Make Medicare Work Coalition Bulletin
March 14, 2018

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Medicare Updates

Don't Forget About the Medicare Part D Transition Supply Policy!
The Centers for Medicare and Medicaid Services (CMS) require Medicare Part D, Medicare Advantage, and Medicaid-Medicaid Alignment Initiative (MMAI) plans to offer newly enrolled beneficiaries a one-time 30-day fill of a prescription that is not on the plan's formulary. This is called a transition supply and can be used anytime within the first 90 days of coverage with a plan. The transition supply policy can also be used for drugs that are on a plan's formulary, but have drug restrictions such as prior authorization or step-therapy.

Once a Part D plan provides a transition supply to a member, the plan is then required to notify the individual in writing within three business days explaining that the drug in question is not on the plan's formulary (or has drug restrictions) and that the supply was temporary. The temporary transition supply is intended to provide the member with enough time to either request a formulary exception from the plan or find an alternate drug on the formulary that works as well.

This policy can be used by

- Medicare beneficiaries who are new to a Part D plan for the first time
- people who switch from one plan to another either during the Medicare Open Enrollment Period or through a special enrollment period
- beneficiaries who are randomly assigned to a Part D plan by CMS (e.g., dual eligibles or people who become eligible for Extra Help)
- people who are new to Medicare and transition over from another type of health coverage, such as employer health insurance or COBRA
- beneficiaries who experience a change in level of care (move into or out of a hospital, skilled nursing facility, or nursing home)

Note, beneficiaries who live in a long-term care facility are eligible to receive a 31-day transition fill (including multiple 31-days fills during the first 90 days of enrollment).

The transition supply policy is especially helpful for beneficiaries who enrolled or switched to a new Medicare Part D plan during the Medicare Open Enrollment Period in late 2017 without thoroughly making sure the plan covers all of their Part D medications.

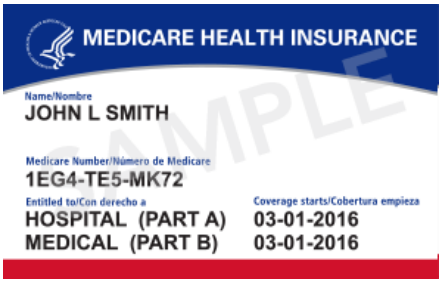
In certain circumstances, beneficiaries who are not enrolled in a new Part D plan and remain in the same plan from one contract year to the next, may also be eligible for a transition supply. If a member experiences a formulary change from one year to the next, they may be eligible to receive a transition supply if the plan did not work with them prior to the new contract year to find an equivalent drug that is on the plan's formulary or to submit a formulary exception before the new coverage year began.

For additional resources on the Medicare Part D Transition Supply Policy, please see the following resources:

- Medicare Prescription Drug Benefit Manual: Chapter 6 (see section 30.4)
- *"Getting to Know: Medicare Part D Transition Supply",* NCOA Center for Benefits Access
- Part D Transition Policy Reminder, Centers for Medicare and Medicaid Services

New Medicare Cards are Coming! (Update)
Last year, CMS announced that all Medicare beneficiaries will receive new red, white, and blue Medicare cards. The initiative was a result of a federal law that requires the removal of Social Security numbers from all Medicare cards and replaced with new cards by April 2019. CMS will replace all Social Security numbers on Medicare cards with a "Medicare Beneficiary Identifier" or MBI. The new MBI will be unique and randomly assigned to each beneficiary. It will consist of 11 characters that contain only numbers and uppercase letters. All Medicare beneficiaries will receive a new MBI, including active and deceased beneficiaries, people in Medicare Advantage plans, and new beneficiaries. MBIs will be unique to each beneficiary, meaning a married couple will each be assigned their own MBI. In addition, gender and the signature line will be removed from the new cards. The Railroad Retirement Board (RRB) will replace and issue new cards to RRB beneficiaries.

A visual of the newly redesigned Medicare card is pictured below and can also be found on the inside front cover of the 2018 Medicare and You handbook and the CMS website here.



CMS recently posted a national mailing schedule that lists when cards will be mailed by geographic location. **In Illinois, the mailing wave will begin after June 2018**. As the date approaches, it is important to remind beneficiaries of the following:

- All beneficiaries will automatically receive a new Medicare card. They do not have to submit a request or do anything to receive one.
- Make certain their mailing address is up-to-date. CMS will use the mailing addresses on file with the Social Security Administration. If a beneficiary has recently moved, they should contact Social Security to update their new address.

- Cards will not be mailed to all beneficiaries at the same time. New card mailings will be staggered, which means a beneficiary may receive their new card at a different date than neighbors or friends.
- Safe guard their new Medicare card as they would any personal information. Just because Social Security numbers will be removed does not mean scammers cannot steal their new MBI and use it for fraudulent claims.
- The new Medicare cards will not affect how beneficiaries receive their Medicare benefits. The goal of the initiative is to combat medical identify theft and better protect beneficiary information.

CMS is working to reach out and educate providers about the systems change and will provide them with a transition period that begins April 2018 and lasts for 21 months, through December 2019. During the transition period, providers may use either the new MBI or the Social Security number listed on the old Medicare card. Beginning January 2020, Medicare cards that contain Social Security numbers will no longer be in use with providers, plans, and beneficiaries. The following resources can be used to help professionals and beneficiaries understand and navigate the upcoming change.

Resources for Medicare consumers

- 10 Things to Know About Your New Medicare Card is a fact sheet created by CMS that can be shared with beneficiaries to help them understand the change.
- A short one-minute YouTube video created by CMS that can be shown at presentations or events.
- A tip sheet created by the Illinois SMP Program at AgeOptions on what beneficiaries need to know about the new Medicare cards. (The tip sheet is available in English and Spanish.)

Resources for professionals and counselors serving Medicare consumers

- Professionals who work with Medicare beneficiaries can review a handout created by CMS that lists New Medicare Card Messaging Guidelines. The handout includes preferred terms and references, and can be used to develop talking points or messages when creating materials such as flyers, presentations, or other outreach materials.
- CMS has created a New Medicare card webpage for professionals, providers, and other Medicare vendors where they can obtain detailed and instructional information about the new cards: https://www.cms.gov/Medicare/New-Medicare-Card/index.html.

CMS Temporarily Suspends Changes That Indicates QMB Status

Last year CMS announced new protections for Medicare beneficiaries who also qualify for the Medicare Qualified Beneficiary (QMB) Program. The QMB program is a Medicare Savings Program that is administered by Medicaid and assists beneficiaries with limited income and assets to pay for Medicare out-of-pocket costs. Medicare beneficiaries who are enrolled in the QMB program are not liable for any Medicare cost sharing amounts. In fact, the Social Security Act prohibits Medicare physicians and providers from improperly billing QMB beneficiaries any Medicare deductible, co-insurance, or co-payment amounts, even if the provider does not accept Medicaid. This federal law applies to beneficiaries in Original Medicare and Medicare Advantage plans.

To help inform Medicare providers that they should not bill QMB beneficiaries any Medicare cost sharing, last October CMS announced that they would introduce changes to their Medicare fee-for-service claims processing systems that would alert physicians and other providers when a beneficiary is eligible for QMB and to not collect any Medicare deductible or co-payment amounts. To educate and remind QMB beneficiaries that they are not liable for any Medicare cost haring, CMS also

planned to reflect a beneficiary's QMB status on their Medicare Summary Notice (MSN) and include language that explains how providers cannot bill them for Medicare cost sharing. In December 2017, due to unforeseen circumstances associated with these system changes, CMS announced that implementation of this change would be temporarily suspended until July 1, 2018.

QMB Medicare beneficiaries who experience improper billing issues with a provider can take the following steps to help educate the provider and rectify the situation.

- Share this CMS notice with the provider that explains how billing QMB beneficiaries is prohibited. If the individual is in a Medicare Advantage plan and has QMB, they can reference CMS guidance here (see page 181).
- If a provider continues to bill a QMB beneficiary even after sharing the CMS notice, the beneficiary can contact 1-800-MEDICARE and report that they have QMB and are being billed Medicare cost sharing amounts. 1-800-Medicare will then work with Medicare Administrative Contractors to issue letters the providers who are improperly billing the beneficiary and instruct them to refund any incorrect charges.

For more information and materials on improper billing of QMB beneficiaries, please see Justice in Aging's website

Limited Time Equitable Relief Opportunity to Enroll in Medicare Part B Extended Through September 30, 2018

Some individuals who are enrolled in Marketplace plans and receiving premium tax subsidies, and then became eligible for Medicare, may have chosen to remain in their Marketplace health plans instead of enrolling in Medicare Part B once they became eligible for Medicare. (Individuals eligible for premium-free Medicare Part A can enroll in Part A at any time.) The decision to delay enrollment into Part B may have been done to save money by not paying the monthly Part B premium or because they were not aware of the consequences.

What they may not have realized is that their eligibility for premium free Medicare Part A made them ineligible to continue receiving any premium tax subsidies regardless if they enrolled in Part B or not. As a result, some of these beneficiaries may have missed their Medicare initial enrollment period (IEP) to enroll in Part B and are now left paying more for their Marketplace plan. In addition, beneficiaries who miss their IEP must wait until the Medicare General Enrollment Period to enroll in Part B and possibly incur late enrollment penalties.

This is a reminder that CMS is offering certain beneficiaries who are enrolled in both premium-free Medicare Part A and a Marketplace health plan a limited time opportunity through September 30, 2018 to request equitable relief. Equitable Relief is a process that may allow retroactive enrollment into Medicare Part B and the elimination or reduction of a Part B late enrollment penalty if an individual erroneously fails to enroll into Part B when they first become eligible. To qualify, individuals must be enrolled in premium free Part A, have an initial enrollment period that began April 1, 2013 or later; or were notified of a retroactive premium free Part A award on October 1, 2013 or later. If approved, CMS will provide individuals with a special enrollment period to enroll in Part B, disenroll from their Marketplace coverage, and also have any Part B late enrollment penalties reduced or eliminated.

CMS is also extending this limited time opportunity to beneficiaries who had a Marketplace plan, did not enroll in Medicare when they first became eligible, and are now paying a Part B late enrollment

penalty because they used the Medicare General Enrolment Period in 2015, 2016, 2017, or 2018 to enroll in Medicare Part B. In these circumstances, individuals may have their penalty reduced or eliminated.

Requests must be submitted to Social Security by September 30, 2018 and are reviewed on case-by-case basis. Individuals will also need to provide documentation that confirms that they are or were enrolled in a Marketplace plan. For more information, visit:

- https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/SHIP-and-Navigators-Fact-Sheet-Limited-Equitable-Relief.pdf
- http://www.justiceinaging.org/wp-content/uploads/2017/03/Equitable_relief.pdf
- https://www.medicareinteractive.org/get-answers/how-original-medicare-works/enrolling-in-original-medicare/time-limited-equitable-relief-for-enrolling-in-part-b.

Bipartisan Budget Act of 2018 and Medicare Changes

On February 9, 2018, Congress passed the Bipartisan Budget Act of 2018. Along with tax and funding provisions, the law includes a number of changes to the Medicare program. Some of the changes include:

- Repealing the Medicare outpatient therapy caps for physical, speech, and occupational therapy. The change is effective January 1, 2018. Previously, Medicare payments for these therapies were "capped" at a specified dollar amount. Medicare beneficiaries were required to file exceptions with Medicare if costs for these therapies exceeded the capped amount. The law now requires outpatient therapy claims that exceed the capped amount to include a KX modifier that indicates they are medically necessary.
- Closing the Medicare Part D Coverage Gap (also knows at the donut hole) one year earlier. The Part D donut hole was scheduled to be eliminated in 2020, but the new law closes the donut hole one year sooner. Beginning in 2019, Medicare Part D cost sharing for beneficiaries will be 25% for prescription drugs that are covered under their Part D plan formularies.
- Higher Medicare Part B and Part D premiums for beneficiaries with higher incomes. Starting in 2019, a beneficiary with a modified adjusted gross incomes of $500,000 or more ($750,000 or more for a couple) will have to pay an additional income related adjustment amount for their Medicare Part B and Part D premiums (increases form 80% of the total cost of Part B premiums to 85%).
- Permanently reauthorizing Medicare Special Needs Plans (SNPs). SNPs are Medicare Advantage plans for specific and vulnerable Medicare populations that include dual-eligibles, beneficiaries with chronic health conditions, or people living in an institution or require nursing home care at home. Please note that Special Needs Plans for dual-eligibles (D-SNPs) are no longer offered in Illinois. Beginning in 2018, the Illinois Department of Healthcare and Family Services no longer contracts with D-SNPs.
- Expanding supplemental benefits offered by Medicare Advantage plans to beneficiaries with certain chronic conditions as long as the supplemental benefits are expected to maintain or improve a beneficiary's health. Supplemental benefits will not be required to be health related and can include benefits such as medical transportation or home delivered meals.
- Allows all states to participate in the Medicare Advantage Value Based Insurance Design pilot by 2020. CMS is currently operating the pilot in ten states (currently not offered in Illinois). The program was created for beneficiaries with certain chronic conditions who are enrolled in Medicare Advantage (MA) plans and to explore whether their health could be improved while lowering their cost sharing amounts. It allows participating MA plans to offer lower cost sharing and additional benefits if beneficiaries choose to utilize "high value" services and/or providers that "positively impact their health".

- An additional two years of funding in 2018 and 2019 to perform outreach and enroll low-income Medicare beneficiaries into benefits programs such as the Extra Help and Medicare Savings Programs. The funding is allocated to Senior Health Insurance Program (SHIP) agencies, Area Agencies on Aging, Aging and Disability Resource Centers, and the National Center for Benefits and Outreach Enrollment.

For additional information and an overview of all Medicare and health-related changes included in the Bipartisan Budget Act, please see below:

- Justice in Aging fact sheet: http://www.justiceinaging.org/fact-sheet-health-care-provisions-bipartisan-budget-act-2018/.
- California Health Advocates overview: https://cahealthadvocates.org/how-does-the-bipartisan-budget-act-of-2018-affect-medicare.
- National Council on Aging (NCOA) blog: https://www.ncoa.org/blog/bipartisan-budget-act-2018.
- Center for Medicare Advocacy: https://www.medicareadvocacy.org/congress-did-repeal-outpatient-therapy-caps-despite-lack-of-information-on-www-cms-gov.

Medicaid Managed Care Updates

MMW Coalition Topical Brief: 2018 Medicaid Managed Care Updates
In case you missed it, the MMW Coalition recently created a topical brief that explains changes made to the Illinois Medicaid program. The brief provides information about HealthChoice Illinois (the new Medicaid Managed Care Program in Illinois for people with Medicaid only or enrolled in the Managed Long Term Services and Supports (MLTSS) Program, Medicare Medicaid Alignment Initiative (MMAI) updates, and information about Dual Special Needs Plans (D-SNPS) no longer being offered in Illinois. The brief also reviews how these changes may impact individuals with Medicaid, describes their coverage options, and links to sample communications that the Illinois Department of Healthcare and Family Services (HFS) is sending to Medicaid beneficiaries regarding these changes. To access the brief, visit http://www.ageoptions.org/services-and-programs_MMW-MedicaidandManagedCare.html.

Affordable Care Act Updates

Marketplace Special Enrollment Periods
The open enrollment period for the Health Insurance Marketplace for health coverage in 2018 ended on December 15, 2017. Most individuals who wish to enroll in or switch Marketplace health plans will have to wait until the next open enrollment period that will begin in the fall of 2018. Some individuals, however, who experience a qualifying event or major life change may be eligible for a special enrollment period (SEP) to enroll in health coverage through the Marketplace outside of the typical open enrollment period.

Some examples of SEPs include the recent loss of qualifying health coverage, a permanent move, a marriage, birth of a baby, a divorce, or gaining citizenship or lawful presence in the U.S. In addition, individuals who experience a change in eligibility for financial assistance may also qualify for a SEP, including individuals who no longer qualify for Medicaid and individuals who experience a change in their household size that impacts their eligibility for premium tax credits.

Health Reform and Beyond the Basics has created a useful guide that explains the various Marketplace SEPs and includes how each SEP is triggered, how long it lasts, who is eligible to use it, and more. This guide is intended as a resource for professionals and counselors assisting clients. The www.healthcare.gov website has created a screening tool that is user friendly and that individuals can complete to determine if they are eligible for a SEP. To apply for a SEP, individuals must call the Marketplace call center at 1-800-318-2596. If they qualify, most SEPs provide 60 days to select and enroll in a Marketplace plan.

Training Opportunities

Medicare Training Webinars Archived by CMS
CMS has recorded and posted multiple educational Medicare training webinars on their website as part of their "Learning Series". These webinars are intended for professionals and great for someone who is new to Medicare counseling or just in need of a refresher. Topics include 2018 Medicare costs, Medicare enrollment periods, Medicare and the Marketplace, Medigap (Medicare Supplement plans), and information about the new Medicare cards. The webinars are free and posted on YouTube, so they can be viewed or listened to at your convenience. For additional information, visit https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Web-Events.html.

Resources

AgeOptions Chart of Benefits - Updated
AgeOptions has released an updated Chart of Benefits to reflect the recently announced 2018 Federal Poverty Levels (FPLs). This chart is meant as a resource tool for professionals to use when screening clients for benefit programs. The chart lists income, asset and eligibility requirements for various public programs in Illinois including Medicaid, Medicare Savings Program, Extra Help, the Benefits Access Program, Supplemental Security Income (SSI), LIHEAP, SNAP (Food Stamps), Access to Care, Community Spousal Impoverishment and other programs.

Please note that this chart is designed for professionals and should not be altered or distributed to clients or consumers. The chart is meant as a quick reference tool (a "cheat sheet") for counselors and does not provide detailed explanations for consumers about how each program works. The chart is updated whenever income, asset or eligibility requirements for programs change. Please note that the new Medicaid and Medicare Savings Programs income limits listed in the chart do not go into effect until April 1, 2018. Click here to view the chart.

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To access the Make Medicare Work Coalition's materials on Medicare, Medicaid, and the Affordable Care Act, sign up for the MMW e-mail list, or to unsubscribe, please visit our website: http://www.ageoptions.org/services-andprograms_makemedicarework.html .

If you have any questions, please contact us calling (708)383-0258 or emailing georgia.gerdes@ageoptions.org, alicia.donegan@ageoptions.org, or gabriela.montoya@ageoptions.org.