Qualified Medicare Beneficiary Part B Coordination of Benefit Barriers and Recommendations

Version 1.0

April 2021

The purpose of this document is to provide electronic data solutions to current barriers for processing claims secondary to a Medicare Part B benefit for Qualified Medicare Beneficiary (QMB) Program participants that align with QMB Program requirements.

Qualified Medicare Beneficiary Part B Coordination of Benefit Barriers and Recommendations

Version1.0

Published by:
National Council for Prescription Drug Programs, Inc.

Publication History:
Version 1.0 2020
Version 1.0 Republication 2021

TABLE OF CONTENTS

Disclaimer

While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice. If you require legal advice, you should consult with an attorney. The information provided here is for reference use only and does not constitute the rendering of legal, financial or other professional advice or recommendations by NCPDP. The listing of an organization does not imply any sort of endorsement, and the NCPDP takes no responsibility for the products or tools.

The existence of a link or organizational reference in any of the following materials should not be assumed as an endorsement by the NCPDP. The writers of this paper will review and possibly update their recommendations should any significant changes occur.

This document is for Education and Awareness Use Only.

1. PURPOSE

The Qualified Medicare Beneficiary (QMB) Program is a Medicare Savings Programs that provides help from the state to pay Medicare premiums and other costs including deductibles, coinsurance and copayments. Since 2006, there have been many documents published by various entities outlining various aspects of the QMB Program with balance billing being of primary significance. Balance billing refers to providers charging the Medicare Part A or B deductible or coinsurance cost share to the patient when the Medicaid program is responsible for coordination of benefits for the QMB Program participants. Many of these documents are intended to be training materials pointing the provider to program regulations and policies. Other materials specifically call out the complicated and manual processes that are currently in place creating administrative and costly barriers to achieving the expected results.

The purpose of this document is to provide electronic data solutions to current barriers for processing claims secondary to a Medicare Part B benefit for QMB Program participants that align with QMB Program requirements. Electronic data solutions using industry standards are necessary, as the current provider training approach is ineffective. Throughout this paper, the program will be referred to as the QMB Program and the individuals as QMB Program participants.

2. SCOPE

While the federal law that bars Medicare providers and suppliers from billing an individual enrolled in the QMB Program applies to both Medicare Part A and Medicare Part B benefits, the recommendations outlined in this white paper are specific to Medicare Part B benefits as it applies to the pharmacy industry.

This document focuses on plan benefit information transparency and real-time claims processing solutions to mitigate risks of Medicare Part B prescription claim deductible and/or 20% cost share amounts being passed-on as the responsibility of the QMB-Program participant.

3. BACKGROUND

3.1 DUAL ELIGIBLE QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM

Medicare-Medicaid enrollees are typically classified according to the benefits they are eligible to receive according to their income and assets at any given point in time. The seven dual eligibility types include:

1. Dual Status Code 1: "Partial-benefit" Qualified Medicare Beneficiaries without other Medicaid (QMB-only)
2. Dual Status Code 2: "Full-benefit" Qualified Medicare Beneficiaries plus full Medicaid (QMB-Plus)
3. Dual Status Code 3: "Partial-benefit" Specified Low-Income Medicare Beneficiaries (SLMB) without other Medicaid (SLMB-only)
4. Dual Status Code 4: "Full-benefit" Specified Low-Income Medicare Beneficiaries plus full Medicaid (SLMB-plus)
5. Dual Status Code 5: "Partial-benefit" Qualified Disabled and Working Individuals (QDWI)
6. Dual Status Code 6: "Partial-benefit"] Qualifying Individuals (QI)
7. Dual Status Code 8: "Full-benefit" Other full benefit dual eligible / Medicaid Only Dual Eligibles (Non-QMB, -SLMB, -QDWI, -QI)

QMB Program participants classified as dual eligibility status codes 1 and 2 are the largest eligibility group within the Medicare-Medicaid QMB Program participant population. Individuals apply for this benefit with their state's Medicaid program and must have their eligibility redetermined at least annually. QMB Program participant who meet the QMB Program's qualifying criteria fall into two groups: "QMB Only" and "QMB Plus." QMB Only Program participants are entitled to QMB Program cost sharing support for Medicare benefits but do not qualify for any other Medicaid benefits. QMB Plus Program participants qualify for both QMB cost sharing support and all services provided by their state's Medicaid program.

Once the Program participant's QMB status is established, the state Medicaid program covers Medicare premium costs in full and all cost sharing amounts to the extent consistent with their State Plan. The Program participant does not pay Medicare Parts A and B deductibles and coinsurance.

QMB Program participants also qualify for the full low-income subsidy for the Medicare Part D prescription drug benefit, including monthly premiums up to a given benchmark, no annual deductible and nominal copayments per covered prescription. Unlike for Medicare Parts A and B, the QMB Program participant is liable for Medicare Part D copayments per prescription and for premium amounts above the level covered by the low-income subsidy.

Medicare-Medicaid Annual Eligibility Status	Medicaid benefits	Medicare Premium Subsidy	Medicare Cost Sharing Assistance	Medicare Part D Low Income Subsidy
Qualified Medicare Beneficiary (QMB Only)	No	Part A, Part B	Yes	Yes
Qualified Medicare Beneficiary Plus (QMB Plus)	Yes	Part A, Part B	Yes	Yes
Medicare-only Beneficiary	No	No	No	No

3.2 REGULATORY AND POLICY BACKGROUND

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB Program for Medicare Part A and Part B cost sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A) and 1848(g)(3)(A) of the Social Security Act [the Act]), to which

providers and suppliers may bill state Medicaid agencies for Medicare cost sharing amounts. Centers for Medicaid and Medicare Services (CMS) recommends the provider determine the billing processes that apply to seeking payment for Medicare cost sharing from the States in which the beneficiaries reside. Different processes may apply to Original Medicare and Medicare Advantage services provided to individuals enrolled in the QMB Program.

State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost sharing that is due for QMB Program participants according to the state's CMS-approved Medicare cost sharing payment methodology. State Medicaid Management Information Systems (MMIS) must process all Medicare "crossover" claims (claims that include primary payment from Medicare) for QMB Program participants, including Medicare-adjusted claims that are submitted by Medicaid-enrolled providers, even if a service or provider category is not currently recognized in the Medicaid State Plan. States must furnish all Medicare-enrolled providers, including out-of-state providers, with a means by which they can enroll in the Medicaid program for purposes of having such claims processed.

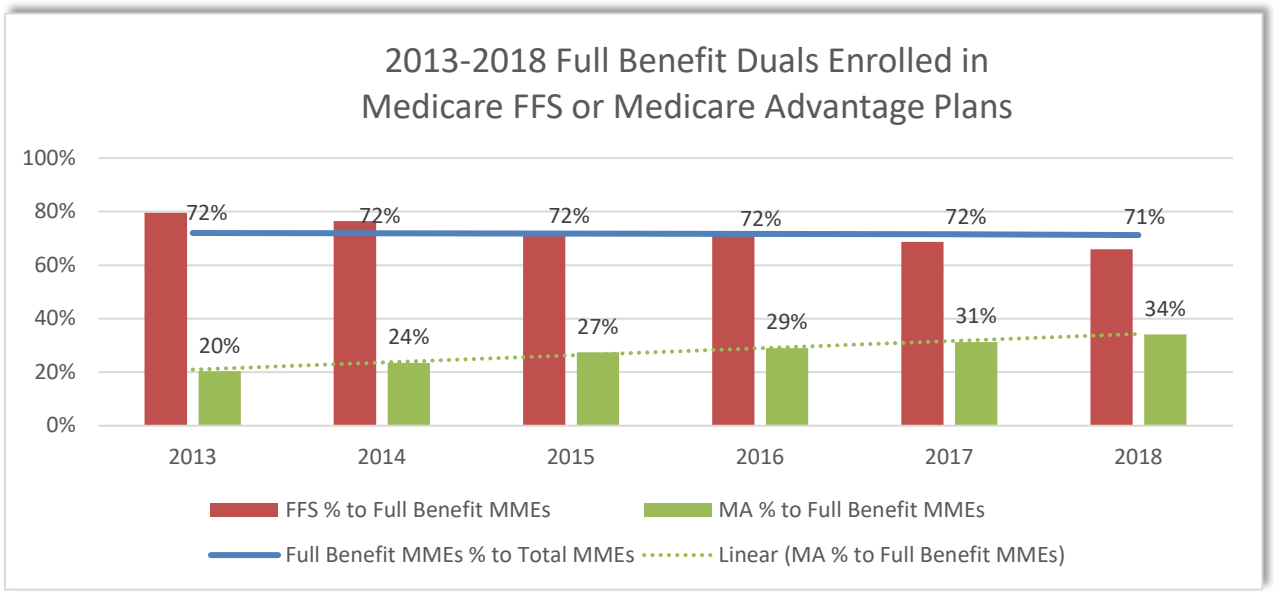
Statutory Authority for Payment of QMB Cost Sharing Amounts Section 1902(a)(10)(E) of the Social Security Act directs state Medicaid agencies to reimburse providers for QMB cost sharing amounts [as defined in §1905(p)(3)], "without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan." Section 1902(n)(2) of the Act does permit the state to limit payment for QMB cost sharing to the amount necessary to provide a total payment to the provider (including Medicare, Medicaid, required nominal Medicaid copayment, and third party payments) equal to the amount a state would have paid for the service under the State Plan. When the crossover claim is for Medicare-covered services that are not included in the Medicaid State Plan, the state is still liable to pay the crossover claim, but may establish reasonable payment limits, approved by CMS, for the service.[1]

3.3 MEDICARE PLAN OPTIONS FOR DUAL ELIGIBLE BENEFICIARIES

As depicted in the below chart, the percent of Medicare/Medicaid dual eligible beneficiaries considered to be full benefit duals (QMB eligible) has remained constant at 72%. However, the percent of duals enrolled in a Medicare Advantage (MA) plan of some type versus Medicare Fee for Service (FFS) for Medicare Part A and B covered services has increased from 20% to 34%. [2]

Special Needs Plans (SNPs) are one type of MA plan benefit. Dual Eligible Special Needs Plans (D-SNPs), one type of SNP, enroll only individuals that are eligible for both Medicare and Medicaid. As of 2013, all D-SNPs must have contracts with the applicable state Medicaid program that contain a description of how the plan will provide and coordinate Medicare and Medicaid-financed care. Although states' D-SNP contracts can help to promote integrated care for dual-eligible beneficiaries, these plans face administrative and operational challenges with overcoming Medicare-Medicaid misalignment. In the last few years, several states, health plans and the federal government have increased their efforts to overcome misalignments in Medicare and Medicaid to address some of the challenges that hindered D-SNPs from more effectively coordinating care for dual-eligible beneficiaries. [3]

1. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/CIB-06-07-2013.pdf
2. https://www.cms.gov/research-statistics-data-systems/cms-program-statistics/2018-medicare-enrollment-section
3. https://aspe.hhs.gov/basic-report/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-and-challenges



MME = Medicare/Medicaid Eligible

4. CURRENT PROCESSES

The 11 million individuals who are dually eligible for Medicare and Medicaid are among the highest need populations in either program. However, a lack of coordination between the Medicare and Medicaid programs makes it difficult for individuals enrolled in both to navigate these fragmented systems of care resulting in additional costs to both programs.

QMB Program participants are enrolled in Medicare Part A (Hospital Insurance), Part B (Medical Insurance) and are also enrolled in full Medicaid benefits. Beneficiaries who qualify for Medicaid automatically qualify for Extra Help (also known as the Low-Income Subsidy program) to help pay for the costs — monthly premiums, annual deductibles and prescription copayments — related to Medicare Part D (Prescription Drug Benefits). These benefits are available through the original Medicare program (Fee For Service) or Medicare Advantage plans.

- When enrolled in Medicare FFS:
    - Part A benefits available through Medicare Part A FFS
    - Part B benefits available through Medicare Part B FFS
    - Part D benefits available through Medicare Prescription Drug Plan (PDP)
- When enrolled in Medicare Advantage (Part C):
    - Part A/B/D benefits available through Medicare Advantage Prescription Drug Plan (MAPD), Medicare Part D, Special Needs Plan (D-SNP) or Medicare/Medicaid Plan (MMP)
    - Part A/B benefits available through a Medicare Advantage Plan without prescription drug coverage (MA)

4.1 MEDICARE FEE FOR SERVICE

Most state Medicaid plans have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare Part B FFS adjudicated claims. The Medicaid plan initiates coordination of benefits processing and reimburses the provider any amounts due. While challenging due to the non-real-time claims processing environment, provider systems can recognize auto-cross conditions, to which the applicable QMB cost share would apply at point of care.

States may elect to delegate coordination of benefits to the Medicaid managed care plans for QMB Program participants enrolled in Medicare Part B FFS. The Medicaid managed care plan must enter into a coordination of benefits agreement with Medicare for the auto-cross process to occur. One challenge the providers face is their lack of visibility to whether the Medicaid Managed Care Organization (MCO) or Medicaid FFS is designated as the auto-cross payer for each QMB Program participant. This results in financial risks to the provider when neither the FFS nor MCO plan process the cross-over claim due to gaps in system processes.

In other states, the Medicaid FFS program is designated within the Medicare BCRC as the auto-cross plan, however the Medicaid FFS program then requires the Medicaid Managed Care plan to coordinate benefits. Similar to above, this can result in claim processing gaps, creating a financial risk for the provider.

4.2 MEDICARE ADVANTAGE

Since Medicare Advantage plans are not accounted for in the Medicare FFS auto-cross process, a point of service solution is needed to coordinate Medicare Part B benefits with the applicable state Medicaid plan. While D-SNP plans are intended to provide this coordination between the payers that would eliminate

the need for the provider to directly bill Medicaid, not all MA enrolled QMB Program participants are enrolled in a D-SNP plan. Additionally, the D-SNP Medicare/Medicaid benefits coordination may be limited to medical benefits, and not include Medicare Part B claims processed under the prescription benefit, using the NCPDP Telecommunication Standard Version D.0.

The Medicaid coordination of benefit process for QMB Program participants becomes increasingly fragile as the number of beneficiaries enrolled in a MA plan increases. When D-SNP benefit coordination is not established between the QMB Program participant's MA and Medicaid plans, the provider is faced with managing the coordination of benefit process. This requires the provider to:

- Identify the patient's QMB Program status
- Determine which Medicaid plan benefit to bill (e.g., FFS RX, FFS Durable Medical Equipment (DME), MCO RX, MCO DME)
- Determine and support the designated Medicaid plan's accepted billing format (e.g., NCPDP, X12)

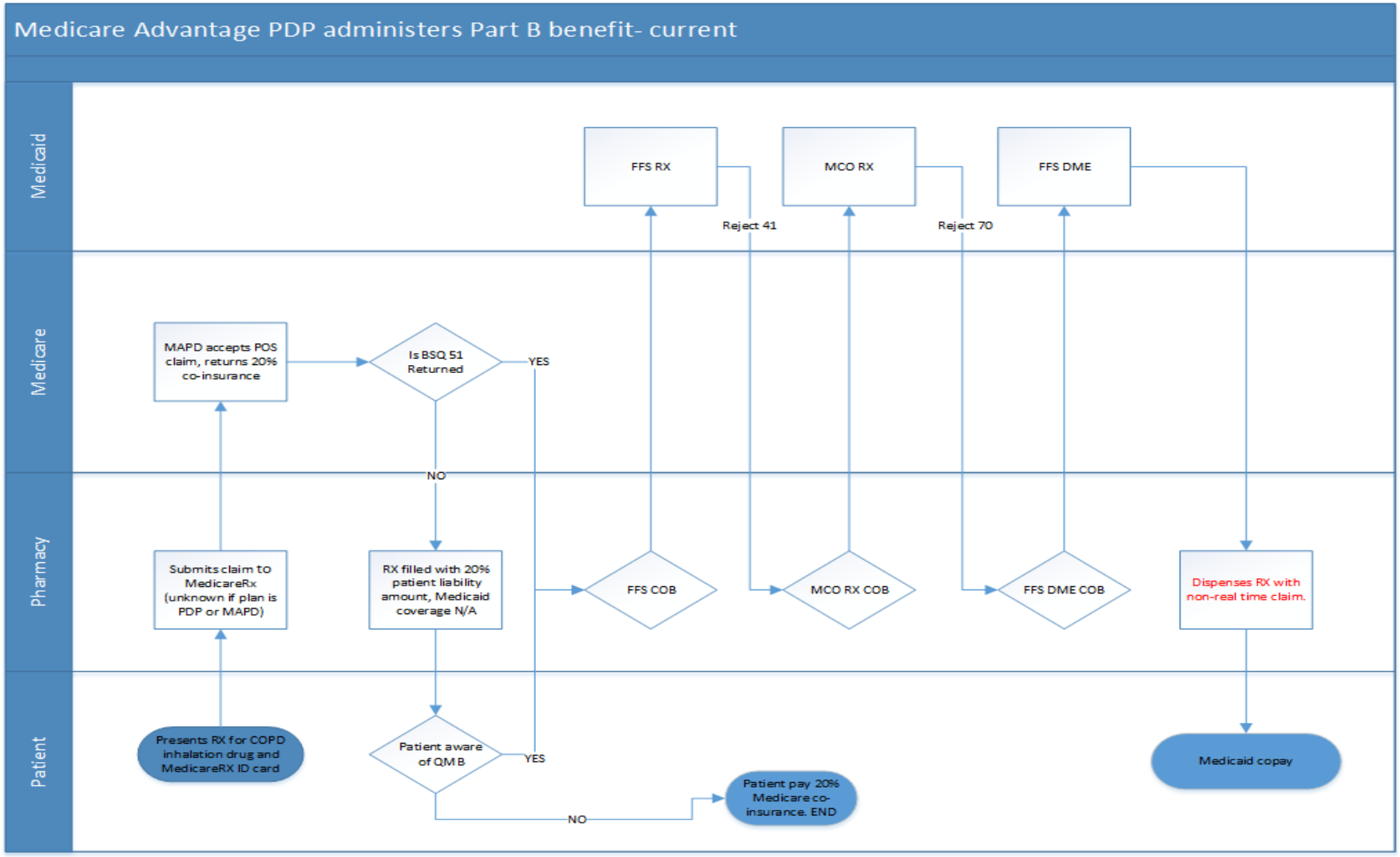
The identification of the patient's QMB Program status has improved to some degree, where CMS shares this information with the Medicare plans, and the Medicare Part B benefit can return a Benefit Stage Qualifier (393-MV) value of 51 on the point of service NCPDP Telecommunication Standard Version D.0 paid claim response. However, there is opportunity to improve the timing, accuracy and ease of access to QMB Program participant eligibility data.

Knowing which Medicaid plan to bill (e.g., FFS RX, FFS Durable Medical Equipment (DME), MCO RX, MCO DME) and which billing format to use still presents major barriers for the providers to support CMS in achieving the expected outcomes. Real-time, electronic solutions that are integrated within the provider workflows need to be established and supported by all stakeholders.

4.3 CURRENT PROCESS FLOW

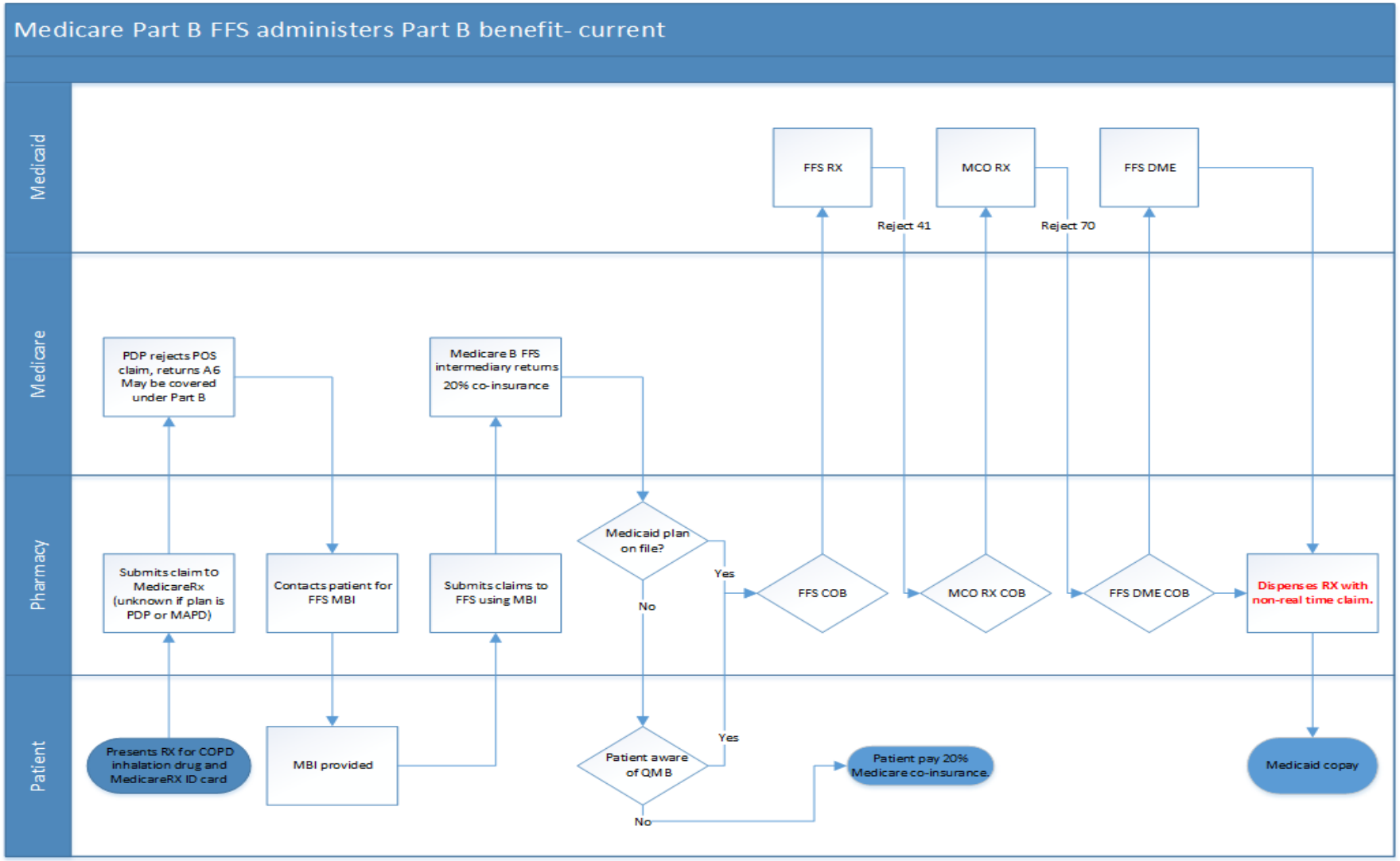
4.3.1 MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN ADMINISTERS PART B BENEFIT

This diagram depicts the business case where the QMB Program participant is enrolled in a MAPD that is not an MMP or D-SNP; therefore, Medicare/Medicaid integrated benefits are not applied to the point of service claim adjudication process.



4.3.2 MEDICARE PART B FFS ADMINISTERS PART B BENEFIT

This diagram depicts the business case where the QMB Program participant is enrolled in a Medicare Part D Prescription Drug Plan (PDP) and Medicare Part B FFS. The Medicare Beneficiary ID (MBI) is not returned on the PDP rejected response for the provider to validate Medicare Part B FFS eligibility. The Medicare Part B intermediary is unable to determine Medicaid auto-cross information, resulting in 20% coinsurance.



5. BUSINESS PROBLEM

In the situation where the QMB Program participant is enrolled in a Medicare Advantage plan, or receives benefits through the Medicare Part B FFS program, and the state Medicaid plan does not participate in the BCRC auto-cross process, real-time claims processing guidance is needed to ensure the Medicare deductible and/or 20% cost share is not passed onto the patient. The business problem is a compilation of several areas of concern.

5.1 MBI Required for Real-Time Medicare Eligibility Verification

When a QMB Program participant enrolls in a PDP versus a MAPD, their Medicare Part B benefits are managed through the Medicare Part B FFS program. Patient profiles established in pharmacy systems will initially only include the PDP plan information as Medicare Part D covered medications are most commonly dispensed. When a claim for a Medicare Part B covered product is submitted to the PDP plan, the claim rejects with either a reject code value of A5 – *Not Covered Under Part D Law* or reject code value of A6 – *This Product/Service May be Covered Under Part B* (B versus D). When these rejects occur, the pharmacy must obtain the QMB Program participant's MBI to validate Medicare Part B FFS eligibility and initiate the non-real-time billing process. Today, the only option the pharmacy has is to contact the patient to obtain the MBI. This creates patient confusion, significant delays to the work-flow process, and in some cases, the inability to effectively complete the Medicare Part B FFS billing process.

5.2 Plan Benefit Information Transparency

Medicare/Medicaid benefit coordination for QMB Program participants varies by state. Currently, pharmacy providers do not have access to the necessary information to be able to determine which Medicaid benefit/program should be billed or is automatically integrating Medicare Part B patient cost share benefits, e.g.:

- Medicaid FFS Pharmacy Benefit
- Medicaid FFS Medical/DME Benefit
- Medicaid MCO Pharmacy Benefit
- Medicaid MCO Medical/DME Benefit
- Medicare D-SNP

5.3 Real-Time Claims Processing

Medicaid claims Processing systems may not be set up to adjudicate real-time COB claims for the Medicare Part B benefit for QMB Program participants. This results in point of care confusion and increased administrative costs for all stakeholders to support retrospective manual claims processing and reconciliation.

5.4 CMS Recognition of Data Sharing Gaps

CMS, including the Medicare/Medicaid Coordination Office, has also recognized there are gaps impacting pharmacy and medical claim billing processes. To begin addressing these concerns, the Interoperability Rule under CMS-9115-F, section titled "Improving the Dually Eligible Experience by Increasing the Frequency of Federal-State Data Exchanges" requires states to increase the data exchange frequency for individuals dually eligible for Medicare and Medicaid from monthly to daily to improve the dual eligible QMB Program participant experience, ensuring beneficiaries are getting access to appropriate services and these services are billed appropriately the first time eliminating waste and burden. States are required to implement this daily exchange starting April 1, 2022. Refer to: Improving the Dually Eligible Experience by

Increasing the Frequency of Federal-State Data Exchanges section of the Interoperability and Patient Access Fact Sheet.

6. NCPDP RECOMMENDATIONS

6.1 PLAN BENEFIT INFORMATION TRANSPARENCY

The Coordination of Benefit Agreement (COBA) Eligibility File is used by trading partners to identify their eligible beneficiaries in order to coordinate supplemental payment to Medicare paid claims. The BCRC process and data sharing capabilities may include:

- Eligibility file processing
- Syntactical and data consistency edits
- Daily transmission of valid eligibility records to the Medicare Common Working File (CWF)
- E02 Drug coverage eligibility file format that includes the BIN, PCN, Group and Cardholder ID (4RX)
    - For Medicare Part B covered drugs, e.g., immunosuppressive or oral cancer drugs, the COBA trading partner (e.g., Medicaid) may indicate within the Network Benefit Indicator field their support of one of the following:
        - NCPDP Point of Sale Claims (1 – Network Point of Sale)
        - X12 – 837 Professional Non-Real Time Claims (0 – Non-network, Paper or Batch)

The BCRC will transmit the E02 drug coverage eligibility data to CMS' Medicare Beneficiary Database to ensure pharmacies will have awareness at point of sale regarding payers that supplement Medicare Part D drug plan payments. The information collected in the E02 is used to create a COB record that will be transmitted to the QMB Program participant's Medicare Part D Plan and the True Out-of-Pocket (TrOOP) Facilitation Contractor for appropriate claims payment order determinations, TrOOP calculation and point-of-sale COB.

6.1.1 RECOMMEND ELECTRONIC ACCESS TO MEDICARE BENEFICIARY ID

Pharmacy providers need access to the patient's MBI in order to validate Medicare Part B FFS eligibility. Currently the only means for a pharmacy provider to access this is directly from the QMB Program participant using manual processes that challenge security objectives and create patient care delays. This current process inhibits the use of current system technology that leverages advanced security protocols to protect the disclosure of the MBI. While there is an MBI look-up tool and the availability of the MBI on the remittance advice, these solutions only support workflows where the claim billing process is not real-time.

The pharmacy industry leverages real-time claims processing services, where real-time eligibility verification is a primary step. When the pharmacy only has the QMB Program participant's PDP information on file and the claim rejects indicating it may be covered under Medicare Part B, the pharmacy needs access to the MBI in order to validate the Medicare Part B coverage. Secure point of service access to the MBI can be achieved using the below NCPDP Telecommunication Standard Version D.0 response fields and values.

In the B1 Claim Billing Response, the PDP would return the appropriate Reject Code and provide information about the correct entity to bill in the Response Coordination of Benefits/Other Payers Segment:

- Reject Codes:
    - Not Covered Under Part D Law (A5), or
    - This Product/Service May Be Covered Under Medicare Part B (A6)
- Response Coordination of Benefits/Other Payers Segment
    - Other Payer ID Count (355-NT) = 1

- Other Payer Coverage Type (338-5C) = 01 (Primary)
- Other Payer ID Qualifier (339-6C) = 10 (Other Payer Name)
- Other Payer ID (340-7C) = 'MEDICARE PART B FFS'
- Other Payer Cardholder ID (356-NU) = MBI e.g., 1EG4TE5MK73

6.1.2 RECOMMEND INCREASED MEDICAID DATA TRANSPARENCY

NCPDP recommends Medicaid plans expand their use of the COBA eligibility file to provide the BIN, PCN, Cardholder ID, Group ID (i.e., 4RX) of the Medicaid benefit (e.g., FFS, MCO, D-SNP) responsible for Medicare Part B benefit coordination for their QMB Program participants. As the drug coverage information is already shared with the Medicare Part D plans, increased data transparency will allow MA plans to return the Medicare Part B QMB Program participant Medicaid 4RX information within the real-time claim response to the pharmacy. When the MA claim also includes a Benefit Stage Qualifier (393-MV) value of 51 "*Not paid under Part D, paid under Part C benefit (for MA-PD plan). Beneficiary is a Qualified Medicare Beneficiary - pharmacy should not attempt to collect cost share, but instead should attempt to bill COB to Medicaid coverage*," the pharmacy can automate the real-time coordination of benefits claim transaction to the applicable Medicaid plan.

Increased data sharing frequency from monthly to daily as required under CMS-9115-F and requiring Medicaid plans to include the 4RX for Medicare Part B claim coordination are fundamental steps to improving the QMB Program participant's experience. This ensures QMB Program participant access to appropriate services and appropriate billing of these services the first time, eliminating waste and burden.

6.1.3 RECOMMEND BENEFICIARY DUAL ELIGIBILITY STATUS IN CLAIM RESPONSE

Various plan types provide benefits to QMB Program participants, where the provider may need to coordinate benefits with supplemental payers. These plan types may include MAPD, Medicare Advantage Plan without prescription drug coverage (MA)Medicare Part B FFS, and Medicaid. Claims processing efficiency, improved patient safety and reduced administrative costs can be achieved when COB claims are processed in real-time using the NCPDP Telecommunication Standard.

The NCPDP Telecommunication Standard supports distinct data elements and values for the Medicare Part B benefit claim response to identify the participant's QMB Program status, to be used by the provider as a trigger to initiate the coordination of benefit claim. The below outline identifies the specific fields and values to be used, based on the Telecommunication Standard version that is in use. This detail can also available within the NCPDP Medicare Part D Frequently Asked Questions document.

- In general:
  - QMB Program information should only be returned in situations where it is applicable for claims payment or coordination of benefits, e.g., products covered under Medicare Part B.
  - Additional standardization is needed as to the claim billing format and which Medicaid benefit (e.g., FFS RX, FFS DME, MCO RX, MCO DME) is responsible for the QMB cost sharing amounts.

- NCPDP Telecommunication Standard Version D.0
  - MAPD
    - Return Benefit Stage Qualifier (393-MV) value of 51 - *Not paid under Part D, paid under Part C benefit. Beneficiary is a Qualified Medicare Beneficiary - pharmacy should not attempt to collect cost share, but instead should attempt to bill COB to Medicaid coverage*
  - MA Standalone, Medicare Part B FFS, Medicaid
    - Return Additional Message Information Qualifier (132-UH) value of 32 - *CMS Dual Status*

        - Return Additional Message Information (526-FQ) codified text message based on the QMB Program participant's dual status
            - *CMS 01 Partial Dual*
            - *CMS 02 Full Dual*

- NCPDP Telecommunication Standard Version F6 and above
    - MAPD
        - Return Benefit Stage Indicator (C51-NX) value of 50 - *Paid under the Part B benefit of the Medicare health plan*
        - Return applicable Other Benefit Detail Information Indicator (D32-MS) value
            - 02 - *CMS Dual Status 01: Eligible. Entitled to Medicare. QMB only (Partial Dual)*
            - 03 - *CMS Dual Status 02: Eligible. Entitled to Medicare. QMB AND Medicaid coverage (Full Dual*)
    - MA, Medicare Part B FFS, Medicaid
        - Return Benefit Stage Indicator (C51-NX) value of 91 - *Paid under Part B benefit of a non-Medicare Advantage Prescription Drug Plan (MA-PD)*
        - Return applicable Other Benefit Detail Information Indicator (D32-MS) value
            - *02 - CMS Dual Status 01: Eligible. Entitled to Medicare. QMB only (Partial Dual)*
            - *03 - CMS Dual Status 02: Eligible. Entitled to Medicare. QMB AND Medicaid coverage (Full Dual)*

6.1.4 RECOMMEND APPROPRIATE NCPDP REJECT CODES & OTHER PAYER 4RX

As outlined above, increasing the data transparency within the COBA eligibility files (E02 Drug Eligibility) to include the 4RX information of the QMB Program Part B responsible Medicaid benefit will allow MAPD and Medicaid plans to return this information on the point of service claim response. When the NCPDP coordination of benefit claim is submitted to a Medicaid benefit that is not responsible for managing the dual eligible Medicare Part B benefits, the rejected claim response should include the appropriate reject codes and the BIN, PCN, etc. billing identifiers (4RX) for the pharmacy to submit the claim to the appropriate Medicaid benefit.

The goal is to standardize the use of specific reject codes to facilitate the billing of QMB Program Medicare Part B coordination of benefit claims to the appropriate Medicaid benefit. A new reject code (984) that can be returned by either the Medicaid FFS or MCO plan has been approved and is recommended for implementation on October 15, 2021. Additionally, the 4RX billing identifiers would be returned in the Response COB/Other Payers Segment.

- Scenario: COB claim submitted to the Medicaid FFS and the Medicaid MCO plan is responsible; or COB claim is submitted to the Medicaid MCO plan and the Medicaid FFS plan is responsible for QMB Program Medicare Part B claim coordination:
    - Return Reject Code 984– "Bill Dual Eligible Medicare Part B Patient Cost Share to Alternate Medicaid Benefit"
    - Return 4RX of applicable Medicaid benefit within the below Response COB/Other Payers Segment fields
        - Other Payer ID Count (355-NT)
        - Other Payer Coverage Type (338-5C)
        - Other Payer ID Qualifier (339-6C)
        - Other Payer ID (340-7C)
        - Other Payer Processor Control Number (991-MH)
        - Other Payer Cardholder ID (356-NU)

        - Other Payer Group ID (992-MJ)
        - Other Payer Person Code (142-UV)

Until the new reject code is available, the following alternate reject codes can be used for the specific business cases outlined, with the 4RX billing identifiers for the applicable Medicaid benefit returned in the Response COB/Other Payers Segment fields.

- COB Claim is submitted to Medicaid FFS RX benefit and Medicaid MCO is responsible for QMB Program Medicare Part B claim coordination:
    - Return Reject Code: AF – "Patient Enrolled Under Managed Care"
    - Return 4RX of Medicaid Managed Care plan within the below Response COB/Other Payers Segment fields
        - Other Payer ID Count (355-NT)
        - Other Payer Coverage Type (338-5C)
        - Other Payer ID Qualifier (339-6C)
        - Other Payer ID (340-7C)
        - Other Payer Processor Control Number (991-MH)
        - Other Payer Cardholder ID (356-NU)
        - Other Payer Group ID (992-MJ)
        - Other Payer Person Code (142-UV)

- COB Claim is submitted to Medicaid MCO benefit and Medicaid FFS RX benefit is responsible for QMB Program Medicare Part B claim coordination:
    - Return Reject Codes:
        - 831 - "Product Service ID Carve-Out, Check Medicaid Fee For Service" and
        - 70 - "Product/Service Not Covered"
    - Return 4RX of Medicaid FFS RX benefit within the below Response COB/Other Payers Segment fields
        - Other Payer ID Count (355-NT)
        - Other Payer Coverage Type (338-5C)
        - Other Payer ID Qualifier (339-6C)
        - Other Payer ID (340-7C)
        - Other Payer Processor Control Number (991-MH)
        - Other Payer Cardholder ID (356-NU)
        - Other Payer Group ID (992-MJ)
        - Other Payer Person Code (142-UV)

- COB Claim is submitted to either the Medicaid FFS RX or Medicaid MCO benefit and Medicaid FFS Medical/DME benefit is responsible for QMB Program Medicare Part B claim coordination:
    - Return Reject Code: 816 – "Pharmacy Benefit Exclusion, May Be Covered Under Patient's Medical Benefit"
    - Return Medicaid FFS DME/Medicaid other payer information within the below Response COB/Other Payers Segment fields
        - Other Payer ID Count (355-NT)
        - Other Payer Coverage Type (338-5C)
        - Other Payer ID Qualifier (339-6C) - *Return Qualifier 10 – Other Payer Name*
        - Other Payer ID (340-7C) - *Return Medicaid FFS DME/Medical benefit name*
        - Other Payer Cardholder ID (356-NU)

6.2 Real-Time Claims Processing Recommendations

6.2.1 Existing Processes

Currently approximately 40% of Medicaid plans support real-time QMB Program Medicare Part B COB claims when a MA plan paid as the primary payer. This aligns to their non-dual eligible processes where typical Medicare Part B covered products such as diabetic supplies, immunosuppressants, anti-cancer or inhalation drugs are covered under the pharmacy benefit. Real-time claims processing allows for improved utilization measures to deliver increased patient safety and expected healthcare outcomes. Extending real-time claims processing capability to their QMB Program participants further enhances the value opportunity. To achieve the benefits of real-time claims processing, Medicaid plans may leverage internal eligibility and product coverage data files and rule sets, use specific COB claim data elements or a combination of both to apply QMB Program Medicare Part B coordination of benefits.

6.2.2 Recommend Increased Use of NCPDP Telecommunication Standard

NCPDP recommends all Medicaid programs leverage the NCPDP Telecommunication Standard for Medicare Part B drug processing to mitigate point of care confusion and increased administrative costs that occur with current retrospective manual claim and reconciliation processes. The NCPDP Telecommunication Standard supports the applicable data elements for Medicaid plans to identify QMB Program Medicare Part B coordination of benefit claims to allow for real-time claims processing when a Medicare benefit paid as the primary payer.

6.2.3 Recommend Use of Benefit Stage Qualifier (393-MV) Field

When the pharmacy receives the Benefit Stage Qualifier value of 51 (*Not paid under Part D, paid under Part C benefit. Beneficiary is a Qualified Medicare Beneficiary - pharmacy should not attempt to collect cost share, but instead should attempt to bill COB to Medicaid coverage*), from the Medicare Part B benefit primary claim response, this value can then be submitted on the COB claim to the Medicaid benefit.

The Benefit Stage Qualifier (393-MV) and Benefit Stage Amount (394-MW) fields are included in the Request Coordination of Benefits/Other Payments Segment of the COB claim transaction. These fields can be used as required if necessary for state/federal/regulatory agency programs. The Benefit Stage Qualifier of 51 allows the Medicaid benefit to trigger the applicable system rules to validate QMB Program and submitted product's Medicare Part B status to adjudicate the real-time claim.

6.2.4 Recommend Not Using Specific Reject Codes

The following reject codes are currently being used but may not be used correctly or convey the actual reason for the reject.

Reject Code MV – M/I Benefit Stage Qualifier

NCPDP recommends Medicaid plans <u>not return</u> reject code MV – M/I Benefit Stage Qualifier when the COB claim request contains a Benefit Stage Qualifier 51.

Benefit Stage Qualifier value of 51 was a January 01, 2018, emergency External Code List (ECL) change to support the identification of a claim for a QMB Program participant paid under a Medicare Part B benefit. Medicaid claims processors should update their systems to support the most current ECL and coordinate system rules to recognize the QMB Program Medicare Part B COB claim request submitted with Benefit Stage Qualifier value 51 versus rejecting the claim as M/I Benefit Stage Qualifier.

Reject Code 74 - Other Carrier Payment Meets or Exceed Payable

While supporting QMB Program Medicare Part B COB real-time claims processing is the desired approach, there are some situations where Medicaid plans are rejecting the COB claim based on reimbursement thresholds versus coverage determination. When the claim rejects indicating the Medicare primary payment meets or exceeds the Medicaid allowable, the pharmacy is faced with artificially reconciling the Medicare patient liability amount. This becomes a risk to the patient and to the pharmacy, as the payer should communicate the reimbursement amount when the claim is considered a covered benefit.

When the Medicaid reimbursement amount is determined to be $0, reject code 74 (Other Carrier Payment Meets or Exceed Payable) should not be returned. Rather than reject the claim, a Paid response should be returned with at least the following fields populated:

- Patient Pay Amount (505-F5)
- Ingredient Cost Paid (506-F6)
- Dispensing Fee Paid (507-F7)
- Other Payer Amount Recognized (566-J5)
- Total Amount Paid (509-F9)

7. NCPDP TELECOMMUNICATION STANDARD vD.0 TRANSACTION DETAIL

7.1 MEDICARE PART B BENEFIT CLAIM RESPONSE

The following depicts a portion of the MAPD paid response detail in the example where Medicare/Medicaid integrated benefits are not in place and the Medicare Part B 20% coinsurance cost share amount applies. To facilitate pharmacy provider processing of the COB claim to the Medicaid program, the MAPD has the Medicaid 4RX claims processing information on file and returns it within the Response COB/Other Payers Segment.

	RESPONSE PRICING SEGMENT	
111-AM	Segment Identification	23
505-F5	Patient Pay Amount	$20.00
506-F6	Ingredient Cost Paid	$90.00
507-F7	Dispensing Fee Paid	$10.00
509-F9	Total Amount Paid	$80.00
392-MU	Benefit Stage Count	1
393-MV	Benefit Stage Qualifier	51
394-MW	Benefit Stage Amount	$100.00

	RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT	
111-AM	Segment Identification	28
355-NT	Other Payer ID Count	1
338-5C	Other Payer Coverage Type	02-SECONDARY
339-6C	Other Payer ID Qualifier	03
340-7C	Other Payer ID	123456
991-MH	Other Payer Processor Control Number	QMB
356-NU	Other Payer Cardholder ID	111222333
992-MJ	Other Payer Group ID	PARTBQMB
142-UV	Other Payer Person Code	01
127-UB	Other Payer Help Desk Phone Number	800-555-5555
143-UW	Other Payer Patient Relationship Code	1-CARDHOLDER
144-UX	Other Payer Benefit Effective Date	01/01/2020
145-UY	Other Payer Benefit Termination Date	06/30/2020

7.2 COORDINATION OF BENEFIT CLAIM REQUEST

The following depicts the NCPDP COB claim submission to the designated Medicaid benefit based on the 4RX information returned on the MAPD paid claim response. The COB segment communicates the results of the MAPD paid claim response, including the 20% coinsurance amount and the Benefit Stage Qualifier of 51 to indicate the QMB Program status. Note: this example uses Government COB, where both the patient pay and the total amount paid values of the previous payer(s) are reported.

	TRANSACTION HEADER SEGMENT	
101-A1	BIN Number	123456
102-A2	Version Release Number	D0
103-A3	Transaction Code	B1
104-A4	Processor Control Number	QMB
109-A9	Transaction Count	1
202-B2	Service Provider ID Qualifier	01
201-B1	Service Provider ID	1234567890
401-D1	Date of Service	06/01/2020
110-AK	Software Vendor/Certification ID	PHARMACYQA1

	INSURANCE SEGMENT	
111-AM	Segment Identification	04
302-C2	Cardholder ID	111222333
301-C1	Group ID	PARTBQMB
303-C3	Person Code	01
306-C6	Patient Relationship Code	1-CARDHOLDER

	COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT	
111-AM	Segment Identification	05
337-4C	Coordination of Benefits/Other Payments Count	1
338-5C	Other Payer Coverage Type	01-PRIMARY
339-6C	Other Payer ID Qualifier	03
340-7C	Other Payer ID	888888
443-E8	Other Payer Date	06/01/2020
341-HB	Other Payer Amount Paid Count	1
342-HC	Other Payer Amount Paid Qualifier	07 - DRUG BENEFIT
431-DV	Other Payer Amount Paid	$80.00
353-NR	Other Payer-Patient Responsibility Amount Count	1
351-NP	Other Payer-Patient Responsibility Amount Qualifier	07- CO-INSURANCE
352-NQ	Other Payer-Patient Responsibility Amount	$20.00
392-MU	Benefit Stage Count	1
393-MV	Benefit Stage Qualifier	51
394-MW	Benefit Stage Amount	$100.00

8. CONCLUSION

Coordinating Medicare Part B with Medicaid benefits for QMB Program participants is currently a fragmented process due to the collision of real-time and non-real time data sharing and claims processing practices. This latency in data sharing creates a significant gap in point of care transparency, resulting in QMB Program participant confusion, retrospective reconciliation processes and increased administrative costs for all stakeholders. NCPDP recommends replacing inefficient manual processes that occur today too late in the process with electronic data sharing solutions between the Medicaid and Medicare plans and real-time claims processing. Real-time claims processing allows the designated payers to manage the benefit, versus current processes that depend on the provider and patient to estimate how and which benefits should apply.

Once the QMB Program eligibility status and the Medicaid QMB Program Part B 4RX information is shared in a timely manner using the existing COBA files, the NCPDP Telecommunication Standard can be used to support real-time claims processing ensuring only the QMB Program Medicare Part B cost share applies. A summary of these technical solutions is outlined below.

Increased Data Transparency

- As outlined under CMS-9115-F, Medicaid plans to provide dual eligibility information to CMS on a daily basis
- Medicaid plans use the COBA E02 drug eligibility file to provide the BIN, PCN, Cardholder ID, Group ID (4RX) of the Medicaid benefit (FFS, MCO, D-SNP) responsible for Part B benefit coordination for their QMB Program participants.
- MAPD plans to return the QMB Program Medicare Part B Medicaid 4RX, supplied in the COBA eligibility files, on the primary paid claim response with Benefit Stage Qualifier 51, to alert the pharmacy of the other coverage information. The pharmacy would access the 4RX to initiate the NCPDP real-time COB claim to the applicable Medicaid benefit.
- Medicaid plan benefits billed but not responsible for QMB Program Medicare Part B coordination to return the designated QMB Program Part B 4RX on the COB rejected claim notifying the pharmacy of the appropriate Medicaid benefit to bill.
- Medicaid plans billed but not responsible for QMB Program Medicare Part B coordination to return the designated NCPDP reject code to alert the pharmacy that an alternate Medicaid benefit is responsible as identified in the 4RX returned.

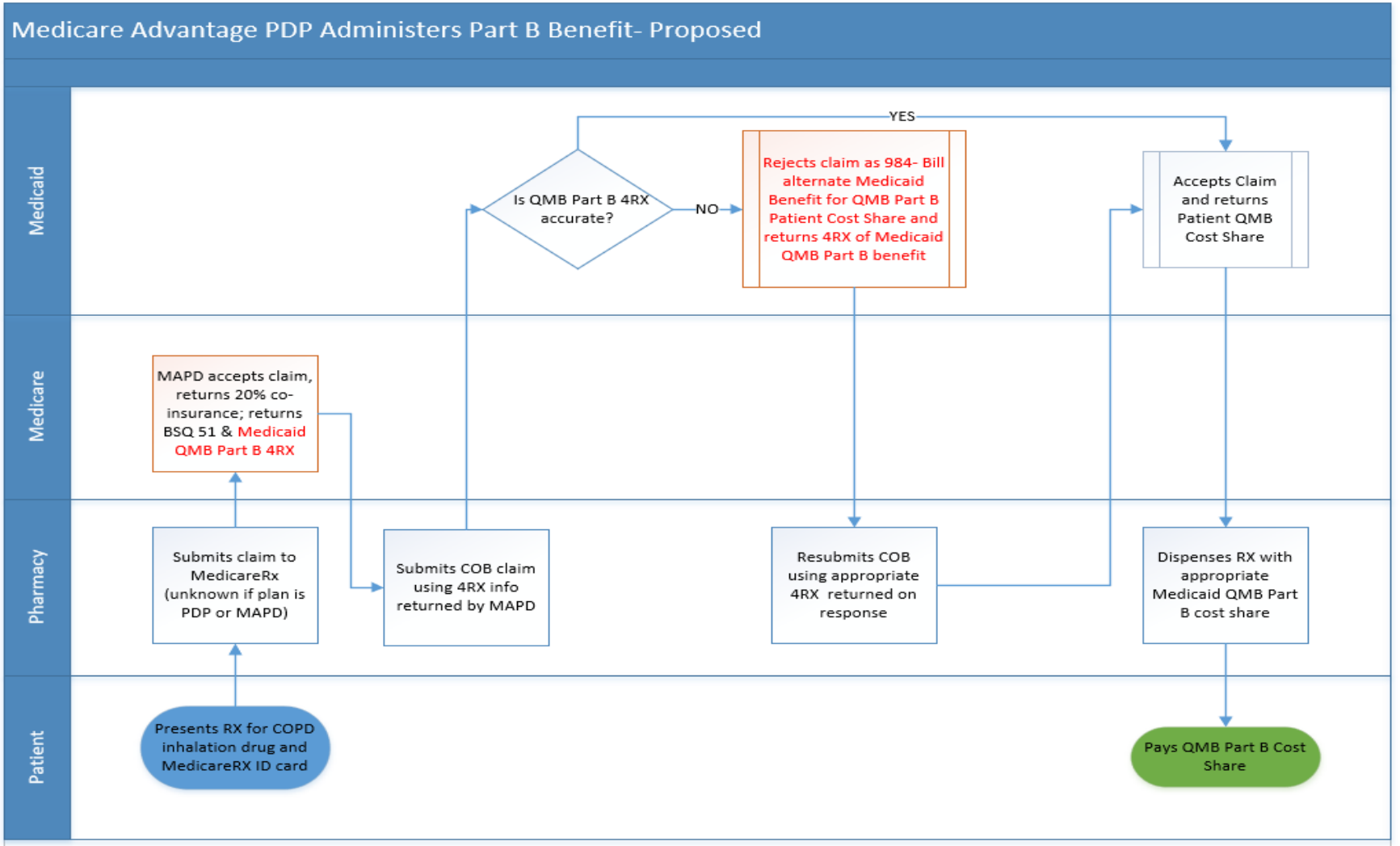
Real-Time Claims Processing Using the NCPDP Telecommunication Standard

- Where CMS auto-cross does not apply, all Medicaid programs must support QMB Program Medicare Part B real-time coordination of benefit claims processing
    - Current primary opportunity is with QMB Program participants enrolled in a MAPD
    - NCPDP Telecommunication Standard allows the MAPD to return Benefit Stage Qualifier (393-MV) value of 51 on the response, and the pharmacy to submit this value on the Medicaid COB claim. The Medicaid plan would use Benefit Stage Qualifier value of 51 as a trigger to validate the primary payer was a Medicare Part B benefit.

8.1 Process Flow Efficiencies Using NCPDP Recommendations

8.1.1 Medicare Advantage Prescription Drug Plan Administers Part B Benefit

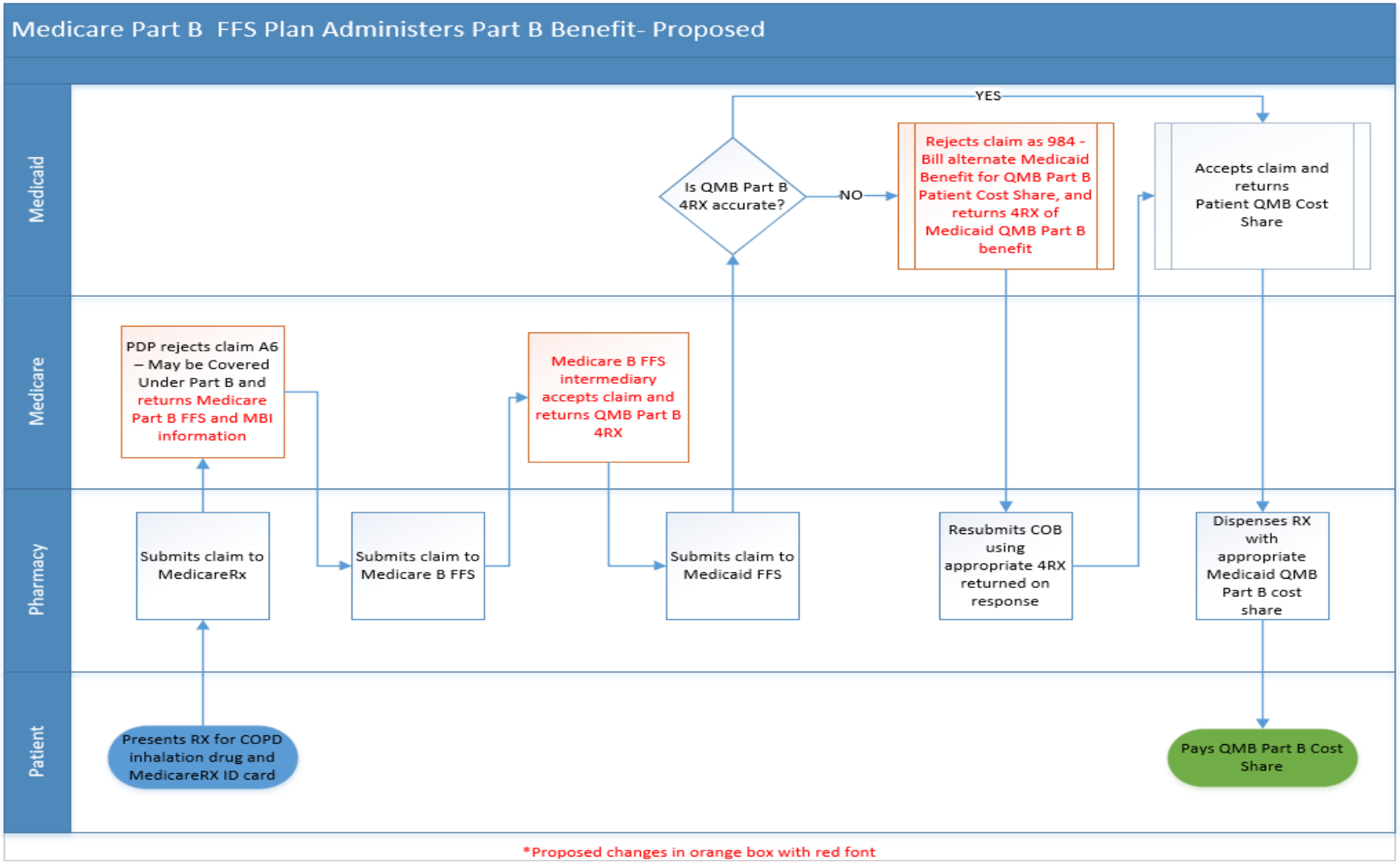
This diagram depicts the business case where the QMB Program participant is enrolled in a MAPD that is not an MMP or D-SNP therefore Medicare/Medicaid integrated benefits are not applied to the point of service claim adjudication process.



*Proposed changes in orange box with red font

8.1.2 MEDICARE PART B FFS PLAN ADMINISTERS PART B BENEFIT

This diagram depicts the business case where the QMB Program participant is enrolled in a PDP and Medicare Part B FFS. The MBI is returned on the PDP rejected response, allowing the provider to validate Medicare Part B FFS eligibility and the Medicare Part B intermediary is able to return the Medicaid QMB Program Part B 4RX information.



9. OTHER RESOURCES

- Medicare-Medicaid Coordination Office, Qualified Medicare Beneficiary (QMB) Program

10. APPENDIX A – HISTORY OF CHANGES

10.1 VERSION 1.0

- Original Publication

10.2 VERSION 1.0

- Republication
- Section 6.1.2: Modified definition of ECL value 51 for Benefit Stage Qualifier (393-MV) to match published definition in the ECL

National Council for Prescription Drug Programs

9240 East Raintree Drive, Scottsdale, AZ 85260
phone: 480.477.1000 | fax: 480.767.1042
ncpdp@ncpdp.org | www.ncpdp.org

NCPDP®