 days of a patient stay in a nursing facility. I have been advised by the Department that it is in the process of correcting the error and that any payment due providers will be paid.