Improving the Customer Service Experience for Qualified Medicare Beneficiaries (QMBs)

Kim Glaun, Medicare-Medicaid Coordination Office (MMCO), Centers for Medicare & Medicaid Services (CMS)
May 9, 2018
CMS Efforts to Reduce Inappropriate Billing of Persons Enrolled in QMB
Enhanced 1-800 Procedures to Assist QMBs

• Call center representatives can:
  – Identify the QMB status of all callers
  – Provide information regarding QMB billing protections
  – Address persistent billing
    • MACs send compliance letters to original Medicare providers (See slide 4)
    • Enter cases into casework system (CTM) for Medicare Advantage enrollees
  – Address inquiries from a QMB MA enrollee regarding a Medicare Advantage provider’s willingness to serve her/him
Outreach to Providers to Address Persistent Billing

• Effective 12/16, 1-800 customer service representatives can send cases to the Medicare Administrative Contractors (MACs) to:
  – Issue letters to providers whom beneficiaries report as persisting in inappropriate billing
  – Send beneficiaries a copy of the compliance letter (with an explanatory cover letter)

• See CMS MLN 99817
Three Tips for QMBs

1. Tell the provider or debt collector that you have QMB and can’t be charged.

2. If the medical provider won’t stop billing you, call 1-800-MEDICARE (TTY-1-800-633-4227).

3. If you have a problem with debt collection, you can send a complaint to the Consumer Financial Protection Bureau (CFPB) online or call the CFPB toll-free at (855) 411-2372. (TTY (855) 729-2372.)

– Medicare blog: 3 Tips for People in the Qualified Medicare Beneficiary Program (QMB) (Jan. 2017)
  • English version
  • Spanish version
Starting July 2018, the Medicare Summary Notice (MSN) will clearly identify when the beneficiary was enrolled in the QMB program, and will accurately reflect the beneficiary’s cost-sharing liability ($0 for the period enrolled in the QMB program).

For more information, see QMB Indicator in the Medicare Fee-For-Service Claims Processing System MLN Matters Article.
Part B Medicare Summary Notice: Page One

Notice for Jennifer Washington

<table>
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<tr>
<th>Medicare Number</th>
<th>XXX-XX-1234A</th>
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<tbody>
<tr>
<td>Date of This Notice</td>
<td>September 16, 2017</td>
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<tr>
<td>Claims Processed Between</td>
<td>June 15 – September 15, 2017</td>
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Your Claims & Costs This Period

- Did Medicare Approve All Services? Yes
- Number of Services Medicare Denied: 0

See claims starting on page 3.

Total You May Be Billed: $0.00

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met $85.00 of your $109.00 deductible for 2017.

Be Informed!

This notice contains claims covered by the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. When you’re enrolled in the QMB program, providers and suppliers who accept Medicare aren’t allowed to bill you for Medicare deductibles, coinsurance, and copayments.

Providers with Claims This Period

- June 18, 2017
  Susan Jones, M.D.
- June 28, 2017
  Craig I. Secosan, M.D.
- June 29 – June 30, 2017
  Edward J. Mckinley M.D.
### Medicare Summary Notice for Part B: Detail Line

**June 18, 2017**

**Dr. Susan Jones, M.D., (555) 555-1234**

**Brevard County Physical Therapy Center, 32 Main Street, Brevard, NC 28712-4187**

<table>
<thead>
<tr>
<th>Service Provided &amp; Billing Code</th>
<th>Service Approved?</th>
<th>Amount Provider Charged</th>
<th>Medicare-Approved Amount</th>
<th>Amount Medicare Paid</th>
<th>Maximum You May Be Billed</th>
<th>See Notes Below</th>
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<td>Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 min (97110)</td>
<td>Yes</td>
<td>$45.00</td>
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<td><strong>$45.00</strong></td>
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<td><strong>$22.83</strong></td>
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</table>

### Notes for Claims Above

A You’re in the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. Health care providers who accept Medicare can’t bill you for the Medicare costs for this item or service, but you may be charged a small Medicaid copay.
New Tools to Identify QMB Status and Assist with Compliance

- Providers, suppliers and their authorized billing agents can use Medicare eligibility data provided by CMS’ HIPPA Eligibility Transaction System (HETS) to verify a beneficiary’s QMB status and exemption from cost-sharing charges. (Effective November 2017).

- Original Medicare providers and suppliers will be able to readily identify the QMB status of patients and billing prohibitions from the Medicare Remittance Advice (which they receive after they bill Medicare). (Effective July 2018).
• Plans must re-educate providers regarding billing rules under 42 CFR §422.504(g)(1)(iii)
  – Identifying the QMB status of enrollees is a key way to promote compliance.
• Plans must have procedures to ensure that MA providers do not refuse to serve enrollees based on QMB status
• See Instructions to Medicare Advantage plans regarding QMB billing prohibitions CY 2017 Call Letter (pp. 181-83); CY 2019 Call Letter (pp.217-219)
Efforts to Promote Outreach
Highlighting SSA Outreach Efforts for the Medicare Savings Programs

• Each spring SSA identifies and sends letters to around 2 million Medicare beneficiaries who might be eligible for the Medicare Savings Programs (MSPs) to encourage them to apply. It also send data files to all 51 state Medicaid agencies identifying those in their state who SSA is sending letters to, to support customer service and outreach. (estimated May 9).

• This year, CMS took steps to highlight this outreach effort, including a:
  – Tweet from Medicare.gov (https://twitter.com/MedicareGov/status/989565523942920193)
Streamlining Enrollment in QMB for 65+ Individuals Who Lack Premium-Free Part A
Certain 65+ individuals only qualify for Part A with a premium (“Premium Part A”)

For eligible persons, QMB will pay the Part A premium (in addition to Parts A and B cost-sharing and Part B premiums)
Section 1905(p)(1) of the Social Security Act requires persons to have Part A to qualify for QMB, but most QMB-eligible persons cannot afford to enroll in Part A.

Two-step application process was created to address this issue

1. At SSA, individual files for Premium Part A conditioned upon approval for QMB.
2. Through the state, person applies for QMB.
Option to Streamline Enrollment

States can simplify enrollment processes by entering into a Part A Buy-In Agreement with CMS.

• 36 states and DC have one
• Benefits:
  – Allows persons to enroll in QMB at any time of the year
  – Removes late premium penalties for states.
  – Allows states to directly enroll persons with Part B in QMB (without a separate trip to the SSA office)

In states without Part A Buy-In Agreements:

• Individuals must complete the two-step application process
• Can only do so during the annual General Enrollment Period (January through March, with coverage effective July 1) and
• States must pay any penalties due to delayed Part A enrollment.