

# JUSTICE IN AGING

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FIGHTING SENIOR POVERTY THROUGH LAW

## Medicare Tips for Low-Income Beneficiaries

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## FIGHTING SENIOR POVERTY THROUGH LAW

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources.

Since 1972 we've focused our efforts primarily on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

# Diversity, Equity, and Inclusion

To achieve Justice in Aging, we must:

- Acknowledge systemic racism and discrimination
- Address the enduring negative effects of racism and differential treatment
- Promote access and equity in economic security, health care, and the courts for our nation's low-income older adults
- Recruit, support, and retain a diverse staff and board, including race, ethnicity, gender, gender identity and presentation, sexual orientation, disability, age, economic class

# Agenda

- ▶ California SMP Current Fraud Trends
- ▶ Justice in Aging: Medicare Tips for Low-Income Beneficiaries

# Current trends:

- **Fraudulent Genetic Tests**
- **Deceptive Hospice Enrollments**
- **Deceptive Home Health Care Enrollments**

# Fraudulent Genetic Tests

- **Cold calls**
- **Medication conflicts, cancer screening**
- **Covered by Medicare**
- **Cheek swab kit in mail**
- **Medicare charged for expensive tests**
- **Tests go on your Medicare record**
- **Your Medicare number compromised for more fraud**



Medicare Summary Notice related to genetic testing:

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Gene analysis (phosphatase and tensin homolog), full sequence analysis (81321-90)	NO	660.00	0.00	0.00	0.00	B
Molecular pathology procedure level 5 (81404-90)	NO	302.31	0.00	0.00	0.00	B
Molecular pathology procedure level 6 (81405-90)	NO	331.49	0.00	0.00	0.00	B
Molecular pathology procedure level 7 (81406-90)	NO	311.17	0.00	0.00	0.00	B
Molecular pathology procedure level 9 (81408-90)	NO	2,200.00	0.00	0.00	0.00	B
Molecular pathology procedure level 5 (81404-9091)	NO	302.31	0.00	0.00	0.00	B
Molecular pathology procedure level 7 (81406-9091)	NO	311.17	0.00	0.00	0.00	B

- **Beneficiaries tricked into enrolling**
- **Caregivers tricked into enrolling their loved ones**
- **Palliative not curative**
- **Older adults denied medications**
- **Health declines**
- **Deaths**

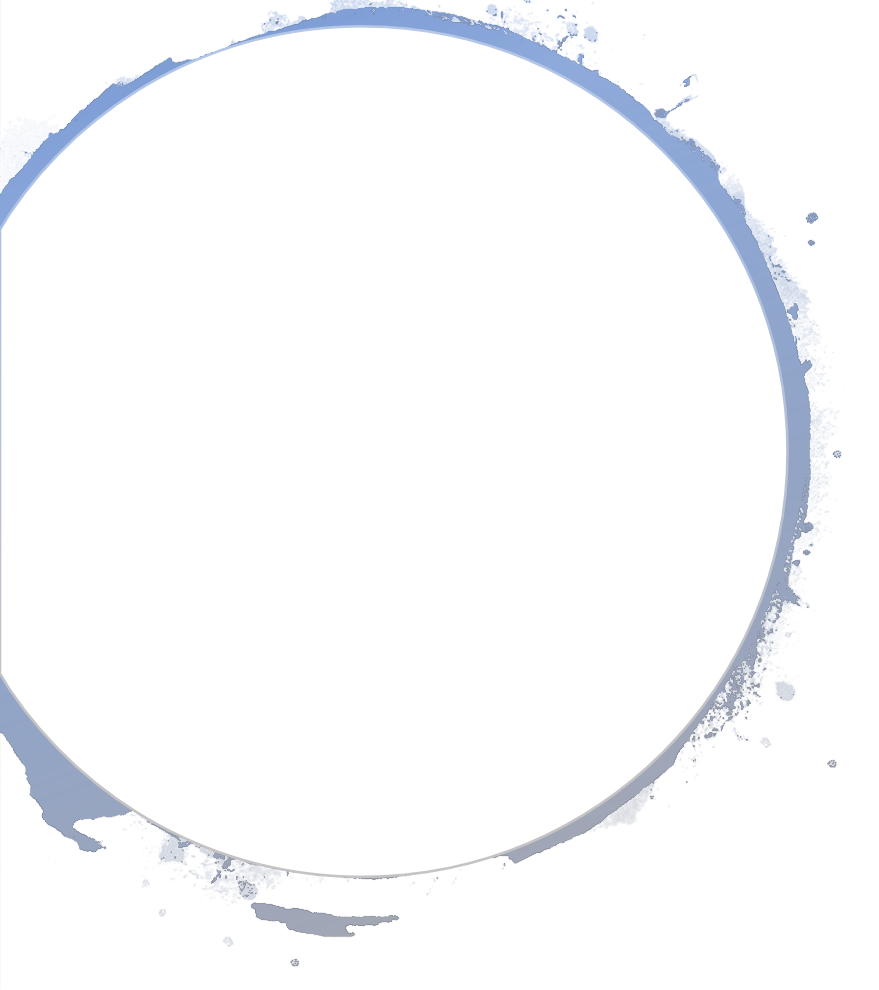


Medicare Summary Notice related to hospice:

December 12 - December 31, 2018

Quantity & Service Provided	Service Approved?	Amount Provider Charged	Medicare- Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
20 Hospice/Rtn Home	Yes	\$4,000.00	\$4,000.00	\$4,270.89	\$0.00	
5 Skilled Nurs/Visit						
1 Med Soc Servs/Visit						
2 Aide/Home Hlth/Visit						
<b>Total for Claim #21900800676007CAR</b>		\$4,000.00	\$4,000.00	\$4,270.89	\$0.00	A,B

# Deceptive Home Health Care Enrollment



- **Home Health Care vendors at outdoor swap meets**
- **Offer a free nutrition program**
- **Medicare numbers compromised**
- **Fraudulent claims billed to Medicare**

Medicare Summary Notice related to home health care:

Quantity & Service Provided	Service Approved?	Amount Provider Charged	Medicare- Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
11 Physical Therp	Yes	\$1,320.00	\$1,320.00	\$0.00	\$0.00	
11 Skilled Nursing	Yes	1,540.00	1,540.00	0.00	0.00	
<b>Total for Claim #21905100221204CAR</b>		\$2,860.00	\$2,860.00	\$0.00	\$0.00	A,B



CALIFORNIA HEALTH ADVOCATES  
Medicare: Policy, Advocacy and Education

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- 4TH Thursday of the month SMP Educational webinar at 10 a.m.
- Like & follow our CHA & SMP Facebook pages
- Subscribe to our e-newsletter

[www.cahealthadvocates.org](http://www.cahealthadvocates.org)

- Share SMP fraud alerts
- Order materials or schedule a presentation at no-charge
- Report fraud, call

855-613-7080

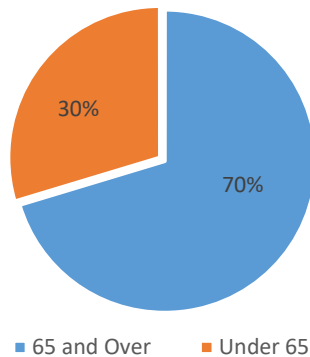
# Agenda

- Overview of Dual Eligibles in California
- Tips
  - SEP
  - Part D Enrollment Penalty
  - Part D Co-Pays for HCBS Dual Eligibles
  - LIS and Overpayments
  - Buy-In
  - MSPs and Improper Billing
- Q&A

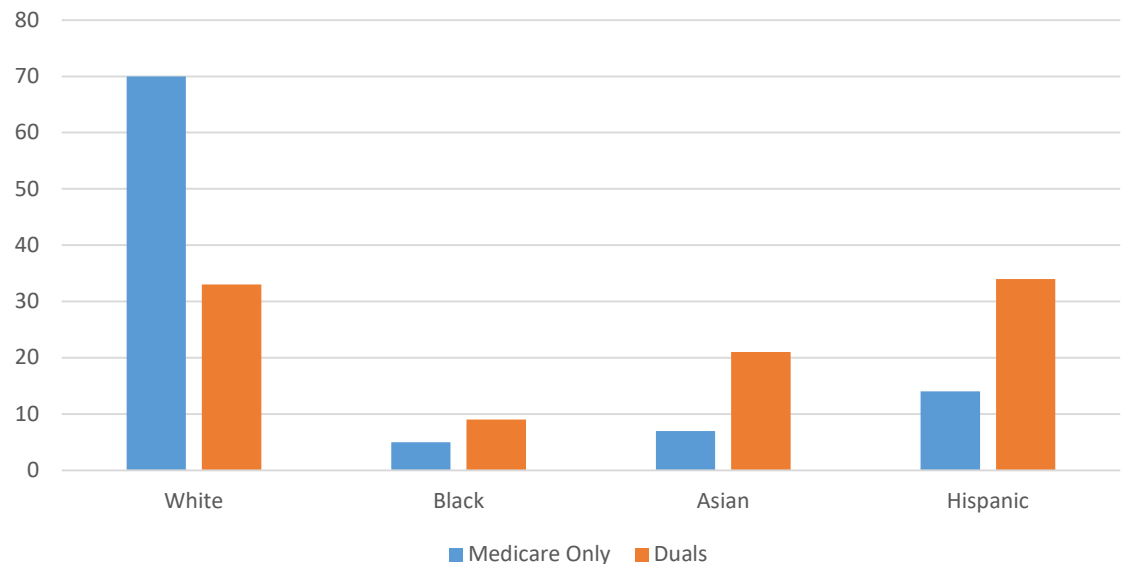
# Low-Income Beneficiaries in California

## 1.4 million full-benefit dual eligibles in California

California Dual Eligibles by Age



Coverage Type by Race of California Beneficiaries



# Special Enrollment Periods (SEP)

- LIS Recipients can change plans more frequently than other Medicare Beneficiaries
- January 1, 2019 forward:
  - One change per quarter
  - In quarters 1-3, effective the following month
  - In 4<sup>th</sup> quarter, participate in Open Enrollment Period, effective Jan 1
  - Other non-LIS SEPs continue to be available
- Need your feedback on impact of changes
- 2019: Exception for Cal MediConnect

# Part D Late Enrollment Penalty Waived

- If a beneficiary does not timely enroll in Part D, they face a Part D late enrollment penalty
  - 1% of the national base premium for each month not enrolled
- If beneficiary becomes eligible for the low-income subsidy (LIS) or “Extra Help” then the Part D late enrollment penalty is waived
- Who is eligible for LIS (3 groups)
  - Full Medi-Cal dual eligibles with countable incomes at or below 100% (FPL) “**deemed** eligible”
  - Full-Medi-Cal dual eligibles above 100% of FPL; QMB, SLMB, QI, “**deemed** eligible”; and non-dual eligible beneficiaries with countable incomes below 135% FPL and limited countable resources (\$7,280 for an individual; \$10,930 for a couple \*) “**determined** eligible”
  - Non-dual beneficiaries with countable incomes below 150% FPL and limited countable resources (\$13,640 individual and \$27,250 married couple\*) “**determined** eligible”



# Duals in HCBS should have \$0 co-pay prescription drugs

- If full dual and in an institution or receiving home and community based services (HCBS) in the community, entitled to \$0 Part D co-pays
  - Under an 1115 demonstration,
  - 1915(c) or (d) waiver,
  - State amendment under 1915(i), or
  - Through an MCO with a contract under 1903(m) or under 1932 of the Social Security Act.

# Extra Help and Overpayments

- Individuals who receive Social Security benefits or SSI sometimes are overpaid.
- If the overpayment is correct and the person does not receive a waiver, can set up payment plan at as little as \$10/month if receiving LIS/Extra Help

# State Medicare Part B Buy-In

- California has a Buy-In agreement with Medicare. Medi-Cal automatically pays Medicare Part B premiums for all Medi-Cal members who have Medicare Part B.
- This Buy-In is separate from Medicare Savings Programs (discussed on the next slide).

# Medicare Savings Programs

- All MSPs help low-income Medicare beneficiaries pay for Medicare cost-sharing.
  - Qualified Medicare Beneficiary
  - Specified Low-Income Medicare Beneficiary
  - Qualified Individual
  - Qualified Disabled Working Individual

# What is Improper Billing?

- Improper billing occurs when Medicare providers seek to bill a dual eligible for Medicare cost-sharing, including deductibles, co-insurance, and co-payments.

# Federal law—All QMBs are protected from improper billing

All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs may not bill QMBs for Medicare cost sharing. Any payment (if any) made by the State Medicaid plan shall be considered payment in full. Provider will be subject to sanctions.

Federal law: 42 U.S.C. Sec. 1396a(n)(3)(B) (Sec. 1902(n)(3)(B) of the Social Security Act)

# California State Law

California: A provider of health care services who obtains proof of Medi-Cal eligibility may not seek payment from the beneficiary for covered services. If receives notice, provider and any debt collector must cease debt collection and correct any reports to consumer reporting agencies.

Cal. Welf. & Inst. Code § 14019.4

# Another Federal Protection— QMBs in Medicare Advantage and Medicare-Medicaid Plans

MA and MMP plans must include in their contracts with providers a protection against cost sharing for dual eligibles.

Federal regulation: 42 CFR Sec. 422.504(g)(1)(iii)



# Changes At 1-800-MEDICARE

- Beginning in September 2016, CSRs at 1-800-MEDICARE are able to identify whether an individual is enrolled in QMB.
- Beginning in March 2017, CSRs are able to escalate improper billing complaints. MACs can issue a compliance letter to recalcitrant providers.

[month] [day], [year]  
[address]  
[City] [ST] [Zip]

Reference ID: (NPI, etc.)

Dear [Beneficiary Name]:

You contacted Medicare about a bill you got from [Provider/Supplier Name]. Then we sent [Provider/Supplier Name] the letter on the next page.

You are in the Qualified Medicare Beneficiary (QMB) program. It helps pay your Medicare costs. **Medicare providers cannot bill you for Medicare deductibles, coinsurance, or copays for covered items and services.**

The letter tells the provider to stop billing you and to refund you any amounts you already paid. **Here's what you can do:**

1. Show this letter to the provider to make sure they fixed your bill.
2. Tell all of your providers and suppliers you are in the QMB program.
3. Show your Medicare and your Medicaid or QMB cards each time you get items or services.

If you have questions about this letter, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use TTY.

Sincerely,

[Name]

[Title]

[MAC name]

[month] [day], [year]  
[address]  
[City] ST [Zip]

Reference ID: (NPI, etc.)  
Dear [Provider/Supplier Name]:

The Centers for Medicare & Medicaid Services (CMS) received information that [Provider/Supplier Name] is improperly billing [Medicare beneficiary name/HICN number] for Medicare cost-sharing.

This beneficiary is enrolled in the Qualified Medicare Beneficiary (QMB) program, a state Medicaid program that helps low-income beneficiaries pay their Medicare cost-sharing. Federal law says Medicare providers can't charge individuals enrolled in the QMB program for Medicare Part A and B deductibles, coinsurances, or copays for items and services Medicare covers.

- **Promptly review your records for efforts to collect Medicare cost-sharing from [Medicare beneficiary name/HICN number], refund any amounts already paid, and recall any past or existing billing (including referrals to collection agencies) for Medicare-covered items and services**
- Ensure that your administrative staff and billing software exempt individuals enrolled in the QMB program from all Medicare cost-sharing billing and related collection efforts

Medicare providers must accept Medicare payment and Medicaid payment (if any) as payment in full for services given to individuals enrolled in the QMB program. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); 1848(g)(3) of the Social Security Act.)

Finally, please refer to this Medicare Learning Network (MLN) Matters® article for more information on the prohibited billing of QMBs: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf>. If you have questions, please contact [MAC information].

Sincerely,

[Name]

[Title]

[MAC name]

# Eligibility Systems Changes

- Effective November 2017, HIPAA Eligibility Transaction System (HETS) includes data to indicate periods when beneficiaries are enrolled in QMB.
- Particularly helpful for Medicare-only providers who treat QMBs.
- Most providers use third-party databases that pull from HETS.

# Medicare Summary Notices

- Beginning July 2018, Medicare Summary Notices (MSNs) sent to QMBs show they have no liability for Medicare cost-sharing.
- MSNs are sent to Original (fee-for-service) Medicare beneficiaries on a quarterly basis.

# Sample MSN

## 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 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.

## 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
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## 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.**

# Sample MSN

**June 18, 2017**

**Dr. Susan Jones, M.D., (555) 555-1234**

Brevard County Physical Therapy Center, 32 Main Street, Brevard, NC 28712-4187

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare- Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minut (97110)	Yes	\$45.00	\$28.54	\$22.83	\$0.00	
<b>Total for Claim #02-10195-592-677</b>		\$45.00	\$28.54	\$22.83	\$0.00	A

# Medicare Remittance Advice

- Effective July 2018, Medicare Remittance Advice for fee-for-service providers includes a notification to providers to refrain from collecting cost-sharing from QMBs. It also zeroes out the deductible and co-insurance amounts.



# Summary of Changes

System or Document	Description of Change	Beneficiary or Provider-Facing
1-800-MEDICARE	<ul style="list-style-type: none"><li>• CSRs can identify QMBs</li><li>• CSRs can escalate problem providers and send a warning letter through MAC</li></ul>	Both
HIPPA Eligibility Transaction System (HETS)	<ul style="list-style-type: none"><li>• Includes QMB eligibility for when beneficiary is enrolled</li></ul>	Provider
Medicare Summary Notice (MSN)	<ul style="list-style-type: none"><li>• Added language about billing protection for QMBs.</li><li>• Displays zero liability for co-pays and deductibles.</li></ul>	Beneficiary
Remittance Advice	<ul style="list-style-type: none"><li>• Added language about billing protection for QMBs.</li><li>• Displays zero liability for co-pays and deductibles.</li></ul>	Provider

# Tips

- Encourage the beneficiary not to pay up front.
- Remind the provider of the beneficiary's status as a QMB and the improper billing rules.
- Go up the chain in the billing department.
- For Medicare Advantage, remember both points of advocacy.
- Medicaid plans are supposed to have automatic crossover processes set up.
- Use Justice in Aging's model letters.
- Identify QMBs and report providers using 1-800-MEDICARE.
- Remember California state law.
- Contact Justice in Aging for technical assistance and systemic issues.

# Beneficiary Options to Protect Against Improper Billing

- Beneficiaries can check their own status and report problems with 1-800-MEDICARE
- Beneficiaries in Medicare Advantage can and should enlist assistance from plan
- Justice in Aging Toolkit:  
[www.justiceinaging.org](http://www.justiceinaging.org)



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