Make Medicare Work Coalition (MMW)

Bulletin Newsletter

August 9, 2017

To view other MMW materials and resources, including past MMW Bulletin newsletters, fact sheets, and recorded webinars, visit our MMW Coalition webpage at http://ageoptions.org/services-and-programs_makemedicarework.html

Medicare Updates

New Medicare Cards are Coming!
Medicare beneficiaries will receive new Medicare cards beginning next year as part of the Social Security Number Removal Initiative. The initiative is a result of the Medicare Access and Chip Reauthorization Act and requires the Center for Medicare and Medicaid Services (CMS) to remove social security numbers from all Medicare cards by April 2019. CMS will replace the social security numbers on Medicare cards (currently called Health Insurance Claim Numbers) with a "Medicare Beneficiary Identifier" or MBI. All Medicare beneficiaries will receive a new MBI, including active, deceased and new beneficiaries. In April 2018, Medicare beneficiaries will begin receiving new Medicare cards by mail that include newly assigned MBIs. CMS intends to replace all Medicare cards by April 2019. The Railroad Retirement Board (RRB) will replace and issue new cards to RRB beneficiaries.

The current Medicare Health Insurance Claim Number on a Medicare card consists of social security number followed by a letter that indicates how the beneficiary is receiving Medicare benefits (i.e. through their own work history, spouse's, former spouse, parent's, etc.). The new MBI will be unique to each beneficiary and randomly assigned. It will contain the same number of characters as the current Medicare Health Insurance Claim Number, but will only contain uppercase letters and numeric characters. In addition, MBIs will include letters and numbers that are not easily confused with each other (e.g., the number 1 being confused with the letter l). 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. A visual of the newly redesigned Medicare card will released in the fall.

It is important to note that the new MBI 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 will conduct outreach and education to beneficiaries, providers, health plans, and other partners to prepare them for the change. Beneficiaries will receive information about the new cards in the 2018 Medicare & You handbook that will be mailed to them this fall and CMS will continue to reach out to beneficiaries afterwards through educational campaigns. Healthcare providers will need to update and adjust their systems to accommodate the new change for billing, claim and eligibility purposes. 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. CMS has posted an article for providers that includes additional information and steps they can begin taking to prepare for the change. To view the article in Spanish, click here. For additional information on the new Medicare cards, visit the CMS website here.

New Protections for QMB Beneficiaries

Qualified Medicare Beneficiary (QMB) is a state Medicaid program and one of three Medicare Savings Programs that helps beneficiaries with limited incomes and resources pay for Medicare's out-of-pocket costs. The Illinois Department of Human Services (DHS) determines eligibility for QMB and other Medicare Savings program benefits in Illinois. Medicare beneficiaries who are enrolled in the QMB program are not liable for any Medicare cost sharing amounts. Section 1902 of the Social Security Act prohibits Medicare physicians and providers from improperly billing beneficiaries with QMB 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. QMB beneficiaries in Original Medicare or a Medicare Advantage plan can, however, be charged a small Medicaid co-pay if the provider chooses to collect it. The Medicaid co-pay in Illinois is currently $3.90 for each service. The most notable difference between Original Medicare and Medicare Advantage plans in regards to QMB rules is that a provider under Original Medicare may refuse to serve a QMB beneficiary because of their QMB status, whereas a QMB beneficiary enrolled in a Medicare Advantage plan cannot be denied service as long as the provider is in the Medicare Advantage plan's network.

Balance billing is when medical providers bill beneficiaries for Medicare cost sharing, such as Part A and Part B deductibles and co-payments. Some Medicare beneficiaries have insurance, like Medigap or group health plans, that help pay some of these costs not covered by Medicare. Other beneficiaries with only original Medicare Part A and Part B pay for these costs out-of-pocket. However, beneficiaries with limited incomes enrolled in the QMB program have their Part A and Part B cost sharing amounts covered by QMB and as a result, do not have to pay these costs. Medicare providers must accept Medicare and, if applicable, Medicaid payments as payment in full and cannot bill QMB beneficiaries anything for Medicare covered services. "Improper Billing" is the term used when a Medicare provider incorrectly balance bills a QMB beneficiary for Medicare Part A & B cost sharing amounts. According to CMS, providers who fail to comply with this law "are violating their Medicare Provider Agreement and may be subject to sanctions".

Many providers may be unaware that they are prohibited from improperly billing QMB beneficiaries. As a result, CMS plans to introduce new protections to raise awareness

and educate providers and QMB beneficiaries that they are not liable for paying Medicare cost sharing. Beginning October 2, 2017, CMS will institute new changes to claims processing systems that will notify providers when a beneficiary is on QMB and instruct them to not collect any deductible, co-payment or co-insurance amounts. Currently, Medicare Summary Notices (MSNs) do not inform beneficiaries with QMB that they do not have to pay Medicare cost sharing amounts. To help inform and remind beneficiaries that they are not liable for any Medicare cost sharing amounts, beginning in October 2017, a beneficiary's QMB status will be reflected on their MSN. CMS has created a sample MSN that can be viewed here. The new MSN sample shows a beneficiary's QMB status and includes language that explains how providers cannot bill them for Medicare costs except for the Medicaid co-pay (if the provider chooses to do so).

Medicare beneficiaries with QMB who experience improper billing issues can share this CMS notice with the provider that explains the rule of prohibiting charging these beneficiaries cost sharing amounts. QMB beneficiaries in Medicare Advantage plans who experience improper billing issues with providers in the plan's network, can reference guidance from CMS found here (see page 181) that states it is prohibited. If a provider continues to bill the QMB beneficiary after receiving the notice, the beneficiary can take specific steps that are listed in a useful presentation created by Justice in Aging (see slides 22-24). Steps include initially educating the provider about the QMB beneficiary's rights and then reaching out to 1-800-MEDICARE if the QMB beneficiary cannot resolve the issue with the provider. Medicare can then work with Medicare Administrative Contractors to issue letters to providers who are improperly billing the beneficiary and instruct them to refund any incorrect charges. For more information and materials on improper billing QMB beneficiaries, please see Justice in Aging's website

Medicare Pre-Claim Review Process for Home Health Services Paused in Illinois

The Medicare Pre-Claim Home Heath Review demonstration in Illinois that began in August 2016 was paused effective April 1, 2017 and will be delayed from being implemented in four other states. The demonstration, which had identified Illinois as one of five states in the U.S. with extensive fraud and abuse, created a new process in how Medicare home health agencies submitted claims to Medicare. The pre-claim review process required home health agencies to submit documentation to Medicare earlier and while services were being provided in order to receive payment from Medicare. Home health agencies that did not submit the supporting documentation before submitting a final claim to Medicare risked receiving a reduced payment rate. CMS paused the demonstration after receiving feedback and is currently exploring changes to improve the process. For more information visit the CMS website at https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/pre-claim-review-initiatives/overview.html.

Medicare Part D Benefit Structure in 2018

The Centers for Medicare and Medicaid Services (CMS) have announced the 2018 standard Medicare Part D benefit amounts. These limits are adjusted each year by CMS using methodology that is based on beneficiaries' drug expenditures and to ensure that the Part D benefit continues to provide coverage for a share of a beneficiary's drug expenses. Note that the limits listed below only apply to prescriptions drugs that are covered by the plan's formulary. Money spent on any prescriptions that are not on the plan's formulary will not count toward reaching the

deductible, donut hole, or catastrophic coverage phases. To view the CMS notice that lists the 2018 Part D benefit parameters please click here (see pages 48-49).

		2017	2018
Annual Deductible	Beneficiary pays this amount out-of-pocket in the beginning of the calendar year, before the plan pays anything for prescriptions on the plan's formulary.	Up to $400	Up to $405
Initial Coverage Limit	Beneficiary pays a co-pay or co-insurance amount for each formulary prescription and the plan pays the rest of the cost.	Up to $3,700	Up to $3,750
Donut Hole begins (also called the Coverage Gap)	During the "donut hole" phase, the Part D plan does not pay anything toward the costs of drugs, but beneficiaries receive discounts. In 2017, beneficiaries receive a 60% discount on brand names and 49% discount on generics. In 2018, beneficiaries will receive a 65% discount on brand names and 56% discount on generics.	$3,700	$3,750
Catastrophic coverage begins once the True Out-of-pocket Threshold (TROOP) is met. (Donut hole ends.)	Once someone's True Out of Pocket Costs (TrOOP) are met, they reach the Catastrophic Coverage phase. During Catastrophic Coverage in 2018, the plan will pay 95% of drug expenses and the beneficiary will pay 5% **or** a co-pay of $3.35 (for generics or preferred multi-source drugs) or $8.35 (for all other drugs on the formulary) - whichever is higher. The beneficiary pays Catastrophic Coverage co-pays for the remainder of the calendar year. TrOOP costs are a beneficiary's out-of-pocket drug costs for a Part D plan (e.g., co-pays, deductible amounts) and determine when catastrophic coverage will begin. TrOOP is tracked by the Part D plan. Note: monthly Part D plan premiums do not count towards TrOOP.	$4,950 (TROOP amount)	$5,000 (TROOP amount)
Copayment amount for		$3.30 or 5%*	$3.35 or 5%*

generic or preferred multi-source drugs after Catastrophic coverage begins			
Copayment amount for all other drugs after Catastrophic coverage begins		$8.25 or 5%*	$8.35 or 5%*

*During the catastrophic coverage phase in 2018, the beneficiary will pay a co-pay of $3.35/$8.35 or 5% of the drug costs, whichever is greater. (In 2017, the beneficiary pays the greater of $3.30/7.40 or 5% of the drug cost.)

Questions from MMW Coalition Members Answered

Question: I have a client who is on Medicare and has a Medigap (Medicare Supplement) policy. She recently qualified for Medicaid Spenddown using the costs of expensive dental procedures she had done earlier this year, her prescription drug co-pays, and her Medicare, Medigap, and Part D plan premiums. She will most likely be able to meet her Medicaid Spenddown for the rest of 2017 using these medical expenses, but is unsure of what to do with her Medigap policy. I told her that if she keeps her policy she will have to continue to pay for the premium, but I am unsure if she should cancel it or not. If she cancels her policy, will she be able to get it back once she no longer has enough medical expenses to meet her Medicaid Spenddown?

Answer: As a result of a provision in the Social Security Act, Medicare beneficiaries who have a Medigap policy first and then become eligible for Medicaid, including Medicaid Spenddown, have the right to suspend their Medigap policy. Beneficiaries do not have to pay premiums for a Medigap policy while it is suspended and the policy **will not** provide any benefits.

If a beneficiary chooses to suspend their Medigap policy, they must contact the company within 90 days of becoming eligible for Medicaid to request that it be suspended. A Medigap policy may be suspended for up to 24 months. Once a beneficiary no longer qualifies for Medicaid, they must reinstate their Medigap policy within 90 days of no longer qualifying for Medicaid. Once the Medigap policy is reinstated, the company cannot impose a waiting period for pre-existing conditions, must offer equivalent coverage, and charge premiums that would have applied to the policy as if it had never been suspended. (Premiums may increase due to inflation, but the beneficiary cannot be charged more for pre-existing medical conditions once the policy is reinstated.)

Suspending a Medigap policy may be a good option for individuals who know they will not continuously qualify for Medicaid for long periods of time (such as Medicaid Spenddown), individuals who would like to keep their Medigap policy in case they need to visit medical providers that do not accept Medicaid, or individuals with medical conditions that may be denied coverage or would have a pre-existing waiting condition

period if they had to purchase a policy again in the future. Click here for a CMS memo and here for CMS training materials that provide more information.

Marketplace Updates

Marketplace Open Enrollment Period is Shorter This Year

The upcoming Health Insurance Marketplace Open Enrollment Period will take place from **November 1, 2017 through December 15, 2017**. Since the Marketplace Open Enrollment Period (OEP) is shorter this year, it is important that individuals who need health coverage or would like to switch plans, do so during this time period to guarantee their coverage begins January 1, 2018. Once the OEP ends on December 15th, individuals will not be able to enroll in or change health plans until the next OEP in late 2018 for health coverage in 2019 unless they qualify for a special enrollment period. The new Marketplace OEP aligns more closely with the open enrollment periods for Medicare and employer-sponsored plans. The change to this OEP was part of a final rule that made additional policy changes including requiring individuals who use Marketplace special enrollment periods to submit supporting documentation and allowing insurers to require enrollees to pay past due premiums in order to stay enrolled with the same company for the following coverage year. To view the CMS press release that outlines all the policy changes, click here.

During the Marketplace OEP, individuals should also make sure to update their Marketplace application and report any change of address, change in health coverage, household size and expected income for 2018. It is important that individuals report any expected income changes since it may impact the amount of premium tax credits and/or cost sharing assistance they are eligible to receive throughout the year. These changes can be reported to the Marketplace at any time during the year. For more information on which changes to report, visit https://www.healthcare.gov/reporting-changes/which-changes-to-report/.

Training Opportunities

MMW Coalition Webinar on
What's to Come: Medicare and Medicaid Updates

The Make Medicare Work (MMW) Coalition will be hosting a webinar on August 30th from 10:30 a.m. to 12:00 p.m. Central Time. This webinar will provide an overview of the following topics:

- MACRA Act
  - New Medicare Cards
  - Medicare Supplement Changes in 2020
- 21st Century Cures Act
  - Medicare Advantage Disenrollment Period
  - ESRD and Medicare Advantage Plans
- Observation Status and MOON Notice
- QMB and Improper Billing

- Medicaid Managed Care Statewide Request for Proposal

To register for the webinar, please use the registration link below:
https://attendee.gotowebinar.com/register/5149294809765420289

After you register, you will receive a confirmation link that you may use to attend the webinar on August 30th.

As always, please do not hesitate to contact us with any questions.

Sincerely,

Georgia Gerdes, Healthcare Choices Specialist
(Mondays, Wednesdays, and Fridays)
AgeOptions
1048 Lake Street, Suite 300
Oak Park, Illinois 60301
phone (708)383-0258 fax (708)524-0870
georgia.gerdes@ageoptions.org
ageoptions.org

To access the Make Medicare Work Coalition's materials on Medicare, Medicaid, and the Affordable Care Act, view a calendar of MMW events or **sign up for our MMW email list,** please visit our website using the button below. If you would like to stop receiving MMW emails, please reply to this email with the word "Unsubscribe."

Please note: If you click "Safe Unsubscribe" at the bottom of this email, you will not be able to receive MMW emails in the future, even if you re-add yourself to our email list. If this occurs and you wish to be reinstated to the list, contact MMW staff at AgeOptions for help.

Visit Our Website