2017 SMP/SHIP National Conference

JULY 10–13, 2017 AUSTIN, TX

Two Medicare Misconceptions: Improvement Standard and Improper Billing

Judith Stein, CMA , Executive Director/Attorney
Kathy Holt, CMA, Associate Director/Attorney
Amber Christ, JIA,

Center for Medicare Advocacy

Medicare Improvement Standard Myth and the *Jimmo v. Sebelius* Case

Judith Stein, Executive Director/Attorney
Kathy Holt, Associate Director/Attorney

Center for Medicare Advocacy

- Established in 1986 – National, nonprofit, nonpartisan law organization
- Offices in CT, DC (with additional attorneys in MA, CA, NJ)
- Assist Medicare beneficiaries
  - 7,000+ calls and emails annually
  - Individual assistance, education, systemic change
  - All care settings
- Provide training and support for CT SHIP program
- Dually Eligible Projects
  - SNF, Home Health, Chronic Disease Hospital
- Developed ACL Under 65 Project

JIMMO v. SEBELIUS, NO. 5:11-CV-17 (D. VT, Settlement Approved Jan. 24, 2013)

- Federal class action to eliminate improvement standard in skilled nursing facilities (SNFs), home health (HH), outpatient therapy (OPT).
- Filed Jan. 18, 2011 by CMA and Vermont Legal Aid
- Settled October 2012 (Court approved 1/2013)
- Plaintiffs: 5 individuals and 6 organizations
  - National MS Society
  - Alzheimer's Association
  - National Committee to Preserve Social Security & Medicare
  - Paralyzed Veterans of America
  - Parkinson's Action Network
  - United Cerebral Palsy

WHY LITIGATION?
Regulation was not followed

- "Restoration potential is not the deciding factor in determining whether skilled care is required. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities." 42 C.F.R. § 409.32(c)
  - Specifically applies to SNF, HH

JIMMO SETTLEMENT

CMS revised Medicare SNF, HH and Outpatient therapy policy manuals, guidelines, instructions:

1. Coverage does not turn on the presence or absence of potential for improvement but rather on the need for skilled care.
2. Services can be skilled and covered when:
   - Needed to maintain, prevent, or slow decline or deterioration; or
   - Skilled professional is needed to provide, or supervise, to ensure services are safe and effective.

Medicare Beneficiary Policy Manual (MBPM) Chapter 8, §§30, 30.2.1

Similar language in MBPMs for HH (Chap. 7) & OPT (Chap. 15)

NURSING TO MAINTAIN FUNCTION OR SLOW DETERIORATION

- "Skilled nursing ...would be covered...where necessary to maintain the patient's current condition or prevent or slow deterioration so long as the beneficiary requires skilled care for the services to be safe and effective"

Medicare Benefit Policy Manual (MBPM) Ch. 8, §30.3

- "Coverage does not turn on presence or absence of an individual's potential for improvement from nursing care, but rather on the beneficiary's need for skilled care."

MBPM Ch. 8, §30.3 (SNF)

Similar language in MBPM for HH (Chap. 7) & OPT (Chap. 15)

THERAPY TO MAINTAIN FUNCTION OR SLOW DETERIORATION

"Coverage for such skilled therapy services does not turn on the presence or absence of a beneficiary's potential for improvement from therapy services, but rather on the beneficiary's need for skilled care. ... These skilled services may be necessary to improve the patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition."

MBPM, Chapter 8, §30.4, §30.4.1.2E

Similar language in MBPM for HH (Chap. 7) & OPT (Chap. 15)

INDIVIDUAL ASSESSMENT, (NOT "RULES OF THUMB") REQUIRED

Certain phrases may indicate Rules of Thumb have been used to deny coverage.

Examples:

- Individual has "plateaued"
- Individual has "reached baseline"
- Individual is "chronic and stable"
- Individual needs "maintenance therapy only"
- Watch for new phrases developing since *Jimmo*

JIMMO SUMMARY

Questions to Ask:

- Is a skilled professional needed to ensure nursing or therapy is safe and effective? Yes? → Medicare covers.
- Is a skilled nurse or therapist needed to provide or supervise the care? Yes? → Medicare coverable

Regardless of whether the skilled care is needed to improve, or maintain, or slow deterioration of the condition. Or if condition is "chronic" or "stable" or has "plateaued."

DOCUMENTATION

- CMS added “enhanced” documentation guidance, mixed in with Jimmo revisions.
  - Not part of Settlement
- CMS message is that the need for and receipt of skilled care must be evident – show that the care was skilled.
- No magic words required – but vague phrases like “patient tolerated treatment well,” “continue with POC,” and “patient remains stable” are NOT sufficient to establish coverage.

PRACTICE TIPS

- Be certain goals clearly include maintenance language if that is intended.
- If improvement is initially expected and goal is reached or changed to maintenance:
  - **New order and goals are needed to state the change to maintain, deter, or slow decline.**
  - Denials seen when this is not done.
- If it can be measured, do so, and record the measurement
- Note what would be anticipated if maintenance services ended

JIMMO UPDATE

- *Jimmo* attorneys went back to Court 8/2016 to seek *Corrective Action Plan*
  - To require implementation, clear statements and education from CMS
- Judge ordered *Corrective Action Plan*
  - To be completed by 9/4/2017
  - To include *Corrective Action Statement*, CMS website, FAQs, CMS Education

Still experiencing problems/denials? Contact us!

PAYMENT, QUALITY AND FRAUD RULES: PRACTICAL BARRIERS TO COVERAGE

- Obtaining services may be difficult, particularly for home health care.
- Individuals not expected to improve often need long-term services that are not appropriately reimbursed by Medicare.
  - Or, at least not from providers point of view
- New Value Based Payment systems seek improvement as the measure to reward providers.
- Continuing services to individuals who need long-term care may [erroneously] trigger fraud investigations.

LIGHTNING ROUND
OTHER MEDICARE HOT TOPICS

- Medicare Advantage – Managed Care & Patient Risk Assessments
- “Outpatient” Hospital Observation Status
- Durable Medical Equipment & Competitive Bid Program
- Outpatient Therapy Caps
- Medicare Appeals System

Center for Medicare Advocacy

DISCUSSION

Center for Medicare Advocacy

Thank you!

For Updates, Sign Up for Weekly *CMA Alert* at

www.MedicareAdvocacy.org

JUSTICE IN AGING

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.

Today's Discussion

QMB Protections

CMS Initiatives

Helping clients

Resources

Legal Protections

- Qualified Medicare Beneficiary (QMB) -- one of several Medicare Savings Programs. Low-income Medicare beneficiaries get help from Medicaid to pay for Medicare Parts A and B.
- QMBs are at or below 100% FPL and meet QMB asset limits.
- Federal law protects all QMBs from improper billing for Medicare deductibles and co-insurance
- Protects both QMB-only and QMB-plus (QMB with full scope Medicaid)
- Protections apply with any Medicare provider, including out-of-state providers

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

Overview of Improper Billing

Sometimes known as a form of “balance billing,” improper billing occurs when Medicare providers seek to bill a beneficiary for Medicare cost sharing. Medicare cost sharing can include deductibles, coinsurance, and copayments.

Are improper billing protections waivable?

NO!

- QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing.
- Medicare providers who violate these billing restrictions are violating their Medicare provider agreement.

The Lesser-Of Policy

- Medicaid program is supposed to pay providers who serve QMBs
- But federal law explicitly allows states to limit payment to the Medicare cost-sharing amount or the state's Medicaid rate for the same service.

The Case of Mr. Bonta

- Mr. Bonta is a dual and QMB. He goes to see Dr. Hart, his cardiologist. The Medicare rate for his visit is $100.
- Medicare is primary, so it pays 80%/$80. The Medicaid rate is only $70.
- **Dr. Hart cannot bill Mr. Bonta for any balance.**
- Mr. Bonta cannot waive his QMB protections.
- Dr. Hart can decide **not** to accept Mr. Bonta as a patient.

Additional protections in Medicare Advantage

MA plans must include in their contracts with providers a protection against cost sharing for all full duals and QMBs.

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

Impact of Medicare Advantage protection

- The regulation binds the Medicare Advantage plans.
- The plan contract binds providers.
- In-network providers and MA plans may not discriminate against QMBs and duals.
- **BOTH are responsible for compliance.**

The Case of Ms. Mendoza

- Ms. Mendoza is a full benefit dual eligible. She is enrolled in *Seniors Rock* MA plan.
- Every time she sees her PCP, the office charges her a $20 co-pay.
- Her PCP is bound by contract not to charge Ms. Mendoza.
- She should complain to both PCP and *Seniors Rock*.

When do QMB billing protections NOT apply?

Medicaid Co-Pays. If your state imposes Medicaid co-pays, the provider may collect them.

Medicare Part D co-pays. Duals and QMBs qualify automatically for the Low Income Subsidy (LIS).They must pay these lowered co-pays.

NOTE: Part B drug co-pays (primarily drugs administered in a doctor's office) are subject to balance billing protections.

When do QMB billing protections NOT apply?

Medicare Advantage out of network providers. If a Medicare Advantage member goes to a provider who is out of her MA plan's network or goes to a specialist without required prior authorization, that is not a Medicare-covered service and is NOT covered by balance billing protections. MA members must follow MA rules.

Services or providers not covered by Medicare. Providers usually must provide an Advance Beneficiary Notice –ABN—before providing the service.

CMS is addressing core issues

- **Quantitative and qualitative study**
  - Found Improper billing is widespread
  - Found "lesser of" policy impacts access to providers
- **Provider and Beneficiary Education**
  - Medicare & You (p. 99)
  - Medicare Learning Network articles
  - Requiring MA plans to educate their providers

CMS is addressing core issues

- **Assistance and Enforcement**
  - 1-800-MEDICARE reps can pull up QMB status
  - Reps advise caller not to pay and to contact provider. If provider still bills, matter referred to MACs
  - MAC instructs provider to stop billing; sends copy of letter to beneficiary
  - If claim is in collections, beneficiary can also file a complaint with the Consumer Financial Protection Bureau

Coming soon!

- **Identification of QMBs through Medicare systems**
  - Accessible to Medicare provider offices
  - Flag that QMB cannot be billed
- **Revised Medicare Summary Notice (MSN) and provider remittance statements**
  - Will show $0 balance
  - Will remind provider and beneficiary of QMB protections
- **Rollout expected October 2017**

Justice in Aging Toolkit Materials

- New issue brief summarizing latest developments
- State-specific authorities library
- Brief questionnaire – share your story!
- Factsheets
- Model letters
- Archived webinars

www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/

Individual assistance

- Tell the beneficiary not to pay!
- Use the Justice in Aging toolkit
- Call 1-800-MEDICARE
- Contact the Medicare Advantage plan—go up the chain
- If the claim is in collections, contact CFPB

Systems level work

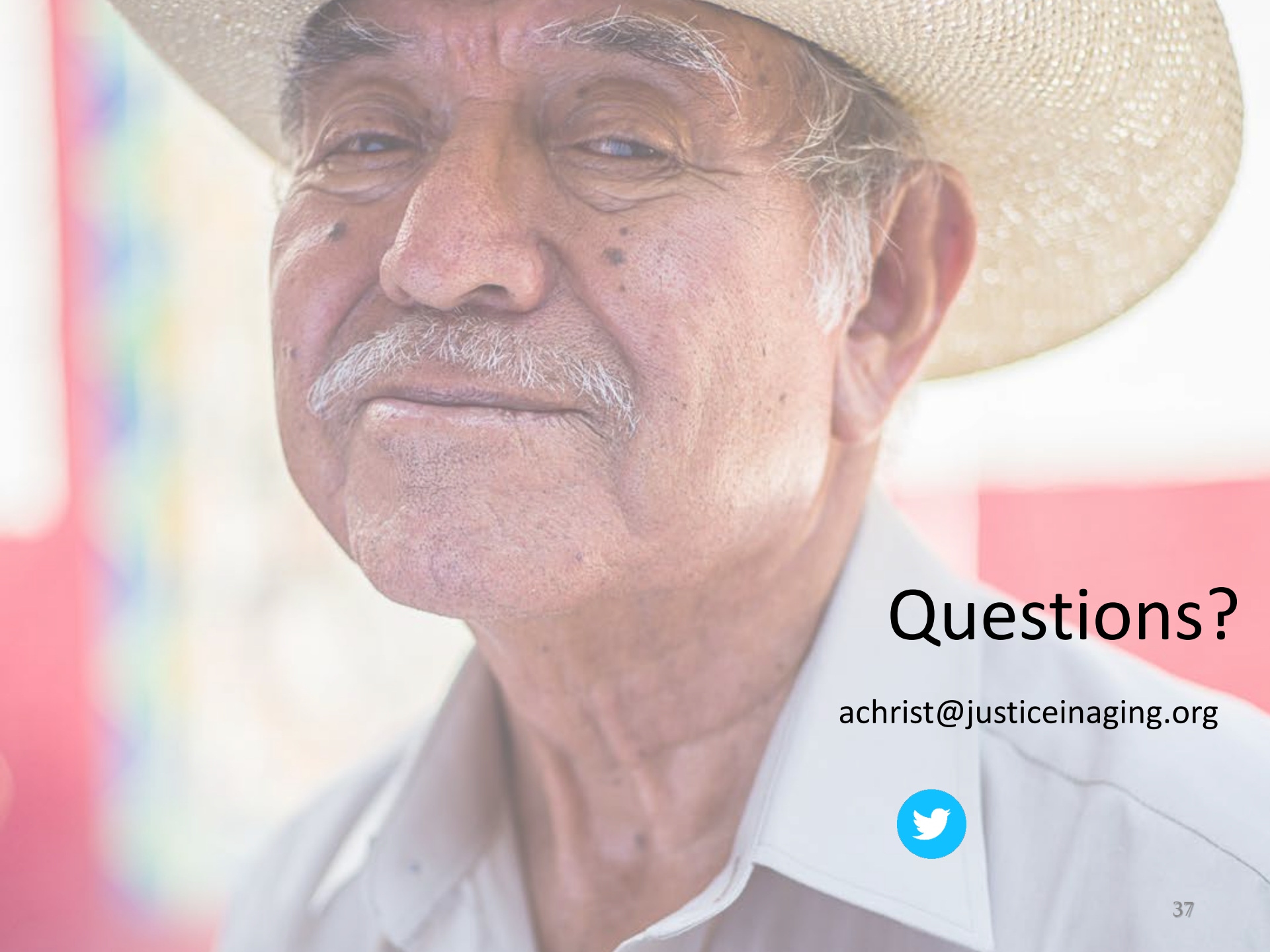
- Educate providers and beneficiaries, and non-attorney advocates
  - Use CMS and JIA resources
- Ensure state Medicaid program staff and Medicaid managed care plans understand the protection
- Share your stories-complete our questionnaire
- Give us feedback on how new CMS enforcement systems are working
- Seek simpler provider enrollment mechanism
- Longer term—work to fix the “lesser of” policy

Resources

- Justice in Aging Toolkit: www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/
- CMS-CFPB Consumer sheet: https://s3.amazonaws.com/files.consumerfinance.gov/f/documents/201701_cfpb_Know-Your-Qualified-Medicare-Beneficiary-Rights_handout_PRINT.PDF
- Provider material:

  Medicare Learning Network (MLN) 1128 on QMB balance billing https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf

  MLN Fact Sheet: Dual Eligibles at a Glance https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf



Questions?

achrist@justiceinaging.org