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A MEDICARE LEARNING NETWORK® (MLN) EVENT

Qualified Medicare Beneficiary Program Requirements and Processes

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Acronyms in this Presentation

- BCRC: Benefits Coordination & Recovery Center
- CARC: Claim Adjustment Reason Code
- COBA: Coordination of Benefits Agreement
- COB: Coordination of Benefits
- CWF: Common Working File
- EDI: Electronic Data Interchange
- FBDE: Full Benefit Dual Eligible
- FFS: Fee-For-Service
- HETS: HIPPA Eligibility Transaction System
- HIPAA: Health Insurance Portability and Accountability Act
- MAC: Medicare Administrative Contractor
- MA: Medicare Advantage
- MCO: Managed Care Organization
- MSN: Medicare Summary Notice
- MSP: Medicare Savings Program
- QMB: Qualified Medicare Beneficiary
- RA: Remittance Advice
- RARC: Remittance Advice Remark Code
- SFR: Store-and-Forward Repository
- SLMB: Specified Low-Income Medicare Beneficiary



Agenda

- Background
- Dual Eligible Categories
- How Medicaid and Medicare Coordinate
- Coordination of Benefits Agreement (COBA) Crossover Processes and Challenges
- CMS steps to Promote Compliance
- CMS Steps to Assist Beneficiaries



Background

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Medicare-Medicaid Coordination Office (MMCO)



The Qualified Medicare Beneficiary (QMB) Program

- 11.7 million people were enrolled in both Medicare and Medicaid in 2016
- Sixty-four percent (7.5 million) were enrolled in the QMB Program:
 - One in eight Medicare beneficiaries
 - Annual incomes at or below \$12,000
- People with Medicare who are in the QMB program are also enrolled in Medicaid and get help with their Medicare Parts A and B premiums and cost-sharing



QMB Billing Requirements

- Medicare providers may not charge QMBs for Medicare cost-sharing for any Part A and B covered items and services
- Rules apply to all original Medicare and Medicare Advantage providers and suppliers
- For more information, see [Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program](#) MLN Matters® Article



Improper Billing

Challenges for Providers	Difficulties for Patients
Confusion and lack of awareness about QMB and Medicaid	Confusion and lack of awareness regarding QMB status and billing protections
Difficulty in identifying QMB status	Improper charges are occurring
State payment policies may result in lower revenue from QMB claims	Many pay improper charges
Automated Crossover to Medicaid has gaps	Unpaid balances sent to collections



Dual Eligible Categories

How Medicaid and Medicare Coordinate

Cathy Sturgill and Ginger Boscas

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Disabled and Elderly Health Programs Group (DEHPG)

Division of Health Homes, PACE, and Coordination of Benefits (COB)/Third Party Liability (TPL)



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Who are Dual Eligibles?

- Dual Eligibles are Medicare beneficiaries:
 - Who have limited income and resources
 - Are also eligible for some form of Medicaid



Categories of Dual Eligibles

- Medicare Savings Programs (MSPs):
 - Qualified Medicare Beneficiaries (QMBs)
 - Specified Low-Income Medicare Beneficiaries (SLMBs)
 - Qualifying Individuals
 - Qualified Disabled Working Individuals
- Persons eligible for MSP as QMBs or SLMBs and also eligible for full Medicaid benefits under another eligibility category:
 - QMB Plus (means “plus” Medicaid)
 - SLMB Plus (means “plus” Medicaid)
- Medicaid beneficiaries who also have Medicare, but who do not qualify for the MSP:
 - Full Benefit Dual Eligibles (FBDEs)



Eligibility Criteria

- What determines which category a dual eligible is in?
- Primarily, it depends on the individual's or couple's countable resources and income
- [Medicare Savings Programs](#) webpage
- Note: Each state may have different disregards based on 1902(r)(2)



Medicare Cost-Sharing for QMBs

- QMB only beneficiaries are eligible for Medicaid payment of all Medicare premiums, deductibles, coinsurance, and co-payments only, regardless of whether or not the services are included in the state plan
- QMB plus beneficiaries are eligible for Medicaid payment of all Medicare premiums, deductibles, coinsurance, and co-payments, regardless of whether or not the services are included in the state plan; these beneficiaries are also eligible to receive all Medicaid state plan services



Medicare Cost-Sharing for SLMBs

- SLMB only beneficiaries receive Medicaid payment of Medicare Part B premiums only
- SLMB plus beneficiaries receive Medicaid payment of Medicare Part B premiums; these beneficiaries are also eligible to receive all Medicaid state plan services
 - States may pay Medicare cost-sharing for all Medicare services or Medicaid state plan services only, as the state chooses



Medicare Cost-Sharing for FBDEs

- FBDE beneficiaries receive Medicaid payment of Medicare Part B premiums and are also eligible to receive all Medicaid state plan services
 - States may pay Medicare cost-sharing for all Medicare services or Medicaid state plan services only, as the state chooses



Coordination of Benefits with Medicare

- Medicaid is the payer of last resort, i.e., Medicare is primary to Medicaid
- States make payment of Medicare cost-sharing according to the payment methodology specified in Supplement 1 to Attachment 4.19-B of the state plan
- States have the option to:
 - Pay full Medicare deductibles, co-insurance, and co-payment amounts (recorded in the state plan as Medicare Rate or MR), or,
 - Limit payments to amounts based on the state plan payment rates (recorded in the state plan as State Payment or SP): or,
 - Identify a negotiated rate that:
 - Sets the payment level between the Medicaid and Medicare rates; or,
 - Establishes a payment level acceptable to CMS for Medicare services that aren't covered in the Medicaid state plan
 - These rates are recorded in the state plan as negotiated rate or NR



Coordination of Benefits with Medicare

- State plans may choose different payment methodologies based on:
 - Category of dual eligible
 - Medicare Part A or Part B services
 - Specific service (e.g., ambulance, nursing home, etc.)
 - Type of provider approved to render a specific type of service
- Limiting payments to the Medicaid rate may result in no actual payment being made for co-insurance and co-payments if the Medicare payment received exceeds the Medicaid rate
- Both Title XVIII and Title XIX prohibit providers from balance billing dual eligibles
- Providers are strictly prohibited under §1902(n)(3) of the Act from seeking to collect any additional amount from a QMB for Medicare deductibles or coinsurance (other than nominal Medicaid copayments), even if the Medicaid program's payment is less than the total amount of the Medicare deductibles and coinsurance
- §1848(g)(3) Medicare provider sanctions



Coordination of Benefits with Medicare Advantage (Part C)

- Some beneficiaries receive their Part A and Part B coverage through private health plans, referred to as Medicare Advantage (MA) plans or Medicare Part C plans. MA plans may also include prescription drug coverage offered under Part D and other supplemental benefits.
- Mandatory supplemental benefits are included for all enrollees in the MA plan.
- Some states make per capita payments for cost sharing for Part C plan beneficiaries. Capitated payments must be based on a methodology identified in the state plan and incorporate the same general payment limitations.
- MA plans, however, are not required to accept these capitation payments. In this case, state Medicaid agencies will still cover Part C cost sharing for QMBs and FBDEs, but the providers must submit claims directly to the state agency.



Benefits for Medicare Advantage (Part C)

Medicaid Payment for Costs Associated with Medicare Part C

Category	Part C Premium for Part A and Part B Benefits plus Mandatory Supplemental Benefits	Part C Premium for Optional Supplemental Benefits	Medicare Deductible, Coinsurance, and Copayment (except Part D)
QMB Only	Optional	Not allowed	Required
QMB Plus	Optional	Optional	Required
SLMB Only	Not allowed	Not allowed	Not allowed
SLMB Plus	Not allowed	Optional	Conditional*



Benefits for Medicare Advantage (Part C)

Medicaid Payment for Costs Associated with Medicare Part C

Category	Part C Premium for Part A and Part B Benefits plus Mandatory Supplemental Benefits	Part C Premium for Optional Supplemental Benefits	Medicare Deductible, Coinsurance, and Copayment (except Part D)
QI	Not allowed	Not allowed	Not allowed
QDWI	Not allowed	Not allowed	Not allowed
FBDE	Not allowed	Optional	Conditional



Benefits for Medicare Advantage (Part C)

- * (From slide 19): State Medicaid agencies are liable for a portion of the cost sharing for beneficiaries in the SLMB Plus category if the following conditions are met:
 - Medicare service is also covered under the state plan.
 - Medicare provider is also enrolled as a Medicaid provider.
 - State plan pays more than the Medicare payment amount. In these circumstances, the agency must reimburse the provider up to the amount for the service specified in the state plan.



Benefits for Medicare Advantage (Part C)

- Required: Coverage of Medicare deductibles and coinsurance are required for QMBs under §1902(a)(10)(E)(i) and §1905(p)(3) of the Act.
- Optional: The state Medicaid agency limits Medicaid payment as specified in Supplement 1 to Attachment 4.19-B of the state plan. These payment limitations may result in a Medicaid payment of zero.
- Conditional: For a non-QMB eligible, there is no Medicaid liability for cost sharing in an MA plan, however, state Medicaid agencies are liable for payment for Medicaid-covered services rendered by Medicaid providers to Medicaid eligible individuals in excess of any third party (including Medicare Part C) liability.



Benefits for Medicare Advantage (Part C)

- When all of the following conditions are met, there may be a liability for a specific service received through a MA plan:
 - Medicare service is also a covered service under the state plan
 - Medicare provider is also a Medicaid provider
 - Amount specified in the state plan is greater than the Medicare payment amount
- Additionally, §1905(a) of the Act permits payment of health insurance premiums, other than Medicare Part B, for coverage of medical or remedial services, except for individuals who could be enrolled in Part B but are not. Medicaid agencies may elect this option in the state plan.



COBA Crossover Processes and Challenges

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Financial Services Group (FSG)

Division of MSP Program Operations (DMPO)



How Does Crossover Work?

- Definition: “Crossover” refers to the automatic transference of Medicare Fee-For-Service (FFS) from Medicare to various supplemental payers for claims payment purposes
- Goal: To reduce burden on providers and beneficiaries
- How does the crossover process work?
 - Supplemental payers (including Medicaid QMB programs) enter into a signed COBA crossover agreement with the CMS Benefits Coordination & Recovery Center (BCRC)
 - These payers then submit a COBA eligibility file of all eligible recipients or covered members to the BCRC - happens initially and then updates occur thereafter either bi-weekly or monthly
 - BCRC submits a copy of the COBA eligibility file and the supplemental payer’s claims selection criteria (i.e., what claims to include or exclude) to the Common Working File (CWF)
 - As Medicare FFS claims are processed through CWF, CWF returns a 29-trailer to the Medicare Administrative Contractor (MAC) to signal that the claim has been selected to be crossed over
 - The MAC sends the Coordination of Benefits (COB) claim, created by the shared system, to the BCRC via its Virtual Data Center
 - The BCRC transmits the claim in correct HIPAA ASC X12N 837 or NCPDP D.0 batch claim format to the supplemental payer.
 - Supplemental payers are permitted to query to obtain Part A, B, and C entitlement



Types of Claims That Can be Excluded under COBA

- Part A, Part B, or Durable Medical Equipment MAC claims (never all 3)
- Claims by states (i.e., by 2 digit state abbreviation) and provider numbers
- Part B Railroad Retirement Board claims
- Original claims paid at greater than 100%
- Fully paid, fully denied, adjustment, mass adjustment, and MSP claims (and various permutations of these)

Note: Under the COBA Coordinated Care process, BCRC sends all claims to Medicoids for care coordination and related purposes. (COBA IDs fall in the 79000—79999 range—defined as “Medicaid Quality Project.”) These claims are in addition to those that the BCRC transmits to the Medicoids as part of the COBA crossover process.



What is Included on the Crossover Claims?

- All detailed Medicare FFS claims adjudication data (subscriber, payer, provider, and claim levels)
- Incoming paper or direct data entry-keyed claims will only contain “required” elements and segments:
 - There is no Store-and-Forward Repository (SFR) for these claims; thus there is no ability to store and forward on data not used for Medicare claims processing
 - The SFR exists for all incoming electronic claims, and the associated data become part of the COBA crossover claim
- All Claim Adjustment Reason Codes (CARCs) used in adjudicating the claim
- Up to 5 Remittance Advice Remark Code (RARC) used in adjudicating the claim:
 - Note: There is a limitation on the number of possible Medicare outpatient/inpatient adjudication segment iterations on 837 claims transactions
 - May include the RARCs N782 and N783, unless other RARCs necessary for explaining adjudication actions do not supersede them
- If the incoming claim is electronic, Medicare should be sending along provider taxonomy code (provider specialty) and National Drug Codes associated with Part B physician claims



COBA and Medicaid Managed Care Options

- Medicare is increasingly entering into COBA crossover arrangements with Medicaid Managed Care Organizations (MCOs)
- There are various models for making this happen:
 - Option A: MCOs may elect to submit the COBA eligibility file (which includes eligibility information on QMB recipients) to and receive claims directly from the BCRC
 - Option B: MCOs may designate the state Medicaid agencies to perform these activities on their behalf as an agent
 - Note: In this case, the COBA ID is specific to the MCO
 - Option C: MCOs may elect to have the SMA receive the claims and then route the claims to them
 - Note: In these instances, the COBA ID may still be under the jurisdiction of the state Medicaid agency
- In some instances, the COBA crossover claim goes to both the MCO and state Medicaid agency - can cause issues for providers:
 - Provider receives a denial from either the MCO or state Medicaid agency when one does not pay the claim



Normal Medicare COB Challenges

- Medicare claims may not be successfully crossed over to Medicais (QMB programs) due to:
 - Rejection at BCRC - not HIPAA compliant (1 to 1.5% of all claims typically per week):
 - When this happens, BCRC notifies the MAC. The MAC, in turn, notifies the providers.
 - Non-acceptance at Medicaid's front-end system (claim fails at the Electronic Data Interchange (EDI) gateway):
 - Example: Claim may not have the desired National Provider Identifier/taxonomy code combination.
 - Important: Details for failed claims at EDI gateways are not always captured - varies per Medicaid/fiscal agent contractual arrangement. Thus, providers are sometimes caught in the middle.
 - Usually errored COBA crossover claims cannot be retransmitted absent the error issue.
- Even if crossover claims are accepted, some Medicais and other payers deny the claims:
 - Provider has to resubmit in another claims format (e.g., FQHC and RHHI claims)
 - Provider has to include unique information not required by HIPAA 837 requirements but required by the payer and resubmit the claim outside the COBA crossover process
- COBA does not accept 999s or 277CA responses from supplemental payers (not currently required); offers automated dispute process as an option for reporting non-acceptance of crossover claims



CMS Steps to Promote Compliance

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New CMS Tools to Identify QMB Status

- Providers, suppliers and their authorized billing agents can use Medicare eligibility data provided by the CMS HIPPA Eligibility Transaction System (HETS) to verify a beneficiary's QMB status and exemption from cost-sharing charges (Effective November 2017). For more information, visit the [HETS](#) website.
- Original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions from new Alert RARCs in the Medicare Remittance Advice (RA) starting July 2018:
 - N781 – Alert: Patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.
 - N782 – Alert: Patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.
- For more information, see [Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare FFS Claims Processing System from CR 9911](#) MLN Matters Article



Instructions to Medicare Advantage Plans

- Plans must re-educate providers regarding QMB billing rules under 42 CFR §422.504(g)(1)(iii)
- Plans must have procedures to ensure that MA providers do not refuse to serve enrollees based on QMB status
- Plans are strongly encouraged to inform providers and enrollees regarding the QMB status of enrollees:
 - Real-time eligibility verification responses
 - Provider portals and phone query mechanisms
 - RA (explanation of payment)
 - Explanation of benefits for members
- For more information:
 - [CY 2017 Call Letter](#), pages 181-83
 - [CY 2019 Call Letter](#), pages 217-219



Recommended Steps for Providers

1. Establish processes to routinely identify the QMB status of your patients prior to billing
 2. Ensure that billing procedures and third-party vendors exempt QMBs from Medicare charges and remedy billing problems should they occur
 3. Determine the state processes to seek Medicare cost-sharing payments
- For more information, see [Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program](#) MLN Matters Article



2018 Provider Outreach

- Medicare Learning Network call on June 6, 2018:
 - See [Event materials](#)
- MLN Matters Articles:
 - [Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program](#)
 - [Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare FFS Claims Processing System](#)
- MLN Connects® messages on:
 - [QMB Billing webpage](#)
 - [QMB Billing FAQs](#)



CMS Steps to Assist Beneficiaries

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QMB Information in Medicare Summary Notices (MSNs)

- Starting July 2, 2018, the MSN will clearly identify when the beneficiary was enrolled in the QMB program and will accurately reflect the beneficiary's cost-sharing liability (\$0 for the period enrolled in the QMB program)
- For more information, see [Reinstating the QMB Indicator in the Medicare FFS Claims Processing System from CR 9911](#) MLN Matters Article



Assistance with QMB Billing Issues

- 1-800 call center representatives can now:
 - Identify the QMB status of all callers
 - Provide information regarding QMB billing protections
 - Address inquiries from a QMB MA enrollee regarding a MA provider's willingness to serve her/him.
- 1-800 customer service representatives can now send cases to the MACs to:
 - Issue letters to providers whom beneficiaries report as persisting in inappropriate billing
 - Send beneficiaries a copy of the compliance letter (with an explanatory cover letter)
 - See [MLN Matters Article 99817](#)
- Regional Office tracking of QMB billing casework
 - CTM (distinguishes QMB MA complaints from other MA complaints)
 - MAISTRO (QMB-specific categories for FFS casework)



Three Tips for QMBs

1. Tell the provider or debt collector that you have QMB and can not be charged
 2. If the medical provider will not stop billing you, call 1-800-MEDICARE (TTY 800-633-4227)
 3. If you have a problem with debt collection, you can [send a complaint to the Consumer Financial Protection Bureau online](#) or call toll-free 855-411-2372. (TTY 855-729-2372)
- Medicare blog: 3 Tips for People in the QMB Program (Jan. 2017) in [English](#) or [Spanish](#)



Question & Answer Session



Resources

- Visit the [QMB Program](#) webpage
- Contact QMBbilling@cms.hhs.gov



Thank You

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