Qualified Medicare Beneficiary Program Billing Requirements Call

Moderated by: Leah Nguyen
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Table of 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'd like to welcome you to this Medicare Learning Network call on the Qualified Medicare Beneficiary, or QMB, program.

During this call, CMS experts discuss billing requirements and their implications. Find out about the July 2018 relaunch of changes to the Remittance Advice and November 2017 changes to the HIPAA Eligibility Transaction System, or HETS, 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 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 would 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 in CMS. And the purpose of today's call is to help you understand the billing requirements that apply to Qualified Medicare Beneficiaries, to learn about new system changes to help providers identify when a beneficiary is enrolled in the program, and to discover key steps to promote compliance.

So slide 2 includes acronyms that we'll use during today's presentation. To follow along, the most important one to know is for the Qualified Medicare Beneficiary program. And I will refer to this program as QMB and persons enrolled in it as QMBs. Also, the information we'll share today applies equally to all Medicare-enrolled physicians, providers, and suppliers, including pharmacies. For simplicity's sake, during the presentation, I will use the term "providers" to refer to all these 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. And next, I'll discuss problems regarding QMB billing and upcoming CMS system releases to address them. Finally, we'll recommend ways for providers to leverage these upcoming system changes and new releases to avoid billing errors and to promote compliance with QMB billing rules.

An FAQ document is included with these materials. But following the presentation, as Leah said, we will take your questions. And I want to add that I'm joined here today by many of my Medicare and Medicaid colleagues,

policy specialists who will also be joining in to answer the questions that you have. We work closely with them on all of these QMB billing issues.

Background

So on slide 5, I wanted to start with some context for the information we'll share today about the QMB program. In 2016, we know that about 7.5 million people were enrolled in QMB. And that's about one in every eight Medicare beneficiaries. Of that total, about 22 percent of them received Medicaid coverage of their Medicare expenses only. And we call that group QMB Only. And about 78 percent received full Medicaid benefits in addition to coverage of their Medicare expenses. We call that group QMB Plus.

The QMB program provides Medicaid coverage of Medicare Part A and B premiums and cost sharing to low-income Medicare beneficiaries. And as some background, we also call – it's important to know that QMB is an eligibility category under the Medicare Savings Program.

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

QMB Billing Requirements

So now, Federal law and regulations, they set forth billing requirements for all Medicare providers who serve QMBs. First and foremost, on page 7, you will see – slide 7, you will see some of these requirements. So keeping to – it's important to keep in mind that Medicare providers may not bill QMBs for Medicare cost sharing under any circumstances.

We have a link to CMS's MLN article on QMB billing that we included on this slide – on the slide 7. And it does include important clarifications about what these requirements mean in practice. And we try to address common areas of confusion or common questions that have come up in that article. But I wanted to highlight a few of them for you today.

And firstly, we do remind providers that the QMB requirements apply to all Medicare providers and suppliers, including Original Medicare and Medicare Advantage providers. We also clarified that all Medicare suppliers and providers are bound by these requirements, even those that do not accept Medicaid.

Additionally, keep in mind that 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, as in boy, drugs. On the other hand, QMB protections do not apply to Part D, as in dog, drugs, and pharmacists may still collect Extra Help copayments from QMBs for Part D, as in dog, drugs.

State Policies Regarding Medicare Cost-Sharing Payments

Moving to slide 9, we explain that Medicare providers can bill state Medicaid programs for QMB cost-sharing amounts. And we do encourage you to explore state processes to obtain Medicare cost-sharing payments with your state. However, it's important to be aware of two caveats.

First, as allowed under Federal law, many states have adopted policies that result in a reduction in amount they pay for QMB cost sharing or even an elimination of the payment altogether.

Second, to obtain Medicare cost-sharing amounts that might be owed by the state, providers need to enroll as a Medicaid provider. 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

Despite the QMB billing rules, improper billing of QMB persists, unfortunately. On page 11, we have a chart that identifies some 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.

And first, as I said, unfortunately, we do know that improper billing has been occurring. And a main cause has been lack of awareness and confusion about the billing rules.

Providers have told us that gaps in eligibility information make it difficult to identify the QMB status of their patients. And we do believe that many billing errors happen simply because the provider does not know that patient is a QMB. They're not intentional; it's just they don't have the information.

With respect to beneficiaries, improper billing, unfortunately, does have a negative impact, as you would imagine. In our 2015 study, most beneficiary participants said that they had paid improper charges either because they weren't aware of the billing protections, they were too sick to contest 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, the beneficiaries in the study found billing processes very confusing and complicated, and they expressed frustration with billing processes and concern about how their access to services might be impacted by them.

So to address these problems, CMS has been working on a number of fronts to promote greater awareness of the QMB billing requirements amongst providers and patients. And in response to providers' requests to – for help in better identifying QMBs among your patients, we are rolling out changes to our Medicare systems to better help you identify who is a QMB and protected from cost sharing. These system updates are really intended to simplify your compliance with QMB billing rules and to address these information gaps that we do know that you have been contending with and to reduce the burden that providers experience with trying to verify the QMB status of patients. Once fully implemented, for the first time, the CMS systems will help providers know if a beneficiary's a QMB both before and after claims are submitted.

Upcoming System Changes To Help Providers Identify QMB Status

First, I want to turn to page 13 – or slide 13 to explain some of the CMS changes to our eligibility system that you can use in your offices to verify whether a patient is a QMB or not in – either during the registration process or at any time before a claim is submitted.

So, effective in November of last year, we implemented changes to Medicare's eligibility system. And that system is called the HIPAA Eligibility Transaction System, or HETS.

Through HETS, CMS releases Medicare eligibility data to Medicare providers, suppliers, and their billing agents, including the clearinghouses that you might use and any third party vendors or eligibility verification products that you use. This is sort of the authoritative source of Medicare eligibility. And it is released and updated on a real-time basis on – nightly, the information is updated.

And starting – and just to let you know, some people know of HETS in terms of a transaction, the transaction that it's – that it relies on. So, HETS users, basically, they submit something called a 270 eligibility request file over to our HETS system over a secure connection. And then they receive from – back from HETS, they receive a 271 response file that addresses the eligibility of the beneficiary and gives, also, patient financial responsibility amounts for Part A and B coverage.

So, effective in November of last year, HETS now includes periods during which the beneficiary is enrolled in QMB and it will owe – and it will show that the patient owes zero cost-sharing amounts for Part A and B deductibles and coinsurance. And again, these HETS changes are intended to enable all Medicare-enrolled providers to readily identify their QMB status – the QMB status of their patients at the point of service or during the registration process. So HET – the intent is to help you head off any billing errors from occurring in the first place.

Moving to slide 14, we also want to tell you about changes that CMS has been making to our fee-for-service Remittance Advice and the Medicare Summary Notice for beneficiaries. These efforts have hit some bumps along the way. So, I'd like to walk you through a timeline of changes that we included on slide 14 just to give you a sense of where things stand now.

First, you might be aware that we attempted to change the QMB Remittance Advice in October of 2017 to include QMB alert messages and indicate a QMB's lack of cost-sharing liability. However, unforeseen problems soon emerged. And specifically, changes to the display of the patient responsibility on the Remittance Advice that we had made were – ended up impeding the ability of many states and secondary payers to process QMB cost-sharing claims that were directly submitted by providers.

Now, these problems did not impact claims that were sent to states through the Medicare crossover process. But these were just claims that providers directly submitted to the state Medicaid agencies themselves. So, we did two things to address these – this problem.

First, we suspended the system changes in December – last December and the Remittance Advice then went back to not reflecting any of these QMB changes we had made.

Second, to assist the providers who were impacted and couldn't get their secondary claims processed, we had – or we have now are in the process of having Medicare Administrative Contractors issue replacement Remittance Advice that impacted providers can use to resubmit Medicaid – to Medicaid agencies their QMB cost-sharing claims.

And these are the claims that the states had initially failed to pay due to the Remittance Advice changes. Again, this is not the claim – the crossover claims, the claims that crossed over states but just the claims that were directly submitted to providers.

And lastly, next month, fortunately, we will be able to reintroduce changes to the QMB Remittance Advice with modifications to avoid disrupting the claims process by secondary payers. These changes are discussed on slide 15.

So essentially, starting in July, the Remittance Advice will start including QMB-specific remark codes. We also call these RARCs. And these messages will designate that the QMB is enrolled in – the beneficiary's enrolled in the QMB program and they may not be billed for Medicare cost-sharing amounts. And again, I've actually included – we've included the messages on slide 15. It's N781 and N782.

To avoid the problems we experienced last year, the Remittance Advice will retain the display of patient liability amounts needed by secondary payers to process claims that are submitted directly to them. And these changes will apply to the ERA, the Electronic Remittance Advice, the 835 for all Part A, B, and DME claims and the standard remit – the paper version for Part B and DME claims as well.

So moving to six – slide 16, as I mentioned, we had also made some changes to the Medicare Summary Notice for beneficiaries. And we're going to reintroduce them as well starting July. Just as some background, 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 basically Original Medicare's version of an explanation of benefits, also known as an EOB.

And starting in July, 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 at zero – would be zero dollars for the period they were enrolled in the Medicare – I mean, in the QMB program.

On page 17, we also address how Medicare Advantage plans may be communicating with you all about the QMB status of enrollees. So the Remittance Advice system changes that we – I just described, they apply to fee-for-service claims of patients in Original Medicare. But we at CMS have strongly recommended a plan also affirmatively inform providers about enrollees' QMB status and their exemption from cost-sharing liability.

We don't mandate specific methods, however. But we do recommend certain measures that plans can use. And, for example, plans can use real-time eligibility verification process – responses that they have set up. They can use provider portals and phone query mechanisms. And they can also use their Remittance Advice and make changes to their EOBs to reflect QMB status.

But we do know that many Medicare Advantage plans are starting to take advantage of these measures. And more and more, we have heard that – this to be the case. But at this point, it's best for providers to contact

their Medicare Advantage plan to learn what their measures are that they're using and to see the best way to identify the QMB status of plan members both before and after claim submission.

Steps for Providers To Promote Compliance

So the last part of the presentation aims to distill the information we've shared so far into actionable steps for providers to promote compliance and avoid errors. And on slide 19, I summarized three steps that we offer for providers that are included in a Medicare Learning Network article that's also included on this slide, the slide 19. They – these steps reflect promising practices and input from providers, administrators, clearinghouses and billers, and others.

So first, given that identifying QMB status is key to ensure compliance, we recommend that all providers establish processes to routinely identify the QMB status of all of your patients – your Medicare patients before billing occurs.

And then second, we recommend that providers institute procedures to make sure that office – that your office practices, your clearinghouses, third party vendors exclude QMB billing from your practices and also fix any billing problems if they do occur.

And then third, as mentioned earlier, we recommend that providers explore processes to seek Medicare cost-sharing payments for Medicaid in your state. In the next few slides, we provide more detail on what each of these recommended steps might entail.

So slide 20, again, identifying the QMB status of your Medicare patients prior to billing for items and services is really an essential part of preventing inappropriate billing.

As we mentioned earlier, beginning in November of last year, providers and suppliers can use information provided by CMS's eligibility system, HETS, to verify a patient's QMB status and exemption from cost-sharing charges at the point of service prior to billing. And then, starting July, once claims are processed, Original Medicare providers and suppliers can look for QMB information in the Medicare provider Remittance Advice as well.

If providers – again, we just stress if providers are serving a Medicare Advantage enrollee, they should contact the plan to learn the best way to identify the QMB status of those plan members.

And then also, providers and suppliers may also look to Medicaid, like they have been, to verify a QMB – a patient's QMB status. So, providers – if you are a Medicare provider, you can use the state online Medicaid eligibility systems. And of course, all providers can ask for patient ID cards – Medicare ID cards or use other proof of QMB status that have been provided to the states. And then starting in July, providers can also ask beneficiaries for a copy of their Medicare Summary Notice to verify their QMB status.

On slide 21, we – again, we recommend that providers are using systems to ensure that – to ensure and – that they're exempting individuals enrolled in the QMB program from Medicare charges. And we know that many practices use third party vendors and other entities that have programs in place. And we just want to make sure – it's good to make sure that all those systems are appropriately configured so that QMBs are not billed.

And providers can also take certain measures to proactively try to detect billing errors should they occur. So for example, the codes in the Remittance Advice now will help you identify any billing errors and additional actions that you might need to take to reconcile any errors or billing that's occurred. Additionally, providers can respond and should respond to outreach that they might receive from Medicare Administrative Contractors, MACs, regarding QMB billing. The MACs, they now send letters to providers if 1-800-MEDICARE receives complaints about persistent billing errors. And these letters identify the patient in question and how the provide – and ask the provider to review the billing records and resolve any billing problems that are found. So, that's another way for you to know that you should look into billing for this patient.

And then just one thing to remember is that if you have erroneously billed an individual enrolled in the QMB program, you need to recall the charges, including any referrals to collection agencies, and refund the invalid charges that the patient has paid.

And lastly, on slide 22, again, we mentioned that we do encourage providers to consider billing Medicaid agencies for cost-sharing amounts. Processes differ across states. So, providers, you should research the billing processes that apply to seeking payment for Medicare cost sharing in your state. Different processes may apply to Original Medicare and Medicaid – Medicare Advantage services.

For Original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination and Recovery Center to automatically receive Medicare-adjudicated claims. And so in this case, if a claim is automatically crossed over to another payer, such as Medicaid, it's noted on the Remittance Advice.

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

Resources

So before we open up to questions, I want to point out some resources listed on slide 24. And first, you will see a QMB program webpage that has a range of information for different audiences, including providers.

Second, if you have questions that are not addressed during the Q&A today, you can email the temporary email address listed in this slide. And if you have tried to – this address in the past, please try it again. At some points, we had some problems with it. But we were able to – we are able to receive emails now and have been able to fix those problems.

So third, while today's presentation describes Federal policies that affect QMBs, it does not address Medicaid policies and procedures in individual states. So for questions about state policies, please contact your state. And the medicaid.gov link on this slide has state contacts.

Question & Answer Session

Leah Nguyen: Thank you, Kim. We will now take your questions. As a reminder, if you have questions about your state's policies, please contact your state. Unfortunately, we cannot address these questions during today's event. See slide 24 for a link to state contacts. Also, 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 1 on your touchtone 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 1 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 Cheryl Bouschor.

Cheryl Bouschor: Hello. My question is, We use an eligibility tool to verify eligibility and we have no problem with Original Medicare. But the Medicare Advantage plans are not returning anything except for a couple of them. I have contacted the Blue Cross and they have told us that they are not giving that information to us—they are telling the patients. So, we're trying to figure out if this HETS thing – is this something that we can access, and how do we go about it?

Rich Cuchna: This is Rich Cuchna, and I'm going to try and address that question. So, the HETS system is for the Original Medicare program Part A and Part B providers to check a patient's eligibility for Medicare. We get back effective and term dates, information with regard to the Part C plan, the beneficiaries, and the Part D plan, and information about home health, hospice, ESRD, next eligible dates for preventative services—a host of information.

That – there is a webpage, and I believe it's referenced in the resource slide. It's on the page where Kim was talking about the eligibility system. The HETS system is referenced there. And if you go to that webpage, it gives more information about – the HETS webpage gives you more information about how to access the eligibility system. And also on that page, there's the companion guide for the 270/271 that goes into detail about the QMB information, that we return the periods of QMB and the fact that we – if somebody is in a period of QMB, we – the coinsurance and deductibles will be zero.

Also if you go to your Medicare Administrative Contractor and you use their interactive voice response unit or you use their portal – their secure internet portals where you log in with your user ID and password, those two self-service tools do utilize HETS to return eligibility data. And so, you will get the same information through the portals and through the interactive voice response units that you would get coming directly to HETS with regard to QMB.

Cheryl Bouschor: Well, I don't have any problem with Original Medicare, because I'm on WPS GHA, which has a multitude of information and is awesome. It's the Medicare Advantage plans that we are unable to verify.

Kim Glaun: So – this is Kim Glaun again. So if I could just jump in, we do understand that it is very difficult in some cases to verify the QMB status when a Medicare Advantage plan is involved. It's a less direct – so we have been advising the Medicare Advantage plans, as I said, encouraging them to provide this information in the responses they have. But in the meantime, we've also said – we have also identified that, as long as a provider has an NPI number and the beneficiary's, like, now it's the beneficiary's ...

Unidentified female on speaker line: Medicare.

Kim Glaun: ... Medicare, yes, the BN – MBI, right, the MBI information. You can actually check on QMB status using HETS. However, you're not going to – so you would get that the patient's enrolled in QMB. However, the problem is that it's not going to show what cost sharing, you know, necessarily applies, and you're not going to get the benefit information that you would.

So, some vendors that we have talked to who are using HETS and they have – also working on serving Medicare Advantage – providers who are in Medicare Advantage networks, they're sort of exploring whether they can use HETS just for that initial yes/no QMB – find out HETS will show that there's a Medicare Advantage plan that the patient has—they're not enrolled in Original Medicare. And then they would then query the Medicare Advantage plan for verification that the patient's enrolled in it and what the benefits are and just to put those two pieces together. It's not ideal.

But another way for you to go about this is – I don't know if you guys are enrolled in the – in Medicaid.

Cheryl Bouschor: They're not – Michigan Medicaid is not accurate 80 percent of the time. I've verified that. I've been following the QMB pretty closely and I have – I've logged in to both places. And Michigan Medicaid does not always reflect the correct QMB status. And they call – they don't even – they call QMB something totally different in Michigan. So ...

Kim Glaun: Okay.

Cheryl Bouschor: So that doesn't – but are – so let's – I want to back up. Can – if I'm on the WPS GHA site and I don't have a Medicare card, because they're not in Original Medicare at that moment, I can look up the MBI lookup and get their – I assume everybody gets in Original Medicare whether they end up being in Original Medicare or not, and then I could look it up that way?

Kim Glaun: Yes.

Cheryl Bouschor: Okay.

Kim Glaun: (crosstalk)

Cheryl Bouschor: If I can do that, then I'm good. If I have to call somebody, it's not going to happen, because it takes over five minutes to get even into Blue Cross Medicare. So, that's not going to be a rational way for us to

handle checking eligibility on, you know, 50 patients a day. It's not – it's just not going to happen. It's just – it's too labor intensive. And I'm not even sure they'll give us the information.

Tricia Rodgers: So one more ...

Cheryl Bouschor: I've already emailed – I have already received an email from them saying they're not going to be returning it on their websites or their portals or anything, that they just (crosstalk).

Tricia Rodgers: So one more piece of information about the WPS portal and all of the MAC portals for the Medicare Beneficiary Identifier, or MBI.

Cheryl Bouschor: Yes.

Tricia Rodgers: As long as the beneficiary's card has been mailed, you'll be able to look up the new MBI number using other patient …

Cheryl Bouschor: Okay.

Tricia Rodgers: … information.

Cheryl Bouschor: Right.

Tricia Rodgers: But – and, you know, we're working on mailing out the 60 million cards. So eventually …

Cheryl Bouschor: Right. I understand that.

Tricia Rodgers: … you will be able to do that at any time. But right now, it's for those cards who have been – for those beneficiaries whose cards have been mailed.

Cheryl Bouschor: That's good to know. I tried to look somebody up the other day and it didn't return any – it didn't even activate at all. So that's probably why because I'm in Michigan and I know Michigan's are going out after June. So ...

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Josie Espinosa.

Josie Espinosa: Hi. I have a question in regards to sales tax for QMB patients, my concern being is that do – are we able to charge sales tax on DME products?

Kim Glaun: Sales tax, you're saying?

Josie Espinosa: Yes.

Kim Glaun: Sales tax. So which state are you located in?

Josie Espinosa: We're from Wisconsin. Sorry. Yes, we're from Wisconsin. I know we're able to charge in eight states overall. But I'm not – eight states – you know, eight states for supplies. But we're not sure if the – if QMB is different compared to, you know, straight Medicare or commercial.

Kim Glaun: On DME? Okay.

Josie Espinosa: Yes.

Kim Glaun: So we actually – so as a general matter, I'll just say that if Medicare cost sharing cannot be charged to patients – so in any state – and we actually haven't heard this question – or I haven't heard this question come up about sales taxes. So we – if you want to email the specifics and the state that you're in and – to the QMB billing website or the email address, then we can try to get back to you. We'll have to talk to some of our DME policy folks internally about it, and then we'll get back to you as soon as we can. But thank you for raising that.

Leah Nguyen: Thank you.

Josie Espinosa: Okay. So ...

Operator: Your next question comes from the line of Jessica Hernandez.

Jessica Hernandez: Hi. I have a question about the coinsurance and deductible. I understand that we're not able to bill the patient for that amount. But what if the patient signs an ABN for a charge?

Kim Glaun: So the ABN – so, basically, when an ABN is given – I want to just sort of ask, Are you giving an ABN when you think it went into totally excluded service, which is optional, or are you giving the ABN in a situation where it's a Medicare-covered service but you believe that, for that individual patient, that the service might not be …

Jessica Hernandez: It's a medical necessity.

Kim Glaun: … medically covered?

Jessica Hernandez: Yes, it would be for a situation where it is typically a covered charge by Medicare. However, the medical necessity, you know, may potentially not be supporting that charge.

Kim Glaun: Okay. Cathy, do you want to jump in? And I can also speak to this. Or, Cathy, who's on the line?

Cathy Sturgill: Sure.

Kim Glaun: Okay.

Cathy Sturgill: So from the Medicaid – the state Medicaid agency's perspective, if this is a covered Medicare service, Medicare – if Medicare's paying for them, the Medicaid agency would have that cost-sharing

responsibility. But when you get into that it is a Medicare-covered service but maybe not – it doesn't support medical necessity, would – Kim, I'm asking this to you. Would – is that something that Medicare would cover?

Kim Glaun: So well, we don't know is there's no – until the claim is actually processed, there's no determination of medical necessity yet. So generally, if a patient has Medicare and Medicaid and an ABN is provided, I think what Medicare suggests is that the patient opt on the ABN for option one, which says, We know that Medicare may not cover this service and that – but we want it anyway, and we know that Medicare – we hope – we are asking you to bill Medicare for the service.

So that's when it's used. Do you want to speak about how you think, for these patients, they might be billed? And I can also answer as well.

Cathy Sturgill: So for – on the Medicaid side, the QMB can opt out. Is that where you're going, Kim? So if …

Kim Glaun: Yes.

Cathy Sturgill: … this is – right. I mean – so they don't have the option of opting out whether or not they choose for Medicaid to cover it or not, their cost sharing. And so, once that claim is billed to Medicare, Medicare crosses that claim to Medicaid. Medicaid then looks at it to – first, to make sure that Medicare paid the claim. If Medicare did not pay, Medicaid has no cost-sharing responsibility. So patients can't – so QMBs cannot opt out of their cost sharing.

Kim Glaun: And just to add to that, what Cathy is saying is, basically, you don't have a – when an ABN is provided, basically, the – it's sort of a sign, right, that you think that Medicare may not cover the service. But there's no official determination by Medicare until the Remittance Advice – you get the Remittance Advice. So – right. So you don't know – you can't – you don't know whether or not you can, you know, sort of bill. So if – you know, whether the service is going to be covered or not. So, in general …

Jessica Hernandez: So, we should still bill with the modifier saying that there's a valid ABN signed, and then, once the remit comes back, allow you guys to make that determination?

Kim Glaun: … except for – yes. Except one caveat, that if the patient has full Medicaid – and I don't know. Are you all Medicaid ...

Jessica Hernandez: Yes, we are.

Kim Glaun: … taking Medicaid?

Jessica Hernandez: Yes. Sometimes, we see that the patient doesn't have the secondary coverage on there or it could be, you know, maybe an AARP or some other insurance as secondary, sometimes "none" as secondary. So, I guess that's our greatest concern, is when they do not have a Medicaid secondary coverage plan.

Kim Glaun: Okay. So if – I think if they're a QMB Only, that they're a patient that doesn't have – only gets help with their Medicare cost-sharing services, then they don't – as you said, they don't have Medicaid coverage of an excluded Medicare service at all. Like, basically …

Cathy Sturgill: Correct.

Kim Glaun: … you would look to the state plan for that. But so, if it's just a QMB – a beneficiary who just says QMB and the state pays their Medicare cost sharing and you see on the Remittance Advice that Medicare denies the claim and that's a denial – and the patient's not protected there because QMBs only get protection from claims that are Medicare coverage. So in those instances, the patient could be billed. But then on the other hand, if a patient does have full Medicaid coverage, then you have to bill Medicaid for the service. And you should check with your state for the procedures as well. But it's possible that Medicaid will actually cover the service in full under its state plan, depending upon what it is.

Cathy Sturgill: So, Kim, this is Cathy. Just to add to what you're saying, too, is it's a very good point that, you know, I guess I thought we were just really talking about the QMB Only. But since this question came up, you know, there are actually six additional dual-eligible coverage groups. All of them have different cost-sharing responsibility from the state. And for those, we'll refer to it as the QMB Plus.

I'm not sure anyone on the call is familiar with that. But that, actually, is that beneficiary that has Medicare cost sharing along with full Medicaid coverage. So, that means that not only will Medicaid look at the cost-sharing responsibility, but they will look at the claim for the service. And if it's a – if it's also covered under the Medicaid state plan, then they will pay as they would for any other Medicaid beneficiary.

So we do have a lot of information that might be helpful. I don't know, Kim, if we can send that or whatever – that describes those different types of dual eligibles along with the cost-sharing payment responsibility that the state Medicaid agencies may have.

Jessica Hernandez: Okay.

Leah Nguyen: Yes. Thank you. If you send your question into our mailbox on slide 24, we can send you some additional information.

Operator: Your next question comes from the line of Phyllis Korzeniowski.

Phyllis Korzeniowski: Hi. I have an eligibility question. We only do Medicare; we're a DME provider. And when you use to call for eligibility, it would tell you if there was the full deductible or the remainder of the deductible left. And then, we would know how much we would be receiving once we billed the patient. But now, that's removed. Now it always says zero. We used to be able to call for a few weeks, and then Medicare said, "No, you can't call anymore to find out if the deductible's been met."

So when you switch the RAs in July, are you also going to give access to everybody that calls for eligibility if the patient has met the deductible or not? I mean, it puts you in the red if you don't know if you're getting $100 or $200. You know, you don't know on each patient if we don't know if they've met the deductible. It's not that

we're going to bill them. We just want to know how much is going to be going into our books once we're done and how to balance every month.

Rich Cuchna: Yes, so, basically, the Eligibility Transaction standard states that the data we should return regarding patient eligibility, coinsurance, and deductibles is what the patient's liable for. And because they're a QMB, they're not liable for that and that's what we need to return per the standard. And so, when you bill the claim, that's when on the Remittance Advice it will show with the appropriate Remittance (crosstalk).

Phyllis Korzeniowski: But no business could possibly function that way. I mean, what if I have 10 patients and none of them have met their deductible and I'm billing all this thinking, well, at least half might have met it. I mean, nobody functions that way. No business can stay in business if you don't know what you're bringing in and what you're putting out. There's got to be a way to find out if the deductible's been met or not. I don't do Medicaid; I only do Medicare. So, all I need to know is if a – if the patient has met their deductible. I'm not going to bill them. I just want to know what's been met. It's for my bookkeeping.

Kim Glaun: Okay. Well, so thank you. You know, I – we appreciate your comment. I think the system change will be, as we said, just because of the constraints of the system.

Rich Cuchna: Right. And the fact that you can't – you can't bill the patient for the deductible or coinsurance. So, even if we did return that deductible or coinsurance, you can't bill for that because they're a QMB patient.

Leah Nguyen: Thank you.

Phyllis Korzeniowski: You broke off on that. I didn't hear the whole – your whole response. So even if I bill a patient for $100 and they've met their deductible – I mean, somebody's paying the deductible, correct?

Cathy Sturgill: Well, for a QMB – okay. So this is Cathy. In that case, if it's a QMB, I think what they're trying to stress is that, even if there was a deductible out there, if you're not enrolled in a Medicaid program to assist with their cost sharing, you can't bill the QMB beneficiary. So, in effect, that is zero for them ...

Phyllis Korzeniowski: Right.

Cathy Sturgill: ... because I think you said you're just involved in Medicare, correct?

Phyllis Korzeniowski: Correct.

Cathy Sturgill: Yes, so, I think what the – what you're seeing is that because your patient is a QMB, that the provider cannot, under Federal law, bill the beneficiary, so it's zeroed out. And that's trying to assist providers so that they don't inadvertently balance bill a QMB. So, technically, there is no deductible for you to be concerned with.

I mean, I know you would like to receive payment for it or how it works. But, really, you're not getting it from the beneficiary, because there is no deductible owed. And you're not enrolled in the Medicaid program, so you can't take the next step to see if maybe the Medicaid program might have some cost sharing that they would apply. Does that help?

Phyllis Korzeniowski: Okay. So when this – it does. But it sort of leaves me broken here because, all of a sudden, now that there's QMB patients and we're told they're QMB patients, even though it never was a problem for our little office, now it is a problem because we have so many. We don't want to deny them. We've done them in the past. It's not like we don't expect, you know, to provide the service. It's just we want to know what we're going to get in return. And I don't know why we can't get that information out of Medicare.

Leah Nguyen: Thank you.

Phyllis Korzeniowski: Because original …

Operator: Your next question comes from the line of Lizeth Pena.

Lizeth Pena: Hi. I had a question in regards to the QMB. I do work for, like – well, I'm in the State of California, and I was wondering if it was going to affect our FQHC clinics.

Kim Glaun: So if you all submit – if the FQHC is submitting Medicare claims, it will affect their – the Remittance Advice that you receive.

Lizeth Pena: Okay. So, basically, as I – what I understand—and I want to clarify—is that it's for billing purposes, when the patient has Medicare and – well, over here in California, it's Medi-Cal. That means that Medicare will pay its part, and then – we'll still send it to Medi-Cal and Medi-Cal will still pay their part, correct?

Kim Glaun: That's right. We don't – all the processes that you use right now to submit claims to Medi-Cal are not impacted by this change.

Lizeth Pena: Okay. So there – it's going to be the same. It's just going to be affected – the parts – I mean, the pieces that are going to be affected only are the patients that are Medicare and do not have Medi-Cal or any other secondary insurance that we cannot – we're not going to be able to charge them. That's all – that 20 percent.

Kim Glaun: Right. The patients that are enrolled in the QMB program ...

Lizeth Pena: Yes.

Kim Glaun: ... the QMB program.

Lizeth Pena: Yes, okay. So I just wanted to confirm. So, like, for example, if a patient, you know, has Medicare only and they no – have no secondary and no Medi-Cal and they still have to pay that 20 percent or they're – I mean, we don't actually charge for their deductible. But 20 percent ...

Kim Glaun: I – yes, sorry. I mean, unless they have – there can be beneficiaries who enrolled in QMB – in the QMB program who are – you know, that falls under the Medi-Cal program in your state and you will receive on the Remittance Advice and you can see it in the eligibility verification that we provide as well through HETS. You can see when the patient is enrolled in the QMB program – in QMB. And in those cases, you can't enroll – you can't charge for the cost sharing.

Lizeth Pena: Okay.

Leah Nguyen: Thank you.

Cathy Sturgill: And I just have – this is Cathy. One thing to add to you – to your question. Were you saying that you were just looking at a Medicare-only beneficiary? They had no Medi-Cal whatsoever. Is that – was that part of your question?

Lizeth Pena: Yes, like, I just wanted to confirm, like, okay, the patient just has Medicare. No other secondary. No Medi-Cal. Just, …

Cathy Sturgill: Okay.

Lizeth Pena: … you know, Medicare only. If we're – that means that we're not going to charge them, not (crosstalk).

Cathy Sturgill: No, that's totally – that would be totally – that's totally separate. So, if you have just a Medicare beneficiary with no – and we're – and I'm – we're only referring to Medicaid. And in California, you're correct that it's Medi-Cal. So, if you're getting – if you're servicing just a straight Medicare recipient, ...

Lizeth Pena: Yes.

Cathy Sturgill: ... then the cost sharing doesn't apply to them. It's only when they are dually eligible, meaning that they have both Medicare and some form of Medicaid. So, if they only have Medicare, this wouldn't apply to them. Am I correct, Kim?

Kim Glaun: Yes. I was just making sure that the caller understood that QMB is a form of Medi-Cal coverage.

Cathy Sturgill: Oh, okay.

Lizeth Pena: Okay.

Rich Cuchna: And also, on the eligibility transaction, we will show the periods when you can charge a coinsurance and deductible and we'll explain what the deductible is and what the coinsurance is. The only time we're showing coinsurance and deductibles of zero is when the – our data systems have identified the beneficiary as a Qualified Medicare Beneficiary, and, under law, you can't charge the beneficiary the coinsurance or deductible. And that's why we return that on the Eligibility Transaction System that way.

Lizeth Pena: So now that I think I'm understanding now. So what you're trying to say is that the QMB program, it has to be – you know, the patient is going to have Medicare and Medi-Cal. It doesn't mean that the patient …

Kim Glaun: Yes.

Lizeth Pena: … is going to have Medicare only.

Kim Glaun: Yes. Correct.

Lizeth Pena: It does not even qualify for the QMB if they have straight Medicare only, like, only.

Kim Glaun: Right. Correct.

Cathy Sturgill: Right.

Kim Glaun: Yes. Correct.

Lizeth Pena: Oh, okay. I was thinking that it was when patient was going to – you know, we were not going to be able to charge the patient that 20 percent when patient only had Medicare, because, you know, they were enrolled into that QMB. But it has to be that – I mean, when – I'm sorry, when patient has QMB, it means that they are enrolled into Medicare and Medi-Cal, correct?

Kim Glaun: Exactly. Yes.

Lizeth Pena: Oh, I understand now. Okay. All right. Thank you very much.

Leah Nguyen: Thank you.

Kim Glaun: You're welcome.

Operator: Your next question comes from the line of Terri Barton.

Terri Barton: Hello. I have a question. I joined the conference late, and I'm wondering how I can get access to the slides.

Leah Nguyen: Yes, they are located at www.cms.gov/npc. And NPC is – that's National Provider Calls. And just look for the date of today's event on the list, and it's – you'll find the slides there.

Terri Barton: Terrific. Thanks so much.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Louise Lam.

Louise Lam: Hi. Sorry. I think I'm now active. So my question is in regards to a statutorily excluded item. It's a DME item, orthotics. They're never covered unless it's a brace. The patient doesn't have a brace. I read in the materials, it says this is for covered items, that QMBs are for covered items. So, what are we doing for noncovered items, never covered items?

Kim Glaun: For never –you're correct. It's only covered items. So, for statutorily excluded items, you – the QMB billing protections don't apply. However, we just always want to stress that if there is – the patient is covered – also has full Medicaid coverage and you participate in Medicaid as well, that you bill Medicaid for any excluded

services should the state plan cover the services for the beneficiary. So I don't know if that's an issue in your state or for you. But just …

Louise Lam: Well, we're in a …

Kim Glaun: in a Medicaid ...

Louise Lam: We're in a – so we're in a border state, and we operate in Idaho, but we get Washington State patients.

Kim Glaun: Okay.

Louise Lam: Unfortunately, for years, Washington Medicaid would not accept the crossover claims from Medicare directly. So, we were manually submitting every single Washington Medicaid claim, and we finally just cut the contract with Washington Medicaid. So, we are not on contract with Washington Medicaid any longer. And my particular patient today that I'm dealing with is a Washington Medicaid.

So, we are not participating with the Washington Medicaid. We are with Medicare. And this is a statutorily noncovered item. So, I'm thinking I don't have to bill Medicare for that since it's a noncovered, because we know we wouldn't be getting payment from the Washington Medicaid.

Rich Cuchna: I'll agree.

Kim Glaun: Right. I …

Cathy Sturgill: Yes.

Kim Glaun: Yes, Cathy, do you want to take that?

Cathy Sturgill: Yes, I was going to say that if you know that it's noncovered by Medicare, then I believe, of course, you wouldn't have to bill Medicare. However, when you're referencing that you're in Idaho and you're seeing a patient that lives in Washington State?

Louise Lam: Yes.

Cathy Sturgill: Okay. Because you're the approved DME supplier in that area. Am I correct? So your area encompasses not only – because right now, for DME, what happens – and this could not even be pertaining to your question because it appears that whatever service you're providing is not covered under Medicare. But how it works for DME in general is that currently Medicare has approved Medicare suppliers and some of their suppliers may not actually be located in the state of residence of their beneficiary. But they're still allowed to provide those supplies. And that was where my question was going. But it could be totally off from what you're asking.

Louise Lam: Essentially, yes, that's going different because it – it's ...

Cathy Sturgill: Okay.

Louise Lam: ... it's a statutorily approved item and, you know, like for something like a walking boot that would be – yes. We would have them go to an approved ...

Cathy Sturgill: Right.

Louise Lam: ... supplier for that. But this is a situation where straight not covered.

Cathy Sturgill: Okay. And, I mean, just to finish out my statement, if it was a DME that was provided through an approved Medicare supplier, even though that provider was located out of the state in which the beneficiary lived, state Medicaid agencies still have a cost-sharing responsibility in that situation. But I think that's just a general add-in, correct, Kim?

Kim Glaun: Okay. Thank you.

Cathy Sturgill: Yes.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Michelle Cooley. Ms. Cooley, your line is open.

Michelle Cooley: Hi. I was, actually, just wondering on these QMB-eligible members or patients, would they be affected by spend-downs? So if they're QMB-eligible, are the state Medicaid programs that have spend-downs – monthly spend-downs, would these patients fall into those categories? Because we do have patients that have spend-downs. And so, in that case, Medicaid then comes back on, let's say, a coinsurance or a deductible from Medicare that was crossed over and they will state, you know, "This isn't going to be paid. It will be patient responsibility for a spend-down amount."

Cathy Sturgill: Okay. So, Kim, I can try to address this one. Okay. So when we talk about Medicaid spend-down, really, we're then referring to what would be categorized as a QMB Plus, okay? Because ...

Michelle Cooley: Okay.

Cathy Sturgill: … what happens is – yes. Because what happens is, technically, the Medicaid agency determines eligibility. They look at up there and they see, "Yes, this person is eligible as a QMB." But additionally, they look at eligibility requirements for Medicaid. And the person is actually in what they call the Medicaid spend-down. And until they meet that spend-down amount, they are not eligible for Medicaid state plan services. So really, the state Medicaid agency's obligation there would to be to review for Medicare cost sharing just as a QMB and have that payment responsibility until the person actually meets their spend-down amount. Once they meet spend-down, …

Michelle Cooley: Okay.

Cathy Sturgill: … effective that date, then they could be eligible for Medicaid – coverage of Medicaid state plan services. Does that help you?

Michelle Cooley: Okay. Yes, that makes perfect sense. So basically, if they're taking it back to us – Medicaid's taking it back to us with a spend-down denial, then we do know it is legitimately a patient responsibility and we don't have to kind of pay it. I was like, "Oh, geez, you know, I've not really paid attention to the ones that we've had in the past. This is a spend-down. We crossed it over." But if they're actually involved in the cost sharing and the QMB eligibility and the spend-down has been met, then it would be something that they would cover.

Cathy Sturgill: Well, they would look at that claim. Once it crosses from Medicare, the state would look at it in two ways. One, they would look at it because we know this person is a QMB. So, they would pay according to their state plan for the Medicare cost sharing.

Secondly, they would say, "Oh, we have to look and see if this service received was covered under the Medicaid state plan." And if it is, if the person has met their spend-down, then they would have a financial responsibility for the Medicaid-covered service. So on those two things they're looking at.

Michelle Cooley: Okay.

Cathy Sturgill: But up front, they are looking at that person. Even though they're a Plus, they still have that cost-sharing responsibility for Medicare. (crosstalk)

Michelle Cooley: Okay. So they – so – yes. So, we wouldn't – we would bill – if we get a spend-down denial from Medicaid, we would bill the patient.

Cathy Sturgill: Actually, you can't bill that QMB because you're – look, it's a little bit difficult to understand. But even when we refer to them as a QMB Plus, we're still saying that this beneficiary meets all the requirements that they need to meet to be a QMB. So, there's no balance billing of that QMB even though they might be in a spend-down for Medicaid. Okay? So, that's why I'm saying that if you're getting a denial from the Medicaid agency, it could be that you need to talk to someone at that agency to have them explain why Medicaid was not looking at the Medicare cost-sharing payment responsibility.

Michelle Cooley: So – okay. So they should be paying it.

Cathy Sturgill: Well – and when you say they should be paying, I agree they should be reviewing and adjudicating according to their Medicaid state plan. So, it could be that you would not get any additional payment. But the reason – the RA should state the exact reason for why the state is not paying the Medicare cost sharing.

Kim Glaun: And just to add, when you talk to your state – sorry. This is to add to what Cathy said. You will want to ask your state, "Is this patient a QMB Plus having Medicaid?" They can have QMB Plus also meet full Medicaid coverage based on the spend-down. Or there are some spend-down – there are some beneficiaries who have just spend-down only; they have Medicaid only and they don't have QMB. And so, what you will want to parse out with your state is, when you're getting this denial, is this for a beneficiary – you know, which category of dual eligible they are. And that's going to affect …

Michelle Cooley: Okay.

Kim Glaun: … who you can bill.

Michelle Cooley: Okay. And as long ...

Cathy Sturgill: And it's always helpful to remember that what the states look at. First of all, they look at what type of beneficiary they have. Then they look at the type of service. And then they apply their state Medicaid payment rate. So that doesn't matter if I'm …

Michelle Cooley: Okay.

Cathy Sturgill: … a QMB or if I'm just a straight Medicaid beneficiary. Those are the things the state needs to identify through its MMIS before it makes payment.

Michelle Cooley: Right.

Leah Nguyen: Thank you.

Michelle Cooley: So – and then, basically, process those claims accordingly so that we were not getting a PR denial but we're getting a, you know, the QMB denial or adjudication on that EOB.

Cathy Sturgill: Right. You should – and, actually, I don't know (inaudible) there, but on the claim for the Medicare cost sharing on your Remittance Advice, it should be specific as to the reason why the state has made payment or has not.

Rich Cuchna: I agree, Cathy.

Michelle Cooley: Okay.

Cathy Sturgill: And that also – and then you can take that one step further because even if it was just a Medicaid – a straight Medicaid beneficiary, when the provider is paid, the state also has to identify why it pays or why it doesn't. So those codes should all be on there.

Michelle Cooley: Okay.

Cathy Sturgill: Yes.

Michelle Cooley: Okay. Great.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Natalie Aslanian. Natalie, your line is open.

Your next question comes from the line of Patti Heflen. Ms. Heflin, your line is open.

Patti Heflen: Yes, I am an – my name is Patti, and I am an ambulance provider. And we have some patients that use the 911 system for not really emergencies. But we go out there; we take their vitals; we check on them. And we bill a $136 charge to Medicare with an A0998 with a GY modifier. And we get denials from these because there was no transport to the facility. And so, when that gets billed to the Blue – to the Medicaid program, they also deny it because Medicare denied it. What are our choices here? Do we just know those patients – we're not ever going to get paid for those? Do you understand what I'm asking? I mean, …

Brian Pabst: This is Brian.

Patti Heflen: … you can't bill a QMB patient if it's – even if it's denied.

Brian Pabst: When it's denied, does it say the patient's responsible?

Patti Heflen: Yes, it has a PR, patient responsible.

Brian Pabst: PR. Okay. Well, that's your answer, then.

Patti Heflen: Yes, and I had a patient, and I got called by Medicare and said, "They are a QMB. You cannot bill them." I said, "Well, you denied it stating that there was no transport and that the patient was responsible."

Cathy Sturgill: And I think it's because of the reason why – Brian, would it be correct that the reason for the service was not what Medicare covered?

Brian Pabst: Right. But, Cathy, in that situation, if someone said that they really shouldn't have went after the beneficiary, could it have been that, really, behind the scenes, the person had QMB Plus unbeknownst to ...

Cathy Sturgill: It could ...

Brian Pabst: You know what I'm saying? Because you were talking about that. That makes a difference compared to…

Patti Heflen: Yes, we don't know at the time that we're – that we get a call – a 911 call ...

Brian Pabst: Right.

Patti Heflen: … and they go out there. We don't have any – especially me because I don't know – I'm not on the ambulance with the ALS crew. And so it's a day or two and I'm like, "Oh my gosh, it's another QMB patient." But we didn't transport. So, I go ahead and I bill it with the correct HCPCS code and the modifier on there letting Medicare know there was no transport. And they automatically deny that and then they say the patient is responsible. Then I bill the patient and I get a call from Medicare, "You can't do that, because Medicaid won't pick it up because Medicare had noncovered charges on there."

Kim Glaun: So are you – when you said Medicare called you, who's calling you from Medicare?

Patti Heflen: I don't have the person's name. And we had one patient that – she's a habitual caller. And whenever I see the RA or the run sheets on this, I'm like, "Oh my gosh." But she never wants to be transferred – transported. She just wants somebody to come out there. And so she calls 911.

Kim Glaun: Okay. You know what? If you can – why don't you email to the email box on – or – on slide 24 about your concerns? And maybe we can explore them a little further …

Patti Heflen: Okay.

Kim Glaun: … for you.

Patti Heflen: And so …

Kim Glaun: And also maybe include whether you provide ABNs or not.

Patti Heflen: And we don't supply the ABNs, ...

Kim Glaun: Okay.

Patti Heflen: ... because our guys – my chief says this is not the EMS personnel problem on your billing. They can't be thinking about that. They – they're to go out there, support that patient, and get it done.

Kim Glaun: Right. Okay. Well, thank you for trying to sort it through. Just if you could email it to us, we could look into it further.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Luz Alfonso.

Luz Alfonso: Hi. Good afternoon. My name is Luz Alfonso. I'm calling you from Florida. My question is about transplant medications, if you could clarify how it's going to be paid for patients that are QMB.

Kim Glaun: So those are covered under B, right, if a person had a Part A–covered transplant, right? So ...

Luz Alfonso: Usually, it's covered like Medicare – I'm sorry. Usually, general Medicare Part B takes 80 percent of the cost and then the other 20, if the patient has Medicaid, is full pay. But the provider that I visit – they have a situation where three patients having QMB, the claims were denied. After a year, they were notified that they're not going to receive that payment. So could you elaborate what the avenues are for the provider to try to get the payment (crosstalk)?

Kim Glaun: So did the provider miss the 1-year window to submit the claim?

Luz Alfonso: They submitted the claim month by month according to where the patient was getting the medication. And a year after, they just get the notification that they won't be paid.

Kim Glaun: Did the patient have a Part A–covered transplant? Do you know?

Luz Alfonso: Did they have what? I'm sorry.

Kim Glaun: Do they have a – when they had a transplant, were they covered by Part A? That's a …

Luz Alfonso: Yes, they were.

Kim Glaun: … requirement for Part B. They were.

Luz Alfonso: Right. Yes. They were.

Kim Glaun: That – yes. So you can't bill – generally, if it's a covered service, you can't bill. I'm not actually – we're not actually clear on why Medicare's denying the service itself. So if you want to email us about the particulars on the – to the email box on 24, please feel free …

Luz Alfonso: Sure.

Kim Glaun: … to do that.

Luz Alfonso: I'll ask to send it. Yes, I'll ask the provider then to ...

Kim Glaun: Okay.

Luz Alfonso: ... email it to you, yes. Because it's my understanding Medicare paid the 80 percent, but it's the 20 percent that has not been paid and it should be paid since Medicaid …

Kim Glaun: Oh, okay. Sorry.

Luz Alfonso: … picked up the 20 percent.

Kim Glaun: You know, okay. So you don't have to – so if Medicare paid its portion, it's Medicare covered ...

Luz Alfonso: Right.

Kim Glaun: ... (crosstalk) QMB. Okay. There's no – the patient cannot be billed for the 20 percent. The only ...

Luz Alfonso: Exactly.

Kim Glaun: The provider can bill Medicaid – right. The provider can bill Medicaid ...

Luz Alfonso: Right.

Kim Glaun: ... but they can't bill the …

Luz Alfonso: But when they billed Medicaid, they got a denial saying that it's not covered. So the ...

Cathy Sturgill: Okay. So if we're talking about this that's straight QMB on the Medicaid side, then, you know, if you want to email your question in and a little bit more specifics, we could check into it because the Medicaid ...

Luz Alfonso: Right.

Cathy Sturgill: ... agency should have looked at it and realized that this is a Part B–covered service by Medicare. And so, then they should apply their cost-sharing methodology. But we could look at it a little closer if you would – if you just want to send …

Luz Alfonso: Great.

Cathy Sturgill: … that question in to us. What state are you?

Luz Alfonso: Absolutely. Florida.

Cathy Sturgill: I'm sorry, I didn't – Florida?

Luz Alfonso: Florida. Yes.

Cathy Sturgill: Okay. Thank you.

Luz Alfonso: Thank you so much.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Linda Bird.

Linda Bird: Hi. My name's Linda, and I'm from Advanced Kidney Medical Group. And so when Medicare – when we run a Medicare patient and they show that they're a QMB or QMBs, is that also meaning they're eligible for the Medicare and Medi-Cal with a cost sharing – with the share of cost? And normally, when we have patients like that that come in and they haven't met the share of cost, we collect the 20 percent ahead of time. Are we still allowed to do that?

Kim Glaun: So, Cathy, you want me – you want to take it, or you want me to take it?

Cathy Sturgill: You know, let me try this. Okay. So I think what I heard you say is that you – when you – are you using the EVS on the – on your Medicaid side to identify the patient? How did you identify what type of dual eligible they were?

Linda Bird: Well, when we run their Medicare, we check their – we'll check their eligibility, and we'll see (crosstalk).

Cathy Sturgill: Okay. So they're Medicare. So, Kim, you can – yes. I thought she was talking about the Medicaid side. So, Kim, you want to answer?

Kim Glaun: You have to do the – so what is showing up in the Medicaid side? Is that what you're saying, that it shows QMB? And something else you were saying?

Linda Bird: On the Medicare, say, it'll show the QMB. Okay.

Kim Glaun: Yes. Okay.

Linda Bird: Does it – on the Medicare side, when it shows the QMB and the patient still has a share of cost, is it – does it show that? We always collect the share of cost ahead of time.

Kim Glaun: Okay. So you can't collect the cost-sharing amount for the patient, because they have the QMB benefit. But because the QMB benefit is separate, it's just what pays the cost-sharing amounts. But in order for the patient to sort of access full Medicaid coverage, they have to meet the share of cost. So – but that's somewhat of a separate issue. Cathy, do you want to add anything to that?

Cathy Sturgill: Okay. I hate to say this, but I'm not following it. Okay. So what I hear this person saying is that, when they check with Medicare, they identify this person as a QMB. And in – and …

Linda Bird: Right.

Cathy Sturgill: … they also identify that there's still a share of cost that is due. Maybe that's deductible premium.

Linda Bird: Correct.

Cathy Sturgill: Am I correct up to this point? Okay. So ...

Linda Bird: Well, a share of cost for Medi-Cal, yes.

Cathy Sturgill: Okay. So for – if it's – then if you're enrolled with the Medicaid program, when your claims cross over from Medicare to Medicaid, then Medicaid's going to once again take a look at the type of beneficiary and they're going to apply their state plan payment methodology. So, if that person is just truly a QMB Only, just a QMB, then you cannot balance bill for that cost of – the share of cost that you were speaking of. Kim, is – am I on the right track here?

Kim Glaun: Right. I guess they're saying if they're QMB Plus and they have a …

Linda Bird: Yes.

Kim Glaun: … share of cost for the Medicaid.

Cathy Sturgill: So you're saying that – and are they actively receiving Medicaid? Can you tell that? Or are they just in a spend-down situation?

Linda Bird: They're in like a spend-down. They have a share of cost, say, $1700, and they haven't met that yet.

Cathy Sturgill: Okay. So then, truly, the state Medicaid agency is responsible for their cost sharing, okay, for their – the cost of their Part A and B deductibles, premiums, coinsurance, etc. But that is a – as I explained before, when you're in spend-down, if you're – if you haven't met your spend-down, you're not eligible for Medicaid-covered services. So once …

Linda Bird: Okay.

Cathy Sturgill: … again, they would just be eligible for the Medicaid cost sharing. Does that help?

Linda Bird: Okay. Yes, so then we can bill them.

Cathy Sturgill: No. You can't – right. You can't bill a QMB.

Kim Glaun: You can't bill them for the Medicare cost-sharing amount.

Cathy Sturgill: Right.

Kim Glaun: But if there are other charges that you're – you know, other services you're giving them – are there other charges involved ...

Linda Bird: No.

Kim Glaun: ... that are non–Medicare covered?

Linda Bird: No, it's just – basically, just an – a specialist visit. They come in for just a visit.

Kim Glaun: Okay. So you can't bill them. Whenever they have QMB show up, even if they have a spend-down, you can't – I think what Cathy was saying, right, is – Cathy, ...

Cathy Sturgill: Yes.

Kim Glaun: … that you can't charge – you cannot charge them.

Cathy Sturgill: Right. Medicare prohibits you from balance billing that QMB. Even though they're identified as a QMB Plus, they still have full protection from Medicare cost sharing. Does that ...

Leah Nguyen: Thank you.

Cathy Sturgill: Yes.

Kim Glaun: But you can bill – Medicaid should be paying that amount. You can bill Medicaid.

Cathy Sturgill: Yes, if you're enrolled in the Medicaid program, they would review the claim and pay according to their state plan for cost sharing.

Operator: Your next question comes from the line of Cynthia Powell.

Cynthia Powell: Hi. My question is regarding the – where you said there were changes to the Medicare system, are you referring to the NGSConnex?

Rich Cuchna: So mainly, the Medicare systems we're talking about are the eligibility system that we changed to basically return zero deductible and coinsurance when in our database the beneficiary has been identified as a QMB. NGSConnex would reflect that change so that when you go in and check a beneficiary's eligibility through NGSConnex, it would show the zero deductible and zero coinsurance.

And so while they're not changing their system directly, they're getting their data from the HETS system. And so, it would be – it'd be reflected through their system. So, you would see that zero coinsurance and deductible. And then also, the claims processing systems at CMS are being changed next month so that on the Remittance Advice, it's also reflecting that the beneficiary is a QMB through the Remittance Advice Remark Codes.

Cynthia Powell: Okay. But the – so it doesn't state QMB patient on the Medicare or the NGSConnex system, correct?

Rich Cuchna: It would show a zero coinsurance and deductible.

Cynthia Powell: Okay. And so the other question is, When are you anticipating the systems to be updated with that – all that information?

Kim Glaun: So HETS was live last November. And next month is when the Remittance Advice Remark Codes will be active—in July.

Cynthia Powell: Okay. And the – another question is, Are there – is there ever going to be on the Medicare ID cards reflection of who is a QMB patient and who is not? I mean, that would make it so much easier.

Kim Glaun: Unfortunately, we don't have plans for that at this time.

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

Operator: Your last question comes from the line of Melissa O'Brien. Ms. O'Brien, your line is open.

Melissa O'Brien: Hi, there. I was checking to see if we were able to see QMB status on the Connex site.

Rich Cuchna: Yes, when you do an eligibility check through Connex, it will show zero deductible and zero coinsurance. And so, when you're looking at all the – on the eligibility response transactions, we're required

under the standard to show all the coinsurances. And you will see a zero coinsurance that the patient's responsible for.

Melissa O'Brien: Okay. Would it also have a zero under the deductible part?

Rich Cuchna: Yes.

Melissa O'Brien: Okay.

Rich Cuchna: And if there's a period where the patient has been a QMB and when the patient has not been a QMB, that will all be separated out so you can see the periods of when you can charge deductible and when you can't.

Melissa O'Brien: Okay. Wonderful. Thank you.

Leah Nguyen: Thank you. Dorothy, can we take one more question?

Operator: Your next question comes from the line of Jolyn Thomas. Ms. Thomas, your line is open.

Jolyn Thomas: Yes. I have a question in relation to – if a patient is just the straight QMB and they're trying to order diapers, if they're in that QMB plan, then the Medicaid's not going to cover it either. So, we are able to collect from those members?

Kim Glaun: So, Cathy, do you want to – so diapers are not – are excluded under Medicare, right? So, I guess would the question be, If they have full Medicaid coverage and what does Medicaid cover?

Cathy Sturgill: So, I think I heard her say – they only – they don't have full Medicaid, correct?

Jolyn Thomas: Yes.

Cathy Sturgill: No full Medicaid? Okay. So, you know, in that situation, it is a noncovered service by Medicare, Kim. So, if it's noncovered and it's still a QMB, I believe they still couldn't balance bill. Am I on – am I correct on that?

Kim Glaun: So actually, if Medicare doesn't cover it ...

Cathy Sturgill: Yes, oh wait a minute. Yes.

Kim Glaun: ... if it's excluded, like diapers, then if they only have QMB, they can be billed for the amount. They can.

Cathy Sturgill: Right. Because it's a noncovered Medicare service.

Kim Glaun: Right.

Jolyn Thomas: Okay.

Cathy Sturgill: Yes.

Jolyn Thomas: And then since they don't have that, do – would we need to check with the individual state plans to see if we need any type of, like, an Advance Beneficiary Notice to collect from them in that scenario?

Kim Glaun: Well, I think if – Cathy, do you want to speak to that? I mean, I think, in general, like, Medicaid would only be covering the service if the – an excluded Medicare service if it's actually excluded like this. They would only be covering it if the beneficiary has full Medicaid.

Cathy Sturgill: Right.

Kim Glaun: And if you're saying they're QMB Only, then I don't – then Medicaid wouldn't be looking to what it covers …

Cathy Sturgill: Right. Medicaid would have – Medicaid wouldn't even be looking at the claim, ...

Kim Glaun: Yes.

Cathy Sturgill: ... because it's not a Medicare-covered service. They would – if it crossed over, they would deny because Medicare didn't pay. And then they would look no further because you said they don't have active Medicaid. So, there would be nothing. And Medicaid – if it – if this person did apply and was eligible for Medicaid and that was a covered service, then Medicaid would review it for payment. But I think you said they had no Medicaid.

Jolyn Thomas: Right. They just have the QMB. So, it's only covering the Medicare-covered items.

Cathy Sturgill: Okay.

Kim Glaun: Yes.

Jolyn Thomas: Then we can collect those. If they were a QMB Plus, then, yes, we would absolutely have to bill the state for reimbursement.

Kim Glaun: That's right.

Leah Nguyen: Thank you.

Jolyn Thomas: Okay.

Leah Nguyen: 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.

Additional Information

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.