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Medicare-Medicaid Coordination Office

DATE: April 3, 2018

TO: All Medicare Advantage Plans and Cost Plans

FROM: Sharon Donovan, Director, Program Alignment Group, Medicare-Medicaid Coordination Office

SUBJECT: Qualified Medicare Beneficiary Program Information in Remittance Advice and Explanation of Benefits

Plans must educate network providers about the federal prohibition on collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from those enrolled in the Qualified Medicare Beneficiary (QMB) Program, a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B cost-sharing. In 2016, 7.5 million individuals (more than one out of every eight Medicare beneficiaries) were enrolled in the QMB program.

To assist plans in promoting provider compliance with QMB billing requirements, CMS has encouraged plans to affirmatively inform providers about enrollee QMB status and exemption from cost-sharing liability. This memo recommends how plans can incorporate QMB information in the plan's Remittance Advice (RA, also known as Explanation of Payment), based upon upcoming changes to the Medicare Fee for Service (FFS) RA, that will take effect July 2, 2018. In addition, this memo encourages plans to incorporate QMB information in the Explanation of Benefits (EOBs) to beneficiaries to promote beneficiary awareness of their protections from being billed for Medicare A/B services.

CMS Suspended 2017 CMS FFS RA Changes

CMS supports recent steps by plans to incorporate QMB information in their RA to network providers. We understand that as part of those efforts, plans may have replicated Remittance Advice changes to the Medicare FFS claims systems CMS released in October 2017 (see CR 9911). Specifically, they may have replicated the CMS change of the display of patient responsibility on the RA to "zero" for QMBs.[1]

We are writing to alert plans that, due to unforeseen issues affecting the processing of claims by secondary payers, CMS suspended the CR 9911 RA changes for FFS QMB claims in December 2017 due to unforeseen issues impacting the processing of secondary payments. We strongly encourage plans that may have replicated these changes to discontinue them and produce "replacement" Medicare RAs that impacted providers can submit to supplemental payers to coordinate benefits as necessary. For more details, please see Attachment 1.

Recommended Steps to Incorporate QMB Information in Plan RAs

Effective July 2, 2018, the CMS will reintroduce Remittance Advice Remark Codes (RARCs) in the RA to notify providers if the beneficiary is a QMB and not liable for Medicare cost-sharing, but retain the display of patient liability amounts needed by secondary payers to process QMB cost-sharing claims. For detailed information about the changes, see https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3965CP.pdf. The provider article can be found here https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10433.pdf.

CMS recommends that plans take the following steps with respect to QMB information in their RAs to align with the upcoming QMB RA information in the FFS claims processing systems.

1. Use Alert RARCs N781/N782/N783 to designate that the beneficiary is enrolled in the QMB program and may not be billed for Medicare cost sharing amounts.
    - N781 - Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.
    - N782 – Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.

[1] CMS showed zero patient responsibility for QMBs by:
- replacing Claim Adjustment Group Code "Patient Responsibility" (PR) with Group Code "Other Adjustment" (OA)
- zeroing out the deductible and coinsurance amounts associated with Claim Adjustment Reason Code (CARC) 1 (deductible) and/or 2 (coinsurance) and
- using CARC 209 – ("Per regulatory or other agreement, the provider cannot collect this amount from the patient.)

- N783– Alert: Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected copayment. This amount may be billed to a subsequent payer.

2. Retain the display of monetary values for deductible and coinsurance amounts in conjunction with Group Code "PR" and associated CARCs for cost-sharing amounts (i.e., "1," "2," and "3"). States and other secondary payers generally require RAs that separately display the Medicare deductible and coinsurance amounts with the Claim Adjustment Group Code "PR" and associated CARCs.

QMB Information in Explanation of Benefits

Improvements to RAs should help providers better comply with QMB billing rules. We believe it is also important to promote enrollees' awareness of QMB billing prohibitions and to accurately reflect cost-sharing liabilities – or lack thereof – in materials that enrollees receive. CMS' October 2017 FFS system changes described above also changed the Medicare Summary Notice to include new messages for QMB beneficiaries and reflect $0 cost-sharing liability for the period they are enrolled in QMB. The MSN changes were also suspended in December 2017 but will be reactivated in their entirety in July 2018. CMS recommends that plans similarly indicate the QMB status and zero cost-sharing liability of QMB enrollees in EOBs to empower enrollees to exercise their rights and educate their providers about billing rules.

Attachment 1 – Additional Information on Last Year's CR9911

To help providers more readily identify the QMB status of their patients, CMS made two types of changes to the Remittance Advice for FFS claims processed on or after October 2, 2017:

- First, the RA included new Alert RARCs to notify providers to refrain from collecting Medicare cost-sharing because the patient is a QMB (N781 is associated with deductible amounts and N782 is associated with coinsurance).
- Second, CMS changed the display of patient responsibility on the RA by replacing Claim Adjustment Group Code "Patient Responsibility" (PR) with Group Code "Other Adjustment" (OA). CMS zeroed out the deductible and coinsurance amounts associated with Claim Adjustment Reason Code (CARC) 1 (deductible) and/or 2 (coinsurance) and used CARC 209 – ("Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to the patient if collected. (Use only with Group code OA).")

However, the new display of cost-sharing in the RAs prevented states and other secondary payers from processing QMB cost-sharing claims submitted by providers outside the Medicare COBA claims crossover process. States and other secondary payers generally require RAs that separately display the Medicare deductible and coinsurance amounts with the Claim Adjustment Group Code "PR" and associated CARCs and cannot process QMB cost-sharing claims submissions with Group Code OA and CARC 209. To address these issues, CMS suspended the RA modifications on December 8, 2017.

CMS will generate "replacement" RAs without the October 2017 changes for impacted claims in order to facilitate re-processing of QMB cost-sharing claims by secondary payers. (See CR to be released- CR 10494). The provider article can be found here https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10433.pdf.