# Qualified Medicare Beneficiary Program Billing Requirements Call

**Moderated by: Leah Nguyen**
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summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

## Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this Medicare Learning Network call on the Qualified Medicare Beneficiary, or QMB, Program. During this call, CMS experts discuss the QMB billing requirements and their implications.

Find out about upcoming changes to the HIPAA Eligibility Transaction System and Remittance Advice to identify the QMB status of your patients and exemption from cost sharing. Also learn key steps to promote compliance.

Before we get started, you received a link to the presentation call materials in your confirmation email. These materials are available at the following URL, go.cms.gov/NPC. Again, that URL is go.cms.gov/NPC.

At this time, I'd like to turn the call over to Kim Glaun from the Medicare–Medicaid Coordination Office at CMS.

## Presentation

Kim Glaun: Hello. Thanks and good afternoon. Again, I'm Kim Glaun, and I work in the Medicare–Medicaid Coordination Office at CMS.

The purpose of today's call is to help you understand the billing requirements for patients enrolled in the Qualified Medicare Beneficiary Program, to learn about upcoming system changes that CMS is releasing around the Qualified Medicare Beneficiary Program and to discover key steps to promote compliance with billing requirements.

You'll see on slide 2 in the presentation that was included with your materials – slide 2 includes acronyms that we'll use during today's presentation. So, follow along.

The most important one to know is the one for the Qualified Medicare Beneficiary program. I will refer to this program as QMB and persons enrolled in it as QMBs. So, that's QMB for the Qualified Medicare Beneficiary program and the individuals who are enrolled in that program will be referred to as QMBs.

Also, the information we'll share today applies equally to all Medicare-enrolled physicians, providers, and suppliers. But for simplicity, during the presentation I will use the term "providers" to refer to the individuals and entities.

On slide 3, you'll see an overview of what we'll cover today. After initial background on the QMB program, I will discuss QMB billing requirements for providers. Then I will review state policies regarding Medicare cost sharing payments and their implications for providers.

Next I'll discuss problems regarding QMB billing and upcoming CMS system releases to address them. At that time, my colleague Ada Sanchez will join me to discuss important changes to the HIPAA Eligibility Transaction System, also known as HETS.

These systems are designed to help you identify the QMB status of your patients at the point of service. And finally, we'll recommend ways for providers to leverage these upcoming system releases and other steps to avoid billing errors.

## Background

So, turning to page 5, we thought we would start with some context for today's information. This slide highlights background about the QMB program. In 2015, about 7.2 million people were enrolled in QMB. That's about one in every eight Medicare beneficiaries.

QMBs are Medicare beneficiaries who receive Medicaid assistance to pay Medicare's costs. The QMB program is a state Medicaid benefit that assists low-income Medicare beneficiaries with Part A and B premiums and cost sharing. That includes deductibles, coinsurance, and copays.

Keep in mind that the purpose of QMB is to enable low-income Medicare beneficiaries to afford their Medicare coverage. With annual incomes of around $12,000, QMBs cannot afford to pay Medicare costs without foregoing other life's necessities.

On page – on the slide 7, we set forth the Federal requirements for all Medicare providers who serve QMBs. First and foremost, Medicare providers may not bill QMBs for Medicare's cost sharing under any circumstances. CMS's MLN article on QMB billing that is listed on this slide includes important clarifications about what the requirements mean in practice.

The QMB facts document that accompanies the materials for today's call also addresses common areas of confusion. For example, we remind providers that the QMB requirements apply to all Medicare providers and suppliers, including original Medicare and Medicare Advantage.

Also, all Medicare providers are bound by these requirements, even those who do not accept Medicaid. Additionally, keep in mind that the QMB billing requirements apply to all covered Part A and B services. With respect to prescription drugs, QMB cost sharing protections apply to Part B covered drugs.

That means pharmacies cannot charge QMBs Medicare cost sharing for Part B drugs. On the other hand, QMB protections do apply to Part D drugs. So, pharmacists may still collect low-income subsidy copayments from QMBs for Part D covered drugs.

## State Policies Regarding Medicare Cost-Sharing Program

On slide 9, we explain that Medicare providers can bill state Medicaid programs for QMB cost sharing amounts. And we encourage you to explore state processes to obtain Medicare cost sharing payments.

However, we want to mention two important caveats. First, as allowed under Federal law, many states have adopted policies that result in a reduction in the amount they pay for QMB cost sharing.

Second, to obtain Medicare cost sharing amounts that might be owed by the state, providers generally need to enroll as a Medicaid provider, although states should allow providers the ability to enroll in Medicaid for the limited purpose of obtaining Medicare cost sharing for QMB patients.

Regardless of the state policy, however, providers must remember that QMBs have no legal liability to pay Medicare providers for Medicare Part A or B cost sharing.

## QMB Billing Problems

So, despite the QMB billing rules, improper billing of QMBs persists.

The chart on slide 11 identifies common challenges with respect to QMB billing. These are based on the agency's 2015 study of beneficiary perspectives as well as input from providers, suppliers, and beneficiary groups.

First, as I said, unfortunately, we know that improperQMB  billing has been occurring. A main cause has been lack of awareness and confusion about the billing rules amongst providers and beneficiaries. Providers have told us that gaps in eligibility information make it difficult to identify the QMB status of their patients.

We believe that many billing errors happen simply because the provider does not know the patient is a QMB. With respect to beneficiaries, improper billing negatively impacts patients and their families.

In our 2015 study, most beneficiary participants said that they had paid improper charges either because they weren't aware of the billing protections, were too sick to contest the errors, or were worried about upsetting their provider and undermining their future access to treatment.

Other study participants reported experiencing distress when unpaid balances were referred to collection agencies. In general, study participants found billing processes very confusing and complex. They expressed frustration with billing processes and concerns about how their access to services might be impacted.

To address these problems, CMS has been working on a number of fronts to promote greater awareness of the QMB billing requirements among providers and patients.

In response to your request for help in identifying QMBs among your patients, CMS also analyzed our own systems for providers and found ways to improve the way we communicate QMB information.

In that regard, this fall we plan to roll out three new changes intended to simplify compliance with QMB billing rules and reduce administrative burdens for providers.

I will now turn things over to my colleague Ada Sanchez from the Center for Medicare to explain one of those changes. Ada will explain upcoming changes to CMS's' eligibility system, the HIPAA Eligibility Transaction System, or HETS, to include new information about the QMB status of your Medicare patients.

## Upcoming System Changes to Help Identify QMB Status

Ada Sanchez: Good afternoon. Thank you, Kim. My name is Ada Sanchez. I actually work for the Provider Communications Group.

I'm here today to discuss HETS and its upcoming changes for the implementation of the QMB data that will be available on the HETS Eligibility Transaction System.

HETS is actually – is the CMS system that releases the Medicare eligibility data to Medicare providers, suppliers, and authorized billing agents, including clearinghouses and third-party vendors, for the purpose of preparing accurate claims, determining beneficiary eligible – liability, or determining eligibility for a specific service. Effective November the 4th, HETS will be returning this information related to QMB.

It will be returning when exactly the beneficiary actually has enrolled within QMB program, and will actually let you know the financial information would not be applicable for the services rendered if that – if those services were rendered through the period of time when the beneficiary was actually enrolled in the QMB period.

They also will provide you, by the way, lifetime reserve date and next eligible date for eligible services, skilled nursing facilities dates, and hospital dates – that will be – also still be available for you through the transaction.

The only differences will be when the beneficiary is enrolled in the QMB program, it will be clearer to determine that deductibles and coinsurances will not be applicable for that particular patient during that period of time. And that's all I have to say for HETS, and I will return it back to Kim.

Kim Glaun: Thanks, Ada. So the HETS changes are intended to enable all Medicare-enrolled providers to readily identify their patients' QMB status at the point of service. And as I'll talk about later, we believe this can head off most billing errors in the first place from even occurring.

But now I'm going to turn to two additional system improvements around QMB billing that we'll also roll out this fall. On slide 14, we explain that CMS is also adding new QMB information to our Fee-for-Service systems on the back end once all Part A, B, and DME claims are processed.

Starting October 3rd, the Provider Remittance Advice will now identify a QMB's – a beneficiary's QMB status and provide detail on beneficiary liability, accurately reflecting zero liability for the period during which the beneficiary was enrolled in the QMB program. The technical details of these changes are explained in the MLN article included in the slide. But I will share some highlights now.

First, deductible and coinsurance amounts for claims for QMBs will generally report zero in any patient responsibility field. Instead, the group code "Other Adjustment" – also, the acronym for that is OA – will be used along with Claim Adjustment Reason Code, or known as CARC, 209.

The language of CARC 209 is included on the slide but basically alerts the provider to bill another payer for the cost sharing – in this case, Medicaid – instead of the patient. If the patient has been billed, the provider must refund the amounts collected.

Second, two new QMB-specific Remittance Advice Remark Codes, also known as RARCs, will be used. They're N781 for the deductible amounts and N782 for the coinsurance amounts.

And these codes explain that the patient can't be charged because he or she is a QMB, and the provider is asked to reconcile this information with any past billing. So we do ask you to use these codes in the remittance advice to understand whether or not you need to reconcile any past billing that has occurred.

So these changes will apply to the Electronic Remittance Advice – that's the 835 – for all Part A, B, and DME claims and also the Standard Remittance Advice, the paper version, for Parts B and DME claims.

As with the HETS changes, we do encourage third-party vendors and products to incorporate these changes upon their release and to alert providers about how you will be incorporating them into your products. For providers, we urge you to contact your third-party vendors and clearinghouses to ask them how they have incorporated this new QMB information if you have – or if you are using vendors.

So on slide 15, we discuss the last system change that will happen this fall. And it relates to changes in the Medicare Summary Notice. The Medicare Summary Notice is the quarterly summary sent to original Medicare beneficiaries that contains their claims and details the amounts patients owe for them. It's essentially original Medicare's version of the Explanation of Benefits or the EOB.

Starting on October 3rd, the Medicare Summary Notice CMS sends to beneficiaries will clearly identify when the beneficiary was enrolled in the QMB program and will accurately reflect the beneficiary's cost sharing liability. So that means $0 for the period they were enrolled in the QMB program.

On the next couple of slides, we've included a mock-up of the changes for a sample Part B MSN.

So on page 16, the MSN – features the first page of the MSN of – that you – that a beneficiary receives. And you can refer to the changes in blue font to see the changes that will affect QMBs.

So first, if a beneficiary is enrolled in QMB for at least one claim in the MSN, the MSN will display a different message under the "Be Informed!" heading to alert the beneficiary that he or she is a QMB. So you'll see that on the left side of the page 1 that's on the slide.

And, second, the "Total You May Be Billed" amount will not include deductible and coinsurance amounts for any QMB claims. In this mock-up the patient was a QMB for the entire period of the MSN, as is common. That's what happens for most QMBs. So, the "You May Be Billed" amount is $0.

Similarly, on slide 17, you will see that the MSN claim detail will not include deductible and coinsurance amounts for any QMB claims. In this mock-up, the patient was a QMB for the entire period of the MSN, as is – again, as is common.

And in this particular claim, that is the case. This person was a QMB. So the "Maximum You May Be Billed" is $0. In addition, a new Medicare Summary Notice message will appear in the Notes section that indicates the patient's QMB status.

## Steps for Providers To Promote Compliance

The last part of this presentation aims to distill the information we've shared so far into actionable steps for providers to promote compliance and avoid errors.

On page 19 of the slides, we list three steps that are recommended for providers to follow to promote compliance with the QMB rules. They're also included in the MLN article on this slide. And this is the same MLN article. So it's a really good reference because it includes – it's pretty comprehensive, explaining all of the changes we've been making and the QMB billing rules as well.

So these steps reflect promising practices and input from providers, administrators, and others that CMS has heard about since we have been reaching out to you all and beneficiary groups in the last few years.

First, given that identifying QMB status is key to ensure compliance, we do recommend that all providers establish processes to routinely identify the QMB status of all your Medicare patients before billing occurs. Given that one out of every eight Medicare beneficiaries might be a QMB, we think this makes a lot of sense for all of your practices.

Second, we recommend that providers institute procedures to make sure that office practices – your clearinghouses and other third-party vendors that you use – exclude QMBs from billing and fix problems if they do occur.

Third, as mentioned earlier, we recommend that providers explore state processes to seek Medicare cost sharing payments from Medicaid in your state.

In the next few slides, we provide more detail on what each of these recommended steps might entail. On slide 20, we drill down on the steps regarding identifying the QMB status of your Medicare patients.

So we do recommend that you do take steps to identify the QMB status of your patients prior to billing. And as we discussed, beginning November 4th, as Ada mentioned, providers and suppliers can use information provided by CMS's HETS system to verify a patient's QMB status and exemption from cost sharing at the point of service.

Then, starting on October 3rd, as I mentioned, once claims are processed, original Medicare providers and suppliers can look for QMB information in the Medicare Provider Remittance Advice as well.

If providers participate in Medicare Advantage plans, providers should also contact the Medicare Advantage plan to learn the best way to identify the QMB status of those plan members. Providers and suppliers may also look to other sources to verify a patient's QMB status. For example, providers can ask patients for their Medicaid ID cards or use state online Medicaid eligibility systems or other documentation provided by the state to verify QMB status.

Finally, providers may ask beneficiaries for a copy of their Medicare Summary Notice to verify their QMB status as of November 3rd – I mean – sorry – October 3rd.

On slide 21, we explain how we would -- do recommend that providers ensure that the billing procedures they use and the third-party vendor products exempts individuals enrolled in the QMB program for Medicare charges.

Providers can adopt measures to deduct billing errors should they occur. That could be – that is a promising practice that we recommend. The codes in the Remittance Advice can help you identify any billing errors and additional actions needed for reconciliation.

Additionally, providers should respond to outreach from MACs regarding QMB billing. MACs now send letters to providers – and those are the Medicare Administrative Contractors.

So I'm calling them MACs for short. The MACs now send letters to providers if 1-800-MEDICARE receives complaint about persistent billing errors. These letters identify the patient in question and asks the provider to review their billing records and resolve any billing problems that are found.

Remember, if you have erroneously billed an individual enrolled in the QMB program, recall the charges, including referrals to collection agencies, and refund the invalid charges the patient has paid.

Lastly, on slide 22, we reiterate that CMS does encourage providers to consider billing Medicaid agencies for Medicare cost sharing amounts. These processes do differ across states. So providers should research the billing processes that apply to seeking payment for Medicare cost sharing in your state. Keep in mind that different processes may apply to original Medicare and Medicare Advantage services.

For original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination and Recovery Center – that's BCRC – to automatically receive Medicare adjudicated claims. If a claim is automatically crossed over to another payer such as Medicaid, it is customarily noted on the Medicare Remittance Advice.

Also, as we mentioned earlier, to obtain payment for Medicare cost sharing, you will need to complete a state provider registration process and be entered into the state payment system to bill the state. But the state is required to permit you to enroll in Medicaid for the limited purpose of obtaining payments for QMB cost sharing amounts.

Before we open up things for questions, I want to point out some resources that we have listed on slide 24.

We created a webpage that is linked to on this page. It's a QMB program webpage. It has a range of information for different audiences, including providers, and we hope you will look at that webpage and use it as a resource.

## Question & Answer Session

Leah Nguyen: Thank you, Kim. We will now take your questions. As a reminder, this event is being recorded and transcribed. All right, Dorothy. We are ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity.

Once your line is open, state your name and organization. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

If you have more than one question, press star, one to get back into the queue, and we will address additional questions as time permits. Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster. Your first question comes from the line of Jackie Becker.

Jackie Becker: Hi. I'm wondering, could you clarify what you said about whether we can collect the Medicaid copays or not?

Kim Glaun: So – this is Kim Glaun – the issue about Medicaid copays has been a confusing one, we know. I might – whether you can collect them will depend on what your state allows in terms of its state plans.

So, if you – and it's a little bit fact-dependent. So if you want to email your question particularly to us at the QMB billing box that we have – it's on page 24 – we'll try to help you. But I think it might be just most efficient to do it that way.

Jackie Becker: Okay.

Kim Glaun: But please do email me about it.

Jackie Becker: Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Ana Deslongchamps.

Ana Deslongchamps: Hi. Good afternoon. I have a question regarding QMB patients who opt out of Medicare Part B. We often see patients in the hospital. The patients have Part A but, for some reason, they do not have Part B insurance.

So, of course, we cannot bill Medicare. And then when we bill Medicaid, Medicaid denies payment, stating that the member has Medicare. So we're having a big issue with these types of patients.

Leah Nguyen: Can you hold on for a moment?

Ana Deslongchamps: Yes. Sure.

Brian Pabst: Hi. It's Brian Pabst, CMS. In your scenario, is the person eligible for Medicaid even though the person doesn't have Part B?

Ana Deslongchamps: Yes, they are eligible for Medicaid. So they have Part A. For some reason, they do not sign up for Part B. And they do have Medicaid.

So, whenever we submit our professional claims, of course, those are covered under Part B. But the patient doesn't have Part B, you know. So we've tried billing Medicaid, and the Medicaid program states they will not make payment because the patient does not have Part B.

So, you know, we're not getting payment from Medicare, of course. We're not getting payment from Medicaid. So we are – we're trying to determine what is the correct course of action for these types of patients since the ruling says we cannot bill them under any circumstance.

Kim Glaun: So – this is Kim Glaun again. And I have to hate to ask you to email us. But, again, because it involves sort of a state Medicaid question here…

Ana Deslongchamps: Okay.

Kim Glaun: …it's probably better and most efficient if you email me at the website – or at the email address on page 24 with the state that you're practice is in…

Ana Deslongchamps: Okay.

Kim Glaun: …and also your specific question.

Ana Deslongchamps: Okay. I'll go ahead and submit the question to the email. To whose attention?

Kim Glaun: So, they all come to Kim Glaun. And I will confer with my colleagues…

Ana Deslongchamps: Okay.

Kim Glaun: …as well. So, you'll hear from me and, possibly, some others back.

Ana Deslongchamps: Okay. Great. Thank you so much.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Sheree Compton.

Sheree Compton: Yes. I'm calling in from Maury Regional Hospital in Tennessee. We bill out our own ambulance claims. And we have non-emergent claims that have to be billed to Medicare as a no-pay claim.

Are those still billable to the patient? Because most of the time, we'll get an EOB back saying that, you know, that the patient's – you know, doesn't have coverage for a non-emergent visit to be transported by EMS. So how do we bill out those claims? Or do we – is it just no payment?

Leah Nguyen: Hold on a moment.

Kim Glaun: So – and so this is Kim Glaun again. And that's a very good question. So as I mentioned before, the QMB protections apply when the services are covered by Medicare. In this case, for the non-emergency transport you mentioned, you said that we – Medicare has said that it is not covered.

Sheree Compton: Right.

Kim Glaun: And in those cases, the coinsurance would be billed to the patient or the deductible. However, depending on the state that you're in that – did you say Tennessee?

Sheree Compton: Yes, ma'am.

Kim Glaun: It's possible – and we recommend that you explore with your state because if the state plan does cover sometimes some non-emergency medical services, you can submit the claim to your state.

Sheree Compton: Right. And for our state, we have a couple of different MCOs. And when those are available, we can bill those directly to them. But when they have just a straight out Medicaid QMB, there's nobody, you know, really for us to bill it to.

Kim Glaun: So you're having trouble billing for Medicare – Medicaid's portion…

Sheree Compton: Right.

Kim Glaun: …because there are Medicaid MCOs involved? Okay.

Sheree Compton: Because they're not involved.

Kim Glaun: So, MCOs – the MCOs are good but the Fee-for-Service is not…

Sheree Compton: Right.

Kim Glaun: Okay.

Wil Gehne: This is Wil Gehne. Did I understand you to say you were billing Medicare for a denial?

Sheree Compton: Well, we have to for – to get the claim – to have an EOB to submit to an MCO, we have to have a denial from Medicare for the non-emergent transportation.

Wil Gehne: Okay. So if you're billing with the codes for – to bill for denials, they would get a patient responsibility group code on the…

Sheree Compton: Okay.

Wil Gehne: …and be unaffected by this process, yes.

Sheree Compton: Okay.

Leah Nguyen: Thank you.

Sheree Compton: All right. Thank you.

Operator: Your next question comes from the line of Lori Workman.

Lori Workman: Hi. Good afternoon. I just wanted to know if the information, the eligibility information in HETS and the information on the remit is going to be real time or up to date. Because I know sometimes Medicare will forward claims to Medicaid and then we'll get denials back saying the patient wasn't eligible at that time or for that date of service.

Leah Nguyen: Hold on a moment.

Kim Glaun: So – this is Kim Glaun again. And that's a very good question. So, the information is generally up to date. But in some cases, there could be a 30-day lag in the data. So just because of the way that the data is transmitted to us and we relay it off to our systems.

Patricia Rodgers: And this is Patricia Rodgers. If I could just add that our HETS systems are updated nightly, and you'll have information on that as current as it is. But, as Kim mentioned, the state sometimes – they have a range of – you know, from nightly to a monthly feedback to CMS.

So you'll have – the CMS systems will update nightly. But if the state, depending on which beneficiaries you're seeing in which state, there might be that longer time lag.

Lori Workman: Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Joni Walters.

Joni Walters: Hi. I'm calling from Gastro Associates in York, Pennsylvania. And just two quick questions. The QMBs – are they any patient or just residents of a long-term care facility?

Kim Glaun: The QMBs can be any Medicare beneficiary, not – it's not limited to residents of long-term care facilities.

Joni Walters: Okay. And then, I had a long-term care facility tell me that a patient was a QMB, but they did not have MA. Is that possible that they can be a QMB without having that MA designation?

Kim Glaun: So, what I think that they might be referring to is the fact that about 20 percent of the QMB patients just receive Medicaid assistance with Medicare cost sharing, and they don't have – otherwise have the full range of Medicaid-covered benefits.

So it could be – and you may want to go back to them to verify this – but it could be that they are telling you that Medicaid is only going to pay the Medicare cost sharing but is not available, necessarily, for that patient to pay additional non-Medicare-covered services.

Joni Walters: Okay. So, it's a Medicare covered service, and they're a QMB. So, obviously, we just need to write off the amount that's – the 20 percent that wouldn't otherwise be billed to Medicaid because they only have the cost share.

Kim Glaun: So I think you can bill the state for the cost sharing amount. So you can still – it is counted as a form of Medicaid assistance. But all you could bill would be for the Medicare cost sharing amount. Does that make sense? I don't know…

Joni Walters: For the – yes. For the deductible and the coinsurance.

Kim Glaun: Yes.

Joni Walters: Okay. Thank you.

Kim Glaun: You don't have to write that off. You can bill for that.

Joni Walters: Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Janet Holder. Ms. Holder, your line is open. There is no response from that line. Your next question comes from the line of Sue Greeno.

Sue Greeno: Hello. I wanted to thank you for all the attention you've paid to this important issue, especially for our low-income beneficiaries.

And this seems to be especially problematic for our beneficiaries with – who are in Advantage plans. And we're finding many providers still believe they are allowed to collect the copays and deductibles. And I think your QMB program webpage is very helpful.

And I just wondered if there was a resource or would be an additional resource maybe that could be put out specific to Advantage plans. For some reason, they think it only applies to Fee-for-Service, despite the excellent MLN articles that have come out.

Kim Glaun: This is Kim Glaun again. So we have put out some additional guidance that is actually on the QMB page. And, first of all, thank you for thanking us.

We do – we are trying to address this longstanding issue. And, again, it is something that we're happy to hear how we can do more, too. So we do appreciate your feedback.

But in terms of Medicare Advantage, we have been communicating with the plans. There is – on the QMB webpage that you mentioned, there is a section for the Medicare Advantage plan.

In it, we have instructions for the plans that were in – that were published in 2016. And we also – last June, we put out a HPMS memo for the plans as well.

And we continue to work with the Medicare Advantage plans to reinforce these rules with them. And so, we're – it's an ongoing process. But we're always open to ideas that you have specifically for ways that we can get the word out more.

Sue Greeno: Well, the new tool for the contact – people who contact 1-800-MEDICARE, getting their calls escalated to the MACs to intervene – will that apply to people who have MA plan as well?

Kim Glaun: So that's a very good question. Just to provide some context. You're right that people who are QMBs – they can call 1-800-MEDICARE. And they – if they have an issue with billing that they can't resolve on their own, we do have mechanisms to help the provider – educate the provider further if it's regional Medicare.

And we mentioned the MAC letters where we reach out through the MACs, the Medicare Administrative Contractors. We reach out through original Medicare.

On the Medicare Advantage side, the MACs aren't involved. But we do have the ability for those customer service reps who are in – who answer the 1-800 calls. They can enter that case into a case tracking system that we have where – and it's called CTM. It's called – but, it's a system that the regional offices use to oversee the planned resolution of certain cases that come up. And so, basically, we are still elevating those cases that come in that involve Medicare Advantage. But they are kind of going through a different route. Basically, they're going through the regional offices. And then they're going – they're put before the plan, and the plan has to take steps to resolve the matter.

Sue Greeno: That's excellent. Does the beneficiary need to request that they have their case entered into the CTM if it's an MA plan and they're getting no resolution directly?

Kim Glaun: That's a really good question. And we've had that one before.

Sue Greeno: Okay.

Kim Glaun: So, the – and when we talk to our 1-800 colleagues, they've told us – they've given us some tips to convey to our partners.

And what they tell us is that the best way to speak to a 1-800 operator is to do it as if you're a beneficiary, to lay out the facts and to kind of avoid using sort of more technical jargon and terms because it sometimes – the CSRs are trained as if the issue is presenting from a beneficiary.

So we have found that this process is working when people lay out the facts. But if you do find that you have beneficiaries who are not assisted or – by just calling 1-800-MEDICARE, you can contact us and we'll try to see where things went awry.

Leah Nguyen: Thank you.

Sue Greeno: Okay. Thank you.

Operator: Your next question comes from the line of Theresa Wilson.

Theresa Wilson: Hello.

Kim Glaun: Hello.

Theresa Wilson: Hello. Hi. This is Theresa. I'm from Practice Synergy in New Jersey. We – a prior caller just mentioned about the Medicare Advantage plans. And my question is, will CMS require the MA plans to comply and provide notification to the providers via an eligibility or claims remittance advice that their member is a QMB?

Leah Nguyen: Hold on a moment.

Kim Glaun: So we have some general guidelines that we have – or requirements that apply to Medicare Advantage plans.

So how we have approached this with them is, basically, our regulations tell Medicare Advantage plan that they have to take steps to ensure that their providers do not inappropriately bill for cost sharing. And, now, we have then given the Medicare Advantage plans steps for how we recommend they reach that result.

And one of those steps, as you mentioned, is providing the information about QMB status directly to their providers. There are different ways they can do it. The HPMS memo that we mentioned earlier from June is on the QMB webpage.

And we talked about steps that the provider needs to take – I mean, that the plan needs to take to communicate with their providers ideally. But we know that we have been working with plans to update their systems. But, we know that they're not all there. So in the interim, we recommend – we are going to recommend that providers – they can use the HETS system that Ada mentioned to verify the QMB status of the patients just for sort of a more real-time way to identify the patient.

Theresa Wilson: So the HETS system is an electronic way of performing the eligibility verification?

Kim Glaun: Yes.

Theresa Wilson: And we'll have direct access to that?

Ada Sanchez: So this is Ada Sanchez – there's many ways that you can get access to the HETS system. You can either use – some of the big corporations have a clearinghouse that currently do have access to the HETS system and you send your eligibility requests to the Medicare program. But it's actually the system that you're being – actually utilizing at this point.

Or the provider or clearinghouse or even the hospital can have access to their MAC's portal, your institution that you actually send the claims to. The portal – provider portal uses the HETS system as well, and it'll be providing that information itself to you.

So for additional information on how to get access to the HETS system, you can definitely visit the HETShelp.gov website where we can actually lay out all the requests and how can you connect to the HETS system.

Theresa Wilson: Okay.

Leah Nguyen: Thank you.

Theresa Wilson: All right. Thank you.

Operator: Your next question comes from the line of Janet Hopkins.

Janet Hopkins: Hello. Are you there?

Leah Nguyen: Yes. Go ahead.

Janet Hopkins: Hello. Can you hear me?

Leah Nguyen: Yes, we can.

Janet Hopkins: Hi. I have a question. If a patient has QMB status but their Medicaid is inactive because they didn't recertify, didn't know that they had to, are they still responsible for Medicare coinsurance?

Leah Nguyen: Hold on a moment.

Kim Glaun: So it sounds like the case that you're describing is that the patient has actually lost their QMB coverage. Is that correct, because they didn't renew – follow the renewal processes? Is that…?

Janet Hopkins: Yes.

Kim Glaun: Okay. So, unfortunately, in that case, if the patient is no longer showing that they have QMB status, they're not protected, although if there are helpers involved to get the patient back enrolled in QMB. The ideal approach would be to get them enrolled as soon as possible back in.

Janet Hopkins: Well, that's really what we have the patients try to do. But, they'll let it lapse for a couple of months and, then it can only be retroactive, say, 3 months. But in that time they've added up their coinsurance amounts.

So they'll – you know, they'll say that they're not responsible, but we're telling them that they are because their Medicare was inactive.

Kim Glaun: Yes, I guess it is an unfortunate situation that you mentioned. I think before billing, we would recommend that you reach out in those cases to the state Medicaid agency just to verify exactly the dates of QMB enrollment, too, because sometimes there can be lags in data, as we mentioned.

So, just to be safe because these are our vulnerable patients who live sort of, you know – who have very marginal incomes, we do recommend that you double check with the state in that case.

Janet Hopkins: Okay. Thank you very much.

Leah Nguyen: Thank you.

Operator: Thank you. Your next question comes from the line of Linda Bezdziecki.

Linda Bezdziecki: Good afternoon. My question is, there was wording used as a registration for QMB. Do the providers need to register for this?

Leah Nguyen: Hold on a moment.

Kim Glaun: So, can you describe what you mean by registration? Did you – were you referring to them as…

Linda Bezdziecki: Yes. When I was listening to the webinar, there was wording in there about the registration. And I took it as you had to register under QMB as a provider?

Kim Glaun: So, just – I think we just will clarify that in order – as you serve a Medicare patient, it doesn't matter whether or not you're registered in particular as a QMB provider. You are bound by the requirements so you can't bill the patient for the Medicare cost sharing.

But, what you might be referring to when we're speaking about the registration process is the step that you might need to take to obtain any payment from the Medicaid agency for Medicare cost sharing. So typically, states require providers to enroll in Medicaid in some fashion to obtain Medicaid payment.

Linda Bezdziecki: Okay. And we are enrolled in that. And we just got enrolled in Medicare as a credentialing provider. So we should be okay then.

Leah Nguyen: Okay. Thank you.

Kim Glaun: Thank you.

Linda Bezdziecki: Another question I have is when a patient comes in, because this is an outpatient service that we provide, how do we identify that it is a QMB client – a QMB client when they come through the door and they're registering for their service? Is it by their card? Or do we have to always check eligibility before they come in? How does that work?

Kim Glaun: So, again, that's a really good question. There are a lot of different strategies that providers can use to verify eligibility. I think come October and November, there will be new tools that we mentioned for you to use through our CMS system.

And, basically, they will be automated, like you can access them. And we recommend that you do do that. You know, you can do it at different points. You could do it when the patient makes – schedules an appointment, when the patient comes into the office before you provide any billing.

Linda Bezdziecki: Right.

Kim Glaun: And we recommend that you do that. Yes.

Linda Bezdziecki: But my question would then, if they come into – as we're providing the service or coming to the door and we need to check the eligibility if they are QMB eligible.

Kim Glaun: Yes

Linda Bezdziecki: So we would have to go onto the cms.gov site to check the eligibility for that?

Kim Glaun: No. So, do you use – what – do you use an eligibility system right now?

Linda Bezdziecki: Well, we just got credentials. So we are going through Novitasphere for eligibility and our claims. That's our….

Ada Sanchez: So – this is – yes. This is Ada Sanchez. I believe that they are actually – are a vendor that come directly to HETS to submit transactions for their clients.

So what you need to do when you request eligibility for that particular patient you are seeing, the HETS system will let you know if that person was enrolled within any of the period that you requested up to 12 months back historical information to let you know when they are enrolled if they are.

Linda Bezdziecki: And that would be through the Novitasphere you're saying, we'd check eligibility…

Ada Sanchez: Through the HETS system. Yes. And Novitasphere will send the transaction to the HETS system. Yes.

Linda Bezdziecki: Okay. That's good to know. And…

Kim Glaun: Sorry. Can I just chime in a little? This is Kim Glaun. So I wanted to say that, you know, we have these new systems that you can use. And as Ada said, they could be – they often are kind of like embedded in a product that you – practice purchases. So you may not know the term "HETS." But, you might know the term of – the name of your product you use.

And we do encourage these products, as I said, to take up this information. And we do encourage providers like – if you do use a clearinghouse or a third-party vendor, ask them. Go back to them and say, "How is that going to be reflected on my screen when I'm looking for – checking in a patient, for example?"

But, just going back, also, you – there's still other methods that you can use to verify QMB status. You can – especially – you all are – it sounds like you're a Medicaid provider as well. But even if you weren't, you could ask for the beneficiary's ID card.

They oftentimes – they will have a Medicaid card. And it will look different in different states and have different information in it. But that's a source of information as well. You also, as a Medicaid provider, should be able to tap into the state Medicaid eligibility system…

Linda Bezdziecki: Yes.

Kim Glaun: …which should you provide you the information. So that's another source for you.

Linda Bezdziecki: Okay. So we do check eligibility that way as well through the state system. So they're going to become – like October, November – that information will now be updated to indicate that they are QMB enrolled?

Kim Glaun: The states should already have the information. But now we're also providing it through a Medicare source. So you're going to have, hopefully, different sources that you can consult that will all show the same thing.

Leah Nguyen: Thank you. Dorothy, can we take our next question?

Operator: Your next question comes from the line of Brette Williams:

Brette Williams: Yes. Good afternoon. Brette Williams from the Orthopedic Institute in Florida. For us, our local Medicare carrier on SPOT is how we access the HETS system.

And I just wanted to clarify the thin line, if you could, for me between a regular "dual-eligible" and a QMB. The QMB – there's no such thing as a waiver. Whatever comes in after Medicare is paid, the adjust off. But if they have – if they're just a dual-eligible, they're not a QMB, we give them notification, "Here's what your 20 percent's going to be." We don't bill Medicaid because we're not Medicaid providers. In those cases, where we've got that documented and they've signed off on that, we're okay to collect in those situations?

Leah Nguyen: Could you hold on a moment?

Kim Glaun: So, I think we would prefer you email that question to…

Brette Williams: Okay.

Kim Glaun: …qmbbilling@cms.hhs.gov on page 24 just because it involves sort of a fact-specific Medicaid question, and we'd like to take a more detailed to look at it.

Brette Williams: And our office sheet here does have that clarification on it. It's just such an interesting blend between the state programs and Federal programs. We just want to make sure that we're walking that thin line correctly. Thank you for today's presentation. I appreciate that. That completes my question.

Kim Glaun: Sure. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jacqueline Griest.

Jacqueline Griest: Good afternoon. This is Jackie. I'm calling from Lancaster Family Medicine in Willow Street, Pennsylvania. And I actually – it's kind of a couple questions but all relates to each other somewhat. I – we have a long-term care facility. And my understanding is that once the patient is on medical assistance, they're considered a Q-M-B – a QMB. Is that correct?

Kim Glaun: So, it's not 100 percent. It will depend upon the person's income and assets. And, so, you will – you can't necessarily assume they're a QMB from the fact that they….

Jacqueline Griest: Because the long-term care facility was telling us we could no longer bill the patients for their percentage. And here in Pennsylvania, you can check the MA provider. So I'm appreciative that you guys are now going to be putting this on the remittance advices. But my question, then, is what about those patients that do have a secondary insurance after Medicare? Will it still show up that they're a QMB?

Leah Nguyen: Hold on a moment.

Brian Pabst: This is Brian Pabst. This – I hope this helps. If there was another commercial insurance besides Medicaid, like, say the beneficiary had a retiree plan from a former work, that would, as we call it, cross over before the Medicaid or it should.

Jacqueline Griest: Right.

Brian Pabst: So, you would probably hear from them before Medicaid anyway. But…

Jacqueline Griest: Well, what happening – what often happens is, for that –because – if Medicare doesn't – like the deductible – a lot of the – some of these patients then, their supplemental insurance does not cover that deductible.

Brian Pabst: Right.

Jacqueline Griest: And so, then we were billing the patient, and the nursing home was saying no, and we had to refund several hundred dollars to the patients at the nursing facility because they were audited and told that we could not collect this. But we had no way of knowing that, A, they had medical assistance, but, B, you're – if I'm understanding you correctly, we may have been able to keep some of that because they may not have been a QMB patient. Correct?

Kim Glaun: Yes. So if they are QMB, come this fall, it will – you will see that on – in your – in – through the HETS release. And you'll see that also through the remittance advice.

Jacqueline Griest: Even if they have a second – a supplemental insurance?

Kim Glaun: Yes.

Jacqueline Griest: Okay. So, it will say that it's going to, say, Highmark. But it will also say that the patient has a zero liability or the – and if it doesn't say that they have a zero liability, then I should be able to collect that from the patient at the nursing facility. Correct?

Kim Glaun: You know what? I think it may be safest for you to email the particulars of your question to us just because we just want to make sure that we're conveying correctly how Medicaid might cover or may or may not cover any remaining coinsurance or deductibles in the state that you're in.

So if you could email us at slide 24 – in slide 24 at the contact, that would be great just so we double check we're giving you the exact right information.

Leah Nguyen: Thank you. And this is Leah. As a reminder, we're going to stick to one question per person. And if you have followup questions or more than one question, you can just press star, one and get back into the queue. Dorothy, we're ready for our next caller.

Operator: Your next question comes from the line of Karen Davis.

Karen Davis: Hi. My question is, we are not providers for any Medicaid products. So I'm curious if when you say Medicaid, if that includes like a CareSource or a Molina. Hello.

Kim Glaun: Yes. So are you – just when you say a product, are you talking about a Medicaid managed care product?

Karen Davis: I guess it would be like – we have – you know, it's not – we don't bill the state for it. We're billing a brand of that, like Medicaid – I'm sorry – we have CareSource or Molina or Buckeye.

Leah Nguyen: Hold on a moment.

Kim Glaun: So if you are enrolled or you participate in one of those products that we think that you're referring to – are Medicaid managed care products or – then the state has delegated its sort of responsibilities in many cases for making payments to that managed care entity.

So you can contact them for questions about how you might obtain payment for the Medicare copays or cost sharing for the services. But I think the important thing to remember is just, regardless, the patient can't be billed for the cost, the copays.

Karen Davis: Okay. So I guess that was my question, whether or not we can bill them since we're not providers for any of those. Then…

Kim Glaun: Right.

Karen Davis: …we have to accept what Medicare has paid us and not bill the patient.

Kim Glaun: That is correct.

Karen Davis: Okay.

Leah Nguyen: Thank you.

Karen Davis: Great.

Operator: Your next question comes from the line of John Cummins.

John Cummins: Yes. Good afternoon. You mentioned on slide 14 that starting October 3rd, 2017, the Medicare remittance will identify QMB status. Is that for claims processed on and after October 3rd, 2017?

Kim Glaun: Yes. Starting October 3rd.

John Cummins: Very good. Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Karen Lawrence.

Karen Lawrence: Hi. My question is – we're in North Carolina, and my questions is specifically for QMB patients that their Medicaid benefit only pays for their Part B premiums.

So our Medicaid has this QMB status for kind of these two classes of patients. Certainly we understand that the Medicaid patient who's getting assistance with their Part B premium and the Medicaid benefit includes, you know, Part B deductible and coinsurances, that we can't balance bill them or, etc.

But there is this other class that they're calling QMB, and their actual Medicaid benefit only pays for Part B premiums. So in that scenario, can we bill these patients for their Medicare coinsurance and deductible or do we have to write that off?

Kim Glaun: So I think who you are referring to are a group of beneficiaries who are known under Federal law as SLMBs – and does that name ring a bell – or QI program?

Karen Lawrence: Say that again. I'm sorry. The line cut out a little bit.

Kim Glaun: So, QI program. Every state sort of has a different name for these programs.

Karen Lawrence: Right.

Kim Glaun: But there are these programs that are collectively known as the Medicare Savings Program.

Karen Lawrence: Yes.

Kim Glaun: And QMB is one of them, actually. We didn't want to get into the weeds with all…

Karen Lawrence: I understand.

Kim Glaun: …today – with everyone today. But QMB is the most generous of the programs because it ends up paying the premiums, as you mentioned. But it also pays the cost sharing.

Karen Lawrence: Right.

Kim Glaun: But, there's a few other programs for people with slightly higher income levels. And those programs are – federally, they're known as the SLMB and QI programs. Those are acronyms for them.

And they only pay the Part B premium.

Karen Lawrence: Right.

Kim Glaun: And anybody who is enrolled in those programs and they don't have any other form of Medicaid coverage that might cover the Medicaid – the Medicare cost sharing – they are not protected…

Karen Lawrence: Right. Okay.

Kim Glaun: …from billing.

Karen Lawrence: I assumed that that was true. And I guess in our state, which again is North Carolina, they just – in their benefit plan list, they have this abbreviation that is QMB, and even further have this benefit plan name that says Qualified Medicare Beneficiary.

But it does go on then to clarify that it's for Part B premium only, where there's yet another plan that says, you know, that the premium as well as the cost sharing. And I assumed that the premium only were not protected, but just wanted to be certain so that we obviously could be sure that we're in compliance and doing things correctly.

Kim Glaun: Right. And it is – I understand you. It's confusing on the ground especially when QMB is possibly referring to different benefits and practice.

Karen Lawrence: Right.

Kim Glaun: So from – if the person's only getting assistance with the premium, then they are not protected. But I would – for your own information, it may be good to double check with the state just to make sure you're understanding the categories appropriately.

Karen Lawrence: Understand. Yes. And we'll do that.

Kim Glaun: Yes.

Karen Lawrence: And so, then, just a followup question to some of the other things people have asked, these questions that are going to be emailed to Kim directly – will there be any kind of Q&A – you know, would they be made public in any way for others to be able to see?

I know some of them have been state-specific, but there have been a couple of questions like about the Med patient with the Medicaid copay or that patient – that of Medicare Part B that, in my – just my opinion only – is not really state-specific. I think in every state we all see patients that have Medicare and Medicaid that are possibly, you know – where Medicaid truly says they have a $3 copay. And if Medicaid is the one saying, "Hey, there's $3 copay and you can bill the patient," you know, are we okay then to pass on that $3 responsibility to the patient?

Kim Glaun: Right. So…

Karen Lawrence: Does that make sense? So that's why I was just asking if some of these questions will be made.

Kim Glaun: It's definitely – yes. So we'll look into providing that. And that question does come up. So we have an FAQ that is associated with the call materials. And we'll look into updating that document with sort of common issues that are coming up. And you should also feel free to email us to chime in if you're seeing that issue, too. But we appreciate that, like, you're pointing that out.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Lynette Davis.

Lynette Davis: Hi. Thank you for taking my call. I have a question regarding the HETS system. I believe I heard you say that the patients that only have traditional Medicare the QMB will be shown. But Medicare Advantage customers or patients – they won't have the QMB on the HETS system. Is that correct?

Ada Sanchez: No. This is Ada Sanchez. No. The – if the beneficiary has a QMB enrollment – if enrolled in a QMB program, regardless of being in Medicare Advantage or straight Medicare Part A or Part B, that will be actually available within the HETS system.

Lynette Davis: Okay. Great. I just wanted to confirm that. Thank you very much.

Ada Sanchez: Sure.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Andrea Barrett.

Andrea Barrett: Hello. You briefly touched on what I'm about to ask. But I need a little more clarification. My question pertains to patients who are seeking treatments that are never covered by Medicare, specifically cosmetic services, but they are QMB patients.

We've been trying to get an answer for a couple of years because we were told at one time you can never bill a QMB. And then we've been told that if it's never covered by Medicare, then they can – you can collect funds from them. So where do you stand on that?

Kim Glaun: So – this is Kim Glaun again. I think – so, if it's never covered under Medicare, we're going to process the claim and say that it's never covered.

And we won't tell you – even though it's a QMB patient, we will not tell you that you can't bill the patient. However – and I – you know, I'm not as familiar with how cosmetic services –what you're providing.

But if there is possibly any coverage under the Medicaid program for that beneficiary and they have full Medicaid coverage, there is a possibility – then you should be billing Medicaid for that service. But I – it will depend on what the beneficiary has and what state you're in and what you're billing for.

Leah Nguyen: Thank you.

Andrea Barrett: Okay.

Operator: Your next question comes from the line of Jolyn Thomas.

Jolyn Thomas: Okay. Hello. Yes. So, I – my question goes along the same lines of what was just asked. However, for like consumables, supplies – say, incontinence items -- we know they're statutorily non-covered by Medicare.

The Medicaid programs, in general, would cover them. But if they have – if they're straight QMB, then they aren't extending that coverage is my understanding. So, are we able to collect from those members?

Leah Nguyen: Hold on a moment.

Kim Glaun: Okay. So, if it is a non-covered item, then Medicare will actually not tell you that you can't bill. But, we do recommend that you check with the secondary payer, if it exists – Medicaid or any other secondary payer to see whether they may offer some coverage.

Jolyn Thomas: Okay.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Carol Reeds.

Carol Reeds: Our question has been answered. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Alison Foster.

Alison Foster: Can you hear me?

Leah Nguyen: Yes, we can.

Alison Foster: Okay. So, my question is for skilled nursing facilities. We have skilled nursing facilities in the state of North Carolina. And a resident might be QMB Medicaid.

But once they come in to the facility and we notify Medicaid that they've been admitted, they will convert them over to long-term care or nursing home Medicaid. Can we then bill them for the charges or we still cannot bill them?

Leah Nguyen: Hold on a moment.

Kim Glaun: So in the case that you described, we're thinking that that person might still have QMB coverage.

So I would – you know, it's important that you verify with the state what exactly they have. They may be calling it something else because they're now in the nursing home.

But if they – it sounds like that person may still also have QMB, you can have multiple forms of Medicaid coverage at the same time. So we recommend that you talk to the state to find out exactly what they have. And if they still have QMB, which it sounds likely, then you cannot bill them.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Sharyn Wolfe.

Sharyn Wolfe: Yes. Hi. A question about if a patient has Medicaid QMB status, is that an automatic that Medicaid is paying the premiums? And I'm sorry if I missed the answer to this in previous questions.

Kim Glaun: That Medicaid is paying their Part A and B premiums – or A or B? Usually it's B. But – yes.

Sharyn Wolfe: B. Yes.

Kim Glaun: B. Yes, It is.

Sharyn Wolfe: It is. So then, if I have a patient that Medicaid thinks is – or Medicaid says they are QMB, and Medicare says that their Medicare termed 6 months ago, then there's some disconnect between Medicare and Medicaid.

Kim Glaun: It sounds like there could be a disconnect. But you may want to email us again at page 24's email, qmbbilling@cms, just about specific.

Sharyn Wolfe: All right. I can do that. I called our Medicaid today and she said, "Well, if he doesn't have Medicare, then you just have to write everything off. You get nothing." So, yes, I'll send you an email.

Kim Glaun: Okay.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Teressia Lewis.

Ms. Lewis, your line is open.

Teressia Lewis: Hello. Are you there?

Leah Nguyen: Yes, we are.

Teressia Lewis: Yes. I think my question is probably very similar to – I don't remember the lady's name, but a couple of questions ago. She was from the state of North Carolina as well.

And as far as QMBs goes, in the state of North Carolina there are three different subtypes or classifications. There's a QMB-B, a QMB-E, and a QMB-Q.

And I think what she was saying, too – and I just wanted to reiterate this and make sure that I understood correctly, like for the QMB-B and the QMB-E, their benefit is only – pays Medicare Part B premiums.

The QMB-Q pays Medicare Part B premiums and they may have benefits for deductibles, copays, coinsurances, drug charge – you know, pharmacy charges, and that sort of thing. So I guess I'm just asking

again like she did – those people or those QMBs that are under the B and E in the state of North Carolina, obviously, are not protected by this.

So since they only have coverage for Part B premiums, if they just have Medicare only and then there's QMB-B or -E, then we can bill them for their Medicare deductible annually and their 20 percent coinsurance. Correct?

Kim Glaun: So, we can't really say for sure exactly what – you know, how North Carolina names the programs.

Teressia Lewis: Yes.

Kim Glaun: So, I think it would be great if you – we do recommend you go back and talk to the state. But, just if – in general, if the patient just is receiving help with the Part B premiums and not the cost sharing…

Teressia Lewis: Correct.

Kim Glaun: …then Federal law would not say that you can't bill them.

Teressia Lewis: Okay. And we did, in fact, call the higher ups at the local Medicaid system, the NCTracks, you know, the regular state Medicaid plus the – because, obviously, they don't have a Managed Care Organization.

We're behavioral health. So we have to do part of ours through Managed Care Organizations. So I spent months contacting the people at the state level. And that was what they, in fact, wound up telling me.

So I just want to make sure that on both sides – you know what I'm saying – on their side, on your side, that every – all the stories kind of – everybody is on the same page because we definitely don't want to do anything incorrectly and charge somebody inadvertently when, in fact, they wouldn't owe something. But, by the same token, if we were able to collect that portion, then, obviously, we would be crazy not to.

Kim Glaun: So – yes. Thank you for following up like that.

Leah Nguyen: Thank you.

Teressia Lewis: Oh, you're very welcome. You're very welcome. Awesome. And this has been great. Thank you all for everything. We appreciate it greatly. It's been some great information because there's been such muddy water.

And like I said, I'm like – those of us particularly here in North Carolina, it's just been kind of like, "Oh my gosh, we want to do the right thing. We want to do the right thing. But are we doing the right thing?" So, thank you all so much. We appreciate your time and all the helpful information.

Kim Glaun: You're very welcome.

Leah Nguyen: Thank you.

Kim Glaun: Thank you.

Operator: Your next question comes from the line of Sheila Roberson.

Sheila Roberson: Thank you. I just wanted to reiterate that some of these questions that people have had are real-life scenarios that all of us experience out in the medical world.

So it'd be very helpful if when you respond to those people's emails that you share that with the rest of us. Because all of us are experiencing these real-life scenarios on a daily basis.

Kim Glaun: Okay. Yes. Thank you. And so, we will look into whether we can sort of take out common themes and add them to our FAQs or another source. Thank you for pointing that out.

Leah Nguyen: And this is Leah. If we do update the FAQs or identify another source, we'll email everyone that registered for the call so that you'll have that information. Thank you.

Operator: Your next question comes from the line of Susan Munday.

Susan Munday: Hi. We're calling from Professional Clinical Laboratories. And we were just questioning, if we obtain the advanced beneficiary notice for the traditional Medicare plans, therefore making the service non-approved by Medicare, can we bill those QMB patients for the non-approved services that we have the advanced beneficiary notices for?

Kim Glaun: So when you deliver an advanced beneficiary notice, the claim – you're still submitting the claim, right, to Medicare, though?

Susan Munday: Yes.

Kim Glaun: And we still provide the remittance advice?

Susan Munday: That's correct.

Kim Glaun: So, I think – I mean, the safest thing to do would be to wait until you get the remittance advice back. And it will tell you whether or not the service was, in fact, covered or not by Medicare.

And if we then say it's not covered by Medicare, then the QMB protections wouldn't apply. I guess, you know, if there is any kind of secondary coverage, they could be billed. But I think that might be the safest way to address those kinds of cases.

Susan Munday: All right. Thank you.

Leah Nguyen: Thank you. And, Dorothy, we have time for one final question.

Operator: Your final question comes from the line of Shannon Danold.

Shannon Danold: Hi. Most of my questions have actually been answered. But as far as the QMB status goes, I thought that the purpose of the patients having QMB meant that they had Medicare A and B and Medicaid was paying for their Part B premiums in order for them to have Part B.

But it kind of reverts to the very first question that we had. We're a Part B facility or provider. And we have patients that come in all the time. They're seen in the hospital, which is Part A.

We're Part B. They don't have Part B. But then they have Medicaid secondary. So it's kind of a sticky situation. I just thought that the whole point of the QMB was because Medicaid was paying for the patients to have Part B. But they're not enrolled.

Leah Nguyen: Hold on a moment.

Kim Glaun: So there are – it can be pretty confusing because there are different Medicaid coverage groups and there are some Medicaid coverage groups that are not QMB. And so, under those coverage groups, the state may not be paying the Part B premium.

So you may want to double check with your state to see what eligibility category those beneficiaries are falling in. But, there can be some cases where you have Medicare and Medicaid but you are not a QMB. Does that make sense?

Shannon Danold: Yes, it does make sense. And we can check the eligibility strip like on our Medicaid eligibility for our state, which is Arkansas. And we can check that. And for the most part, it says "QMB." So that's why we are like…

Kim Glaun: It does say QMB?

Shannon Danold: Yes. Because we'll bill Medicaid and Medicaid will deny it saying Medicare is responsible. But, the patient doesn't have Part B. They have facility, which is Part A, but no Part B. So…

Kim Glaun: Well, if they're showing up as QMB and then you're seeing they don't have B, there could be some kind of disconnect. So if you want to email us with…

Shannon Danold: Okay.

Kim Glaun: …some more facts that we can try to follow up.

Shannon Danold: Sure.

## Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on slide 24. For information on evaluating today's event, see slide 25.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network event on Qualified Medicare Beneficiary Program Billing Requirements. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.