Update from Centers for Medicare and Medicaid Services (CMS)

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TO: All Medicare Advantage Organizations, Section 1876 Cost Plans, Section 1833 Cost Plans, Medicare-Medicaid Plans, and PACE Organizations

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SUBJECT: Qualified Medicare Beneficiary Program Enrollee Status Resources

This memorandum provides information regarding existing Centers for Medicare & Medicaid Services (CMS) resources for plans to identify the status of Qualified Medicare Beneficiary (QMB) Program enrollees. In 2017, CMS reminded plans of their obligations to educate network providers about QMB billing rules and to maintain procedures that ensure network providers do not discriminate against enrollees based on their payment status, e.g., QMB.[1] In response we received several questions about how to identify QMB status and promote compliance. This memorandum addresses these questions and offers resources and potential strategies for plans.

The QMB Program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans. As a reminder, for Medicare-Medicaid Plans in the capitated model of the Financial Alignment Initiative and for Program of All-Inclusive Care for the Elderly (PACE) organizations, coinsurance, copays, and deductibles are zero for all Medicare A/B services.

[1] See Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter; Medicare Managed Care Manual, Ch. 4, Section 10.5.2.

Identifying QMBs

Timely access to enrollees' QMB status is critical to inform, monitor, and promote provider compliance with these rules. CMS provides the following ways for plans to identify the QMB status of their enrollees.

- *Medicare Advantage Medicaid Status Data File*
  - Effective January 1, 2017, CMS began sending plans a new monthly Medicare Advantage Medicaid Status File that provides the monthly dual statuses and corresponding dual status codes for members who are full or partial duals. Each report will provide the most recent Medicaid information on the plan's enrollees.[2]
  - QMB status is reflected in data element (Field 8) – Medicaid Dual Status Code;

Length – 2 bytes; Field Position 40-41; Codes Values for QMBs are 01 and 02.

- *Monthly Membership Detail Data (MMDD) File*
  - QMB status can be identified in data element (Field 84) – Medicaid Dual Status Code; Length – 2 bytes; Field Position – 446-447; Code Values for QMBs are 01 and 02.[3]
  - Note that the MMDD is generated late in a given month to identify enrollees for the following month. Thus, it would not include individuals who enroll late in the month (i.e., after MMDD is generated).
- *MARx UI (M257 screen)*
  - This screen can be used to identify dual status code on a specific individual.
  - See Medicaid Dual Status Code 01 or 02.

CMS encourages plans to affirmatively inform contracted providers about enrollees' QMB status. Potential strategies include providing QMB status information and indicators through member ID cards, online provider portals, Evidence of Benefits statements, and provider online and phone query mechanisms. Medicare-Medicaid Plans should make clear that all enrollees –regardless of whether they have QMB status or not – have zero Medicare A/B coinsurance, copayments, and deductibles.

Provider Education

CMS encourages plans to educate providers about the prohibition on billing for Medicare A/B deductibles and coinsurance. Potential strategies include holding recurring trainings, conducting targeted education to providers that improperly bill members, and adding language to provider-focused websites, provider newsletters, and/or provider manuals.

Plans may want to leverage CMS's MedLearn Matters article that notifies Medicare providers of the prohibition on billing QMBs for Medicare A/B deductibles and coinsurance, available on our website at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf

Moreover, starting in March 2017, the Complaints Tracking Module (CTM) began distinguishing QMB complaints from other complaints.When appropriate, CMS encourages plans to use this source of information, alongside grievance and plan call center data, to identify further opportunities to strengthen provider education activities, improve internal call center messaging, and reduce future CTM complaints.

[2] See Advance Notice of February 2017 System Release https://www.cms.gov/Research-Statistics-Data-and- Systems/CMS-Information-Technology/mapdhelpdesk/Downloads/Advance-Announcement-of-the-February-2017- Software-Release.pdf. See also MAPD Plan Communications User Guide (PCUG), https://www.cms.gov/Research- Statistics-Data-and-Systems/CMS-Information-technology/mapdhelpdesk/Plan_Communications_User_Guide.html. In the February 28, 2017, version, it is in Appendix F.30, pages F-213-215.

[3] See MAPD PCUG, https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-technology/mapdhelpdesk/Plan_Communications_User_Guide.html. In the February 28, 2017, version, it is in Appendix F.12, Item 84, page F-92.

For More Information on the MARx UI or MARx Reports:
Plans may direct any questions or concerns to the MAPD Help Desk at 1-800-927-8069, or email mapdhelp@cms.hhs.gov.

Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

What You Need to Know

STOP – Impact to You

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds **all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing.** QMB is a Medicare Savings Program (MSP) that exempts Medicare beneficiaries from Medicare cost-sharing liability.

CAUTION – What You Need to Know

The QMB program is a State Medicaid benefit that covers Medicare premiums and deductibles, coinsurance, and copayments, subject to State payment limits. (States may limit their liability to providers for Medicare deductibles, coinsurance, and copayments under certain circumstances.) Medicare providers may not bill QMB individuals for Medicare cost-sharing, regardless of whether the State reimburses providers for the full Medicare cost-sharing amounts. Further, all original Medicare and MA providers--not only those that accept Medicaid--must refrain from charging QMB individuals for Medicare cost- sharing. Providers who inappropriately bill QMB individuals are subject to sanctions.

GO – What You Need to Do

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staff are aware of the Federal billing law and policies regarding QMB individuals. Contact the Medicaid Agency in the States in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for their Medicare cost- sharing. If you are a MA provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments.

Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers from billing a QMB beneficiary under any circumstances. See **Section 1902(n)(3)(B) of the Social Security Act (the Act), as modified by Section 4714 of the Balanced Budget Act of 1997.** QMB is a Medicaid program for Medicare beneficiaries that exempts them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, States can limit provider reimbursement for Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who do not follow these billing prohibitions are

violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

Inappropriate Billing of QMB Individuals Persists

Despite Federal law, improper billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information, refer to Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015.

Important Clarifications Concerning the QMB Billing Law

Be aware of the following policy clarifications to ensure compliance with QMB billing requirements.

1. All original Medicare and MA providers--not only those that accept Medicaid—must abide by the billing prohibitions.
2. QMB individuals retain their protection from billing when they cross State lines to receive care. Providers cannot charge QMB individuals even if the patient's QMB benefit is provided by a different State than the State in which care is rendered.
3. Note that QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The Federal statute referenced above supersedes Section 3490.14 of the State Medicaid Manual, which is no longer in effect.

Ways to Improve Processes Related to QMBs

Proactive steps to identify QMB individuals you serve and to communicate with State Medicaid Agencies (and MA plans if applicable), can promote compliance with QMB billing prohibitions.

1. Determine effective means to identify QMB individuals among your patients, such as finding out the cards that are issued to QMB individuals, so you can in turn ask all your patients if they have them. Learn if you can query State systems to verify QMB enrollment among your patients. MA providers should contact the plan to determine how to identify the plan's QMB enrollees. Beginning October 1, 2017, you will be able to readily identify the QMB status of your patients with new Medicare Fee-For-Services improvements. Refer to **Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System** for more information about these improvements.
2. Determine the billing processes that apply to seeking reimbursement for Medicare cost-sharing from the States in which you operate. Different processes may apply to Original Medicare and MA services provided to QMB beneficiaries. For Original Medicare claims, nearly all States have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.
    - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare Remittance Advice.
    - Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system to bill the State.

3. Ensure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

QMB Eligibility and Benefits

Program	Income Criteria*	Resources Criteria*	Medicare Part A and Part B Enrollment	Other Criteria	Benefits
QMB Only	≤100% of Federal Poverty Line (FPL)	≤3 times SSI resource limit, adjusted annually in accordance with increases in Consumer Price Index	Part A***	Not Applicable	Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)

QMB Plus	≤100% of FPL	Determined by State	Part A***	Meets financial and other criteria for full Medicaid benefits	• Full Medicaid coverage • Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)

* States can effectively raise these Federal income and resources criteria under Section **1902(r)(2)** of the Act.

*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a "conditional basis"). For more information on this process, refer to Section HI 00801.140 of the **Social Security Administration Program Operations Manual System**.

Additional Information

For more information about dual eligibles under Medicare and Medicaid, please visit **https://www.medicaid.gov/affordable-care-act/dual-eligibles/index.html** and **https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html** and refer to **Dual Eligible Beneficiaries Under Medicare and Medicaid**. For general Medicaid information, please visit **http://www.medicaid.gov/index.html**.