GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Subject: Qualified Medicare Beneficiaries
Policy Number: HCPRA-DEP-

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1. PURPOSE

The purpose of this policy is to establish policies and procedures for the Qualified Medicare Beneficiary (QMB) program.

The Qualified Medicare Beneficiary (QMB) program provides cost-sharing assistance for Medicare Part A and Medicare Part B for low-income Medicare beneficiaries. In addition, participation in the QMB program automatically qualifies beneficiaries for the low-income subsidy (LIS) for the Medicare Part D prescription drug benefit.[1] QMB coverage is effective on the first day of the month following the month in which the applicant was determined eligible.[2]

2. APPLICABILITY

This policy applies to the Economic Security Administration (ESA) and the Department of Health Care Finance (DHCF).

3. AUTHORITY

The Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109); 42 U.S.C. §1396a(e)(8); 42 U.S.C. §1396a(34); 42 U.S.C. §1396a(n)(3)(B); 42 U.S.C. §1395w-114(a)(3)(B)(v)(II); State Plan for Medical Assistance, Attachment 2.2A,

[1] 42 U.S.C. §1395w-114(a)(3)(B)(v)(II); Medicare Prescription Drug Manual, 30.1, effective November 21, 2008; Centers for Medicaid and CHIP Services, "Annual Redetermination of Medicare Part D Low-Income Subsidy Deemed Status (Re-deeming)," July 19, 2012.
[2] 42 U.S.C. §1396a(e)(8).

pages 9b and 9b1; Supplement 8a to Attachment 2.6-A, page 2; Supplement 8b to Attachment 2.6-A, page 5; Supplement 1 to Attachment 4.19B, pages 1-3.

4. BENEFITS, ELIGIBILITY, AND EFFECTIVE DATES OF COVERAGE

A. QMB Program

1. QMB Program Benefits

   a. Medicaid pays Part A and/or Part B premiums.[3]
   b. Medicaid pays Part A deductibles up to the Medicare amount and Part B deductibles up to the Medicaid amount.[4]
   c. Medicaid pays Part B coinsurance up to the Medicaid amount.[5]
   d. For APDRG facilities, Medicaid pays Part A coinsurance up to the lesser of: the coinsurance amount as determined by Medicare Part A, the District's All Payor Diagnosis Related Group (APDRG) amount, or the Medicare Diagnosis Related Group (DRG) amount.[6] For non-APDRG facilities, Medicaid pays Part A coinsurance up to the lesser of: the coinsurance amount as determined by Medicare Part A, the District Medicaid calculated rate (*i.e.*, per-diem), or the Medicare DRG amount.[7]
   e. Beneficiaries may not be billed for cost-sharing or coinsurance by any Medicare provider, even if the District does not pay the full amount of coinsurance for a covered service and/or the provider does not participate with the District's Medicaid program.[8]
   f. QMB beneficiaries are automatically eligible for the LIS for the Medicare Part D prescription drug benefit.[9]

2. Eligibility for the QMB Program

   a. To be eligible for the District's QMB program, an applicant must meet the following requirements:
      1. Be a District of Columbia resident;
      2. Be entitled to Medicare Part A benefits and
      3. Have countable income at or below 300% of the Federal Poverty Level (FPL).[10]
   b. The District of Columbia has no resource limit for the QMB program.[11]

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[3] District of Columbia Medicaid State Plan, Supplement 1 to Attachment 4.19B, page 2.
[4] Id.
[5] Id.
[6] Id. at 3.
[7] Id.
[8] 42 U.S.C. §1396a(n)(3)(B).
[9] 42 U.S.C. §1395w-114(a)(3)(B)(v)(II); Medicare Prescription Drug Manual, 30.1 effective November 21, 2008; Centers for Medicaid and CHIP Services, "Annual Redetermination of Medicare Part D Low-Income Subsidy Deemed Status (Re-deeming)," July 19, 2012.
[10] District of Columbia Medicaid State Plan, Supplement 8a to Attachment 2.6-A, page 2.
[11] District of Columbia Medicaid State Plan, Supplement 8b to Attachment 2.6-A, page 5.

c. QMB eligibility is not tied to eligibility for other Medicaid services. Failure to recertify for another service, such as the Elderly and Physically Disabled (EPD) Waiver, does not terminate QMB eligibility.
d. QMB eligibility is renewed on an annual basis. A beneficiary's eligibility must be reevaluated at least every twelve months to determine whether she/he remains QMB eligible.

e. Renewal Process : QMB and QMB Plus beneficiaries will receive a renewal form 90 days prior to the end of the QMB certification to renew their QMB eligibility. At renewal all non-financial and financial eligibility factors will be verified to determine if the beneficiary remains eligible for coverage. To the greatest extent possible, electronic data sources will be used to verify eligibility factors.

3. Effective Dates of QMB Coverage

a. QMB coverage is effective on the first day of the month following the month in which the applicant was determined eligible.[12]
b. The QMB eligibility period is 12 months from the start of coverage.[13]

B. QMB Plus Program

1. QMB Plus provides full Medicaid benefits and coverage of the beneficiary's Medicare premiums and cost sharing. These individuals are fully eligible for Medicaid and Medicare.

2. QMB Plus Program Benefits:

a. Full Medicaid benefits.[14]
b. Medicaid pays Part A and/or Part B premiums.[15]
c. Medicaid pays Part A deductibles up to the Medicare amount and Part B deductibles up to the Medicaid amount. [16]
d. Medicaid pays Part B coinsurance up to the Medicaid amount.[17]
e. For APDRG facilities, Medicaid pays Part A coinsurance up to the lesser of: the coinsurance amount as determined by Medicare Part A, the District's All Payor Diagnosis Related Group (APDRG) amount, or the Medicare Diagnosis Related Group (DRG) amount.[18] For non-APDRG facilities, Medicaid pays Part A coinsurance up to the lesser of: the coinsurance amount as determined by Medicare

[12] 42 U.S.C. §1396a(e)(8).
[13] Id.
[14] District of Columbia Medicaid State Plan, Supplement 1 to Attachment 4.19B, page 2.
[15] Id.
[16] Id.
[17] Id.
[18] Id. at 3.

Part A, the District Medicaid calculated rate (*i.e.*, per-diem), or the Medicare DRG amount.[19]

f. Beneficiaries may not be billed for cost-sharing or coinsurance by any Medicare provider, even if the District does not pay the full amount of coinsurance for a covered service and/or the provider does not participate with the District's Medicaid program.[20]
g. QMB beneficiaries are automatically eligible for the LIS for the Medicare Part D prescription drug benefit.[21]

2. Eligibility for the QMB Plus Program

a. To be eligible for the District's QMB Plus program, an applicant must meet the following requirements:
   1) Be a District of Columbia resident;
   2) Be entitled to Medicare Part A benefits, including voluntary enrollment (premium Part A for the Aged), but excluding premium Part A for the Working Disabled;[22] and
   3) Have countable income at or below 100% of the Federal Poverty Level (FPL).[23]
   4) Have countable assets below $4,000 for a single individual (or $6,000 for couples).[24]

3. Effective Dates of QMB Plus Coverage

a. QMB benefits are effective on the first day of the month following the month in which the applicant was determined eligible.[25]
b. Medicaid benefits are effective on the first day of the month of application.[26]
c. The QMB Plus eligibility periods are 12 months from the start of coverage.[27]

C. Elimination of the SLMB and QI Programs

1. Effective November 1, 2014, the District eliminated the Specified Low-Income Beneficiary (SLMB) and Qualified Individual (QI) programs. The District's election to expand the QMB program income threshold to 300% FPL which is over the income standards for both the SLMB and QI programs' income eligibility thresholds eliminated

[19] Id.
[20] 42 U.S.C. §1396a(n)(3)(B).
[21] 42 U.S.C. §1395w-114(a)(3)(B)(v)(II); Medicare Prescription Drug Manual, 30.1 effective November 21, 2008; Centers for Medicaid and CHIP Services, "Annual Redetermination of Medicare Part D Low-Income Subsidy Deemed Status (Re-deeming)," July 19, 2012.
[22] District of Columbia Medicaid State Plan, Attachment 2.2A, page 9b.
[23] District of Columbia Medicaid State Plan, Supplement 8a to Attachment 2.6-A, page 2.
[24] District of Columbia Medicaid State Plan, Supplement 8b to Attachment 2.6-A, page 5.
[25] 42 U.S.C. §1396a(e)(8).
[26] 42 CFR 435.914 (b)
[27] Id.

the SLMB and QI programs. In accordance with CMS guidance, individuals may not be eligible for the QMB and SLMB or QI programs concurrently.
2. Individuals will no longer be able to receive retroactive eligibility to cover any Medicare costs incurred prior to the effective date of QMB benefits.

D. APPLICATION PROCEDURES

1. Current Automatic System Enrollment

a. Individuals with Medicaid benefits who are enrolled in Medicare Part A but not Medicare Part B are automatically enrolled into Medicare Part B if there is a BENDEX record with an option code of Y, R, T or W.
b. Individuals with Medicaid benefits who are enrolled in Medicare Part B but not Medicare Part A are automatically enrolled into Medicare Part A if there is a BENDEX record with an option code of Y, R, T or W.
c. Medicaid beneficiaries who are receiving Social Security Disability Insurance (SSDI) are generally bought in automatically one month before their Medicare eligibility begins when their Medicare eligibility information is indicated on the BENDEX records.
d. Automatic enrollment may not be possible in certain complex situations, such as: individuals who were originally refused SSDI and then won their appeal and received retroactive coverage; and individuals who enrolled late in Medicare and are subject to a penalty period. These individuals can be bought in manually.

2. Application Submission

a. There are two applications that individuals can use to apply for QMB benefits:
   1) The Combined Application, which is an application for Temporary Assistance to Needy Families (TANF), Supplemental Nutrition Assistance (SNAP or food stamps), and all Medicaid services except long-term care coverage; or
   2) An application for QMB benefits only.
b. ESA shall accept QMB applications up to 45 days in advance of the start of the applicants' Medicare eligibility. Medicare eligibility is indicated by the individuals Health Insurance Claim (HIC) number and/or by the BENDEX file. If an individual applies for QMB benefits before Medicare eligibility begins, the eligibility period for QMB coverage will begin on the first day of Medicare coverage, not the date of application.
c. If the applicant is eligible for Medicare but not receiving Medicare Part A or Part B coverage and is not known to the Social Security Administration (SSA) system, ESA shall instruct the applicant to go to SSA and apply provisionally for Medicare Part A coverage. SSA will then issue the applicant a claim number. The applicant should return to ESA to provide the agency with the claim number for application processing. ESA shall enter the claim number and entitlement date into ACEDS for transmission to the Centers for Medicare and Medicaid Services (CMS), which will enroll the applicant in Medicare Parts A and/or B.

d. If additional documentation is required to process a QMB application, ESA shall send a written notice to the applicant requesting additional documentation.
e. If the QMB application is complete, ESA shall determine if the applicant is eligible for the QMB program. See Section 4 for benefits, eligibility, and effective dates of this program.

3. Relationship between the Low-Income Subsidy and QMB Program

a. A Low-Income Subsidy (LIS) application is treated as an application for QMB benefits, even if the Social Security Administration (SSA) denied the LIS application.
b. LIS enrollment is retroactive to the start date of QMB coverage.
c. Medicare Modernization Act (MMA) File
    1) Each Friday, DHCF shall send the Medicare Modernization Act (MMA) Data File (which includes information relating to individuals dually eligible for Medicare and Medicaid or who are QMB-eligible) to CMS. The purpose of the MMA file is to notify CMS of individuals who are eligible for the LIS for Part D prescription drug coverage.
    2) After DHCF receives the MMA Response File Report, DHCF shall correct any errors related to the Medicaid Management Information System (MMIS). DHCF shall forward any ACEDS-related eligibility errors to ESA, which shall correct such errors and forward the updated report through ACEDS to MMIS for transmission to CMS. Such errors shall be corrected within one week of receiving the Response File.

4. Buy-In File and Response Report

a. After eligibility has been determined, ESA automatically creates the Buy-In/Input File ("Buy-In File") from ACEDS data. This file is submitted to the Centers for Medicare and Medicaid Services (CMS).
b. After ESA receives the Response Report from CMS, DHCF and ESA shall identify the individuals who were not bought in as requested, make the necessary corrections, and resubmit the updated file to CMS.
c. In order to ensure timely processing, this shall occur before the next buy-in or within seven (7) days, whichever is earlier.

5. Program Codes and Timeline

a. ESA shall assign a program code a letter "Q" suffix to indicate buy-in for applicants who are determined eligible for the QMB program.
b. ESA must process QMB applications within 45 calendar days.

6. RESPONSIBILITY

The Economic Security Administration (ESA) and Department of Healthcare Finance (DHCF) are responsible for the implementation of this policy and procedures.

For more information regarding this policy, please contact Danielle Lewis, Associate Director for the Division of Eligibility Policy at Danielle.Lewis@dc.gov or Gary Watts, Management Analyst, Division of Eligibility Policy at Gary.Watts@dc.gov

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3/13/15
Date