California Senior Medicare Patrol and Center for Medicare Advocacy Webinar Series
The Center for Medicare Advocacy is a national, non-profit law organization founded in 1986 that works to advance access to comprehensive Medicare and quality health care. Based in Washington, DC and CT, with additional attorneys in CA and MA.

- Staffed by attorneys, advocates, communication and technical experts
- Education, legal analysis, writing, assistance, and advocacy
- Systemic change – Policy and Litigation
  - Based on our experience with the problems of real people
- Medicare coverage and appeals expertise
- Medicare/Medicaid Third Party Liability Projects
The Power of Prevention: Senior Medicare Patrol (SMP) and the Fight Against Medicare Fraud

Presented By:
Catherina Isidro,
CHA Executive Director/SMP Project Director
Tatiana Fassieux
Education and Training Specialist
What is SMP?

- One of 54 Senior Medicare Patrol (SMP) programs found throughout the 50 states plus the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands.
- Federally funded through the Administration for Community Living (ACL) under the Department of Health and Human Services.
- Administered through our home agency, the California Health Advocates (CHA).
Our Motto

PREVENT
SMPs provide focused outreach and messaging designed to protect Medicare beneficiaries from Medicare fraud.

DETECT
As local trusted connections in the community the SMPs are often the first to hear of new issues as they begin to emerge.

REPORT
SMPs provide in-depth one-on-one assistance to Medicare beneficiaries and other complainants.
Trending Schemes

- COVID-19 Fraud Schemes
Misleading Marketing

Tri-fold mailer
Unemployment Benefits Guide??
Bait & Switch!
Fine print:
Insurance solicitation!

Looks like an IRS form!
What to Look Out For:

- **Keep track of medical appointments**
  - Use journal or calendar

- **Medicare Summary Notice (MSN)**
  - Sent to FFS Medicare beneficiaries

- **Explanation of Benefits (EOB)**
  - Sent to MA members and beneficiaries with a prescription drug plan

- **Check statements for accuracy. Look for:**
  - Services/items charged twice

- **Charges for services not rendered**

- **Charges for services different than those rendered (upcoding)**

- **Charges for services not ordered by primary care physician**
# Red Flags on an MSN

Help prevent Medicare fraud by checking these things

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider Information</th>
<th>Is this a provider you know?</th>
<th>Did you receive services on this day?</th>
<th>If you live in CT, did you really receive services in OH?</th>
<th>Do any services appear twice when they shouldn’t?</th>
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<tr>
<td>November 28, 2019</td>
<td>Leo Zygelman, CH, (555) 555-123 200 West Center St, Manchester CT 06040-0000</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Service Provided &amp; Billing Code</td>
<td>Service Approved?</td>
<td>Amount Provider Charged</td>
<td>Medicare-Approved Amount</td>
<td>Medicare Paid You</td>
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<td></td>
<td>Chiropractic manipulative treatment, 3 to 4 spinal regions (98941-GA)</td>
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<td>December 25, 2019</td>
<td>Joshua Richards, M.D., (555) 555-1234 848 Scioto St, Urbana, OH 3078-2255</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Service Provided &amp; Billing Code</td>
<td>Service Approved?</td>
<td>Amount Provider Charged</td>
<td>Medicare-Approved Amount</td>
<td>Medicare Paid You</td>
</tr>
<tr>
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<td>Established patient office or other outpatient visit (98213-GA)</td>
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SUPPORTED BY GRANT # 90MPR00001 FROM ACL

CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education
“Guard the Medicare Card”

Scammers do not discriminate between Original Medicare and Medicare Advantage enrolled beneficiaries. Their target is anyone with this Medicare card.
Deceptive Marketing Practices

The US Senate Finance Committee launched an inquiry in August 2022. Findings included:

- Complaints about Medicare Advantage plans marketing more than doubled from 2020 to 2021
- Misleading information or behavior included:
  - Seniors approached by agents at local grocery stores
  - Misleading seniors about their doctor being in the plan’s network
  - Mailers that look like official government mailers
  - Agents calling beneficiaries 20 times a day
  - Widespread television advertisement with celebrities that had claimed seniors were “missing out” on benefits

For a copy of report go to:
THANK YOU!

- Remember to report Medicare fraud to your local SM

- SMP Resource Center and SMP Locator link:

- If in California, call our CA SMP Hotline at 855-613-7080
Contact Us

916-465-8104 CA HEALTH ADVOCATES (CHA)

855-613-7080 SENIOR MEDICARE PATROL (SMP)

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Thank You

Presented By:
Catherine Isidro,
CHA Executive Director/SMP Project Director

Tatiana Fassieux
Education and Training Specialist
Pressing Beneficiary Issues & Stories

May 15, 2023

Judy Stein
Kathy Holt
David Lipschutz
Agenda

I. Overview of Several Pressing Beneficiary Issues
II. Hospital, Inpatient Rehab, Skilled Nursing, Home Health
    Case Example: Mr. C.
III. *Jimmo* Issues
IV. Medicare Advantage Prior Authorization and Denials
    Will New Rules Help?
V. Medicare Advantage Supplemental Benefits
    Dental Benefits: Case example
VI. Discussion: What are you hearing/seeing?
I. OVERVIEW of SEVERAL PRESSING BENEFICIARY ISSUES
Ongoing Issues

- Access to care/coverage in various care settings, including:
  - Inpatient Rehab Facility (IRF)
  - Skilled Nursing Facilities (SNF)
  - Home Health (HH)
- Inappropriate application of coverage rules, including *Jimmo* issues
- Medicare Advantage – access to care challenges often exacerbated
II. CHALLENGES ACCESSING MEDICARE COVERED CARE:

• Hospital
• Inpatient Rehab Hospital/Facility
• Skilled Nursing Facility
• Home Health Care
In October 2021, otherwise healthy Mr. C, age 80, was hospitalized due to cardiac concerns and renal failure.

Knowing his recovery would be lengthy, he asked for, but didn’t get, a case-coordinator from the managed care plan.

After 6 weeks, it was time to leave the hospital, but he was deconditioned, so his doctors wrote orders for Mr. C to be transferred to an inpatient rehabilitation facility (IRF) for intense, multi-discipline therapy to regain his strength.

But, Mr. C’s Medicare Advantage (MA) plan denied IRF prior authorization, stating “your doctor [must] expect you to improve a lot in a reasonable amount of time.”
Medicare Coverage Summary

Criteria to Qualify for an IRF

- Patient requires coordinated, multiple therapy disciplines (PT, OT, SLP, PO), one of which must be PT or OT.
- Require rehab physician supervision and meet at least 3 days/wk.
- Generally, patient requires an intense therapy program - at least 15 hours of intensive rehab within a 7-day period.
- Must actively participate in and benefit from therapy
- Must make practical improvement OR adapt to impairments in prescribed period of time.
- No need to achieve complete independence or return to prior level of function.
Mr. C Goes to a Skilled Nursing Facility

- Mr. C languished in the acute care hospital for weeks, unable to get authorization for the critical skilled therapy that he needed and qualified for in the IRF.

- Unable to obtain IRF authorization from the MA plan, hospital discharge planners then determined a less optimal alternative was for Mr. C to go to a skilled nursing facility (SNF) for limited rehabilitation services.

- The MA plan wanted Mr. C to go directly home from the hospital, but an appeal of his SNF prior authorization denial allowed him discharge to a SNF in February 2022.
Medicare Coverage Summary

Criteria to Qualify for an SNF

- With a doctor’s order, a patient requires/receives daily skilled care
  - “Daily” is 7 days a week of skilled nursing and/or therapy OR 5 days a week of therapy.
  - “Skilled” is a task that can be safely and effectively performed (or supervised) only by professional or technical personnel (Nurse, PT, OT, SLP).
  - Care must be medically reasonable and necessary.

- Generally, admitted to a SNF within 30 days of a 3-day inpatient hospital stay (most MA plans waive)
Mr. C Fights to Stay in the Skilled Nursing Facility

- In the SNF, Mr. C received about an hour of daily therapy. His ability to do activities of daily living (ADLs) slowly returned, but since months had passed when he could have participated in IRF level-care, he was even more deconditioned.

- After a few weeks at the SNF, the MA plan told Mr. C his condition had “stabilized” so more incorrectly found services weren’t coverable by Medicare. SNF disagreed & said he would decline rapidly without daily therapy.

- Mr. C appealed to stay in the SNF. He won. The MA plan was relentless, sent noncoverage notices weekly. He won.
Mr. C Goes Home

- Despite constant (and stressful) denial notices from the MA plan, Mr. C continued to win additional Medicare SNF coverage. Daily therapy strengthened both his body and his resolve to adjust to living back in the community.

- After 6 months at the SNF (his MA plan had unlimited SNF coverage), Mr. C made plans to return to his home, but he would be homebound and he needed further therapy to adjust to his home surroundings.

- The MA plan denied prior authorization of Mr. C’s doctor’s order for Medicare-covered home health services. On appeal, home health services were approved.
Medicare Coverage Summary

Criteria to Qualify for Home Health

- Under the care of a physician or allowed practitioner who orders care and reviews every 60 days. Need at least one face-to-face visit.
- Homebound (not bedbound, need assistance to leave home and it’s a taxing effort).
- In need of at least one (reasonable and necessary) skilled service (intermittent or part-time nurse, PT, or SLP to start, OT to continue services).
- Note: Once receiving a skilled service, may receive necessary aide services &/or medical social services.
Mr. C’s Care at Home

- Mr. C returned home. Without daily therapy, his condition weakened, but receiving every-other-day therapy, he began “holding his own”. He was getting about the house.

- In September 2022, while fighting side effects of an antibiotic, the MA plan discharged him from home health stating he wasn’t making progress. He didn’t win the expedited appeal to keep services in place. He won the standard appeal at a hearing 4 months later.

- It was too late. Without timely therapy, his condition had declined rapidly. He has become completely dependent on full-time care.
Summary of Mr. C’s Health Care Journey

▪ Mr. C’s doctors provided strong appeal support in every step.
▪ Critical care weeks passed as Mr. C languished in the hospital, rather than be allowed rehab at the IRF. (Note: Generally, MA plans do not approve IRF level services or include in network.)
▪ Mr. C was finally allowed limited rehab at a SNF, too little and too late for maximum recovery & adjustment to new limits.
▪ Repeated denials, and wins, for continued services still left Mr. C continuously anxious and distracted from recovery.
▪ When he got home, MA plan used a minor medication side effect to improperly deny him continued home health care.
▪ Mr. C had no Medicare option. It was chosen for him - EGHP.
Jimmo v. Sebelius (D.VT. 1/ 24/2013); Corrective Action Plan (8/11/2017)

III. JIMMO ISSUES
Jimmo Summary

- 2011: Filed. Individuals and organizations. National class action

- 2013: Settlement approved by court – *Is skilled care required, NOT is individual improving? Care to maintain condition or slow decline IS covered*
  - Medicare manuals greatly edited to reflect these standards

- 2017: Corrective Action Plan – CMS required “to **affirmatively disavow**” an **improvement standard** and maintain *Important Message About Jimmo* on CMS.gov
  - Medicare must make “Individualized Assessment”

- **Longstanding Regulation: Restoration potential is not the deciding factor**
  - 42 CFR §409.32(c)
  - Reiterated in various CMS transmittals 2020, 2022
Jimmo v Sebelius

How should it apply to Mr. C in the various care-settings in which he sought Medicare-covered care?
“The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient’s condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient’s functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, as defined in section 110.3 and if such improvement can be expected to be made within a prescribed period of time.”

“The patient need not be expected to achieve complete independence in the domain of self-care nor be expected to return to his or her prior level of functioning in order to meet this standard.”
“CMS notes that … an IRF claim could never be denied … (1) because the patient could not be expected to achieve complete independence in … self-care or (2) because the patient could not be expected to return to his or her prior level of functioning.”
“Coverage of nursing and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual’s potential for improvement from the nursing and/or therapy, but rather on the beneficiary’s need for skilled care.”
“Skilled care may be necessary to improve a patient’s condition, or to prevent or slow further deterioration of the patient’s condition.”
“Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on the presence or absence of a patient’s potential for improvement…, but rather on the patient’s need for skilled care. Skilled care may be necessary to improve a patient’s current condition, to maintain the patient’s current condition, to prevent or slow further deterioration of the patient’s condition.”
Important Message About the Jimmo Settlement (CMS.gov, 12/12/2017)

“The Jimmo Settlement Agreement may reflect a change in practice for those...who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The Jimmo Settlement is consistent with the Medicare program’s regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level care that such hospitals provide.” [Emphasis added]


Jimmo = Clearly Established Law
IV. MEDICARE ADVANTAGE PRIOR AUTHORIZATION & DENIALS
MA and Prior Authorization

- Nearly all MA enrollees (99%) are in plans that use PA for some services - “most often required for relatively expensive services, such as Part B drugs (99%), skilled nursing facility stays (98%), and inpatient hospital stays (acute: 98%; psychiatric: 94%), and is rarely required for preventive services (6%)” (KFF, Aug. 2022)

- KFF (Feb 2023) – in 2021, 6% of all prior auth determinations were denied in full or in part
  - Just 11% of prior auth denials were appealed
  - Of those that were appealed, 82% resulted in fully or partially overturning the initial denial

- Also see HHS OIG (2018): plans overturn 75% of prior auth and payment denials, but benes and providers appeal only 1% of denials; (2022): among sample of 2019 denials, found 13% of prior auth denials met Medicare coverage rules
Final Part C & D Rule

- CMS recently published a final rule for 2024 re: Medicare Advantage and Part D, available in the Federal Register at 88 Fed Reg 22120 (April 12, 2023) – see [here](#)
- The rules make meaningful improvements to MA prior authorization, marketing and other changes
  - See CMA [Special Report](#) for summary (May 2023)
  - See CMS [Fact Sheet](#) (April 2023)
- In short, PA should only be used to confirm diagnoses or other criteria, to ensure item/service is medically necessary

• **Coverage Criteria Clearly Established** under Medicare rules (plans can’t use any other criteria)
  - TIP: make sure plans follow subregulatory guidance

• **Coverage Criteria Not Clearly Established** “when additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently; NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD, or there is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria” (88 Fed Reg 22122)
  - Plans can use “widely used treatment guidelines or clinical literature” which must be made publicly available
    - TIP – if criteria is still too restrictive, challenge it: New language at §422.101(b)(6)(i)(A) states: “The MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services.”
Final Rule: MA Prior Auth Provisions (cont’d)

• **Continuity of care** - An approval granted through PA processes must be valid for as long as medically necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient’s medical history, and the treating provider’s recommendation.
  - “Course of treatment means is a prescribed order or ordered course of treatment for a specific individual with a specific condition as outlined and decided upon ahead of time with the patient and provider. A course of treatment may but is not required to be part of a treatment plan.”
  - “Active course of treatment means a course of treatment in which a patient is actively seeing the provider and following the course of treatment.”

• Plans must provide a minimum 90-day transition period when an enrollee who is currently undergoing an active course of treatment switches to a new MA plan

• **BUT plans can authorize less care than treating clinician ordered** – boils down to medical necessity determination
Final Rule – Use of AI and Algorithmic Tools

• NOTE: CMS does not explicitly prohibit use of AI or algorithmic-driven tools, but states that “MA organizations must ensure that they are making medical necessity determinations based on the circumstances of the specific individual, as outlined at § 422.101(c), as opposed to using an algorithm or software that doesn’t account for an individual’s circumstances” and plans “will need to understand the external clinical evidence relied upon in these products and how that evidence supports the coverage criteria applied by these tools” and “must make the evidence that supports the internal criteria used by (or used in developing) these tools publicly available, along with the internal coverage policies themselves” (88 Fed Reg 22195) (Emphasis added)
V. MEDICARE ADVANTAGE SUPPLEMENTAL BENEFITS
Most Medicare Advantage Plans Offer Benefits Not Covered Under Traditional Medicare in 2022

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Eye exams and/or eyeglasses</td>
<td>98%</td>
</tr>
<tr>
<td>Fitness</td>
<td>97%</td>
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<tr>
<td>Telehealth</td>
<td>95%</td>
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<tr>
<td>Hearing exams and/or aids</td>
<td>95%</td>
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<tr>
<td>Dental</td>
<td>94%</td>
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<td>Remote Access Technologies</td>
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<td>Meal Benefit</td>
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<td>Transportation</td>
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<td>In-Home Support Services</td>
<td>10%</td>
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<tr>
<td>Bathroom Safety Devices</td>
<td>8%</td>
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How Broad are the Benefits?

- KFF (Nov. 2022): “In 2023, 97% or more individual plans offer some vision, fitness, telehealth, hearing or dental benefits. Though these benefits are widely available, the scope of coverage for these services varies. For example, a dental benefit may include cleanings and preventive care or more comprehensive coverage, and often is subject to an annual dollar cap on the amount covered by the plan. […] Plans are not required to report data about utilization of these benefits or associated costs, so it is not clear the extent to which supplemental benefits are used by enrollees.” [emphasis added]
- Also see KFF (April 2023) re: other gaps in MA data
MA and Dental Coverage

- In recent weeks, we have received calls from NJ, CA, FL, TX, NY, and DC – all different MA plans – re: complaints/frustrations about being unclear about and/or misled about MA plans’ dental coverage
  - Including, e.g., caller from DC had been told that a root canal would be covered, but the plan only paid a small percentage of it
  - MA enrollees often think that because there’s an annual cap that they are just simply covered up to that cap; however, they don’t realize that the cap only applies to the specific items, procedures, services defined under the plan, and often with strict limitations
  - It is important for people to get full details about what is covered and not covered
Case Example

- Ms. M is in a D-SNP with a pretty generous annual cap for dental ($2500). She was treated in January for an oral infection, and then needed care in August for a new infection. When she called the insurance plan in August about this, the plan said her benefits would cover and gave her a list of participating dentists. When she went to one of the dentists, they also told her that her care would be covered and proceeded to do x-rays, an exam, and referred her to a specialist for consult, which she did.

- She was later billed for the full cost of the exam, the consult, and both of the imagings. This is because the plan only covers ONE exam per year to assess a problem, does not cover a specialist consult, only covers one set of bitewings per year, and does not cover the special x-ray that is used when regular dental/facial x-rays are not sufficient.

- The D-SNP’s coverage is indicated in a chart of dental diagnostic codes in the plan’s Evidence of Coverage (EOC) for that year. But the plan never sent her a physical copy of that booklet, and she was never referred to the online version.

- CMS has added a list of required elements agents and brokers must discuss with beneficiaries prior to enrollment in an MA or Part D plan. Will this help with informed decision-making?
  - The final rule adds new language at 42 CFR §422.2274(c)(12) (for Part D, see §423.2274(c)(12)); MA organizations must: “(12) Ensure that, prior to an enrollment, CMS’ required questions and topics regarding beneficiary needs in a health plan choice are fully discussed. Topics include information regarding primary care providers and specialists (that is, whether or not the beneficiary’s current providers are in the plan’s network), regarding pharmacies (that is, whether or not the beneficiary’s current pharmacy is in the plan’s network), prescription drug coverage and costs (including whether or not the beneficiary’s current prescriptions are covered), costs of health care services, premiums, benefits, and specific health care needs.”
VI. DISCUSSION and QUESTIONS
For further information, to receive the Center’s free weekly electronic newsletter, *CMA Alert*, update emails and webinar announcements, contact:

Communications@MedicareAdvocacy.org

Or visit

MedicareAdvocacy.org

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