Avisery Webinar: Medicare and Medicaid Updates
July 24, 2019

Webinar Logistics:

• Audio: Listen through your computer speakers or call in using a telephone. To get call-in information, click “telephone” under “audio”.
• Because there will be a large number of people on the call, all lines will be muted to ensure good audio quality.
• If you have a question during the webinar, please type your question into the question box. Questions will be answered at the end of the webinar.
• The webinar slides and recording will be sent to all registrants within approximately one week of the webinar.
Updates: Medicare & Medicaid

Alicia Donegan Lomas, Manager of Healthcare Education & Counseling
Make Medicare Work Coalition

- MMW is a coalition led by AgeOptions, Progress Center for Independent Living and Smart Policy Works
- Together we continue to promote affordable, accessible healthcare options in Illinois to ensure that older adults and people with disabilities make informed choices about their healthcare.
- Since February 1st, the MMW email policy changed. Each MMW lead agency will use their copy of the email list to send information to MMW members in keeping with the Make Medicare Work mission.
• Through the Avisery by AgeOptions program, we support the work of MMW.

• Avisery by AgeOptions provides tools and support to professionals serving older adults and people with disabilities, enabling them to help their clients access healthcare coverage that allows them to thrive as they age.

• Avisery will continue offering trainings, technical assistance, and webinars, including our daylong Medicare/Medicaid Counselor trainings for providers like you!
What We Do

• Educate Medicare consumers, service providers and policymakers

• Provide impartial information through in-person trainings, webinars and technical assistance for professionals and volunteers

• Gather and create practical, accessible educational materials for service providers & consumers

• Problem solving – individual and systemic

• Advocate for consumer focused laws and policies

• Target underserved groups in Illinois
How to Access Avisery Services

• In Person Trainings & Webinars
  – Seasonal Calendar of Events & event registration sent through our Avisery Email List

• Technical Assistance (TA)
  – Send TA request through our program’s Email Address: Avisery@ageoptions.org

• Counseling Tools (Charts, Materials, etc.)
  – Sent through our Avisery Email List
  – Available on http://www.ageoptions.org/services-and-programs_makemedicarework.html
Contact Information

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Oak Park, IL 60301

Avisery Phone Number: (708)628-3440

Avisery Email Address: Avisery@ageoptions.org

Avisery Website: http://avisery.org/
Thank you to our funders

- Kott Memorial Foundation
- Retirement Research Foundation
- Avisery
- SHIP
- Other Grants
- Revenue from Business (FFS)
Today’s Webinar

• Medicare Updates
  – Kepro Transition
  – DMEPOS
  – Hot topic from Senior Medicare Patrol (SMP)

• Medicaid Updates
  – HealthChoice Illinois
  – MMAI
  – ...and more!!

• Frequently Asked Questions
Upcoming Plan Finder Transition

• CMS is planning to replace the Medicare Plan Finder with the Medicare Coverage Tool (MCT)

• The process will be rolled out in three phases:
  – 1. External Stakeholder Preview
    • CMS will let send a private link and gather feedback from CSRs, SHIPs, and Advocacy Groups
  – 2. Public Preview
    • Allow the public a chance to use the Medicare Coverage Tools. The public will still be able to use the Medicare Plan Finder during this time.
  – 3. Full Launch
    • All users will need to use the new Medicare Coverage Tools and will no longer be able to use the Medicare Plan Finder.
Collection of Plan Premiums

- Due to an issue with Social Security payments, premiums were not deducted from some client’s Social Security Benefits Checks.
- This affects clients enrolled either in a Medicare Advantage Plan or in a Medicare Prescription Drug Plan for coverage starting January 1, 2019.
- The MA Plan or Medicare PDP may send the client a bill. It is Mandatory for the plan to offer the client a “grace period” to payback the premiums they owe.
KEPRO Transition

• As of June 8, 2019 KEPRO is no longer Illinois’ Beneficiary and Family Centered Care QIO (BFCC-QIO)
• BFCC-QIOs are responsible for medical case review, which supports the rights of people on Medicare.
• Livanta is Illinois new provider and have taken over the case load from KEPRO.
• Livanta can be reached at (888) 524-9900

Livanta: Beneficiary & Family Services

• **Appeal of Discharge** if you think your Medicare services are ending too soon.
  – Example: Being discharged from a hospital, but you feel too sick to leave
  – To file an appeal, call Livanta’s hotline

• **Immediate Quality of Care Concern**
  – Can be addressed through Immediate Advocacy services. Livanta advocate can assist in real time.

• **Beneficiary Complaint**
  – Example: Received wrong Rx or developed infection in the hospital
  – To file complaint, fill out quality of care concern form & mail or fax to Livanta
MediGap & Guaranteed Issue in Illinois

• Reminder: Under federal and Illinois law you have a right to buy a MediGap policy without any pre-existing condition exclusions (this is called the right to Guaranteed Issue) during your Initial Open Enrollment Period.

• In Illinois, there is one Guaranteed Issue company that will issue a policy (outside of Open Enrollment Period) regardless of their health history
  – Blue Cross Blue Shield is the insurance company offering Guaranteed Issue plans at this time
QMB Updates

• Federal law states that you cannot charge a Qualified Medicare Beneficiary (QMB) with cost-sharing for services and items that Medicare covers.
• Providers are able to check a beneficiary’s QMB status on real time by accessing the HIPPA Eligibility Transaction System (HETS)
• Beneficiaries are able confirm their QMB status by calling 1-800-MEDICARE or checking their Medicare Summary Notice (MSN) (example on next slide)
Notice for Jennifer Washington
Medicare Number: XXX-XX-1234A
Date of This Notice: September 16, 2017
Claims Processed Between: June 15 – September 15, 2017

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. Mcginley M.D.

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>Amount Provider Charged</th>
<th>Amount Medicare Approved</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</td>
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<td>$28.54</td>
<td>$22.83</td>
<td>$0.00</td>
<td>A</td>
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<tr>
<td>develop strength, endurance,</td>
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<td>range of motion, and flexibility,</td>
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<tr>
<td>each 15 min (97110)</td>
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Total for Claim #02-10195-592-677: $45.00

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.
Medicare Advantage Plans and Beneficiaries with End Stage Renal

- Medicare Advantage Plans are available to End Stage Renal Disease (ESRD) patients only in certain circumstances
  - Example: A beneficiary developed ESRD while they were enrolled in an Medicare Advantage Plan.
- Reminder! The 2016 CURES Act will allow people diagnosed with ESRD to enroll in a Medicare Advantage Plan beginning in 2021.
Genetic Testing and Medicare Fraud

- Illinois has seen an influx of reports about genetic testing companies that are targeting Medicare beneficiaries at health fairs, community events, Medicaid offices, and other public places with offers of “free” genetic tests.
- This is potentially Medicare fraud since there is no medical necessity for testing every person at an event.
- To legitimately bill Medicare, a beneficiary’s doctor should order any tests, services or equipment.
- If you have a client who has been targeted by this scam, they can report it to the Illinois SMP at AgeOptions (800)699-9043.
DMEPOS Temporary Gap

- January 1, 2019 through approximately December 31, 2020 there is a temporary gap with the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) program.
- During this time beneficiaries may use any Medicare DMEPOS supplier to obtain items and services.
- Beneficiaries should visit [www.medicare.gov/supplier](http://www.medicare.gov/supplier) or call 1-800-MEDICARE to locate a supplier.
- Beneficiaries should be aware of aggressive marketing by suppliers and talk to their supplier first to see if they need to switch suppliers or remain with the same one.
- If a beneficiary thinks there is fraud surrounding their DMEPOS supplier, they can call the Illinois SMP at AgeOptions (800)699-9043.
New Medicare Cards - Reminder!

-The old Medicare cards can still be used until December 31, 2019.

-Starting January 1, 2020, everyone should be using their new Medicare cards, as the old cards will not be valid anymore.
Jimmo v. Sebelius- Reminder!

- Recap: This lawsuit was brought by Medicare beneficiaries who had or will have Medicare coverage of nursing or therapy services denied, terminated, or reduced on the basis that they were not *improving* or not demonstrating a *potential for improvement*.

- Settlement Agreement: To clarify that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration.

- CMS is required to clarify and revise their material to increase education on this matter, as **beneficiaries are continuing to have issues with providers** not understanding that they may continue to treat beneficiaries whether or not they meet the “improvement standard”
Marketplace Equitable Relief (no deadline)

• CMS announced that Marketplace enrollees will no longer have a time limit to apply for “Equitable Relief.” Previously, individuals in a Marketplace plan who did not enroll in Part B and wanted equitable relief from Late Enrollment Penalties were only allowed to apply for this provision by a certain time period.

• Now, beneficiaries who chose to delay Part B in order to keep their Marketplace plan can apply for equitable relief at any time. Applying for equitable relief allows these individuals to:
  – Enroll in Medicare Part B without penalty
  – Eliminate or reduce their Part B Late Enrollment Penalty if already enrolled in Part B but delayed enrollment when they had coverage through a Qualified Health Plan

Medicaid Managed Care: HealthChoice Illinois MLTSS Update

• As of July 1, 2019, it is **mandatory** for Medicare enrollees **across the state** of Illinois to receive coverage of their Long Term Services and Supports through one of the following Medicaid Managed Care programs:
  – HealthChoice Illinois MLTSS
  – MMAI (Medicare Medicaid Alignment Initiative)
    • Only available to those who are eligible and live in program’s geographic area

• Previously, HealthChoice IL was limited to certain geographical areas of Illinois. It has now expanded and is being implemented across the entire state.
  – **There are no changes for HealthChoice Illinois in the Chicagoland area.**
Long Term Services & Supports

“LTSS” or long term services and supports include, but are not limited to:

– Skilled nursing facility care (long-term care typically covered by Medicaid, NOT short-term rehab that is typically covered by Medicare)
– One of the following 5 Home and Community Based Waiver Services programs:
  • The Elderly Waiver is for those people 60 years or older that live in the community.
  • The Persons with Disabilities Waiver is for those people 59 years of age or younger who have a physical disability.
  • The Persons with a Brain Injury Waiver
  • The People with HIV or AIDS Waiver
  • The Supportive Living Facilities (SLF) Waiver
HealthChoice IL MLTSS: The Who and the What

• Mandatory for those who:
  – Have full Medicare (A & B) & full Medicaid (no spenddown) benefits,
  – Are receiving LTSS through nursing home care or through one of the five HCBS waivers, and
  – Not enrolled in MMAI (either because MMAI is not available in their county or they chose to opt out)

HealthChoice Illinois MLTSS: Excluded Populations

- These groups of people are ineligible to join a HealthChoice Illinois MLTSS Plan:
  - MMAI enrollees
  - Individuals with Medicare & full Medicaid who do not receive LTSS services
  - Those with Medicaid Spenddown
  - Individuals enrolled in private health insurance coverage (e.g., retiree or employer coverage)
  - Medicaid Presumptive eligibility groups (temporary benefits)
  - ALL Kids Premium Level 2 enrollees
  - Enrolled in a Medicaid waiver program for individuals with Developmental Disabilities or receiving developmental disability institutional services
  - Individuals enrolled in partial/limited Medicaid benefits
  - Individuals who are American Indian/Alaskan Natives (can voluntarily enroll)
July 1st, 2019

HealthChoice Illinois Plans

STATEWIDE
These health plans serve all counties in the state, including Cook County.

Blue Cross Community Health Plans
IlliniCare Health
MeridianHealth
Molina Healthcare

The HealthChoice Illinois Program includes Managed Long Term Supports and Services (MLTSS) membership.

Medicare-Medicaid Alignment Initiative (MMAI) Plans

Aetna Better Health Premier Plan
Cook, DuPage, Kane, Kankakee, Will

Blue Cross Community MMAI
Cook, DuPage, Kane, Kankakee, Lake, Will

Humana Health Plan
Cook, DuPage, Kane, Kankakee, Lake, Will

IlliniCare Health
Cook, DuPage, Kane, Kankakee, Lake, Will

Meridian Complete
Cook, DuPage, Kane, Will

Molina Healthcare
Champaign, Christian, DeWitt, Ford,
Knox, Logan, Macon, McLean, Menard, Peoria, Piatt,
Sangamon, Stark, Tazewell, Vermillion

HealthChoice IL MLTSS Reminders:

• MLTSS enrollees should NOT have to choose a new provider/PCP for their routine medical care that is covered by Medicare and/or Medicaid.

• After selecting a HealthChoice IL MLTSS plan, beneficiaries are locked into that plan for 12 months after effective date*
  – However, health plans must offer an initial 90-day transition period for members new to the plan.

• All plans offered through HealthChoice IL offer MLTSS plans.

• Consumers should check that their LTSS provider is in-network with whichever plan they choose.
MMAI in Central Illinois

• Beginning July 1, 2019, MMAI will be an option once again for individuals living in the Central Illinois counties of Christian, Logan, Macon, Menard, Piatt, and Sangamon
  – Passive enrollment packets will be sent to full dual eligibles who qualify for MMAI in these areas in June 2019 with the first auto-enrollment effective dates of September 2019

• Molina is still currently the only MMAI plan option in the Central Illinois area and will continue to be for calendar year 2019 and calendar year 2020

• If a beneficiary receives an MMAI passive enrollment packet, but wants to keep their current coverage, they must contact Client Enrollment Services to opt out before the end of their 60 day choice period or they will be automatically enrolled in Molina
The state of Illinois and CMS are currently working on the contract that will extend the MMAI program for another three years, through December of 2022.

Request has not been approved yet; the state and CMS are still discussing details.

At this point, MMAI will remain only in current counties and not be expanded to other counties.
Medicaid Omnibus Bill

- **SB1321** was passed in early June. This bill included several provisions specific to Medicaid Eligibility and Redetermination:
  - Hiring more caseworkers at HFS and DHS
  - A complete review of the Medicaid rede process
    - Must identify changes that would allow for more Medicaid consumers to be automatically renewed (through “ex-parte” redetermination).
  - Streamlining continuing eligibility by leveraging data from other public benefit programs, like SNAP
  - Extend the reasonable compatibility threshold for income
  - Improving public reporting requirements that will enable stakeholders to better work with HFS on policy and process solutions
  - Explore and implement opportunities for community organizations and other agencies to assist in eligibility determinations and renewals
  - And more!
Identity Proofing within ABE and MMC

• DHS implemented a state-level identity proofing process for consumers who are not able to verify their identity through Experian when setting up Manage My Case accounts.

• Consumers should attempt to verify identity through the Experian proofing process first when setting up their Manage My Case and only use proofing by the state if absolutely necessary.
  – The form is available in Spanish and English.

• For guidance on this process, http://www.dhs.state.il.us/page.aspx?item=76721.

• At this time, DHS asks that consumers mail the form instead of bringing their form directly to local DHS offices. The form and accompanying documents should be mailed to:
  
  Illinois Department of Healthcare and Family Services
  Attention: ID Proofing Unit
  P.O. Box 19122
  Springfield, Illinois 62794-9122
Medicaid Updates: for Providers

• **MEDI System Update**
  - Long Term Care providers can now use MEDI to find out when each resident’s redetermination is scheduled
  - Previously, HFS sent a monthly notification of which residents were up for redetermination – This process has been discontinued.

• **Ordering, referring, prescribing- National Provider Identification Number Requirement**
  - The requirement that each provider who orders, refers, or prescribes must have an NPI number to bill Medicaid (either primary or secondary) has been **DELAYED** – this applies for both fee-for-service and HealthChoice IL claims
  - New implementation date for this is October 1, 2019
Reminder: T-card Process

• In cases where HFS has taken longer than 54 days to process a new Medical application, consumers have the right to ask for a Temporary Medical Card, also known as a T-Card.

• For a step-by-step guidance on the T-Card process, please review this guide from Help Hub: 

• Reminder: for URGENT cases where a consumer’s health is at risk due to not having coverage, but you believe they are eligible for Medicaid, professionals may email hfs.aca@illinois.gov to ask for emergency Medical coverage. Please reserve this for the most urgent of cases only.
How to: Request T-Card by Phone

• HFS has hired staff to fulfill Temporary Card requests by phone
  – Clients and providers may call the All Kids toll-free number: (877)805-5312
  – Have the ABE application tracking number available for the caseworker, if possible. If you do not have this, they should be able to look the application up by SSN, Name, and address of the applicant

• Temporary cards should be issued within 48 hours of request
New Avisery Medicaid Tipsheets

- Medicaid Redetermination: Tips for Success
- Emergency Medicaid: A Guide for Professionals
Frequently Asked Questions:

Frequently Asked Questions from our technical assistance calls & trainings

• *If the coverage gap is closed for brand names, why do consumers still pay different cost-sharing amounts throughout the year?*

• *Can a physician order more than a 7 day supply (of opioids) or do they need to order multiple 7 day supplies?*
FAQ’s continued:

• My client has a Medicaid spenddown which is met monthly using their Department on Aging waiver services. Do they have to choose a HealthChoice IL MLTSS plan for their homemaker services, since Medicaid is paying?

• My client lives in a nursing home and we are waiting for the Medicaid application to be approved. It’s been 60 days since we applied, so are they eligible for a T-card?
  – No, they are not eligible for a T-card. HOWEVER, HFS will authorize Provisional Authorization (PE) when there is a delay in LTC application processing or payment of LTC services to providers.
  – Please note that if PE is authorized, the consumer will be enrolled into Managed Care (HealthChoice IL) as per current rules.
  – HFS Policy Memo: https://www.dhs.state.il.us/page.aspx?item=115419
FAQ’s continued...

• How do I know if my client has QMB? Will they get a card indicating their QMB status?
  – No. recently, HFS changed the medical card and it no longer indicates if they are QMB-only.
  – *NEW Medicare beneficiaries can check their Medicare Summary Notice to see if they are in the QMB program.

• Client is over the income limit for Medicaid. Can they use CCP/LTC costs to meet spenddown?
Since 1974, AgeOptions has established a national reputation for meeting the needs, wants and expectations of older adults in suburban Cook County. We are recognized as a leader in developing and helping to deliver innovative community-based resources and options to the evolving, diverse communities we serve.

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