MMW Webinar
Medicare & Medicaid Updates
August 30, 2017

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.
Medicare & Medicaid Updates

August 30, 2017

© AgeOptions 2017. All rights reserved.

PRESENTED BY:

AGEOPTIONS

Connecting Older Adults with Community-based Resources and Options

The Area Agency on Aging of Suburban Cook County, since 1974
MMW work is supported by grants from local and regional foundations:

- Retirement Research Foundation
- Michael Reese Health Trust
- Chicago Community Trust
Who We Are: MMW Leadership

- **AgeOptions**
  - Area Agency on Aging (AAA) for suburban Cook County

- **Health & Disability Advocates**
  - Policy and advocacy organization

- **Progress Center for Independent Living**
  - Cross-disability, non-residential – suburban Cook County
What We Do

• Gather and create practical, accessible information and materials
• Educate Medicare consumers, service providers and policymakers
• Problem solving – individual and systemic
• Provide training and technical support for professionals and volunteers
• Advocate for consumer focused laws and policies
• Target underserved groups
What We’ll Cover Today

• **MACRA Act** *(Gaby Montoya, AgeOptions)*
  - New Medicare Card
  - Medicare Supplement Changes

• **21st Century CURES Act** *(Gaby Montoya, AgeOptions)*
  - Medicare Advantage Open Enrollment Period
  - ESRD & Medicare Advantage Plans

• **Observation Status & MOON Notice** *(Alicia Donegan, AgeOptions)*

• **QMB & Improper Billing** *(Alicia Donegan, AgeOptions)*

• **Medicaid Managed Care State-wide Request for Proposal** *(John Jansa, Health & Disability Advocates)*
MACRA Act-Social Security Number Removal Initiative (SSNRI)

- The Medicare Access and CHIP Reauthorization Act (MACRA) requires CMS to remove the Social Security number from Medicare cards and replace it with a Medicare Beneficiary Identifier (MBI).
- The MBI is a non-intelligent number that is randomly generated.
- The card will no longer have the gender and the signature line will also be taken out.
- April 2018, CMS will send out the new Medicare Cards with new numbers to all Medicare Beneficiaries.
Please note: The Medicare card will be redesigned and we will send out a picture of the new design to the MMW Email list once released.
Understanding the Medicare Beneficiary Identifier (MBI) Format

How many characters will the MBI have?
The MBI has 11 characters, like the Health Insurance Claim Number (HICN), which can have up to 11.

Will the MBI’s characters have any meaning?
Each MBI is randomly generated. This makes MBIs different than HICNs, which are based on the Social Security Numbers (SSNs) of people with Medicare. The MBI’s characters are “non-intelligent” so they don’t have any hidden or special meaning.

What kinds of characters will be used in the MBI?
MBIs are numbers and upper-case letters. We’ll use numbers 0-9 and all letters from A to Z, except for S, L, O, I, B, and Z. This will help the characters be easier to read.

How will the MBI look on the new card?
The MBI will contain letters and numbers. Here’s an example: 1EG4-TE5-MK73

- The MBI’s 2nd, 5th, 8th, and 9th characters will always be a letter.
- Characters 1, 4, 7, 10, and 11 will always be a number.
- The 3rd and 6th characters will be a letter or a number.
- The dashes aren’t used as part of the MBI. They won’t be entered into computer systems or used in file formats.

<table>
<thead>
<tr>
<th>Pos.</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>C</td>
<td>A</td>
<td>AN</td>
<td>N</td>
<td>A</td>
<td>AN</td>
<td>N</td>
<td>A</td>
<td>A</td>
<td>AN</td>
<td>N</td>
</tr>
</tbody>
</table>

Where will the MBI’s characters go?
- C – Numeric 1 thru 9
- N – Numeric 0 thru 9
- AN – Either A or N
- A – Alphabetic Character (A…Z); Excluding (S, L, O, I, B, Z)

<table>
<thead>
<tr>
<th>Position</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>numeric values 1 thru 9</td>
</tr>
<tr>
<td>2</td>
<td>alphabetic values A thru Z (minus S, L, O, I, B, Z)</td>
</tr>
<tr>
<td>3</td>
<td>alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)</td>
</tr>
<tr>
<td>4</td>
<td>numeric values 0 thru 9</td>
</tr>
<tr>
<td>5</td>
<td>alphabetic values A thru Z (minus S, L, O, I, B, Z)</td>
</tr>
<tr>
<td>6</td>
<td>alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)</td>
</tr>
<tr>
<td>7</td>
<td>numeric values 0 thru 9</td>
</tr>
<tr>
<td>8</td>
<td>alphabetic values A thru Z (minus S, L, O, I, B, Z)</td>
</tr>
<tr>
<td>9</td>
<td>alphabetic values A thru Z (minus S, L, O, I, B, Z)</td>
</tr>
<tr>
<td>10</td>
<td>numeric values 0 thru 9</td>
</tr>
<tr>
<td>11</td>
<td>numeric values 0 thru 9</td>
</tr>
</tbody>
</table>

How will the MBI fit on forms?
MBIs will fit on forms the same way HICNs do. You don’t need spaces for dashes.

Who will get a new MBI?
Each person with Medicare will get their own randomly-generated MBI. Spouses or dependents who may have had similar HICNs will each get their own different MBI.

<table>
<thead>
<tr>
<th>Key</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSA HICN</td>
<td>123-45-6789-A1</td>
</tr>
<tr>
<td>MBI</td>
<td>1EG4-TE5-MK73</td>
</tr>
</tbody>
</table>
Timeline for SSNRI

• January 2018- Activate MBI Generator

• April 2018-December 2019 Transition Period
  – April 2018-Beneficiaries will receive their new cards
  – During the transition period beneficiaries will be able to use their old and new Medicare numbers

• January 2020- Medicare cards with the social security number will no longer be in use with plans, hospitals, and beneficiaries.
MACRA Act- Medigap Changes

• All insurance companies will **NOT** be allowed to market or sell plans C & F to people **newly eligible** for Medicare on or after January 1, 2020.
• If you enroll into a Plan C & F before 12/31/2019, you will be grandfathered in.
• This means that **all** policies sold after 01/01/2020 will not cover the Part B deductible.
• Plan options D & G offer similar covered services as C & F
  – Plans D & G do not offer coverage of the Part B deductible.
### Medigap Chart 2020

Note: A ✓ means 100% of the benefit is paid.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Plans Available to All Applicants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
</tr>
<tr>
<td>Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Part B coinsurance or Copayment</td>
<td>✓</td>
</tr>
<tr>
<td>Blood (first three pints)</td>
<td>✓</td>
</tr>
<tr>
<td>Part A hospice care coinsurance or copayment</td>
<td>✓</td>
</tr>
<tr>
<td>Skilled nursing facility coinsurance</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Part A deductible</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Part B deductible</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Part B excess charges</td>
<td>✓</td>
</tr>
<tr>
<td>Foreign travel emergency (up to plan limits)</td>
<td>✓</td>
</tr>
<tr>
<td>Out-of-pocket limit in 2016</td>
<td>[S4,960](^2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare first eligible before 2020 only</th>
<th>C</th>
<th>F(^1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
21\textsuperscript{st} Century CURES Act

• Signed into law on December 13, 2016

• The Act funds and cuts a wide range of issues including medical research, drug approval process, Medicare provisions, and etc.
  – Changes in the Medicare Advantage disenrollment and enrollment period
  – Changes for individuals with End Stage Renal Disease
Medicare Advantage Disenrollment Period

• As of now, disenrollment is from Jan. 1- Feb. 14 and beneficiary can disenroll and return to original Medicare and obtain a stand-alone Part D plan

• Due to the CURES act this is will change in 2018
Reinstatement to the MA Open Enrollment Period

• Effective 2019, there will be a continuous open enrollment \textit{and} disenrollment period January 1\textsuperscript{st} – March 31\textsuperscript{st} of every year.

• An MA beneficiary will be able to make a one-time change to another MA or return to Original Medicare and enroll in a stand alone PDP.

• Section 17005 of the Cures Act
Individuals with ESRD and MA Plans

• Currently individuals with ESRD can not enroll in MA Plans

• Beginning 2021, Individuals with ESRD will be able to enroll in MA Plans

• There will still be limitations for some individuals but still an improvement for individuals with ESRD’s treatment and payment options
  – Organ procurement will be covered under Original Medicare
MACRA and 21st Century CURES Act Resources

- [https://www.illinois.gov/aging/ship/Pages/default.aspx](https://www.illinois.gov/aging/ship/Pages/default.aspx)
- [https://www.congress.gov/bill/114th-congress/house-bill/34/text#toc-HD71F5272E8AD4D73B970964CC1B95C5E](https://www.congress.gov/bill/114th-congress/house-bill/34/text#toc-HD71F5272E8AD4D73B970964CC1B95C5E)
Observation Status = Outpatient Status

• A term hospitals use to bill for Medicare
• Also a medical decision made by the doctor
  – Used to determine need for further treatment or inpatient admission
  – Stay is expected to be less than 48 hours
• Because a patient on observation status is considered an outpatient, Medicare Part B cost-sharing rules apply
• Time on observation status will not be counted toward Medicare’s three-nights stay requirement to cover care at a skilled nursing facility after discharge
MOON Notice

• Beginning March 8, 2017, hospitals had to start providing a written and oral notice of a beneficiary’s outpatient status

• Standardized notice created by CMS

• Notice must include:
  • Cost-sharing requirements for current hospitalization
  • Post-hospitalization eligibility for Medicare covered Skilled Nursing Facility Care
MOON Notice

• Notice given to patients who have been in observation status for 24 hours
  – Hospital is required to give the written and verbal notice within 36 hours of being in observation status

• Challenges:
  – Hospital is not required to explain why the patient is an outpatient
  – No formalized appeal process
Balance Billing Definition
When a provider seeks payment from a beneficiary for Medicare cost sharing, including:

- Deductibles
- Coinsurance
- Copayments
QMB & Improper Billing

QMB Eligibility in 2017

• Must be Entitled to Part A and eligible for Part B
• Meet Income & Asset Limits:

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Monthly Income</th>
<th>Asset Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$1,030</td>
<td>$8,890</td>
</tr>
<tr>
<td>Couple</td>
<td>$1,378</td>
<td>$14,090</td>
</tr>
</tbody>
</table>

*Income limits include a $25 income disregard
**Asset limits includes $1500 pre-paid burial and some life insurance policies

• Medicaid pays for Part A premiums, Part B premiums and deductibles, coinsurance and copayments through the QMB program
QMB Billing Rules

• Medicare providers are NOT allowed to charge QMB beneficiaries Medicare cost sharing, even if they do not accept Medicaid

• This includes providers under Original Medicare, Medicare Advantage plans, Medicare providers who do not accept Medicaid, out of state providers, DME suppliers, etc.
  – Providers who violate balance billing rules may be subject to sanction

• Any payment made by Medicaid is considered payment in full
  – Medicaid only pays up to the Medicaid authorized amount, so providers may sometimes receive little or no Medicaid reimbursement
QMB & Original Medicare

• Providers under Original Medicare are allowed to deny services to beneficiaries with QMB

• Beneficiaries cannot opt out of QMB status
  – Meaning, beneficiaries cannot make an agreement with the provider to be billed the Medicare cost sharing amounts
QMB & Medicare Advantage (MA)

• Beneficiaries enrolled in a Medicare Advantage plan are protected against balance billing and not liable for MA cost sharing when, unless they go out of network
  – Beneficiary may be liable for MA plan premiums

• Medicare Advantage providers cannot deny service to a beneficiary

• Medicare Advantage plans sign contracts with their network providers that include protections against balance billing QMBs

• Both the Medicare Advantage plan and provider are responsible in ensuring the beneficiary does not get balance billed by an in network provider
QMB & Improper Billing

What if a beneficiary with QMB is wrongfully balance billed?

– Beneficiary with QMB should never pay the bill
– Ensure the provider knows the beneficiary’s QMB status
– Educate provider on QMB rules
  • Provide MLN Notice to providers
– If enrolled in a Medicare Advance plan, make 3 way call between provider’s office and Medicare Advantage plan
– File a complaint with 1-800-MEDICARE
– If unable to resolve, contact local legal services provider and CMS Regional office
  • CMS Chicago Regional Office- ROCHIDMO@cms.hhs.gov
– If you have a problem with a debt collector, file a complaint with Consumer Financial Protection Bureau at 1-855-411-2372
QMB & Improper Billing Updates

• Medicare Advantage plans must re-educate providers on balance billing rules in 2017

• Enhanced 1-800-MEDICARE Procedures
  – Can identify QMB status
  – Trained to provide information regarding QMB billing protections and address Medicare Advantage balance billing issues
  – Can forward issues to Medicare Administrative Contractors (MAC) to issue compliance letters
QMB & Improper Billing Updates

• CMS partnered with Consumer Financial Protection Bureau to address inappropriate QMB billing by providers & debt collectors

• New language around QMB billing in Medicare & You booklets

• In October 2017, Medicare fee for service systems will send notifications regarding patient’s QMB status through the Provider Remittance Advance and Medicare Summary Notices
QMB & Improper Billing Resources

– Justice in Aging Fact Sheets, Webinars, Model Letters to Providers

– Centers for Medicare & Medicaid Services
  • https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/MedicareMedicaidGeneralInformation.html

– Medicare Learning Network Provider Notice
Medicaid RFP - Managed Care Expansion

• Illinois is expanding Medicaid managed care to every county in 2018
  – Currently, about 65% of the state is enrolled
  – RFP expands to cover 80% of Medicaid enrollees

• Family Health Plans, ACA Adult, Integrated Care Program, and MLTSS program will be consolidated into one program
  – MMAI is not part of this expansion. It will remain in its current program areas
Medicaid RFP- Goals

• Align State and MCO objectives to enhance quality and improve outcomes
• Increase integration of behavioral and physical health
• Streamline current managed care programs and reduce complexity for members and providers
• Achieve greater managed care coverage across Illinois
• Bring fiscal sustainability to Illinois’ Medicaid program by managing costs, without compromising quality or access
Medicaid RFP - Health Plans

• 5 health plans selected to cover the entire state of Illinois, including Chicago
• 1 additional plan selected to serve Cook County ONLY
• 1 of the 5 statewide plans selected to serve the DCFS youth population
• New contracts begin January 1, 2018
• Contract length = 4 years
Medicaid RFP- Winning Proposals

- IlliniCare Health Plan*
- Blue Cross Blue Shield of Illinois
- Harmony Health Plan
- Meridian Health
- Molina Healthcare of Illinois
- County Care Health Plan (Cook County)

https://www.illinois.gov/hfs/SiteCollectionDocuments/Notice_of_Award_MCO_RFP.pdf
Exhibit 2: Landscape of Illinois Medicaid enrollees

Medicaid populations by inclusion in managed care (Medicaid enrollees, in thousands)

- Families and children eligible through Title XIX or XXI: 1,434 (368) 1,803
- Affordable Care Act expansion adults: 449 (127) 577
- Adults with disabilities and non-dual-eligible older adults: 121 (25) 146
- Dual-eligible adults (non-MMAI): 21 (93) 115
- Special-needs children: 2 (29) 33
- DCFS Youth: 39 (2) 42
- Dual-eligible adults (MMAI): 45
- Other Medicaid enrollees: 387
- Total Medicaid enrollees: 2,028 (683) 435 3,146

1 Includes all dual-eligible adults who are receiving long term services and supports (LTSS) in an institutional care setting or through an HCBS waiver, excluding those receiving partial benefits, and who are enrolled in the Illinois Medicare-Medicaid Alignment Initiative (MMAI), or are subject to other exclusions.
2 SSI, Department of Specialized Care for Children (DSCC), disabled, and DD Waiver children; includes 1,800 children currently enrolled in managed care, 29,300 children for inclusion in managed care, and 1,500 children with other exclusions (e.g., spenddown, high TPL, etc.).
3 Children aligned to Department of Children and Family Services (DCFS), including youth in care, guardianship, and adoption; includes less than 50 children currently enrolled in managed care, 39,400 for inclusion in managed care, and 2,200 with other exclusions.
4 MMAI program is currently under managed care contracts but is out of scope of this RFP.
5 Includes high TPL, spenddown, partial benefits, etc.
Medicaid RFP- Services

• All Medicaid covered medical & behavioral health services
• Long Term Care Services & Supports
  – Nursing Care Facilities
  – Home & Community Based Waiver services (HCBS)
  – DD waiver services are not part of the initial roll out. HOWEVER, all plans must be ready to serve this population if the state adds it.
• Additional services as outlined by the pending 1115 waiver and state plan amendment
  – Services will be delivered through an Integrated Health Home (IHH) Model
Building upon a managed care system that carves behavioral health into the medical program, the State, in collaboration with its managed care partners, aims to enhance true integration of behavioral and physical healthcare through an ambitious integrated behavioral and physical health home program that promotes accountability, rewards team-based integrated care, and shifts away from fee-for-service (FFS) towards a system that pays for value and outcomes.

-Sec. 1.2.3, Illinois’ Behavioral Health Transformation, October 5, 2016

Integrated Health Home (IHH) SPA approval would provide a 90% federal match for the comprehensive care coordination services for 8 quarters.
Integrated Health Homes

- A model for care coordination that includes providers of all types
- Every Medicaid member will be enrolled in an IHH (members can disenroll if they choose)
- The IHH can provide varying levels of care coordination depending on the member’s needs
- Enhanced match will support providers as they take on a greater role in care coordination

1115 Demonstration Waiver – Illinois’ BH Transformation

- Designed to pilot new service packages and extend services to certain populations not eligible for the service under the Medicaid state plan
- Promote behavioral and physical health care integration for people with low-high level needs
- Support behavioral health service development
- Invest in support services to address other needs (housing/employment/justice populations)

Think of the Integrated Health Home model as a tool that helps build the 1115 house.
Medicaid RFP- Implementation

• Current Medicaid managed care members will be affected first (mailings in mid-Oct to early Nov)
  – Those with plans who won contracts
    • 30 days to change plans if they choose
    • If the member does nothing, will remain with their current plan
  – Those with plans who lost (Aetna, Next Level)
    • 30 days to choose a new plan. They cannot stay with their current plan.
    • If the member does nothing, will be auto-assigned

• Both groups will have 90 days following go-live (Jan. 1) to change plans
Medicaid RFP- Implementation

• New managed care members (those living in new counties) will have their mailings sent after go-live (Jan. 1, 2018)
  – Will have 30 days to pick a plan
  – If no choice is made, they will be auto-assigned
  – Estimated go-live for new counties is April 1
  – New enrollees will also have 90 days from their effective date to change plans

• For more information, see RFP & Materials:
  https://www.illinois.gov/hfs/info/MedicaidManagedCareRFP/Pages/default.aspx
Questions??
Alicia Donegan, AgeOptions
Gaby Montoya, AgeOptions
John Jansa, Health & Disability Advocates

AgeOptions
1048 Lake Street, Suite 300
Oak Park, Illinois 60301
phone (708)383-0258  fax (708)524-0870
alicia.donegan@ageoptions.org

For more information, resources, and to join our MMW Email list, visit our MMW webpage at: