Medicare Minute Teaching Materials — July 2024
Cost Saving Programs

1. What are the Medicare Savings Programs (MSPs)?
The Medicare Savings Programs, also known as Medicare Buy-In programs or Medicare Premium Payment Programs, help pay your Medicare costs if you have limited income and savings. There are three main programs, each with different benefits and eligibility requirements. If you qualify for one of the three main MSPs, your Medicare Part B monthly premium will no longer be deducted from your Social Security check. Additionally, you will automatically be enrolled in Extra Help, the federal program that helps with Part D prescription drugs costs (see question 9). Each MSP also offers separate benefits (see question 2). You cannot choose to apply for a certain MSP; you will be enrolled in the MSP that corresponds to your income, assets (if applicable in your state), and other application details.

2. What are the differences between the three main MSPs?
First, note that not every state has three main MSPs (some have more or less) and they may call their MSPs by different names. The three main MSPs, though, are the following:

Qualified Individual (QI): If you are enrolled in the QI program, you may receive up to three months of retroactive reimbursement for Part B premiums deducted from your Social Security check. Note that you can only be reimbursed for premiums paid up to three months before your MSP effective date, and within the same year of that effective date. For example, if you submitted an MSP application at the end of 2024 and are approved for February 2025, you can only receive premium reimbursement for January 2025 because you cannot be reimbursed for premiums paid in the previous year. If your QI effective date is April 2025, you would receive premium reimbursements for January, February, and March. You cannot have both QI and Medicaid.

Specified Low-income Medicare Beneficiary (SLMB): If you are enrolled in the SLMB program, you may receive up to three months of retroactive reimbursement for Part B premiums. Unlike QI, you may be reimbursed for premiums from the previous calendar year. For example, if you submitted an MSP application at the end of 2024 and are approved for February 2025, you may be reimbursed for premiums paid in November and December of 2024 as well as January 2025. You can have both SLMB and Medicaid.

Qualified Medicare Beneficiary (QMB): Unlike QI and SLMB, QMB does not offer retroactive premium reimbursement and only covers premium costs for months after you apply for the benefit. However, QMB does offer coverage for Medicare cost-sharing and federal law prohibits Medicare providers from billing you for cost sharing amounts if you are enrolled in QMB. This means Medicare providers should not bill you for any Medicare-covered services you receive. Additionally, if you have to pay Part A premiums because you do not have 10 years of documented work history in the United States, QMB will pay the Part A premium for you. You can have both QMB and Medicaid.

Note: Qualified Disabled Working Individual (QDWI) is a fourth MSP and pays for the Medicare Part A premium only. To be eligible for QDWI, you must:
- Be under age 65
- Be working but continue to have a disabling impairment
- Have limited income and assets

- And, not already be eligible for Medicaid

3. What are the Medicare Savings Program income and asset limits?
To qualify for an MSP, you must meet your state's income and asset limits. Listed below are the baseline federal income and asset limits for each MSP for 2024. Most states use these limits, but some states have different guidelines. For example, some states have higher income limits, including Alaska, Connecticut, the District of Columbia (DC), Hawaii, and Maine. The following states do not apply asset limits: Alabama, Arizona, Connecticut, Delaware, DC, Louisiana, Mississippi, New York, Oregon, and Vermont. .

Qualifying Individual (QI)
Gross monthly income limits: 135% Federal Poverty Line (FPL) + $20*
- Most states: $1,715 for individual ($2,320 for couple)
- Asset limits: $9,430 for individual ($14,130 for couple)

Specified Low-income Medicare Beneficiary (SLMB)
Gross monthly income limits: 120% FPL + $20
- Most states: $1,526 for individual ($2,064 for couple)
- Asset limits: $9,430 for individual ($14,130 for couple)

Qualified Medicare Beneficiary (QMB)
Gross monthly income limits: 100% Federal Poverty Level, or FPL, + $20
- Most states: $1,275 for individual ($1,724 for couple)
- Asset limits: $9,430 for individual ($14,130 for couple)

*The amounts listed above include a standard $20 income disregard. Your state may disregard other income as well. Contact your local Medicaid office or State Health Insurance Assistance Program (SHIP) for state-specific guidelines and information. Contact information for your SHIP is on the final page of this document.

4. If my income seems a bit over my state's Medicare Savings Program income and asset guidelines, should I still apply?
Yes. This is because you may still qualify for an MSP because certain income and assets may not be counted when determining your eligibility. In all states, the following income is not counted:
- The first $20 of your monthly income
- The first $65 of your monthly wages
- Half of your monthly wages (after the $65 is deducted)
- Food stamps (Supplemental Nutrition Assistance Program (SNAP) support)

Some states exclude more of your monthly income than the examples listed above.

In all states, the following assets are not counted:
- Your primary house
- One car
- Household goods and wedding/engagement rings

- Burial spaces
- Burials funds up to $1,500 per person
- Life insurance with a cash value of less than $1,500

Remember, how your income and assets are counted to determine eligibility varies from state to state. Call your local Medicaid office or SHIP to find out if you are eligible for an MSP in your state. Contact information for your SHIP is on the final page of this document.

5. How can I apply for an MSP?
Applications and required documentation vary by state. Before applying for an MSP, you should call your local Medicaid office for application steps, submission information (online, mail, appointment, or through community health centers and other organizations), and other state-specific guidelines. You can also call your State Health Insurance Assistance Program (SHIP) to find out if you are eligible for an MSP in your state or for help with your application. Before submitting your application, be sure to make and keep a copy. If you are at a Medicaid office, ask that they make a copy for you.

You should be sent a Notice of Action within 45 days of filing an application. This notice will inform you of your application status. If you receive a denial and are told you do not qualify for an MSP, you have the right to request a fair hearing to challenge the decision. If you receive an approval:

- And are found eligible for SLMB or QI, the state will pay your Part B premium starting the month indicated on your Notice of Action. However, it may take several months for the Part B premium ($174.70 in 2024) to be added back to your monthly Social Security check. Do not be concerned: you should be reimbursed with a lump-sum check for each month that your premium should be paid for.
- And are found eligible for QMB, your benefits begin the next month.

If you do not receive a Notice of Action within 45 days, contact the Medicaid office where you applied.

Note: Some Medicare Advantage Plans offer to assist beneficiaries with the MSP application. Plans may contract with companies that work with the beneficiaries, collecting information and helping submit an MSP application. Remember, however, that MSPs are available to all people with Medicare, not just those enrolled in certain Medicare Advantage Plans. All people with Medicare can apply for an MSP and can contact their local SHIP if they need assistance applying.

6. What if I have Medicare Part A but not Part B? Can I still apply for an MSP?
Yes. The MSP will allow you to enroll in Medicare Part B outside of usual enrollment periods and eliminate your Part B late enrollment penalty, if you have one. This is called the Part B buy-in. After enrolling in any of the three main programs, you should receive premium-free Part B. Your premium-free Part B effective date is the same day as your MSP effective date. If you are approved, it may take three to four months before your benefits take effect—but you should receive the MSP and premium-free Part B retroactive to the effective date on your decision notice.

Note: To use the MSP to enroll in Part B, you must already have Part A, unless you qualify for QMB. If you do not currently have Part A, you should enroll before applying for an MSP. If you do not qualify for premium-free

Part A, contact your SHIP or state Medicaid office to see whether you can use QMB to enroll in Part A outside of the usual enrollment periods.

7. How do I keep my MSP from year to year?
If you are approved, you will need to renew (recertify) your MSP every year. If you do not receive a notice in the mail to recertify, contact your local Medicaid office and ask what you need to do to make sure you receive your MSP benefits in the following year.

8. What is QMB improper billing?
In Medicare, the term improper billing refers to a provider inappropriately billing a beneficiary for Medicare cost-sharing. Cost-sharing can include deductibles, coinsurance, and copayments. Federal law prohibits providers from billing people enrolled in the QMB program for any Medicare cost-sharing. This means that if you have QMB, Medicare providers should not bill you for any Medicare-covered services you receive. More specifically, if you have QMB and are enrolled in Original Medicare, you should not be billed when receiving a Medicare-covered service from either:

- A participating provider: a provider who agrees to always take assignment, meaning they accept Medicare's approved amount for health care services as full payment.
- A non-participating provider: a provider who accepts Medicare payment but has not agreed to take assignment in all cases.

If you have QMB and are enrolled in a Medicare Advantage Plan, you should not be billed when receiving a plan-covered service from in-network providers, as long as you meet your plan's coverage rules, such as getting prior authorization to see certain specialists.

Protect yourself from improper billing by being aware that:

- You retain improper billing protections when seeing Original Medicare and Medicare Advantage providers who do not accept Medicaid.
- You keep your improper billing protections even when receiving care from Medicare providers in other states.
- You can be billed if you are enrolled in a Medicare Advantage Plan and see an out-of-network provider, or if you have Original Medicare and see an opt-out provider.
- You cannot choose to waive these protections and pay Medicare cost-sharing, and a provider cannot ask you to do this.
- It is important to read your Medicare and Medicaid statements to ensure that the billing is correct.

Remember that if you have QMB, the Medicare providers you see must accept Medicare payment and any QMB payment as the full payment for any Medicare-covered services you received. Providers who violate improper billing protections may be subject to penalties. If you are having issues with a provider who continually attempts to bill you, or if you have unpaid cost-sharing bills that have been sent to collection agencies due to improper billing that could be due to potential fraud, errors, or abuse, call your local Senior Medicare Patrol (SMP) and 1-800-MEDICARE (or contact your Medicare Advantage Plan). Contact information for your SMP is on the last page of this document.

Note: Some states may impose Medicaid copays for certain Medicare-covered services. If that is the case in your state, Medicare and Medicaid should pay the majority of the cost, leaving you a nominal, or small, copay. Contact your local Medicaid office to learn more about Medicaid copays in your state.

9. What is Extra Help?

Extra Help is a federal program that helps pay for some to most of the out-of-pocket costs of Medicare prescription drug coverage. It is also known as the Part D Low-Income Subsidy (LIS). The Extra Help program offers the following benefits:

- Pays for your Part D premium up to a state-specific benchmark amount
- Lowers the cost of your prescription drugs
- Gives you a Special Enrollment Period (SEP) once per calendar quarter during the first nine months of the year to enroll in a Part D plan or to switch between plans (You cannot use the Extra Help SEP during the fourth calendar quarter of the year (October through December). You should use Fall Open Enrollment during this time to make prescription drug coverage changes.)
- Eliminates any Part D late enrollment penalty you may have incurred if you delayed Part D enrollment

To receive such assistance, your prescriptions should be on your plan's formulary and you should use pharmacies in your plan's network. Remember that Extra Help is not a replacement for Part D or a plan on its own: You must still have a Part D plan to receive Medicare prescription drug coverage and Extra Help assistance. If you do not choose a plan, you will in most cases be automatically enrolled in one.

10. Who is eligible for Extra Help?

There are two ways to be eligible for Extra Help:

1. If your monthly income is up to $1,903 in 2024 ($2,575 for couples) and your assets are below $17,220 in 2024 ($34,360 for couples), you may be eligible for Extra Help. These limits include a $20 income disregard that the Social Security Administration (SSA) automatically subtracts from your monthly unearned income (e.g., retirement income). Even if your income or assets are above the eligibility limits, you could still qualify for Extra Help because certain types of income and assets may not be counted, in addition to the $20 mentioned above.

2. If you are enrolled in Medicaid, Supplemental Security Income (SSI), or a Medicare Savings Program (MSP), you automatically qualify for Extra Help regardless of whether you meet Extra Help's eligibility requirements. You should receive a purple-colored notice from the Centers for Medicare & Medicaid Services (CMS) informing you that you do not need to apply for Extra Help.

11. I am eligible for Extra Help, but I have a form of prescription drug coverage other than Part D. What should I do?

If you are eligible for Extra Help and already have other creditable drug coverage, you should evaluate your costs and coverage to decide whether to enroll in Part D and Extra Help or to keep your current drug coverage, or both. Be sure to ask your former employer or union if you can get a Part D plan and/or decline the prescription coverage portion of your retiree benefits without losing the ones you want to keep, including any benefits for your dependents. If you cannot have Part D and your retiree benefits, or if having both is not cost-effective, think carefully about whether you should get a Part D plan, especially if your retiree plan also covers your spouse or dependents. You can enroll in Part D at any time if you are eligible for Extra Help.

Finally, even though people with Medicaid are generally automatically enrolled in Extra Help and Part D, those with Medicaid and certain kinds of employer, union, or retiree drug coverage may in some cases decline Extra Help. Contact your local Medicaid office to learn how to do this without affecting your Medicaid. If you later want Part D, you can enroll at any time without penalty if you are still enrolled in Medicaid or are eligible for Extra Help.

12. How can I apply for Extra Help?
If you do not have Medicaid, Supplemental Security Income (SSI), or a Medicare Savings Program (MSP), you can apply for the Extra Help program through the Social Security Administration (SSA) using either the agency's print or online application. (If you have Medicaid, SSI, or an MSP, you should be automatically enrolled in Extra Help.) To apply online, visit www.ssa.gov. Depending on processes in your state, this application can also serve to screen you for a Medicare Savings Program, which helps pay your Medicare costs. Be sure to complete the entire application and provide accurate information so you get all the benefits for which you qualify. For assistance applying, you can call your SHIP. Contact information for your SHIP is on the final page of this document. Remember, Extra Help reduces your prescription drug costs only for drugs covered by your Part D plan. If you do not have a Part D plan but are eligible for Extra Help, you can use the Special Enrollment Period (SEP) to enroll in Part D drug coverage.

If your application for Extra Help is denied, you can appeal to SSA. You will have the opportunity to submit information about why you qualify when you appeal.

13. How do I keep my Extra Help from year to year?
To keep your Extra Help benefits from year to year, you must continue to meet the eligibility requirements. Depending on your state and how you initially qualified for Extra Help, this process may be automatic or require that you submit information to confirm your continued eligibility.

If you qualified for Extra Help automatically because you had Medicaid, Supplemental Security Income (SSI), or a Medicare Savings Program (MSP), and:

- You still have Medicaid, SSI, or an MSP in the fall, you do not have to do anything. Your state should inform Medicare that you are still enrolled in one of these programs, and you will continue receiving Extra Help. You should not receive any notice unless your copayments are changing for the next year. If your income changed enough to affect your copayments, you should receive a notice telling you this in early October.
- You no longer have Medicaid, SSI, or an MSP in the fall, you should apply for Extra Help. If you do not apply, your Extra Help ends December 31. You should receive a letter in the fall explaining that you will lose Extra Help, along with an application and postage-paid envelope. You may also choose to apply for Extra Help online.

If you applied for Extra Help:

- The Social Security Administration (SSA) may send you a letter in August or September titled Social Security Administration Review of Your Eligibility for Extra Help. The letter outlines the financial and personal information you provided when you applied and asks if any of it has changed. Note that if you and your spouse applied for Extra Help together, you will receive only one letter. If you receive the

letter, you must complete the enclosed Review of Your Eligibility form and send it back to SSA within 30 days. SSA will use your answers to decide if you still qualify for Extra Help, depending on how your income and assets changed. If you do not fill out and return the Review of Your Eligibility form, your Extra Help assistance will end December 31. If you need more time to fill out the form, call your local Social Security office and ask for a 30-day extension. Any changes to your Extra Help assistance will take effect January 1.

Once SSA has reviewed any forms you have submitted, you will receive a notice explaining if you will be keeping your Extra Help benefit. Remember, you can appeal or reapply if you lose Extra Help.

14. Does my state offer other programs to assist with prescription drug costs?
Many states offer State Pharmaceutical Assistance Programs (SPAPs) to help residents pay for prescription drugs. Each program works differently. States may coordinate their drug assistance programs with Medicare's prescription drug benefit (Part D). Some SPAPs require that you sign up for Part D in order to qualify for assistance. In these cases, if a drug is covered by both your SPAP and your Part D plan, both the amount you pay for your prescriptions plus the amount the SPAP pays will count toward the out-of-pocket maximum you have to pay before reaching catastrophic coverage. Your SPAP may help pay for your Part D plan's premium, deductible, and/or copayments. Certain states have qualified SPAPs. Qualified SPAPs provide a Special Enrollment Period (SEP) to allow you to enroll in or make changes to your Part D or Medicare Advantage coverage.

You can contact your State Health Insurance Assistance Program (SHIP) to learn about possible SPAPs in your state. Contact information for your SHIP is on the final page of this document.

15. Are there certain facilities that may offer health services at a reduced cost?
If you require health services at a reduced cost, there are two types of facilities that may be able to help.

1. There are hundreds of government-funded health centers around the country that provide medical care regardless of your ability to pay. These clinics generally receive funding and supervision from the Health Resources and Services Administration (HRSA). You may hear them referred to as HRSA Health Centers. They may also be called:
    - Federally Qualified Health Centers (FQHCs)
    - FQHC look-alikes
    - Migrant Health Centers
    - Health Care for the Homeless Program Centers
    - Public Housing Primary Care Centers
    - Or, Tribal Organization-run Outpatient Health Programs

    People with Medicare are eligible to receive services from these government-funded health centers. The health centers provide Medicare-covered medical services as well as some preventive services that Medicare does not cover. A unique advantage of government-funded health centers is that they may waive the Part B deductible. Additionally, these clinics may waive or reduce the 20% coinsurance for Medicare-covered services if your annual income is at or below the federal poverty level ($15,060 for an

individual, $20,440 for a couple in 2024). Some government-funded health centers may also provide dental services. For more information, contact your State Health Insurance Assistance Program (SHIP).

2. The Hill-Burton program offers free or reduced cost care at Hill-Burton facilities. Most states have the Hill-Burton program. Each facility chooses which services it will provide, and at what (if any) cost. Services that are fully covered by other types of insurance (like Medicare or Medicaid) are not eligible for Hill-Burton coverage. The Hill-Burton program will not cover Medicare cost-sharing. However, it will cover Medicaid copayments, except long-term care facility care, as well as Medicaid spend-down amounts. Note that there are a limited number of Hill-Burton facilities in the country (most are outpatient facilities), so access to a facility in your area may be limited. Eligibility for the Hill-Burton program is based on your income and family size. You may apply for Hill-Burton assistance before or after you receive care, or after a bill has been sent to collections. To apply, call the Admissions, Business, or Patient Accounts office at a Hill-Burton facility.

16. What is Medicaid?

Medicaid is a federal and state program that provides health coverage for certain people with limited income and assets. Each state runs different Medicaid-funded programs for different groups of people, including older adults, people with disabilities, children, pregnant people, and parents and/or caretakers of children. All states have Medicaid programs for people with limited incomes and assets who need nursing home care, long-term care services, and home health care services. Some states also have programs for individual adults who don't fit any of these categories. Each state uses financial eligibility guidelines to determine whether you are eligible for Medicaid coverage. Generally, your income and assets must be below a certain amount to qualify, but this amount varies from state to state and from program to program. You are eligible for Medicaid if you fall into an eligible group and meet that group's financial eligibility requirements.

17. Can I have both Medicare and Medicaid?

Yes. If you are eligible for Medicare and Medicaid (dually eligible), you can enroll in both. Medicaid can cover services that Medicare does not, like long-term care. It can also pick up Medicare's out-of-pocket costs (deductibles, coinsurances, copayments). In other words, Medicaid can work *with* Medicare, as secondary coverage. Make sure to call 1-800-MEDICARE or contact your local Medicaid office to learn more about Medicare and Medicaid costs and coverage, especially if you are dually eligible.

18. How can I apply for Medicaid?

Below is a general guide to the Medicaid application process. Be sure to contact your local Medicaid office for state-specific rules. Your Medicaid office may be called the Department of Health, the Department of Social Services, the Department of Insurance, or by another name.

- Contact your local Medicaid office to ask how you need to submit your application.
- Find out which documents and forms of identification you may need in order to apply. Your Medicaid office may ask you to show proof of information like date of birth, U.S. citizenship or lawful residence, all types of income, or residence.

Note: Medicaid coverage is available, regardless of citizenship status, if you are pregnant or require treatment for an emergency medical condition. A doctor must certify that you are pregnant or had an emergency, and you must meet all other eligibility requirements.

If you have any problems applying at a Medicaid office, ask to speak with a supervisor. If you do not receive a timely decision on your Medicaid application or are turned down for Medicaid, you can appeal by asking for a state fair hearing (not a city or local one). Check with your Medicaid office to learn more about requesting a fair hearing.

19. Who can I contact for more information?

State Health Insurance Assistance Program (SHIP): Contact your local SHIP to learn if you are eligible for cost assistance programs in your state (such as the MSP, Extra Help, and SPAPs) and for assistance with your application. Contact information for your SHIP is on the final page of this document.

Senior Medicare Patrol (SMP): SMPs empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report potential Medicare fraud, errors, and abuse. Your SMP can help you address potential QMB improper billing. Contact information for your SMP is on the final page of this document.

Your local Medicaid office: Contact your local Medicaid office to learn more about MSP and Medicaid eligibility guidelines in your state or to request an application.

Social Security Administration (SSA): Apply for Extra Help through SSA online, in person, or by mail.

Medicare: If you have QMB, contact Medicare at 1-800-MEDICARE (or your Medicare Advantage Plan if you have one) if a provider continually tries to bill you or if you have unpaid cost-sharing bills that were sent to a collections agency.

SHIP case study
Aditi is covered by a Part D prescription drug plan, but her medication copays are too high for her to afford. She is single and has a gross income of $1,230 per month, but she has to spend about $200 per month on the copays for just one of her drugs, in addition to the Part D premium. She has a couple thousand dollars in savings and no other assets.

What should Aditi do?

- Aditi should call her State Health Insurance Assistance Program (SHIP) to seek help lowering her drug costs.
    - If Aditi doesn't know how to find her SHIP, she can call 877-839-2675 and say "Medicare" when prompted or visit www.shiphelp.org.
- The counselor will talk to Aditi about the programs she may be eligible for that will lower her drug and other health care costs.
    - Aditi's income and assets are below the limits for both Extra Help and the Medicare Savings Program. If Aditi enrolls in an MSP, she will be automatically enrolled in Extra Help. The counselor can help Aditi apply for an MSP in her state. Once enrolled in the MSP, Aditi will not have to pay the Medicare Part B premium. With Extra Help, Aditi will not have to pay her Part D premium up to her state's benchmark amount, and she will pay lower copays at the pharmacy.

  - Note: If Aditi's assets had been above the Extra Help limits, it's possible she still could have enrolled in Extra Help, depending on her state. Some states do not have asset limits for the Medicare Savings Program. If Aditi lives in one of those states and qualifies for the MSP based on her income, her MSP enrollment would also automatically enroll her into Extra Help regardless of her assets.
- A SHIP counselor will also let Aditi know if her state has a State Pharmaceutical Assistance Program, and if Aditi is eligible for it. If so, the counselor can tell her how to apply.
- The counselor will also make sure that Aditi knows how her drug plan and her drug costs work.
  - The counselor can make sure that Aditi's drugs are all included on her plan's formulary, or list of covered drugs, and that she is getting her drugs from an in-network pharmacy. They can also talk to Aditi about the different tiers of drug coverage in a Part D plan.
    - If Aditi's drugs are not covered, or are covered with high cost-sharing, the counselor can advise her to speak to her doctor about finding covered drugs or appealing to the plan for a formulary or tiering exception.

SMP case study

Larry recently enrolled in an MSP with the help of his local SHIP. He is now a QMB beneficiary and understands that he should no longer owe any Medicare cost-sharing when seeing Medicare providers. When he next sees his primary care provider, though, he is still charged the usual copay. Larry has a great relationship with his doctor and is too nervous to bring up the topic of improper billing. He is considering just paying the coinsurance.

What should Larry do?

- Larry can contact his local Senior Medicare Patrol (SMP), which helps Medicare beneficiaries (as well as family members and caregivers of those with Medicare) detect and prevent Medicare related errors, fraud, and abuse.
  - If Larry doesn't know how to contact his local SMP, he can visit www.smpresource.org or call 877-808-2468.
- The SMP can empower Larry to bring up this issue to his provider. Not all providers are familiar with QMB protections, so the improper billing could be an honest mistake or error from Larry's provider.
  - The SMP can refer Larry to CMS resources, for example MLN SE1128, which can be useful in showing providers to remind them of QMB billing protections.
  - Also, the SMP may suggest Larry check if his state imposes Medicaid copays for certain Medicare-covered services. If that is the case in his state, Medicare and Medicaid should pay the majority of the cost but there may be a nominal, or small, copay.
  - The SMP can also help Larry show his provider how they may confirm his QMB status, such as from a Medicare Summary Notice (MSN) or in provider Remittance Advices (RAs).
    - Note: Remittance Advices (RAs) are forms that health care providers receive from their Medicare claims processing contractor, notifying them of if their claims were paid in full, partially paid, or denied. Providers may receive their RAs electronically or in paper format. They can use an RA to confirm a beneficiary's QMB status.
- If the provider continues to bill him, the SMP can assist Larry in reporting it as potential abuse to 1-800-MEDICARE and the proper authorities, if appropriate.

- Medicare representatives can refer improper billing cases to the Medicare Administrative Contractors, which will send notices to both the provider and the beneficiary.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: 800-247-4422 **SHIP email:** idahoshiba@doi.idaho.gov **SHIP website:** shiba.idaho.gov **To find a SHIP in another state:** Call 877-839-2675 and say "Medicare" when prompted or visit www.shiphelp.org.	**SMP toll-free:** 800-247-4422 **SMP email:** idahoshiba@doi.idaho.gov **SMP website:** https://aging.idaho.gove/stay-safe/senior-medicare-patrol-fraud-prevention **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

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SHIP Technical Assistance Center: 877-839-2675 | www.shiphelp.org | info@shiptacenter.org
SMP Resource Center: 877-808-2468 | www.smpresource.org | info@smpresource.org