

Medicare Part B: Advanced Issues

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About NCLER

The National Center on Law and Elder Rights (NCLER) provides the legal services and aging and disability communities with the tools and resources they need to serve older adults with the greatest economic and social needs. A centralized, one-stop shop for legal assistance, NCLER provides Legal Training, Case Consultations, and Technical Assistance on Legal Systems Development. Justice in Aging administers the NCLER through a contract with the Administration for Community Living's Administration on Aging.

About Justice in Aging

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 Agenda

- Advance Beneficiary Notices of Noncoverage (ABNs)
- Medicare Part B drug coverage
- Temporary suspension of competitive bidding for Durable Medical Equipment (DME)

Key Lessons

- ABNs put Medicare beneficiaries on notice that they may be liable for specific Part A or Part B services that Medicare won't cover.
- Special ABN requirements apply for QMBs and Medicaid beneficiaries.
- ABNs can be challenged if they are defective or were not explained.

Key Lessons (continued)

- The rules and procedures for coverage of drugs under Medicare Part B are different from Part D in several important ways.
- In 2019 and 2020, beneficiaries are not limited to using DME providers who have competitive bidding contracts with CMS.

ABNs

Advance Beneficiary Notices of Noncoverage

What is an ABN (1 of 2)

- A standardized one-page notice with specific items filled in and with boxes for a beneficiary to check.
- Provides notice that **Medicare is likely to deny coverage** for health care services or supplies.
- Identifies the particular service affected and gives the reason.

What is an ABN (2 of 2)

Gives the beneficiary the option of:

1. Not accepting the service
2. Accepting the service and telling the provider not to bill Medicare, or
3. Accepting the service and directing the provider to bill Medicare

ABNs are used in Original Medicare. In Medicare Advantage, prior authorization procedures apply instead.

Why do ABNs Matter (1 of 2)

- ABNs shift liability to the beneficiary.
- If an ABN is not given, the beneficiary is not required to pay, even when Medicare denies coverage.
 - ABNs are not required if a service is never covered by Medicare, e.g., eye examinations for prescriptions for glasses.
 - ABNs may not be given in emergency situations.

Why do ABNs Matter (2 of 2)

- If a beneficiary accepts a service after signing an ABN, the provider may charge the beneficiary up-front for the full cost of the service.
 - If Medicare subsequently approves the service, the provider must refund the payment minus any co-insurance owed by the beneficiary.

ABNs and Dual Eligibles

- Dual eligibles and QMBs can be liable for charges if they sign an ABN and the service is not covered by Medicare.
 - If a service is not covered by Medicare or, for dual eligibles, by Medicaid, the beneficiary is responsible for payment.
 - Providers may not collect payment up-front from a QMB or dual eligible. They may not attempt to collect until the claim has passed through Medicare and if applicable through Medicaid.

ABN or private contract—what is the beneficiary being asked to sign?

- An ABN is a notice about services that Medicare likely won't cover. Providers are required to give ABNs to beneficiaries when appropriate.
- Private contracts requiring Qualified Medicare Beneficiaries and people with Medicaid to pay co-insurance for services that Medicare does cover are not permitted. Even if a beneficiary signs one, it is not enforceable.

Example: Mary and an ABN

- Mary is a QMB
- Mary's doctor orders a long list of blood tests after her annual physical. The lab gives her an **ABN** saying that two of the tests are likely not to be covered by Medicare. She decides to wait on the tests and ask her doctor whether he can provide justification for the tests.

Example: Roberto and a Contract

- Roberto is a QMB
- He visits a cardiologist after a referral by his primary care provider. On seeing that Roberto is a QMB, the office staff tells him that he must sign a **contract** consenting to be billed for Medicare co-insurance. Roberto is skeptical but signs because he has waited two months for the visit and does not want to lose the appointment.
- The cardiologist **should not** have presented the contract and Roberto **should not** have signed it. The contract is not valid and Roberto, as a QMB, has no obligation to pay co-insurance for a service that Medicare covers.

Challenging an ABN

- Was it filled out with sufficient specificity?
- Did the beneficiary have sufficient time to make a decision?
- Did the provider's office offer to explain?
 - Monolingual or limited English proficient patient?
 - Other facts?
- Was the beneficiary given incorrect information?

Part B Drugs

When does Part B cover drugs?

- Most prescription drugs are covered under Medicare Part D.
- Drugs administered in a physician's office or other out-patient setting are generally covered under Part B.
- Other Part B drugs: oral chemotherapy drugs; anti-nausea drugs for chemotherapy patients, some ESRD drugs, etc.
- Some drugs may be covered by Part B or Part D, depending on the circumstances.

Part B costs and cost protections

- Typically Part B co-insurance is 20%.
- In Medicare Advantage, co-pays may vary.
- LIS (“Extra Help”) co-pays do not apply.
- QMB cost sharing protection do apply.

Mary's drugs (1 of 3)

Mary is a dual eligible beneficiary and a QMB. She recently started cancer treatment with intravenous chemotherapy drugs at her oncologist's office. At her pharmacy, she picked up prescriptions for oral anti-nausea drugs to help with her chemo side effects. She also picked up her usual prescription for a generic statin for her cholesterol.

Who bills Mary? What does Mary pay?

Mary's drugs (2 of 3)

Chemo drugs: These are Part B drugs.

- Mary's doctor bills Medicare. Medicare pays 80%
- Mary receives a Medicare Summary Notice (MSN) saying she owes nothing because she is a QMB.

Anti-nausea drugs: These are Part B drugs.

- Mary's pharmacy transmits the bill to Medicare. Medicare pays 80%
- Again, Mary receives an MSN showing she pays nothing because of her QMB status.

Mary's drugs (3 of 3)

Statin: Because she is a QMB, Mary also has the Part D Low Income Subsidy.

- Mary picks up the prescription for a generic statin for her cholesterol.
- Mary pays her \$1.25 LIS co-pay at the counter.
- Her PDP Explanation of Benefits shows her payment.

Hector's drugs

Hector is on the same drug regimen as Mary.

- His income is too high for the QMB program in his state but he does have the Low Income Subsidy.
- Hector belongs to Get Healthy Medicare Advantage plan. He is careful to use in-network doctors and in-network pharmacies. His doctor helped him get required prior authorizations for his cancer drugs.

Who bills Hector and what does he pay?

Hector's drugs (continued)

- Chemo drugs: These are Part B drugs. Get Healthy charges 25% co-insurance for these drugs. Because he is not a QMB, Hector is responsible for those costs.
- Anti-nausea drugs: Hector also must pay at the pharmacy for these Part B drugs.
- Statin: With LIS, Hector pays \$3.40 for his generic statin.

Appeal criteria for Part B drug coverage

- Look for:
 - National Coverage Determination (NCD)
 - Local Coverage Determination (LCD)
 - Case-by-case medical necessity
- Same criteria apply whether in Original Medicare or Medicare Advantage

Durable Medical Equipment

Suspension of Competitive Bidding

Temporary Suspension

- In Original Medicare, prior to 2019, many categories of DME were subject to competitive bidding.
 - Beneficiaries had to use competitive bidding contractors
- CMS suspended competitive bidding for 2019 and 2020.
 - Legislation required changes in contracting
 - CMS needed time to rewrite and rebid
- CMS expects that competitive bidding will be back in place in 2021.

Temporary Suspension Impact on Beneficiaries

- May use any supplier that is enrolled in Medicare
- Generally no need to change suppliers
 - May need to change if supplier decides to drop some items
- May encounter aggressive or misleading marketing
 - Report marketing scams to Senior Medicare Patrol (SMP)

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