CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2280	**Date: April 19, 2019**
	Change Request 11250

SUBJECT: MAC Reporting of Issuance of Compliance Letters to Specific Providers and Suppliers Regarding Inappropriate Billing of Qualified Medicare Beneficiaries (QMBs) for Medicare Cost-Sharing

I. SUMMARY OF CHANGES: The purpose of this Change Request is to instruct Medicare Administrative Contractors (MACs) to report on an ongoing basis the issuance of provider compliance letters as first outlined in CR9817 and subsequent technical direction. This CR also instructs the MACs to use the attached revised provider compliance letter, revised explanatory beneficiary cover letter, and reporting templates.

EFFECTIVE DATE: May 20, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 21, 2019 - 30 days after issuance for BR3 and BR4; 10 days after the end of each calendar year quarter for BR2 and BR2.1

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	**CHAPTER / SECTION / SUBSECTION / TITLE**
N/A	

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 2280	Date: April 19, 2019	Change Request: 11250

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I. GENERAL INFORMATION

A. Background: Change Request 9817, issued November 8, 2016, required Medicare Administrative Contractors (MACs) to accept Beneficiary Contact Center (BCC) referrals of beneficiary inquiries involving Qualified Medicare Beneficiary (QMB) billing problems, issue compliance letters to named providers and send a copy of the provider compliance letter to the named beneficiary with an explanatory cover letter. See Publication (Pub.) 100-20. The purpose of this CR is to request data on the issuance of provider compliance letters by month since September 1, 2017, and on a quarterly basis (with counts by month within the quarter) beginning in 2019.

Federal law bars Medicare providers from charging individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) for Medicare deductibles, coinsurances, or copays for covered Parts A and B items and services. Medicare operations the QMB program to assist low-income beneficiaries with Medicare A/B premiums and cost-sharing. In 2017, approximately 7.7 million Medicare beneficiaries were enrolled in the QMB program.

State Medicaid programs are liable to pay Medicare providers who serve QMB individuals for the Medicare cost-sharing. However, as permitted by federal law, states can limit provider payment for Medicare cost-sharing to the lesser of the Medicare cost-sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service. Regardless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost-sharing from the beneficiary) as payment in full for services rendered to a QMB individual. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See sections 1902(n)(3); 1905(p); 1866(a)(1)(A); 1848(g)(3) of the Social Security Act.)

A July 2015 CMS study found that, despite federal law, erroneous balance billing of QMB individuals is relatively commonplace and that confusion about billing rules persists among providers and beneficiaries. (See *Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)*, Centers for Medicare & Medicaid Services July 2015 at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.)

CMS continues to receive anecdotal evidence that provider and beneficiary confusion persist.

Medicare &You, which is mailed to all beneficiaries in September of each year, contains language to advise QMB individuals about their billing protections and to call 1-800-MEDICARE if they cannot resolve billing problems with their providers. In addition, effective September 2016, Beneficiary Contact Center (BCC) Customer Service Representatives (CSRs) will identify a caller's QMB status and advise them about their billing rights.

B. Policy: MACs are instructed by CMS to report the number of compliance letters sent to providers from September 1, 2017 - March 31, 2019 (delineated by month) within 60 calendar days of the issuance of this CR. As requested in the September 1, 2017 Technical Direction Letter, each report should include:

• MAC Jurisdiction

• Line of Business (Part A, Part B, DME)

• State

• Month

• Number of Letters Sent

Please see attached template for Business Requirements 1.1 (BR1.1).

In addition, starting with the first calendar quarter of 2019, the MACs are instructed to report on a quarterly basis the number of compliance letters sent to providers each month within that quarter, according to the following schedule and within 10 business days of the close of the reporting period:

- January 1-March 31
- April 1-June 30
- July 1-September 30
- October 1-December 31.

Please see attached template for BR2.1.

Lastly, MACs are instructed to use the attached, updated versions of the provider compliance letter and explanatory cover letter for beneficiaries.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11250.1	The MAC shall report to CMS a monthly count of QMB billing compliance letters issued to providers and suppliers for all months from September 2017 - March 2019. The report shall be submitted to CMS within 60 calendar days of the issuance of this CR.	X	X		X					
11250.1.1	The MAC shall ensure that the report identified in BR1 stratifies the data by MAC jurisdiction, line of business (A/B/DME), state, month, and number of letters sent. [see attached one-time report template]	X	X		X					

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
11250.2	The MAC shall report to CMS a monthly count of QMB billing compliance letters issued to providers on a quarterly basis from January 2019 forward for each of the following quarters: January-March; April-June; July-September; October-December. The report shall be submitted to CMS within 10 business days of the end of each quarterly reporting period, except for the first quarter of 2019 report which shall be submitted within 30 calendar days of the issuance of this CR. For example, the first report covering letters sent from April 1-June 30, 2019 shall be submitted by July 15, 2019.	X	X		X					
11250.2.1	The MAC shall ensure that the report identified in BR2 stratifies the data by MAC jurisdiction, line of business (A/B/DME), state, month, and number of letters sent. [see attached quarterly report template]	X	X		X					
11250.3	The MAC shall use the revised provider compliance letter attached to this CR, dated February 14, 2019, no later than 30 days from the issuance of this CR.	X	X		X					
11250.4	The MAC shall use the revised beneficiary cover letter attached to this CR, dated February 14 2019, no later than 30 days from the issuance of this CR.	X	X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Carolyn Milanowski, 410-786-0437 or carolyn.milanowski@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 4

Jurisdiction X - [Name of] MAC/Line of Business (e.g., A or B or DME)- Count from Sept 2017-Dec 2018

Request for MAC Letter Counts for CR 11250/BR1.1

State	**Sept.2017**	**Oct.2017**	**Nov.2017**	**Dec.2017**	**Jan.2018**	**Feb.2018**	**Mar.2018**	**Apr.2018**	**May.2018**
State	0	0	1	0	0	0	0	0	0
State	0	0	0	0	1	1	0	0	0
State	0	0	0	0	0	0	0	0	0
State	0	0	0	0	0	0	0	0	0
State	0	0	0	0	0	0	0	0	0
State	0	0	1	0	0	0	0	0	0
State	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**2**	**0**	**1**	**1**	**0**	**0**	**0**

State	**June.2018**	**July.2018**	**Aug.2018**	**Sept.2018**	**Oct.2018**	**Nov.2018**	**Dec.2018**
State	0	0	1	0	0	0	1
State	0	0	0	0	0	0	0
State	0	0	0	0	0	0	0
State	0	0	0	0	0	0	0
State	0	0	0	0	0	0	0
State	0	0	1	0	0	0	1
State	0	0	0	0	0	0	0
Total	**0**	**0**	**2**	**0**	**0**	**0**	**2**

Jurisdiction X - [Name of] MAC/Line of Business (e.g., A or B or DME)- Quarterly Report

Request for MAC Letter Counts for CR 11250/BR2.1

State	**Jan.2019**	**Feb.2019**	**Mar.2019**
State	0	0	1
State	0	0	0
State	0	0	0
State	0	0	0
State	0	0	0
State	0	0	1
State	0	0	0
Total	**0**	**0**	**2**

[REMOVE PRIOR TO SENDING: Compliance Letter to Providers]
[month] [day], [year]
[address]
[City] ST [Zip]

Reference ID: (NPI, etc.)

Dear [Provider/Supplier Name]:

The Centers for Medicare & Medicaid Services (CMS) received information that [Provider/Supplier Name] is improperly billing [Medicare beneficiary name/MBI (or HICN) number] for Medicare cost-sharing.

This beneficiary is enrolled in the Qualified Medicare Beneficiary (QMB) program, a state Medicaid program that helps low-income beneficiaries pay their Medicare cost-sharing. Federal law says Medicare providers can't charge individuals enrolled in the QMB program for Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) deductibles, coinsurances, or copays for items and services that Medicare covers. Please take the following actions:

- **Promptly review your records for efforts to collect Medicare cost-sharing from [Medicare beneficiary name/MBI (or HICN) number];**
- **Refund any amounts already paid; and**
- **Recall any past or existing billing (including referrals to collection agencies) for Medicare-covered items and services.** Make sure that your administrative staff and billing software exempt individuals enrolled in the QMB program from all Medicare cost-sharing billing and related collection efforts.

For services given to individuals enrolled in the QMB program, Medicare providers and suppliers must accept Medicare payment and Medicaid payment (if any) as payment in full. Medicare providers and suppliers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); 1848(g)(3) of the Social Security Act.)

To make sure they're complying with QMB billing requirements, Medicare providers and suppliers should have processes in place to routinely identify the QMB status of beneficiaries. You can do this by:

- Using eligibility data you get through Medicare's HETS (HIPPA) 270/271 transaction to verify a beneficiary's QMB status and exemption from cost-sharing charges prior to billing Medicare;
- Using the Medicare Provider Remittance Advice to verify your patient's QMB status after claims are processed; and
- Using state online Medicaid eligibility systems or other documentation, including Medicaid identification cards, Medicare Summary Notices, and documents issued by the state proving the patient is enrolled in the QMB program.

For more information on QMB billing requirements and to learn how to promote compliance, read this Medicare Learning Network (MLN) Matters® article at CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf. If you have questions, please contact [MAC information].

Sincerely,
[Name] [Title]

[MAC name]

[REMOVE PRIOR TO SENDING: Cover Letter for affected QMB Individuals sent by MAC]

[month] [day], [year]

[address]
[City] [ST] [Zip]

Reference ID: (NPI, etc.)

Dear [Beneficiary Name]:

You contacted Medicare about a bill you got from your Medicare health care provider or supplier, [Provider/Supplier Name]. Because you're in the Qualified Medicare Beneficiary (QMB) program, which helps pay your Medicare costs, **Medicare providers can't bill you for Medicare deductibles, coinsurance, or copays for covered items and services.**

After you contacted us, we sent [Provider/Supplier Name] the letter shown on the next page. It tells the provider or supplier to stop billing you and to refund you any amounts you already paid.

Here's what you can do:

1. Show this letter to [Provider/Supplier Name] to make sure they fixed your bill.
2. Give your provider or supplier a copy of the Medicare Summary Notice we send you anytime you're billed for care that Medicare covers. It will prove you have QMB and shouldn't be billed.
3. Tell all of your providers and suppliers you are in the QMB program and shouldn't be billed.
4. Show your Medicare card and your Medicaid or QMB cards each time you get items or services.

If you have questions about this letter, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-.

Sincerely,

[Name]

[Title]

[MAC name]

[month] [day], [year]
[address]
[City] ST [Zip]

Reference ID: (NPI, etc.)

Dear [Provider/Supplier Name]:

The Centers for Medicare & Medicaid Services (CMS) received information that [Provider/Supplier Name] is improperly billing [Medicare beneficiary name/MBI (or HICN) number] for Medicare cost-sharing.

This beneficiary is enrolled in the Qualified Medicare Beneficiary (QMB) program, a state Medicaid program that helps low-income beneficiaries pay their Medicare cost-sharing. Federal law says Medicare providers can't charge individuals enrolled in the QMB program for Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) deductibles, coinsurances, or copays for items and services that Medicare covers. Please take the following actions:

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Sincerely,
[Name] [Title]

[MAC name]