GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Deputy Director

Transmittal No.: 13-06

To: Providers and Other Stakeholders

From: Linda Elam, Ph.D, M.P.H
Deputy Director/Medicaid Director

Date: FEB 11 2013

Subject: Policies and Procedures for the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs

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Effective immediately, the following policy governs the administration of the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Beneficiary (SLMB) programs.

The 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. QMB coverage is effective on the first day of the month following the month in which the applicant was determined eligible.

The SLMB program provides payment for Medicare Part B premiums, as well as automatic eligibility for the LIS for the Medicare Part D prescription drug benefit. SLMB benefits can begin up to three months prior to the month of application if the beneficiary was eligible during that period. The District shall retroactively enroll SLMB beneficiaries in Medicare Part B if they are not enrolled in Part B at the time of application. LIS eligibility is retroactive to the start of SLMB coverage.

A copy of this policy is posted at: http://dhcf.dc.gov/page/dhcf-transmittals.

Questions regarding this policy should be directed to Claudia Schlosberg, Director, Health Care Policy and Research Administration, Department of Health Care Finance, at 202-442-9107 or via email at Claudia.schlosberg@dc.gov.

Questions regarding operational issues with the QMB and SLMB programs should be directed to Rebecca Shields, Program Manager of the Medicaid Branch, Economic Security Administration, at 202-698-4338 or via email at rebecca.shields@dc.gov.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Subject: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries

Policy Number: HCRPA-DEP-02

Policy Scope: Procedures for Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary Applications	**Number of Pages: 7**
Responsible Office or Division: Health Care Policy and Research Administration	**Number of Attachments: N/A**
Supersedes Policy Dated: N/A	**Effective Date:** February 7, 20013
Cross Reference and Related Policies: State Plan for Medical Assistance, Attachment 2.2A; Supplement 8b to Attachment 2.6-A; Supplement 1 to Attachment 4.19B	**Expiration Date, if Any: N/A**

1. PURPOSE

The purpose of this policy is to establish policies and procedures for the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs.

The 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]

The SLMB program provides payment for Medicare Part B premiums, as well as automatic eligibility for the LIS for the Medicare Part D prescription drug benefit.[3] SLMB benefits can begin up to three months prior to the month of application if the beneficiary was eligible during that period.[4] The District shall

[1] 42 U.S.C. §1395w-114(a)(3)(B)(v)(II); Centers for Medicare and Medicaid Services, 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).
[3] 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.
[4] 42 U.S.C. §1396a(a)(34).

retroactively enroll SLMB beneficiaries in Medicare Part B if they were not enrolled in Medicare Part B at the time of application. LIS eligibility is retroactive to the start of SLMB coverage.[5]

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, 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. Benefits of the QMB Program

    a. Medicaid pays Part A and/or Part B premiums.[6]
    b. Medicaid pays Part A deductibles up to the Medicare amount and Part B deductibles up to the Medicaid amount.[7]
    c. Medicaid pays Part B coinsurance up to the Medicaid amount.[8]
    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. 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.[9]
    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.[10]
    f. QMB beneficiaries are automatically eligible for the LIS for the Medicare Part D prescription drug benefit.[11]

2. Eligibility for the QMB Program

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[5] Centers for Medicare and Medicaid Services, Medicare Prescription Drug Manual, 40.2.2, effective January 1, 2011.
[6] District of Columbia Medicaid State Plan, Supplement 1 to Attachment 4.19B, page 2.
[7] Id.
[8] Id.
[9] Id.
[10] 42 U.S.C. §1396a(n)(3)(B).
[11] 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.

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, including voluntary enrollment (premium Part A for the Aged), but excluding premium Part A for the Working Disabled;[12] and
    3. Have countable income at or below 300% of the Federal Poverty Level (FPL).[13]
b. The District of Columbia has no resource limit for the QMB program.[14]
c. QMB eligibility is not tied to eligibility for other Medicaid services. Failure to recertify for another service, such as Elderly and Physically Disabled (EPD) Waiver, does not automatically terminate QMB eligibility.

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.[15]
b. The QMB eligibility period is 12 months from the start of coverage.[16]

B. SLMB Program

1. Benefits of the SLMB Program

a. Medicaid pays Medicare Part B premiums.[17]
b. Beneficiaries are automatically eligible for the LIS for the Medicare Part D prescription drug benefit.[18]

2. Eligibility for the SLMB Program

a. To be eligible for the District's SLMB 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;[19] and
    3. Have countable income between 100 % and 300% of the Federal Poverty Level (FPL).[20]

b. The District of Columbia has no resource limit for the SLMB program.[21]

[12] District of Columbia Medicaid State Plan, Attachment 2.2A, page 9b.
[13] District of Columbia Medicaid State Plan, Supplement 8a to Attachment 2.6-A, page 2
[14] District of Columbia Medicaid State Plan, Supplement 8b to Attachment 2.6-A, page 5.
[15] 42 U.S.C. §1396a(e)(8).
[16] Id.
[17] District of Columbia Medicaid State Plan, Supplement 1 to Attachment 4.19B, page 2.
[18] 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.
[19] District of Columbia Medicaid State Plan, Attachment 2.2A, page 9b1.
[20] District of Columbia Medicaid State Plan, Supplement 8a to Attachment 2.6-A, page 2.

3. Effective Dates of Coverage for the SLMB Program

   a. SLMB coverage becomes effective in the month of application or up to three months prior to the month of application if the applicant met SLMB eligibility requirements during those months.[22]
   b. SLMB coverage continues until QMB coverage begins.[23]

5. APPLICATION PROCEDURES

A. Automatic Accretion

1. Individuals with Medicaid benefits who are enrolled in Medicare Part A but not Medicare Part B are automatically accreted into Medicare Part B if there is a BENDEX record with an option code of Y, R, T or W.
2. Individuals with Medicaid benefits who are enrolled in Medicare Part B but not Medicare Part A are automatically accreted into Medicare Part A if there is a BENDEX record with an option code of Y, R, T or W.
3. 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.
4. Automatic accretion 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.

B. Application Submission

1. There are two applications that individuals can use to apply for QMB and SLMB benefits:
   a. The combined services 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
   b. An application for QMB and SLMB benefits only.
2. ESA shall accept QMB applications up to 45 days in advance of the start of applicants' Medicare eligibility. Medicare eligibility is indicated by the individual's 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 on the date of application.
3. 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

[21] District of Columbia Medicaid State Plan, Supplement 8b to Attachment 2.6-A, page 5.
[22] 42 U.S.C. §1396a(a)(34).
[23] Email from Keith Johnson, Health Insurance Specialist at the Centers for Medicare and Medicaid Services, November 8, 2012.

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.

4. If additional documentation is required to process a QMB/SLMB application, ESA shall send a written notice to the applicant requesting that the additional documentation be sent within 15 (fifteen) business days of the date of the written notice.
5. If the QMB/SLMB application is complete, ESA shall determine if the applicant is eligible for the QMB and SLMB programs. See Section 4 for the benefits, eligibility, and effective dates of these programs.
6. If the applicant reports current information that meets the SLMB program requirements and attests that his or her income and residency have not changed in the three months prior to the month of application, the applicant shall be determined eligible for SLMB coverage beginning three months prior to the month of application. If the applicant reports that his or her income has changed but that income is still within the SLMB range for all or part of the three months prior to the month of application, ESA shall determine the applicant eligible for retrospective SLMB coverage for the time period in which SLMB eligibility requirements were met.
7. When the individual was not previously enrolled in Medicare Part B but meets SLMB eligibility requirements, ESA should retroactively enroll the individual in Medicare Part B for the time that the individual was eligible, up to three months prior to the month of application.
8. If an individual has completed a combined QMB/SLMB and Medicaid application and the SLMB benefits are denied because the applicant's income is below 100% of the FPL, the Medicaid application shall be processed within 45 days from the date of application.
9. If the individual has completed a QMB/SLMB application only and the SLMB application is denied because the applicant's income is below 100% of the FPL, the denial notice shall explain this reason for denial and include information on how to apply for Medicaid.

C. Relationship between the Low-Income Subsidy and QMB/SLMB Programs

1. A Low-Income Subsidy (LIS) application is treated as an application for QMB and SLMB benefits, even if the Social Security Administration (SSA) denied the LIS application.
2. LIS enrollment is retroactive to the start date of QMB or SLMB coverage.
3. Medicare Modernization Act (MMA) File
    a. 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- or SLMB-eligible) to CMS. The purpose of the MMA file is to notify CMS of individuals who are eligible for the LIS for Medicare Part D prescription drug coverage.
    b. 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 for transmission to CMS. Such errors shall be corrected within one week of receiving the Response File Report.

D. Buy-In File and Response Report

1. 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).
2. 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.
3. In order to ensure timely processing, this shall occur before the next buy-in or within fifteen (15) days, whichever is earlier.

E. Program Codes and Timeline

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

F. Premium Reimbursement under the SLMB Program

1. For individuals who were previously enrolled in Medicare Part B and receive SLMB coverage, the District of Columbia will pay premiums for the months of SLMB coverage. SSA will reimburse the beneficiaries for premiums that they paid. This process takes between 30 and 90 days.
2. Beneficiaries, including QMBs whose application processing was delayed, shall be advised that if they do not receive a refund within 90 days, they should either:
    a. Contact the CMS Office of Public Engagement (OPE) Division of Exceptions (DOE) via fax to (410) 786-0319; or
    b. Contact the DC Health Care Ombudsman's Office by phone at (202) 724-7491, by confidential fax at (202) 535-1216, or by email at healthcareombudsman@dc.gov.
3. ESA shall provide this information on the SLMB approval notice.

6. RESPONSIBILITY

Operational questions concerning the QMB and SLMB programs should be directed to:

Rebecca Shields
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Economic Security Administration
rebecca.shields@dc.gov
(202) 698-4338

Policy questions concerning the QMB and SLMB programs should be directed to:

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