REFERENCE HANDBOOK

SHICK Hotline (800) 860-5260

503 S Kansas Ave.
Topeka, KS 66603
(785) 296-4986
Fax (785) 296-0256
Toll-free (800) 432-3535

This handbook is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

KDADS does not discriminate on the basis of race, color, national origin, sex, age, or handicap. If you feel that you have been discriminated against, you have the right to file a complaint with KDADS, at 1-800-432-3535 or TDD: 785-291-3167 or 1-800-766-3777.

The SHICK Program is funded by a grant from the U.S. Administration for Community Living (ACL), U.S. Department of Health and Human Services (DHHS).

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WELCOME TO SHICK

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Welcome to SHICK

People with Medicare often have questions about health insurance, but all too frequently they have limited resources to obtain objective information. Many need information and assistance regarding their decisions in the following areas:

- What kinds of benefits would suit their needs;
- What type of health insurance coverage they should have;
- How much health insurance coverage they should have;
- How to take advantage of the coverage they already have.

Some people with Medicare have problems such as the following:

- They don't know what to do about rising health insurance premiums;
- They are overwhelmed with claims paperwork, and they don't know what they owe and what they don't owe;
- They can't afford the cost of prescription medications;
- They don't know where to get help with their health insurance problems and other problems.

To help with these needs, Congress created State Health Insurance Assistance Programs (SHIPs). The State Health Insurance Assistance Program, or SHIP, is a state-based program that offers local one-on-one counseling and assistance to people with Medicare and their families. Through CMS funded grants directed to states, SHIPs provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities.

There is a SHIP in every state as well as in Guam, Puerto Rico, the Virgin Islands, and the District of Columbia. **Senior Health Insurance Counseling for Kansas (SHICK)** is the SHIP for Kansas.

What is the Mission of SHICK?

SHICK educates the public and assists consumers on topics related to Medicare and health insurance so they can make informed decisions.

Two Primary Services Support the SHICK Program's Mission:

Information and Education

Consumer education, provided in several ways, reaches a broad section of the population. Consumer education services provide objective information about Medicare A, B, C, & D, Medicare supplement insurance, long-term care insurance, prescription drug assistance, receiving Medicare through managed care plans and other insurance-related topics. Consumers receive information through public forums, presentations to organizations and groups, displays, radio, television, and a variety of printed materials.

One-on-One Counseling

One-on-one confidential sessions with trained counselors focus on specific information or problems. Individual counseling sessions are an effective way to objectively provide information on health insurance coverage, claims assistance, and referrals to appropriate agencies. Individual decision-making and problem-solving are supported at all times.

Administrative and National Policy Requirements

SHIP Minimum Requirements

The State Health Insurance Assistance Program (SHIP) grant is intended to strengthen the capability of States to provide all Medicare eligible individuals information, counseling, and assistance on health insurance matters. The grant from the Administration for Community Living (ACL), U.S. Department of Health and Human Services (DHHS) helps ensure that States have a network of staff and volunteers to provide accurate and objective health insurance information and assistance in making informed health coverage decisions and understanding related rights and protections. Although States have adopted a variety of methods to provide such services to individuals, Section 4360 of the Omnibus Budget Reconciliation Act of 1990 requires that each State program must encompass all of the following activities:

1. Counseling and assistance to eligible individuals in need of health insurance information including:
    a. Information that may assist individuals in obtaining benefits and filing claims under Titles XVIII and XIX of the Social Security Act.
    b. Policy comparison information for Medicare supplemental policies (as described in section 1882(g)(1) of the Social Security Act, as amended) and information that may assist eligible individuals with filing claims under such Medicare supplemental policies.
    c. Information regarding long-term care insurance.
    d. Information regarding Medicaid programs, including Medicare Savings Programs.
    e. Information regarding other types of health insurance benefits that may be provided to eligible individuals in the State.
    f. Information regarding health insurance coverage options created under the Balanced Budget Act of 1997 and subsequent amendments under the Balanced Budget Refinement Act of 1999, the Benefits Improvement and Protection Act of 2000, and the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.
2. Outreach programs, other than one-on-one counseling, to provide health insurance information, counseling, and assistance to eligible individuals.
3. Systems of referral to appropriate Federal or State departments or agencies that provide assistance with problems related to health insurance coverage (including legal problems).
4. Establishing a sufficient number of staff positions (including volunteers) necessary to provide the services of a health insurance information, counseling and assistance program.
5. Assuring that SHIP staff members (including volunteers) have no conflict of interest in providing health insurance information, counseling and assistance, and abiding by the *SHIP Security Plan Guidelines* for safeguarding confidential beneficiary information.
6. Collecting and disseminating timely and accurate health insurance information to staff members (including volunteers).
7. Training programs for staff members (including volunteers).

8. Coordinating the exchange of health insurance information between the staff of departments and agencies of the State government, other pertinent federal agencies including ACL, and SHIP staff (including volunteers).
9. Making recommendations concerning consumer issues and complaints related to the provision of health care to agencies and departments of the State and federal government responsible for providing or regulating health insurance.

Program Services

Guidelines as outlined by our Grant agreement with ACL:

Sec. 1395b-4. b.

(2)

As part of an application for a grant under this section, a State shall submit a plan for a State-wide health insurance information, counseling, and assistance program. Such program shall -

(A)

establish or improve upon a health insurance information, counseling, and assistance program that provides counseling and assistance to eligible individuals in need of health insurance information, including

(i)

information that may assist individuals in obtaining benefits and filing claims under this subchapter and subchapter XIX of this chapter;

(ii)

policy comparison information for Medicare supplemental policies (as described in section 1395ss(g)(1) of this title) and information that may assist individuals in filing claims under such Medicare supplemental policies;

(iii)

information regarding long-term care insurance; and

(iv)

information regarding other types of health insurance benefits that the Secretary determines to be appropriate;

Responsibilities of the State SHICK Office

- Support Sponsoring Organizations in the recruitment of Counselors and Partners.
- Determine criteria for counselor certifications and re-certification.
- Conduct ongoing education for Counselors, Partners, and Coordinators.
- Supply Sponsoring Organization, Coordinator, and Counselors with information resources.
- Refer clients to Sponsoring Organizations.
- Monitor performance of Sponsoring Organizations, Coordinators, and Counselors to ensure the provisions of the *SHICK Minimum Requirements* are met.
- Provide information to the public regarding SHICK, Medicare, and other health insurance issues.
- Market the SHICK program through coordinated efforts with the Sponsoring Organizations.
- Promote the SHICK program on a statewide basis.
- Manage and assist the SHICK Call Centers.

Responsibilities of the SHICK Sponsoring Organization and the SHICK Coordinator

- Appoint a properly qualified Coordinator of Counselor Activities and a backup in case of absence.
- Monitor performance of Coordinator & local counselors to ensure the *SHIP Minimum Requirements* are met.
- Provide expenditure reports to the Kansas Department for Aging and Disability Services for funds awarded pursuant to the Program Agreement with SHICK.
- Recruit Counselors and Partners in the local area.
- Screen volunteers for suitability as SHICK Counselors (e.g. ensure no conflict of interest exists).
- Ensure that Coordinators and Counselors have fulfilled training requirements, are certified by the SHICK program, and are competent to provide counseling services.
- Work with SHICK program staff and other agencies to coordinate presentations and outreach events.
- Collaborate with community organizations to ensure that low-income and hard-to-reach populations have access to SHICK counseling services.
- Provide speakers for public events as requested.
- Host Initial & Update trainings for local Counselors and Partners.
- Receive client telephone calls & assign to Counselors based on the needs of the client.
- Market the SHICK program through coordinated efforts with the State SHICK Office.
- Serve as a clearinghouse for supplies and materials to Counselors and Clients.
- Provide Counselors access to a copy machine, telephone, and computer with Internet at the Sponsoring Organization for the purposes of counseling Clients.

- Maintain frequent communication with Counselors regarding activities and job performance. This includes disseminating updated information necessary for counseling.
- Complete Beneficiary Contact reports and Group and Media reports for each contact or public or media event.
- Enter Beneficiary Contact reports and Group and Media Reports on the National STARS data entry system every month by the last day of the following month.
- Provide a monthly calendar of events to the State SHICK Office.
- Participate in SHICK conference calls or meetings as scheduled (teleconference and/or webinar).
- Attend SHICK Update Training each year. (Required each year to maintain Active Counselor status.)
- Read SHICK listserv messages and disseminate information to Counselors & Partners.
- Ensure that all Volunteers are registered on the STARS data entry system.
- Attend other Special Trainings as announced.

Responsibilities of the SHICK Counselor or SHICK Partner*

- Satisfactorily complete certification training.
- Attend SHICK Update Training each year.
- Read and sign the Memorandum of Understanding each year.
- Provide confidential individual health insurance counseling services without conflict of interest and in compliance with *SHIP Security Plan Guidelines* for safeguarding confidential beneficiary information.
- Provide referrals to appropriate resources.
- Maintain frequent communication with their Coordinator.
- Complete Client Contact reports for each contact and Public and Media reports for each public or media event and complete the online reports on STARS.
- Email/internet access is required.
- Subscribe to SHICK listserv and read listserv messages.
- Provide information to the public regarding Medicare and other health insurance issues as outlined in the *SHIP Minimum Requirements.*

Optional:

- Give public presentations
- Help with Health Fairs & Other Events

*The "SHICK PARTNER" is trained and signs the Memorandum of Understanding just as the Volunteer Counselor does. Other SHIP Minimum Requirements apply as well, though the Partner takes this training for use in his or her job (e.g. social worker, case manager, discharge planner).

KDADS Programs

SHICK is a program of the Kansas Department for Aging and Disability Services under the Aging & Disability Community Services and Programs (A&D CSP) Commission. It is part of the Medicare Grants Division, which encompasses the following three grant programs funded by a grant from the U.S. Administration for Community Living (ACL), U.S. Department of Health and Human Services (DHHS).

SHICK

Senior Health Insurance Counseling for Kansas (SHICK) provides free, unbiased, and confidential assistance to Kansans who have questions about Medicare and related insurance issues. SHICK's trained community counselors provide information and assistance with Medicare issues, Medicare claims and appeals, Medicare Prescription Drug Coverage (Part D), Medicare supplemental insurance (Medigap) policies, long-term care financing and options, and other health insurance issues. SHICK counselors also help eligible consumers access the assistance programs offered by pharmaceutical companies to reduce medication costs.

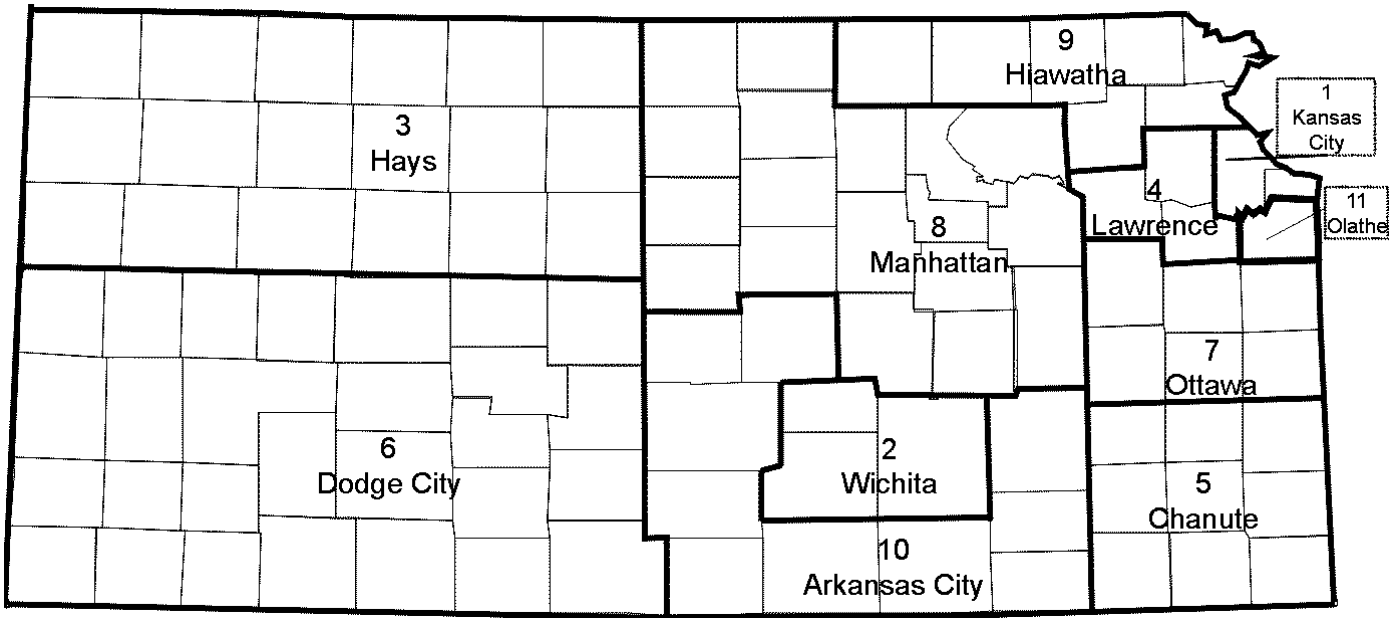
Kansas SMP

The Kansas SMP (Senior Medicare Patrol) project educates Medicare and Medicaid beneficiaries and providers about health care fraud, error, and abuse. Kansas SMP has created a statewide coalition of regulatory agencies, law enforcement officials, and community organizations to help alert the public to potential fraud activities. Trained SMP volunteers provide education, outreach, one-on-one assistance, and problem resolution to beneficiaries, helping them to identify and report health care fraud and abuse.

MIPPA

On July 15, 2008, Congress enacted into law the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Pub. Law 110-275. In 2013, KDADS received a grant to promote outreach and assistance for Medicare beneficiaries eligible for Medicare Part D Extra Help and Medicare Savings Programs. This act also provided funding to promote Medicare Part D counseling and assistance in rural areas, as well as funding to promote preventive services covered by Medicare Part B.

In the state of Kansas in 2015, KDADS contracted with 11 organizations across the state to implement the MIPPA grant, including Area Agencies on Aging, SHICK Sponsoring Organizations, and Adult Disability Resource Centers. These organizations have gone across the state to promote Medicare Part D to rural areas, preventive services, Extra Help, and Medicare savings programs through many venues including health fairs, enrollment events, social media, and media outlets including television and newspapers, as well as providing information to Medicare beneficiaries who come into their office. SHICK trained counselors within these organizations also provide assistance with applications for Medicare Savings Programs and Extra Help.



Area Agencies on Aging

There are 11 Area Agencies on Aging (AAA) in Kansas, each covering a specific geographical area. These agencies coordinate service and programs for persons age 60 and over in each area. The numbers on the above map refer to Area Agencies. Of the 11 AAA's, 10 are SHICK Sponsoring Organizations. Johnson County AAA (11) is not a SHICK sponsoring organization. The SHICK program for Johnson County is coordinated through the East Central Kansas AAA.

SHICK Sponsoring Organizations

Wyandotte/Leavenworth County Area Agency on Aging
913-573-8545 / 1-888-661-1444 / (fax) 913-573-8577
849 N 47th St., Kansas City, Kansas 66102
Counties: Leavenworth, Wyandotte

Sedgwick County Extension & SHICK Call Center
316-660-0100/ ext. 0117 / 316-722-1432 (fax)
7001 W. 21st North, Wichita, KS 67205
County: Butler, Harvey, Sedgwick

Central Plains Area Agency on Aging
316-660-5120 / 800-367-7298 ext. 5132
271 W 3rd St N Suite 500, Wichita 67202
County: Butler, Harvey, Sedgwick

Northwest Kansas Area Agency on Aging
785-628-8204 / 800-432-7422 / 785-628-6096 (fax)
510 West 29th, Suite B, P O Box 610, Hays, KS 67601
Counties: Cheyenne, Decatur, Ellis, Gove, Graham, Logan, Norton, Osborne, Phillips, Rawlins, Rooks, Russell, Sheridan, Sherman, Smith, Thomas, Trego, Wallace

Senior Resource Center for Douglas County
785-842-0543 / 877-295-3277 / 785-842-0562 (fax)
745 Vermont, Lawrence, KS 66044
County: Douglas

Jayhawk Area Agency on Aging
785-235-1367 / 800-798-1366 (outside Topeka) / 785-354-5346(fax)
2910 SW Topeka Boulevard, Topeka, KS 66611
County: Jefferson, Shawnee

Southeast Kansas Area Agency on Aging
620-431-2980 / 800-794-2440 / 620-431-2988 (fax)
1 West Ash, P. O. Box J, Chanute, KS 66720
County: Allen, Bourbon, Cherokee, Crawford, Labette, Montgomery, Neosho, Wilson, Woodson

Southwest Kansas Area Agency on Aging
620-225-8230 / 800-742-9531 / 620-225-8240 (fax)
236 San Jose Dr., P. O. Box 1636, Dodge City, KS 67801
County: Barber, Barton, Clark, Comanche, Edwards, Finney, Ford, Grant, Gray, Greeley, Hamilton, Haskell, Hodgeman, Kearny, Kiowa, Lane, Meade, Morton, Ness, Pawnee, Pratt, Rush, Scott, Seward, Stevens, Stafford, Stanton, Wichita

East Central Kansas Area Agency on Aging
785-242-7200 / 800-633-5621 / 785-242-7202 (fax)
117 South Main, Ottawa, KS 66067
County: Anderson, Coffey, Franklin, Johnson, Linn, Miami, Osage

North Central Flint Hills Area Agency on Aging
785-776-9294 / 800-432-2703 / 785-776-9479 (fax)
401 Houston, Manhattan, KS 66502
County: Chase, Clay, Cloud, Dickinson, Ellsworth, Geary, Jewell, Lincoln, Lyon, Marion, Mitchell, Morris, Ottawa, Pottawatomie, Republic, Riley, Saline, Wabaunsee

Northeast Kansas Area Agency on Aging
785-742-7152 / 800-883-2549 / 785-742-7154 (fax)
1803 Oregon, Hiawatha, KS 66434
County: Atchison, Brown, Doniphan, Jackson, Marshall, Nemaha, Washington

South Central Kansas Area Agency on Aging
620-442-0268 / 800-362-0264 / 620-442-0296 (fax)
P. O. Box 1122, 304 S Summit, Arkansas City, KS 67005
County: Rice, McPherson, Reno, Kingman, Harper, Sumner, Cowley, Chautauqua, Elk, Greenwood

TOLL-FREE HOTLINE: 1-800-860-5260

SHICK WEB SITE

http://www.kdads.ks.gov/shick

How to Find SHIPs Outside the state of Kansas

- **Call 1-800-MEDICARE - (1-800-633-4227)**
- **Ask the SHICK Call Center Operator at 1-800-860-5260**
- **Go to:** https://www.shiptacenter.org/
  - **Under "Find a State SHIP", click on the box "Select a State"**
    - **Select the preferred state**
    - **Click on the Go button**
    - **The state's SHIP Profile page will open**

Privacy Practices and Conflict of Interest

All SHICK counselors are required to complete annual training in Privacy practices and conflict of interest. This training is provided during the 24-hour Initial Training or Annual Update training.

Definitions:

Privacy- According to Merriam-Webster Dictionary - 1 a**:** the quality or state of being apart from company or observation**: seclusion b:** freedom from unauthorized intrusion <one's right to *privacy*> 15th Century

Confidential- According to Merriam-Webster Dictionary - 1**:** marked by intimacy or willingness to **confide** <a *confidential* tone> 2**: private**, **secret** <*confidential* information> 3**:** entrusted with **confidences** <a *confidential* clerk> 4**:** containing information whose unauthorized disclosure could be prejudicial to the national interest - 1759

Gossip- According to Merriam-Webster Dictionary - 1 a *dialect British*: **godparent b: companion**, **crony c:** a person who habitually reveals personal or sensational facts about others 2 a**:** rumor or report of an intimate nature **b:** a chatty talk **c:** the subject matter of gossip – Before the 12th Century

Your Health Information Is Protected by Federal Law

Most of us believe that our medical and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Understanding HIPAA Privacy

HIPAA- Health Insurance Portability and Accountability Act – 1996

According to HHS (Health & Human Services) - The Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

Why the HIPAA Privacy Rule is needed

In enacting HIPAA, Congress mandated the establishment of Federal standards for the privacy of individually identifiable health information. When it comes to personal information that moves across hospitals, doctors' offices, insurers or third party payers, and State lines, our country has relied on a patchwork of Federal and State laws. Under the patchwork of laws existing prior to adoption of HIPAA and the Privacy Rule, personal health information could be distributed—without either notice or authorization—for reasons that had nothing to do with a patient's medical treatment or health care reimbursement. For example, unless otherwise forbidden by State or local law, without the Privacy Rule patient information held by a health plan could, without the patient's permission, be passed on to a lender who could then deny the patient's application for a home mortgage or a credit card, or to an employer who could use it in personnel decisions. The Privacy Rule establishes a Federal floor of safeguards to protect the confidentiality of medical information. State laws which provide stronger privacy protections will continue to apply over and above the Federal privacy standards.

Health care providers have a strong tradition of safeguarding private health information. However, in today's world, the old system of paper records in locked filing cabinets is not enough. With information

broadly held and transmitted electronically, the Rule provides clear standards for the protection of personal health information.

Who Must Follow the HIPAA Privacy Rule

We call the entities that must follow the Privacy Rule "***covered entities***." Individuals, organizations, and agencies that met the definition of a covered entity under HIPAA must comply with the Privacy Rule's requirements to protect the privacy of health information and must provide individuals with certain rights with respect to their health information. If an entity is not a covered entity, it does not have to comply with the Privacy Rule.

Covered entities include:

- **Health Plans**, including health insurance companies, HMOs, company health plans, and certain government programs that pay for health care, such as Medicare and Medicaid.
- **Most Health Care Providers**—those that conduct certain business electronically, such as electronically billing your health insurance—including most doctors, clinics, hospitals, psychologists, chiropractors, nursing homes, pharmacies, and dentists.
- **Health Care Clearinghouses**—entities that process nonstandard health information they receive from another entity into a standard (i.e., standard electronic format or data content), or vice versa.

Who Is Not Required to Follow This Law

Many organizations that have health information about you do not have to follow this law**.**

Examples of organizations that do not have to follow the Privacy Rule include:

- life insurers,
- employers,
- workers compensation carriers,
- many schools and school districts,
- many state agencies like child protective service agencies,
- many law enforcement agencies,
- many municipal offices.

What Information Is Protected

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow this law

How Is This Information Protected

- Covered entities must put in place safeguards to protect your health information.
- Covered entities must reasonably limit uses and disclosures to the minimum necessary to accomplish their intended purpose.
- Covered entities must have contracts in place with their contractors and others ensuring that they use and disclose your health information properly and safeguard it appropriately.

- Covered entities must have procedures in place to limit who can view and access your health information as well as implement training programs for employees about how to protect your health information.

What Rights Does This Law Give Me over My Health Information

Health Insurers and Providers who are covered entities must comply with your right to:

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can
    - File a complaint with your provider or health insurer
    - File a complaint with the U.S. Government

You should get to know these important rights, which help you protect your health information. You can ask your provider or health insurer questions about your rights.

Who Can Look at and Receive Your Health Information

The law sets rules and limits on who can look at and receive your health information

To make sure that your health information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and to help run their businesses
- With your family, relatives, friends, or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health, such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer
- Use or share your information for marketing or advertising purposes
- Share private notes about your health care

Is SHICK a covered entity?

The Kansas Department on Aging and Disability Services is a Hybrid Entity, a single legal entity where only some of the divisions or programs meet the definition of a Covered Entity,

Although SHICK is part of that Hybrid Entity, SHICK is not considered a covered entity. More information will be forthcoming.

Protecting Beneficiary Privacy

As a SHICK counselor, you will have access to beneficiaries' health information as well as personal identifying information like Medicare numbers and Social Security Numbers. You must handle this information carefully and keep it confidential to protect beneficiaries from fraud, identity theft, health-based discrimination, and other potential problems.

- Only collect the information you need to provide the help the beneficiary has asked for (for example, you don't need a list of medications to help someone enroll in a Medigap plan).
- Only share beneficiary information with people or agencies who are directly involved in providing the help the beneficiary has asked for (like a Part D plan, for example).
- Don't keep beneficiary information on a laptop or in a file that you take out of the office with you.
- Don't leave beneficiary information out on a desk or up on a computer screen where it can be seen by others.
- Conduct counseling sessions in private where personal information shared by the beneficiary won't be overheard by others.
- If you believe beneficiary information has been lost, stolen, or misused, contact your SHICK Coordinator immediately.
- If you believe a beneficiary has been the victim of fraud or identity theft, contact your SHICK Coordinator and/or the Kansas SMP Coordinator immediately.

Conflict of Interest

Conflict of Interest Definition – According to Merriam-Webster Dictionary**:** a conflict between the private interests and the official responsibilities of a person in a position of trust - 1843

SHICK adopted the following rule regarding financial conflict of interest for SHICK volunteer counselors and partners.

Adopted rule: Determination of when a financial conflict of interest exists between the responsibilities of a SHICK Volunteer Counselor and the business interests of that volunteer.

When screening potential SHICK Volunteer Counselors, Volunteer Coordinators should make a determination as to whether applicants have a financial conflict of interest. Obviously, anyone who is currently associated with the insurance industry in any financial capacity is strictly prohibited from being a SHICK volunteer counselor by law. As well, all individuals who could, even remotely, use their position as a SHICK Counselor as an avenue to solicit business from seniors are prohibited from becoming a SHICK Volunteer.

If a situation arises where it is unclear to a SHICK Coordinator whether a financial conflict of interest exists, the Coordinator should forward a request to the SHICK Director for a determination of whether such a conflict of interest exists. All final decisions remain with the Director.

No volunteer applicant shall take any SHICK training until the Coordinator or Director has determined that no financial conflict of interest exists.

People who have positions with agencies and other organizations who serve older people are not excluded from being a SHICK volunteer as long as they do not use their position to solicit business of any kind from Medicare beneficiaries.

The purpose of this rule is to ensure that volunteers do not have any financial conflicts of interest between their personal business interests and their responsibilities as a counselor which might compromise their responsibility to provide unbiased information to Medicare beneficiaries.

Revised and Approved October 14, 1997

Conflict of Interest - Counselors

SHICK counselors are trusted resources for Medicare beneficiaries. To maintain that trust, counselors cannot be allowed to profit in any way from their contacts with beneficiaries. SHICK has adopted several rules to ensure that no volunteer has a conflict of interest that would prevent him or her from providing unbiased counseling.

- Anyone who is currently associated with the insurance industry is prohibited from being a SHICK volunteer counselor.
- Anyone who could use their position as a SHICK counselor to solicit business from beneficiaries is prohibited from being a SHICK volunteer.
- If a SHICK Coordinator is unclear about whether a conflict of interest exists, the Coordinator should request a ruling from the SHICK Director.
- Potential volunteers cannot take SHICK training until the Coordinator or Director has determined that no conflict of interest exists.
- People who work for organizations that serve Medicare beneficiaries may be SHICK volunteers as long as they do not use their position to solicit business of any kind.

Chapter 2
MEDICARE OVERVIEW

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MEDICARE OVERVIEW

Medicare is a federal health insurance program which began in 1965. States are not involved in the program's administration. In general, the rules governing Medicare's operation are the same nationwide, though more detailed rules sometimes apply in specific states or regions and payments rates often vary from one region to another. Still, the program is virtually the same throughout the country.

Medicare is not free for the people, called beneficiaries, who benefit from the program. Congress designed Medicare so beneficiaries would share the total cost of health care with the federal government through:

- Premiums
- Deductibles
- Coinsurance charges, and
- Payment for non-covered (excluded) services and items

Eligibility for Medicare is available to three groups: those who are 65 and older, people with disabilities, and people with end-stage renal disease (ESRD). Medicare eligibility is open to people regardless of income. Eligibility is not based on financial need. In that respect, Medicare differs greatly from Medicaid, the state-sponsored health insurance program for low-income older Americans and others. Instead, Medicare is tied largely to employment. The financing for Medicare Part A's Hospital Insurance benefits, for example, derives from a FICA withholding tax applied to wages.

Medicare has a fairly comprehensive set of covered benefits. It also offers a number of service delivery options. Beneficiaries have the option to receive services through the "Original Medicare" program (Medicare Parts A and B, also called "Traditional Medicare") or through a variety of privately sponsored "Medicare Advantage" plans. Regardless of the choice they make between these options, beneficiaries have coverage for the Part A benefits that include inpatient hospital, skilled nursing facility, home health, and hospice care services. They also have coverage for Medicare Part B's benefits that include physician, outpatient hospital, home health, ambulance, and preventive services, along with medical equipment, supplies, and many other services and items.

The Medicare Advantage program is another name for Medicare Part C. Congress enacted Part C in 1998, and through it, set up several different systems for delivering Medicare-covered benefits and services through private contractors. These contractors, called "health plan sponsors" or Medicare Advantage Organizations (MAOs), offer Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private-Fee-for-Service (PFFS) plans, and more, to Medicare beneficiaries. These private plans must cover the same services and benefits that are available through the Original Medicare program.

In 2003, Congress enacted the Medicare Modernization Act (MMA) and created the Medicare Part D prescription drug program. From the start, the Original Medicare program did not cover most outpatient prescription drugs. Medicare Part D addresses this shortcoming by delivering drug coverage through privately-sponsored prescription drug plans (PDPs) and Medicare Advantage plans with Part D drug coverage (MA-PDs). The Part D program also offers assistance for low-income Medicare beneficiaries through a low-income subsidy (LIS), or "Extra Help" program.

Medicare covers health care services only when they meet Medicare's definitions for medical necessity. With some exceptions, a service must be "reasonable and necessary in the diagnosis or treatment of an illness or injury" in order to qualify for Medicare payments. Nonetheless, Congress has added a number of health care screening and preventive care services to Medicare's covered benefits since 1990.

Regardless of medical necessity, Medicare specifically excludes some services and items from its covered benefits. Medicare's exclusions include:

- Most care received outside the United States (with exceptions for emergencies along the Canadian and Mexican borders)
- Custodial care, including most long-term nursing home care
- Hearing aids
- Routine dental care
- Routine eye care
- Routine foot care
- Eyeglasses (except in connection with cataract surgery)
- Dentures
- Acupuncture and homeopathic care
- Cosmetic surgery (except in connection with an illness or injury)
- Private duty nursing

Who Runs Medicare?

Medicare's administration is the combined work of federal agencies and contractors. Here are brief descriptions of the main actors:

The Centers for Medicare & Medicaid Services (CMS)

CMS is the federal agency that administers Medicare and Medicaid. Its headquarters are in Baltimore, with Regional Offices (ROs) in 10 cities around the country. It is the largest agency within the Department of Health & Human Services (HHS). CMS contracts with many private companies that handle aspects of Medicare's program operations including claims processing, monitoring the quality of care for patients, handling complaints, and reviewing appeals.

1-800-MEDICARE: CMS offers the agency's nationwide, toll-free, Medicare beneficiary Service Center. The Service Center is set up to answer questions about billing and claims, to provide information on Medicare health plans, to receive complaints, and to order publications. Customer service representatives are available 24 hours a day, seven days a week.

The Social Security Administration (SSA)

SSA handles Medicare eligibility and enrollment for Social Security recipients. SSA sends enrollment packets and Medicare cards to new Medicare beneficiaries. It also processes applications for Medicare Part D's low-income subsidy (LIS) program. The Railroad Retirement Board's (RRB) role is similar to SSA's. It handles Medicare eligibility and enrollment for Railroad Retirees.

Social Security replaces lost and damaged Medicare cards free of charge. Refer clients to SSA's toll-free phone number, 1-800-772-1213, or to their My Social Security account. SSA takes about 30 days to replace a Medicare card. Railroad retirees should call the RRB at 1-800-808-0772.

The agency's role in Medicare is limited mainly to eligibility and enrollment issues, including enrollment in the program that provides "Extra Help" in paying for prescription drugs for those with limited incomes.

The Office of Medicare Hearings and Appeals (OMHA)

OMHA is a separate agency within the federal Department of Health and Human Services (HHS). It employs Administrative Law Judges (ALJ) to provide hearings in the Medicare appeals process.

CMS' mission is to ensure health care security for beneficiaries.

Original Medicare's payment contractors currently include:

- **A/B Medicare Administrative Contractors (A/B MACs)** who contract with CMS to process Part A claims for hospitals and skilled nursing facilities and Part B claims for hospital outpatient services, physicians, ambulance providers, and others in a multi-state/territory region.
- **Home Health and Hospice Medicare Administrative Contractors (HH MACs)** who contract with CMS to process claims for home health agencies and hospice organizations in four multi-state regions.
- **DME Medicare Administrative Contractors (DME MACs)** who contract with CMS to process Part B claims for durable medical equipment (DME) and supplies, including Part B drugs, in four multi-state regions. CMS has phased out the former Durable Medical Equipment Regional Carriers (DMERCs).

CMS also contracts with private companies to investigate quality of care complaints and to review coverage and payment decisions at certain points in the Medicare appeals process. These contractors include:

- **Quality Improvement Organizations (QIOs)** who contract with CMS to investigate complaints about poor care, review hospital discharge decisions, and handle expedited review requests for skilled nursing facility and home health service terminations. QIOs also work with providers on quality of care improvement projects. In 2014, CMS redesigned its QIO Program to further enhance the quality of services for Medicare beneficiaries. The new program structure maximizes learning and collaboration in improving care, enhances flexibility, supports the spread of effective new practices and models of care, helps achieve the priorities of the National Quality Strategy and the goals of the CMS Quality Strategy, and delivers program value to beneficiaries, patients, and taxpayers.
    - The QIO Program changes include separating case review from quality improvement, extending the contract period of performance from three (3) to five (5) years, removing requirements to restrict QIO activity to a single entity in each state/ territory, and opening contractor consideration to a broad range of entities to perform the work.
    - Now, one group of QIOs will handle complaints while another group will provide technical assistance to support providers and suppliers. QIOs will have new skills for transforming practices, employing lean methodologies, assisting with value based purchasing programs and developing innovative approaches to quality improvement.
    - See http://www.cms.hhs.gov/QualityImprovementOrgs/ .
- **Qualified Independent Contractors (QICs)** who contract with CMS to review coverage denials in the second stage of the Original Medicare appeals process called "reconsideration." QICs handle Part A reconsiderations for east and west regions, Part B reconsiderations for north and south regions, and DME reconsiderations for all the states and territories. See http://www.cms.hhs.gov/OrgMedFFSAppeals.

Sources of Medicare Eligibility, Coverage, and Payment Rules

Congress enacts the Medicare statutes in which the lawmakers broadly define Medicare's terms and its scope of benefits. CMS, the federal Medicare agency, issues federal regulations, policy manuals, and other guidance documents that interpret the Medicare statute and gives details about CMS's coverage and payment rules.

- The Medicare Statutes, known as Title XVIII of the Social Security Act and codified at 42 United States Code (USC) Section 1395, were enacted and are often amended by Congress.
- The Medicare Regulations are found at 42 Code of Federal Regulations (CFR), Parts 400-429. CMS publishes proposed regulations in the Federal Register and seeks public comment before finalizing the regulations that eventually appear in the Code of Federal Regulations.
- The Medicare Policy Manuals appear on-line at CMS's website at http://www.cms.hhs.gov/Manuals/IOM/list.asp . The "Internet Only Manuals" contain CMS's interpretation of the Medicare statute and regulations. They also include "Medicare National Coverage Determinations" that guide Medicare coverage decisions throughout the country on certain services, procedures, and devices.
- Medicare Program Transmittals, available at http://www.cms.hhs.gov/Transmittals/ are sent by CMS to its contractors to put new or revised policies into action.
- Local Coverage Determinations that Medicare's payment contractors create to clarify payment policy on some Medicare coverage issues.

Eligibility and Enrollment

Eligibility in General

Congress conceived Medicare as a health insurance program for workers who are no longer able to work due to age or disability. Hence close ties exist between Medicare eligibility and eligibility for Social Security benefits. Note, however, that Medicare coverage is available for some individuals who otherwise do not qualify for Social Security retirement payments.

Three groups of people are eligible for Medicare benefits. Those who benefit from the program are called beneficiaries. The three eligibility groups include:

- People 65 and older
- People with disabilities who have been receiving Social Security or Railroad Disability payments for 24 months, except for persons with Lou Gehrig's disease (ALS)—they are eligible for Medicare in the sixth month of disability.
- People with end-stage renal disease (ESRD), that is, kidney disease that requires dialysis or transplant.

Most of those who are eligible for Medicare are entitled to benefits because they paid into the Medicare hospital insurance trust fund through FICA payroll deductions at work. But a work record in the United States is not required for people 65 and older. Citizens of the U.S. who are 65 and older and did not pay long enough into Medicare trust fund, as well as permanent resident non-citizens aged 65 and older who have lived in the United States for five years prior to applying for Medicare, are eligible for Medicare benefits. They must, however, pay monthly premiums for both Medicare Part A and Part B benefits.

Enrollment in General

The Social Security Administration (SSA) and Railroad Retirement Board (RRB) for railroad retirees determine eligibility for those entitled to Medicare benefits and handle enrollment. SSA uses both automatic and voluntary enrollment procedures. Many people are enrolled automatically in Medicare. Others must apply for Medicare coverage at a Social Security office or online. Note that some enrollment rules differ for Part A and Part B, including rules for some people who work beyond age 65.

SSA and RRB issue Medicare cards to enrolled beneficiaries. For more information about Medicare eligibility and enrollment, contact:

- The SSA at 1-800-772-1213, or go to http://www.ssa.gov.
- The RRB at 1-800-808-0772, or go to http://www.rrb.gov.

Eligibility and Enrollment for Medicare Part A

Persons Entitled to Retirement Benefits

Even though the age for full Social Security retirement benefits is later than age 65 for persons born after 1938, Medicare eligibility is still at age 65. Most people 65 and older are entitled to Part A benefits because they or a spouse have 40 credits (formerly "quarters of coverage") in Social Security-covered employment. Those who choose to receive Social Security or railroad retirement benefits at age 65 or earlier do not need to apply separately for Medicare. Social Security enrolls them automatically in Medicare Part A. About 99 percent of Medicare beneficiaries do not pay a premium for Medicare Part A benefits. For more information on quarters of coverage, visit SSA's website at http://www.ssa.gov/OACT/COLA/QC.html.

Those who wait past age 65 to apply for their monthly Social Security or railroad retirement benefit payments can apply for Medicare benefits at a Social Security office or online through http://www.ssa.gov/. They can apply for premium-free Part A anytime during the year. Their Part A benefits can take effect retroactively, up to six months before they applied.

People with Disabilities or ESRD

People of any age with disabilities who are entitled to Social Security or Railroad disability benefits for 24 months are also entitled to Medicare Part A without paying a premium. Their Medicare benefits start in the 25th month of receiving disability benefit payments.

People of any age who have end-stage renal disease (ESRD) and have had a kidney transplant or have received dialysis for three months are entitled to Medicare Part A benefits. People with ESRD must contact Social Security to apply for Medicare.

An exception to the 24-month disability waiting period applies to people who have Lou Gehrig's disease (amyotrophic lateral sclerosis, ALS). The law waives the waiting period. Because Social Security disability payments start after five months of the onset of a disability, Medicare coverage takes effect on the first day of the sixth month of the ALS disability.

Voluntary Enrollment in Medicare Part A

Those not entitled to Medicare through employment can enroll in Medicare voluntarily. This group includes certain people with disabilities and certain people aged 65 and older who do not have enough work credits to qualify for premium-free Medicare. They must, however, be willing to pay monthly premiums for the benefits. Seniors and people with disabilities who have fewer than 40 credits in Social

Security-covered employment must pay a monthly premium for Part A benefits. The Medicare premium amount for the current year can be found in the Appendix. A late enrollment penalty may apply for those who enroll a year or more after their 65th birthday. Voluntary enrollees have three time frames to enroll in the Part A program, just as with Medicare Part B.

Eligibility and Enrollment for Medicare Part B

Persons eligible for Part B

Those who are eligible for Part A benefits also are eligible for Medicare Part B. In addition, persons aged 65 and older who are U.S. citizens or permanent resident non-citizens for five years who are not entitled to Part A through Social Security-covered employment can enroll in Part B without enrolling in Part A.

Enrollment Periods

People who are eligible for Medicare Part B benefits must enroll in the program during an enrollment period. Original Medicare has three distinct enrollment periods. Note that Original Medicare does not have the six-week Annual Enrollment Period (October 15 to December 7) that exists for Medicare drug plans (Part D) and Medicare Advantage plans (Part C).

Initial Enrollment Period (IEP)

The IEP is a seven-month time frame that includes the three months before and after the month of a person's 65th birthday.

- If a person enrolls (or is automatically enrolled) in Medicare during the first three months of the initial enrollment period, Medicare coverage starts on the first day of the month in which the person turns 65 (unless their birthday is on the 1st of the month, when their Medicare eligibility begins on the 1st of the month prior to their birthday month).
- If a person enrolls in the month of her 65th birthday, coverage starts on the first day of the next month.
- If a person enrolls in the fifth month of the IEP, coverage will start two months after enrollment.
- If a person enrolls in the sixth or seventh month of the IEP, coverage will start three months after enrollment.

General Enrollment Period

The General Enrollment Period is a three-month time frame at the beginning of each calendar year (January-March) during which a beneficiary who did not enroll during an initial enrollment period can enroll in Medicare Premium Part A and Part B.

- Coverage for Premium Part A and/or Part B takes effect on July 1.
- Premium penalties apply for those who enroll more than 12 months following their initial eligibility date.
- Part A Penalty: 10% premium surcharge for twice the number of years you could have had Part A, but didn't sign up.
- Part B Penalty: 10% premium surcharge for each 12-month period that had passed when a person could have been, but was not, enrolled in Part B.
    - Note that beneficiaries under the age of 65 currently paying this premium penalty will not have to pay that penalty upon turning 65.

- Currently there is no cap on the penalty amount. For example, beneficiaries could be responsible for paying anywhere from 10% (1-year delay) to 300% (25-year delay) depending on how long they delayed enrolling.

Special Enrollment Period

The law requires employers with 20 or more employees to offer the same health coverage that it makes available to younger employees. In other words, these employers cannot force an older worker to get her health insurance through Medicare. Those who work beyond age 65 (the working aged) for employers with 20 or more employees, and who have continued health insurance coverage through an employer group health plan have an eight-month time frame to enroll in Medicare. The SEP starts in the month when a retiree is no longer working and her employee group coverage ends.

- Coverage takes effect on the first day of the month following enrollment.
- No penalties apply for late enrollment.
- A Special Enrollment Period is also available to spouses of the working aged.
- The Special Enrollment Period does not apply to those who continue their group plan coverage through COBRA rights and stopped working more than seven months ago.

Enrollment Procedures

Enrolling in Medicare Part B is optional. A person who enrolls in Medicare Part A is also enrolled in Part B unless they opt out of Part B.

- Most people do not opt out of Part B because they need the coverage.
- Social Security sends an enrollment packet that contains the red, white, and blue Medicare card.
- For automatic enrollees, Social Security enrolls them in both Part A and Part B, unless the beneficiary signs and returns an official post-card or other written statement to SSA in which they opt out of Part B coverage.
- The working aged (and their spouses) with employer group coverage can enroll in Part A (because they are entitled to it without premiums) and opt out of Part B. Part A Hospital Insurance pays second to the employer group plan. These beneficiaries can enroll in Part B later (as described above).
- Part B Premium - The standard Part B premium for the current year is listed in the appendix. However, the Hold Harmless rule that ensures that Social Security checks will not decline from one year to the next because of increases in Medicare Part B premiums. In some years, if there is no cost of living increase in the Social Security benefit, Medicare beneficiaries who had their Medicare Part B premium deducted from their Social Security or Railroad Retirement pensions will not have an increase in their Part B premium and will continue to pay the same premium in the next year. Some low-income persons may qualify for state assistance in paying the Part B premium through Medicaid or the Medicare Savings Programs.
- IRMAA - the law requires Medicare beneficiaries who have higher incomes to pay the monthly Part B premium along with an income-related adjustment to the premium. The income adjustment applies to beneficiaries who file individual tax returns and to beneficiaries who file a joint tax return, and have modified adjusted gross annual income above a certain amount. The monthly premium adjustment amounts for each level can be found in the *Medicare Premium and Cost-Sharing Amounts* in the appendix.

Medicare Cards and Numbers

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 required CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) replaced the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

Between April 1, 2018 and April 1, 2019, CMS removed Social Security numbers from Medicare cards and mailed each person a new card. This helps keep people's information more secure and helps protect their identity.

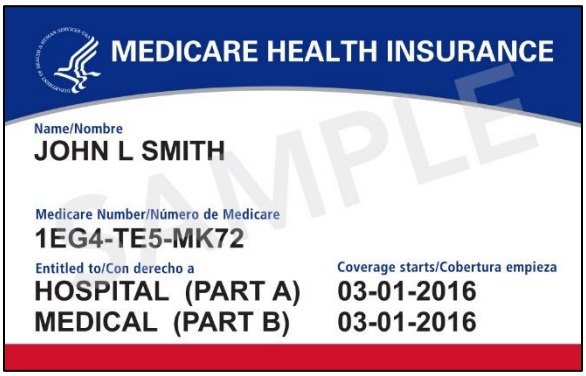
The Medicare Number is unique and will only be used for Medicare coverage. The new number doesn't change coverage or benefits.

The new cards no longer include gender or a signature line. They are also smaller, the size of a standard credit card to fit in wallets easier and can be laminated.

The MBI is:

- Clearly different than the HICN and RRB number
- 11-characters in length
- Made up only of numbers and uppercase letters (no special characters)

Each MBI is unique, randomly generated, and the characters are "non-intelligent," which means they don't have any hidden or special meaning. MBI format specifications can be found in Chapter 14 – Appendix page 14-16.



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Chapter 3
MEDICARE PART A

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MEDICARE PART A

Medicare Part A has four main benefits:

- Inpatient Hospital Care (including rehabilitation hospital and psychiatric hospital care)
- Skilled Nursing Facility Care
- Home Health Care
- Hospice Care

Part A providers submit payment claims for their services to a Medicare claims contractor. Depending on the type of provider, they send claims to a Part A and Part B Medicare Administrative Contractor (A/B MAC), or a Home Health and Hospice Medicare Administrative Contractor (HH MAC). Afterwards, the claims contractor sends a *Medicare Summary Notice* to the patient that explains the coverage decision and the patient's share of the costs.

Part A providers have one calendar year from the date of service to submit claims to Medicare. Medicare Advantage plans may have different time frames.

Inpatient Hospital Coverage

Acute Care Hospitals

Medicare will pay for acute care hospital stays only when the services can be provided on an inpatient basis in a hospital. Hospital staff, including the internal Utilization Review (UR) Committee, reviews a patient's stay considering Medicare's coverage rules to decide if hospitalization admission is "reasonable and necessary," or if a patient's condition justifies an ongoing hospital stay. Hospital staff will assess if a patient can move safely to a lower level of care.

Medicare's inpatient hospital benefit covers:

- Semi-private room (Medicare covers the cost of private rooms when they are medically necessary)
- Regular nursing services (but not private duty nursing)
- Drugs, supplies, and equipment
- Physical therapy
- Medical social services
- Medical services provided by interns or residents

> Medicare Part A generally does not cover the services that surgeons, anesthesiologists, or other physicians provide in the hospital. Physicians bill separately for their services and submit claims to Medicare Part B. When helping clients sort through their paperwork following a hospital stay, keep this difference in mind.

Medicare excludes some services from its inpatient hospital coverage.

Services <u>Not</u> Covered During Hospital Stays

- Physician services (covered by Medicare Part B)
- Personal convenience items such as television, radio, and telephone if billed separately
- Private duty nurse
- Extra charges for private room unless required for medical reasons
- First three pints of blood
- Care received outside the United States.
    - Exceptions: The following very limited situations involving qualified Canadian or Mexican hospitals are covered.

- The beneficiary is in the U.S. when an **emergency** occurs and Canadian or a Mexican hospital is closer than the nearest U.S. hospital which could provide needed emergency care.
- The beneficiary lives in the U.S. and a Canadian or Mexican hospital is closer to his or her home than the nearest U.S. hospital, regardless of whether an emergency exists.
- The beneficiary is in Canada traveling the most direct route to or from Alaska and a lower-48 state, and an emergency occurs that requires admittance to a Canadian hospital. Medicare *will **not*** pay for emergency situations in Canada while traveling as a tourist.

Covered Days and Costs for Inpatient Hospital Services

Medicare covers up to 150 days of inpatient hospital care within a benefit period as long as the covered days are medically necessary. With the start of each new benefit period, a Medicare patient has 90 renewable covered days. Medicare patients also have 60 non-renewable "lifetime reserve days."

A benefit period, also called a "spell of illness," starts on the first day that a Medicare patient enters a hospital and ends when the person has not received inpatient hospital or skilled nursing facility levels of care for 60 days in a row. The number of covered days remaining for a patient depends on the continuation—or end—of the benefit period (see examples below).

The costs that beneficiaries owe for inpatient hospital stays relate to the number of covered inpatient hospital days that they use in a benefit period. Part A's cost-sharing charges include a first-day deductible for inpatient hospital services and coinsurance charges that apply to some hospital stays.

- Part A Deductible and Days 1 to 60: At the start of a hospital stay in a new benefit period, the patient owes a deductible. After a patient meets the deductible, Medicare covers in full the first 60 inpatient hospital days in the benefit period. The Part A deductible is ***not*** an annual deductible. Clients who have a series of hospital stays could multiple Part A deductibles in a calendar year if more than 60 days separate their repeated hospital stays.
- Coinsurance for Days 61 to 90: Patients owe a daily copay (1/4 of the Part A deductible) when they use days 61 through 90 in a benefit period. Medicare covers the balance of the hospital bill.
- Coinsurance for Days 91 to 150: Patients owe a daily copay (1/2 of the Part A deductible) when they use these "lifetime reserve days." Medicare covers the balance of the hospital bill.
- Day 151 and Beyond: If the hospital stay continues beyond Medicare's 150 covered hospital days in a benefit period, the patient is responsible for the entire hospital bill. But if the patient leaves the hospital for 60 days in a row and ends the benefit period, they have a new set of 90 covered hospital days if they enter the hospital again.

Medicare Part A and Part B have separate patient cost-sharing systems.[1] Part A's deductible is tied to the benefit period. Part B has an annual deductible. While many beneficiaries are familiar with Part B's costs, they may not know as much about Part A. What are the origins of the two deductibles? Congress patterned Part A and Part B on the Blue Cross (hospital) and Blue Shield (medical) plans of the early 1960's.

The fact that a person may owe more than one Part A deductible during the year may surprise some beneficiaries who often expect an annual deductible.

[1] Annual cost-sharing amounts are available in the appendix under *Annual Medicare Premium and Cost-Sharing Amounts*.

Inpatient Rehabilitation Facility (IRF)

Inpatient rehabilitation facilities, or rehabilitation hospitals, specialize in providing post-acute rehabilitative care for injured, disabled, or sick persons, including those who have had strokes, joint replacements, and injuries. Medicare treats rehabilitation hospital stays the same as acute care hospital stays for purposes of the Part A benefit period. The number of days spent in a rehabilitation hospital count toward the 150 Medicare-covered inpatient hospital days in a benefit period. Medicare covers rehabilitation hospital stays if:

- A physician certifies the need for the care;
- The patient needs a relatively intense, multi-disciplinary rehabilitation program;
- A team that includes speech therapists, physical therapists and/or occupational therapists, and rehabilitation nurses working under the supervision of a physician specializing in rehabilitation medicine provides the care; and
- The patient is progressing toward the goal of functioning as independently as possible.

Long-Term Care Hospitals (LTCHs)

Since 1999, Medicare has certified some facilities to operate as long-term care hospitals (LTCHs). Their average inpatient length of stay must be 25 days or longer. These hospitals typically provide post-acute extended medical and rehabilitative care for patients whose conditions are complex and who may have more than one acute or chronic condition. They provide services such as rehabilitation, respiratory therapy, cancer treatment, head trauma care, and pain management.

For purposes of covered days in a benefit period, Medicare treats LTCHs the same as acute care and rehabilitation hospitals. The number of days spent in a LTCH count toward Medicare's 150 covered inpatient hospital days in a benefit period. Where they exist, LTCHs provide an alternative to skilled nursing facilities for some patients.

Psychiatric Hospitals

Medicare covers inpatient psychiatric hospital stays when a physician determines that the patient, at the time of admission, needs and will benefit from the hospital stay. For Medicare coverage to continue, the patient must require a hospital level of care and receive active treatment.

Unlike acute care and rehabilitation hospital stays, Medicare covers 190 days of inpatient psychiatric hospital care in a patient's lifetime. The patient can use a maximum of 150 days in a benefit period. The lifetime limit applies only to services received in a psychiatric hospital, and not to services in the psychiatric unit of a general hospital.

Payments to Hospitals and the Right to Needed Care

Medicare pays hospitals based on a patient's diagnosis and condition using a Prospective Payment System (PPS). Thus, hospitals generally know in advance what their payment rates will be, given the patient's principal diagnosis. Medicare's acute care hospital prospective payment system has different payment rates for more than 470 diagnosis related groups (DRG). CMS uses different prospective payment systems for acute care, rehabilitation, long-term care, and psychiatric hospitals.

The PPS creates cost-containment incentives for hospitals. Generally, they must provide all the medically necessary services that a patient needs within a fixed payment. If the care costs more, the hospital loses

money. The PPS also establishes average lengths of stay for the various diagnoses that hospitals can use as guidelines. Medicare rules do not require hospitals to discharge patients after a certain number of days.

Under Medicare rules, hospitals must provide all the care that is medically necessary. Nevertheless, hospitals and physicians may sometimes decide to discharge a patient prematurely. When a patient disagrees with a proposed discharge, they or someone on their behalf should call the Medicare Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) no later than the planned discharge date to request a quick review. Instructions for this process appear on *An Important Message from Medicare from Medicare about Your Rights* that hospitals must give to all inpatients. After a person requests the QIO review, the hospital must give the patient a *Detailed Notice of Discharge* that contains specific information about the Medicare coverage policies upon which the hospital has based its decision.

The BFCC-QIO is an independent medical review organization under contract with Medicare. It reviews the case and decides if the patient is ready to leave the hospital. It must make its decision within one day of receiving all the necessary information. Medicare continues to cover the hospital stay until noon of the day after the BFCC-QIO gives notice to the patient of its decision.

What Are Your Hospital Rights?

"You (the Medicare patient) have the right to receive all the hospital care necessary for the proper diagnosis and treatment of your injury or illness. According to Federal law, your discharge date must be determined solely by your medical needs, not by Medicare payment." (Excerpt from "An Important Message from Medicare.")

It cannot be emphasized enough that the Medicare patient's discharge date should be determined solely according to the individual's medical needs and not because of the DRG assignment.

Skilled Nursing Facility (SNF) Coverage

A skilled nursing facility (SNF) provides medical services under the direction of a physician that are performed by, or under the supervision of, licensed professionals that include Registered Nurses (RN), Licensed Practical Nurses (LPN), and rehabilitation therapists. SNFs typically are distinct units located within a nursing facility. Some hospitals designated a specific wing as the skilled nursing portion of the hospital. Other hospitals, generally in small towns, have a specific number of beds designated as "skilled nursing." In these situations, the term "swing bed" is used when a patient is transferred from inpatient hospital care to skilled nursing care. The patient may physically remain in the same bed.

Medicare will pay for services that can only be provided, as a practical matter, in a skilled nursing facility. The key issue is whether the patient needs skilled nursing or rehabilitation services on a daily basis, or not. SNF staff and the Utilization Review (UR) Committee reviews a patient's stay considering Medicare's coverage rules to decide if SNF care is "reasonable and necessary," or if the patient could safely move to a lower level of care in the nursing facility or to home. Medicare's SNF benefit covers:

- Semi-private room (Medicare covers the cost of private rooms when they are medically necessary)
- Skilled nursing services
- Meals, including special diets
- Drugs
- Supplies and equipment for use during the SNF stay
- Rehabilitation services, including physical therapy, occupational therapy, and speech therapy services

- Medical social services

Medicare's SNF benefit excludes these services from coverage:

- Private duty nursing
- Custodial care (where patient receives personal care services without daily skilled care)
- First three pints of blood for transfusions

To qualify for Medicare coverage of a SNF stay, these coverage rules or "conditions of coverage" must be met:

- The SNF must be Medicare certified.
- The patient must transfer to the SNF within 30 days of discharge from a hospital (there is an exception for cases in which it is medically necessary to start treatment later than 30 days).
- The hospital stay was three days or longer. To calculate the "three day prior hospital stay," Medicare counts the day of admission to the hospital, but not the day of discharge.
- The patient receives care in the SNF for a condition for which they received care in the hospital.
- The patient needs skilled nursing or rehabilitation services on a "daily basis."
- The patient's physician orders the skilled services.

How does Medicare define daily basis? "Daily" means seven days per week for nursing services and five days per week for rehabilitation services. A patient meets the daily basis test if they receive a combination of skilled nursing and rehabilitation services over the course of a week.

Skilled Nursing and Rehabilitation Services

Skilled nursing services are those provided by, or under the supervision of, licensed nursing staff. Skilled rehabilitation services are those provided by, or under the supervision of, licensed physical therapists, occupational therapists, and speech therapists. Examples of skilled nursing services include:

- Patient education
- Insertion, sterile irrigation, and replacement of catheters
- Intravenous or intramuscular injections
- Tube feedings
- Applying dressings that involve prescription medications
- Treatment of bed sores (decubitus ulcers)
- Observation and assessment of a patient's changing condition

Examples of skilled rehabilitation services include:

- Therapeutic exercises
- Gait evaluation and training
- Range of motion exercises
- Ongoing assessment of rehabilitation needs and potential.

Many people think that a patient must make significant improvement or show "rehabilitation potential" to qualify for Medicare SNF coverage. They think that when a patient's condition stabilizes, or reaches a "plateau," that Medicare coverage automatically ends. While rehabilitation potential is one among many factors to consider, Medicare's rules say this: "When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be

carried out by non-skilled personnel." Elsewhere, the rules say, "Even when a patient's full or partial recovery is not possible, a skilled service still could be needed to prevent deterioration or to maintain current capabilities."

Covered Days and Costs for SNF Care

Medicare covers up to 100 days of SNF care within a benefit period, as long as the covered days are medically necessary. With the start of each new benefit, a Medicare patient has 100 renewable covered days.

- Days 1 to 20: Medicare payments cover the cost of the first 20 days of SNF care in full. There is no SNF deductible as with inpatient hospital stays.
- Coinsurance Days 21 to 100: The patient owes a copay[2] (1/8 of the Part A deductible) for each of these days. Medicare payments cover the balance of the bill.
- Day 101 and Beyond: Medicare coverage ends. The patient is responsible for the entire bill while SNF care continues. But if the benefit period ends with the patient's absence from the SNF (or a hospital) for 60 days in a row, they receive a new set of 100 covered SNF days at the start of the next benefit period.

Claims, Payment, and the Right to Needed Care

SNFs send their bills for Medicare-covered stays to a Medicare Administrative Contractor (A/B MAC). Medicare pays them directly, and the payment contractor issues a Part A *Medicare Summary Notice (MSN)* to the patient explaining Medicare's payment and detailing the beneficiary's cost-sharing charges.

SNFs sometimes are hesitant, however, to submit claims to Medicare. There are many reasons for this. A key reason is that Medicare penalizes SNFs when they submit too many claims that Medicare denies for lack of medically necessity. If the SNF refuses to submit the bill to Medicare, the patient can ask for a "demand bill," meaning that the SNF must submit a claim to Medicare on the patient's behalf. There is no penalty for the patient or SNF when using this procedure. The A/B MAC then makes an official Medicare coverage decision on the claim.

As with hospitals, Medicare pays SNFs on a prospective basis under a system that groups patients according to their condition and the kind of facility resources they use.

SNF patients have the right to receive medically necessary care. SNFs must provide all the care that is medically necessary before discharging a patient to a lower level of care in the nursing facility or to home. Under Medicare rules, SNFs must give a written notice called a *Notice of Medicare Provider Non-Coverage* no later than two days before it intends to end a Medicare-covered stay. When a patient disagrees with a proposed discharge, they or someone on their behalf should call the BFCC-QIO immediately, but no later than noon of the planned service termination date, to request an immediate appeal. After a person requests the BFCC-QIO appeal, the hospital must give the patient a *Detailed Explanation of Non-Coverage* that contains specific information about the Medicare coverage policies upon which the SNF has based its decision.

The BFCC-QIO is an independent medical review organization under contract with Medicare. It reviews the case and decides if the patient is ready to leave the SNF. If the BFCC-QIO decides that the patient still needs a skilled level of care, Medicare coverage for the SNF stay continues.

[2] Annual cost-sharing amounts are available in the appendix under Annual Medicare Premium and Cost-Sharing Amounts.

Home Health Care

A home health agency (HHA) is a public agency or private organization that provides skilled nursing services, therapy services, social services and other types of care in a patient's home or place of residence. One well-known example of an HHA is the Visiting Nurse Association (VNA). In some communities, home health agencies operate as affiliates of hospital systems.

Medicare home health benefit covers:

- Skilled nursing care on a part-time or intermittent basis
- Physical therapy
- Speech therapy
- Occupational therapy, if the patient initially received physical or speech therapy
- Medical social services
- Medical equipment and supplies provided by the HHA
- Home health aide services (e.g., bathing), if the patient also receives skilled care

Medicare's home health benefit excludes these services from coverage:

- Full-time care in the home
- Private duty nursing
- Home-delivered meals
- Homemaker services like cleaning, washing dishes, and shopping for groceries

For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. In determining whether homebound criteria are met, it is necessary to look at the patient's condition over a period of time rather than for short periods within the home health stay.

CMS makes clear that the aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet the specific criteria outlined below.

Criteria for Homebound Status

CMS advises that an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

Criteria One: The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence or
- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria One conditions, then the patient must also meet two additional requirements defined in Criteria Two below.

Criteria Two: There must exist a normal inability to leave home and leaving home must require a considerable and taxing effort.

The definition and interpretation of the term "homebound" is often the key issue in Medicare coverage for home health care. A patient need not be bedridden to be considered homebound. Also, a patient may leave home if the absences are "of short duration," or infrequent, or for medical purposes. The rules also say that an occasional trip to the barber, a walk around the block, attendance at worship services, or a drive would not require a finding that the person is not homebound so long as they are on an infrequent basis or are of relatively short duration.

Medicare defines "part-time" as 28 to 35 hours per week of combined skilled nursing and home health aide services. "Intermittent" means from once daily, for periods up to 21 days if there is a predictable end to the daily care, to once every 60 days.

Medicare will cover medically necessary home health services for patients with chronic conditions, such as diabetes and neuromuscular conditions, even though there is no chance for recovery. Medicare's rules say that the decision about whether skilled care is medically necessary depends "solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time."

Covered Days for Home Health services

Unlike Medicare's inpatient hospital and SNF coverage, there is no limit on the number of Medicare-covered home health service days. Medicare coverage can continue indefinitely as long as the patient continues to need therapy or skilled nursing care on a part-time or intermittent basis and is homebound.

Patients do not owe a deductible or coinsurance charges for most home health care services, including the nursing, therapy, and home health aide services. Medicare payments to the home health agency cover the cost of these services in full. The one exception is that the patient owes a coinsurance charge of 20% of Medicare's approved amount for any Durable Medical Equipment (DME) that the HHA provides.

Under Medicare's home health prospective payment system, HHAs submit claims to a Home Health and Hospice Medicare Administrative Contractor (HH MAC) and receive payments for a 60-day episode of care. The payments reflect the complexity of a patient's condition and her skilled care needs. A physician must recertify the patient's need for home health care on a bi-monthly basis.

HHAs must provide all the care that is medically necessary before discharging a patient. Under Medicare rules, an HHA must give a written notice called a *Notice of Medicare Provider Non-Coverage* no later than two days before it intends to end Medicare-covered services. When a patient disagrees with a service termination decision, they or someone on their behalf should call the BFCC-QIO) immediately, but no later than noon of the planned service termination date, to request an immediate appeal. Instructions for this process appear on the *Notice of Medicare Provider Non-Coverage*. After a person requests the BFCC-QIO appeal, the HHA must give the patient a *Detailed Explanation of Non-Coverage* that contains specific information about the Medicare coverage policies upon which the HHA has based its decision.

The BFCC-QIO is an independent medical review organization under contract with Medicare. It reviews the case and decides if the patient no longer is homebound or needs skilled nursing or rehabilitation care. If the BFCC-QIO disagrees with the HHA's decision, Medicare coverage for home health services continues.

Medicare Part A and Part B both cover home health care. Since 1997, HHAs submit claims under Part A if the patient has been in a hospital for three days and starts to receive home health services within 14 days of discharge from the hospital or SNF. If the HHA cannot bill to Part A, they bill to Part B. Regardless of the

payment source, the benefits are the same. Also, if a patient only has Part B coverage, the HHA submits claims exclusively under Part B.

Hospice Care

A hospice is a public agency or private organization that is primarily involved in providing "palliative care" to patients with a terminal illness. Hospice programs in the United States commonly offer home-based care, including care for beneficiaries who reside in nursing homes. The hospice benefit also has limited coverage for facility-based hospice care under certain conditions. Unlike Medicare's home health coverage, hospice programs often provide in-home care around the clock. There is no "part-time or intermittent" requirement for hospice.

Medicare's hospice benefit covers these services:

- Physician care (including the patient's personal physician who need not be affiliated with the hospice)
- Nursing care
- Counseling, including bereavement counseling
- Medical social services
- Physical, occupational, and speech therapy
- Home health aide and homemaker services
- Medications to manage the patient's pain and symptoms
- Short-term inpatient care for pain control or acute or chronic symptom management
- Respite care for five days or less to provide relief for the patient's caregiver

Medicare's hospice benefit excludes these services from coverage:

- Treatment for the terminal illness that is not for symptom management and pain control
- Care that another hospice provides that was not arranged by the patient's hospice
- Care from another provider that duplicates the care that Medicare requires the hospice to give

To qualify for Medicare payments for hospice care, a patient must meet the following conditions of coverage:

- Be certified by a physician and the hospice director as having a terminal illness, meaning that they are expected to live six or fewer months if the illness runs its normal course
- File a written "hospice election" with the hospice agreeing to give up other Medicare coverage aimed at curing the terminal condition, except for physician services. A patient, however, can cancel hospice at any time and return to regular Medicare coverage. Also, in making this election, the patient only gives up regular Medicare benefits in connection with treatment for the terminal condition.
- Receive services from a Medicare-certified hospice

Covered Days and Costs for Hospice Services

Medicare covers an unlimited number of days, grouped into two 90-day "election periods" followed by an unlimited number of 60-day election periods, as long as the patient is terminally ill.

Hospice organizations submit claims to Home Health and Hospice Medicare Administrative Contractors (HH MAC). Medicare payments to the hospice cover the cost of most hospice services including the physician, nursing, therapy, and counseling services. There is, however, a nominal copayment for palliative

drugs and respite care. Patients pay up to $5 for each prescription and 5% coinsurance per day for respite care.

Your Rights as a Medicare Beneficiary

- Good quality medical care, including the right to make choices about the treatment you receive in hospitals, nursing homes, outpatient centers, and home health agencies.
- Written notice of any decision made by your hospital or Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) denying you Medicare coverage for hospital services.
- Reconsideration by your BFCC-QIO of a denial decision for hospital services.
- Notification and explanation of the final decision.
- Receiving a statement about your further appeal rights, including information on proper procedures.

What to do if you think you are being discharged from a hospital too soon, or if you are told Medicare will no longer pay for your continued stay in the hospital:

- Discuss your concerns with your doctor, your representative, or hospital discharge planner.
- Ask for a written statement that indicates when you will be responsible for the bill if you choose to remain in the hospital.
- If you are a resident of Kansas, telephone KEPRO at 1-855-408-8557 (Monday-Friday 9:00 a.m. to 5:00 p.m., 11:00 a.m. to 3:00 p.m. weekends and holidays) to file a complaint.

Your Rights If You Feel Quality Care Was NOT Delivered:

If you feel you did not receive acceptable quality of care in the hospital, nursing home, outpatient center or by a home health agency or Medicare Health Plan, and your care was received in Kansas, you may have your care reviewed by submitting a written complaint to:

KEPRO
5201 West Kennedy Boulevard, Suite 900
Tampa, Florida 33609
Attention: Beneficiary Complaints
Medicare Beneficiary Help Line
Toll free: (855) 408-8557
Website: www.keproqio.com

This help line is available to assist you with problems about the quality of medical care you receive in a hospital, hospital outpatient department, ambulatory surgery center, skilled nursing facility, or care provided by a home health agency or a Medicare Health Plan.

Medicare Outpatient Observation Notice (MOON)

The MOON is a standardized notice to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH). The MOON is mandated by the Federal Notice of Observation Treatment and Implication

for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. The NOTICE Act requires all hospitals and CAHs to provide written and oral notification under specified guidelines.

The MOON must be delivered to beneficiaries in Original Medicare (fee-for-service) and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours. The hospital or CAH must provide the MOON no later than 36 hours after observation services as an outpatient begin. The MOON may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.

Chapter 4
MEDICARE PART B

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MEDICARE PART B

Medicare Part B, officially called the Supplementary Medical Insurance (SMI) program (see the Medicare card), was designed to cover a wide range of medical services to complement Medicare's Part A hospital insurance benefits. Unlike Part A, which most beneficiaries receive automatically because they paid a Medicare tax through FICA payroll deductions, people must elect to enroll in Part B and pay a monthly premium.

The financing for Medicare Part B comes largely from federal general revenues, monthly premiums, and beneficiary cost-sharing charges that include the annual deductible and 20% coinsurance for most covered services and items. By law, the monthly premiums cover 25% of Part B program costs. FICA payroll taxes do not help finance Medicare Part B. The Part A and Part B trust funds are separate.

Some of the most common services that Medicare Part B covers are:

- Physician care
- Outpatient hospital treatment and surgery
- Home health care
- Durable medical equipment (DME) and supplies
- Ambulance services
- Prevention and screening services

The payment contractors for Medicare Part B services are the A/B Medicare Administrative Contractors (A/B MAC) for physician, ambulance, and many other covered services; the Home Health and Hospice Medicare Administrative Contractors (HH MAC) for Part B covered home health care; and the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for medical equipment, prosthetics, and supplies. Providers submit claims to these contractors for Medicare payments.

Part B Covered Services, Items, and Coverage Rules

Generally, Medicare Part B covers medical services and items when they are medically necessary. This means that they must be reasonable and necessary in the diagnosis or treatment of an illness or injury. Since 1990, however, Congress has added many preventive and screening services to the list of Part B covered benefits. Part B covered services include physician, outpatient hospital, and ambulance services, along with durable medical equipment (DME) items. See the descriptions of these services, items, and coverage rules below.

Physician Services

Medicare Part B generally covers physician services, including diagnostic and surgical services. Medicare defines a "physician" as a licensed Medical doctor (MD), Osteopathic doctor (DO), Chiropractor (DC), Optometrist, Ophthalmologist, or Podiatrist (DPM). Medicare also covers services from other providers who include:

- Certified registered nurse anesthetist (CRNA)
- Clinical psychologist
- Clinical social worker
- Physician assistant (PA)
- Nurse practitioner and clinical nurse specialist
- Medicare covers a wide range of physician services that include:

- Office, hospital, and home visits
- Second opinions before surgery
- Surgical services
- Anesthesiology and radiology services
- Mental health services
- Chiropractic services under limited conditions
- Podiatric services under limited conditions
- Dental surgery under limited conditions

Medicare has limited coverage for some types of physician services, including chiropractic, podiatric, and dental care.

Chiropractic care: Medicare pays for the manual manipulation of a subluxation of the spine. It will cover chiropractic services for both acute and chronic subluxations with the short-term goal of improving the patient's condition or function. Rules state that chiropractic maintenance treatments are not "reasonable and necessary." Also, since 2000 Medicare has not required an x-ray to document the subluxation.

Podiatric services: Medicare pays for the debridement of mycotic toenails, ingrown toenails, bunions, and heel spurs. It pays for routine foot care only for patients with "systemic conditions" involving their circulation, nervous system, or metabolism, for example, diabetes.

Dental surgery: Medicare coverage is limited to paying dental surgeons to perform surgeries to set a fractured jaw, remove cancerous tissue, or to treat oral infections. It does not cover services in connection with the care, treatment, filling, removal, or replacement of teeth (although Part A pays for an inpatient hospital stay when a patient's medical condition requires inpatient care for the safe removal of teeth).

Outpatient Hospital Services

Medicare covers many outpatient hospital services. They include but are not limited to:

- Medical treatments, such as chemotherapy administration for cancer patients
- Emergency room services
- Outpatient surgical services, including many common "day surgery" procedures
- Rehabilitation services, such as physical therapy and cardiac rehabilitation programs
- Diagnostic services, such as x-rays, CT scans, and Magnetic Resonance Imaging (MRI)

Since 2000, Medicare has been using the Outpatient Prospective Payment System (OPPS) for many outpatient hospital services. Because of the OPPS, you may find that coinsurance charges for some outpatient hospital services, for example outpatient surgery, exceed 20% of the Medicare approved amount. You may also find that payment rates for the same outpatient service vary among hospitals. Note that the coinsurance charge for outpatient services in no case may exceed the Part A inpatient hospital deductible and that insurance rules require Medigap policies to cover the cost.

Durable Medical Equipment (DME), Prosthetics, and Supplies

Common examples of DME are wheelchairs, walkers, power operated vehicles, hospital beds, lift devices (e.g., Hoyer lift), and oxygen equipment. Medicare-covered DME includes customized equipment to meet a beneficiary's unique medical needs. DME suppliers include pharmacies, home health agencies, and companies that specialize in the sale and service of medical equipment and supplies. Some large suppliers have nationwide mail order operations and advertise extensively.

Medicare defines DME as equipment that is:

- Able to withstand repeated use
- Used primarily for a medical purpose
- Generally not useful in the absence of an illness or injury
- Appropriate for use in the home

To qualify for payment, Medicare requires that:

- The equipment is reasonable and necessary for the treatment of a person's illness or injury or to improve the functioning of his malformed body part.
- A physician orders the DME and certifies the patient's need for DME through a prescription or, in some cases, a Certificate of Medical Necessity.
- The DME provider is Medicare enrolled and certified.

For purposes of Part B DME payments, a beneficiary's home may be her own house, apartment, a relative's home, a home for the aged, or some institutions. A home is not, however, a hospital or an institution (i.e., nursing home) that has a skilled nursing facility (SNF) unit. CMS assumes that Part A or Medicaid payments to hospitals and nursing facilities, or the private pay rates that residents pay to nursing facilities, should cover the cost of DME and supplies.

Even though an item serves a useful medical purpose and a physician has prescribed it, Medicare also considers if it is reasonable to pay for the DME. The Medicare Administrative Contractor (DME MAC) asks, for example, if the prescribed item is substantially more costly than other "appropriate and feasible alternatives." This analysis can result in coverage denials that may surprise some of your clients. DME denials usually are good cases to appeal.

Medicare excludes certain items from its list of covered DME. Because their purpose is not primarily medical, Medicare does not pay for:

- Air conditioners
- Humidifiers
- Stairway lifts
- Fitness equipment
- Safety grab bars
- Seat-lift chairs (but Medicare pays for the seat-lift device inside the chair)

Medicare has special coverage rules that CMS changed in 2005 for power-operated wheelchairs and scooters. In the past, Medicare required a patient to be "bed or chair confined" to show medical necessity. That is no longer the case. While coverage for such Mobility Assistive Equipment (MAE) is available only to meet a medical purpose in the home, Medicare has changed the rule to set up a function-based measure of medical necessity. Medicare now looks more broadly at the patient's inability to safely accomplish activities of daily living such as toileting, feeding, and dressing when deciding to cover MAE.

Prosthetics

Prosthetic devices are designed to replace all or part of a missing body organ or an inoperative or malfunctioning body organ. They include:

- Breast prostheses and reconstruction following a mastectomy
- Pacemakers

- Cataract lenses and glasses
- Artificial limbs and eyes
- Braces and trusses
- Therapeutic shoes for people with diabetes
- Urinary collection and retention systems

Medicare does not cover these items as prosthetic devices:

- Eyeglasses or contact lenses (except for cataracts)
- Hearing aids
- Dentures or dental implants
- Orthopedic shoes

Medicare rules allow for the rental or purchase of DME and prosthetics. Generally, beneficiaries decide whether to purchase or rent equipment, but CMS decides how to pay for an item. The agency categorizes DME, prosthetics, and supplies into six categories. It groups items, for example, that are inexpensive or routinely purchased, or that require frequent and substantial service, or that are customized. Based on the grouping, CMS decides whether to pay a monthly rental fee or a lump sum payment.

- For inexpensive items that cost less than $150, like walkers, Medicare pays either a monthly rental fee or a lump sum.
- For expensive items, like hospital beds and wheelchairs, Medicare pays a monthly rental fee until payments reach the purchase price. Afterwards, Medicare pays the supplier a smaller monthly maintenance fee to cover repairs.
- For items that need frequent service, like ventilators and nebulizers, Medicare pays a monthly rental fee only.
- For customized equipment and prosthetics, Medicare pays a lump sum.
- For oxygen equipment, Medicare pays a monthly fee schedule amount only. It does not pay for the purchase of oxygen equipment.

With most rented DME, called “capped rental items,” Medicare gives beneficiaries the option to purchase the item in the tenth month of rental. If a beneficiary declines the purchase option, ownership of the DME stays with the equipment supplier after Medicare makes rental payments for 15 months. Afterwards, Medicare pays the supplier to service the equipment twice each year. If the beneficiary accepts the purchase option, they own an item after 13 months of rental payments. Medicare covers servicing as needed. Different rules apply to oxygen equipment where Medicare now makes rental payments for 36 months. Medicare no longer pays to maintain oxygen concentrators or transfilling equipment after the 36-month rental period. The supplier of oxygen equipment in the 36th month of use must continue to furnish the oxygen and oxygen equipment for the remainder of the 5-year reasonable useful lifetime of the equipment.

Supplies

Medicare Part B pays for supplies that are furnished in connection with a physician’s services or that are needed to use DME effectively. Some examples of covered supplies are:

- Oxygen
- Ostomy bags and supplies
- Heparin when used with a home dialysis system

- Surgical dressings, limited to primary and secondary dressings to treat surgical wounds
- Splints

Medicare does not cover chucks, diapers, and rubber sheets for persons with urinary or bowel incontinence.

Competitive Bidding Program for DMEPOS

Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program changes the amount Medicare pays for certain DMEPOS items. Under this program, suppliers submit bids to provide certain medical equipment and supplies to people with Medicare living in, or visiting, competitive bidding areas. Medicare uses these bids to set the amount it pays for each item. All suppliers are thoroughly screened to make sure they meet Medicare requirements (like eligibility and financial, quality, and accreditation standards) before they're awarded contracts.

If you have Original Medicare, the Competitive Bidding Program requires you to get competitive bidding items in competitive bidding areas from a contract supplier, unless an exception applies.

The Kansas City Metro area and the Wichita area are included in this program. A complete list of affected areas can be found at https://www.cms.gov/DMEPOSCompetitiveBid/01a_MSAs_and_CBAs.asp.

This program has been temporarily suspended pending contract re-bids until 2021.

Drugs and Biologicals

Medicare covers drugs that are given incident to a physician's services as long as the drugs are not usually self-administered by the patients who take them. Part B covered drugs and biologicals include:

- Erythropoetin for kidney failure
- Epoietin Alfa (Epogen or Procrit) for severe anemia
- Blood clotting factors
- Immunosuppressive drugs, like cyclosporine, for transplant patients
- Certain oral medications for cancer patients, including anti-nausea drugs
- Osteoporosis medications for homebound patients
- Whole blood (except for the first three pints)

Medicare Part B uses the "self-administered drug rule" to determine medical necessity. Medicare looks at the usual method for taking a drug to decide if it is usually "self-administered." If the usual method for taking a drug is orally by tablet or capsule, or by self-administered injection, like insulin, Medicare Part B does not pay. Coverage for these drugs often is available through a Medicare Part D drug plan.

When Medicare Part D drug coverage took effect in 2006, Medicare coverage for the drugs and biologicals listed above continued under Medicare Part B for those who meet the Part B coverage rules. Two advantages for beneficiaries who receive coverage for drugs under Part B is that there is no coverage gap and the coinsurance is 20% of Medicare's approved amount.

Medicare Supplement insurance policies normally cover the coinsurance cost, leaving the patient with no out-of-pocket costs if they own one. Note that out-of-pocket costs connected with the Part B drug coverage do not count as True Out-of-Pocket (TrOOP) costs in the Part D drug program.

Ambulance Services

Medicare pays for ambulance services when the ambulance provider and the patient's situation meet certain conditions of coverage. The ambulance service provider must be Medicare-certified, meaning that the equipment and personnel comply with federal standards. Medicare then considers such factors as the severity of the beneficiary's condition and the distance to the nearest emergency facilities. Generally, Medicare only covers ambulance services in a locality (with some exceptions) to/from a hospital, skilled nursing facility (SNF), some other treatment facilities (e.g., dialysis centers), and the beneficiary's home.

Medicare covers ambulance services when, given the patient's condition, other transportation modes are "contraindicated," meaning that the other transportation could endanger the person's health. If a patient could use some other means of transportation without danger (even if that transport is not available), Medicare rules say that the ambulance trip is not medically necessary and cannot be covered.

> **EXAMPLE:** *A beneficiary who fractures his collarbone in a fall may be able to travel safely to an emergency room in a car. But if he has other conditions or injuries that complicate the situation and endanger his health, Medicare may pay for an ambulance trip. Physician and ambulance service provider documentation is essential to Medicare payment.*

Medicare pays for ambulance trips to the "nearest appropriate facility," i.e., the nearest institution (for example, hospital or skilled nursing facility) that is generally equipped to provide the care for the illness or injury involved. It makes no difference if a patient's attending physician has staff privileges at the nearest hospital. If an institution has no bed available, however, it is not an appropriate facility and Medicare will pay for the trip to a more distant facility with an open bed. If an ambulance takes a patient to a facility beyond the nearest appropriate facility, Medicare limits its payment to the cost of transport to the nearer facility.

Medicare has special rules for non-emergency ambulance transportation. It only pays for non-emergency transport when the patient cannot get up from bed without assistance or cannot walk or sit up in a chair or wheelchair. If the patient meets this condition, Medicare may pay for ambulance transport from a facility to the person's home.

Medicare also covers air ambulance services when ground transport is not medically appropriate. This occurs when the time or instability involved in transporting a patient by ground ambulance threatens their survival or seriously endangers their health. Some examples of these serious situations are intracranial bleeding that requires immediate neurosurgery, multiple serious injuries, and treatment in a hyperbaric oxygen unit. The nearest appropriate facility rule applies to claims for air ambulance payment.

Preventive and Screening Services

Medicare Part B covers a growing array of screening and prevention services. Medicare began covering common screening procedures in 1991 after Congress added screening mammograms and other screening services to Medicare's covered benefits. In many cases, Medicare waives the Part B annual deductible, the 20% coinsurance charge, or both for these services.

Preventive Services and Screenings Covered by Original Medicare without a Coinsurance or Deductible

Currently, Medicare's covered screening services are:

- Abdominal Aortic Aneurysm (AAA) screening for those at high risk, once in lifetime

- Alcohol misuse screening, once a year, and counseling, up to 4 times a year
- Bone mass measurements once every 24 months; more frequently if medically necessary
- Breast Cancer Screenings
    - Mammogram screening once every 12 months for women 40+; women between ages 35 and 39 can get one baseline mammogram
    - Breast examination once every 24 months, if at risk, once every 12 months
- Cardiovascular disease (behavioral therapy) once a year
- Cardiovascular disease screening for high-risk persons once every five years
- Cervical and vaginal cancer screening (Pap smear screening and pelvic exams every two years; more often for high-risk women)
- Colorectal cancer screening
    - Fecal occult blood tests once every 12 months for people age 50 and older
    - Colonoscopy once every 10 years
    - Flexible sigmoidoscopy once every 48 months
- Depression screening once a year
- Diabetes screening tests once every 12 months if you have a family history or are at risk for diabetes, twice a year if you have been diagnosed with pre-diabetes
- Hepatitis C Screening Test, one time
- HIV screening once every 12 months or up to three times during a pregnancy
- Immunizations
    - Flu shots once a season
    - Pneumococcal shot to prevent pneumococcal infections (like certain types of pneumonia). Also covers a different second shot if it's given at least 11 months after the first shot.
    - Hepatitis B vaccine only for people at medium to high risk
- Medical nutrition therapy for people with diabetes or kidney disease – yearly
- Obesity Screening and Counseling
    - Requires a body mass index (BMI) of 30 or more
    - Medicare covers behavioral counseling sessions to help you lose weight.
- Prostate cancer screening
    - Prostate specific antigen (PSA) test: once every 12 months
    - Digital rectal examination: once every 12 months
- Sexually transmitted infections screening and counseling
- Tobacco Use cessation counseling
- “Welcome to Medicare” preventive visit for new Medicare beneficiaries (if received in the first 12 months of Medicare coverage)
- Annual Wellness Visit

Services Covered by Original Medicare WITH Coinsurances and/or Deductibles

- Glaucoma screening for persons at high risk (once every 12 months)
- Prostate cancer screening – digital rectal exam once every 12 months
- Colorectal Cancer screening - Barium enema once every 48 months or every 24 months if you are at high risk
- Diabetes testing devices and supplies
- Diabetes self-management training

Mental Health Services

Covered mental health services include counseling and therapy services from doctors, clinical psychologists, and clinical social workers. Medicare pays for outpatient mental health services at the same level as other Part B services, 80% of Medicare's approved amount.

Other Covered Services

The list of other Part B covered services includes, but is not limited to:

- Physical, speech, and occupational therapy
- Laboratory, x-ray, and other diagnostic procedures
- X-ray, radium, and isotope therapy
- Devices for the reduction of fractures
- Comprehensive Outpatient Rehabilitation Facility (CORF) services
- Ambulatory surgical center services
- Rural health clinic outpatient mental health services
- Home health care
- Nutritional therapy for persons with diabetes or renal disease

Excluded Services and Items

Medicare excludes some services and items from its Part B benefits. These include:

- Acupuncture
- Immunizations (except for flu, pneumonia, and hepatitis B vaccines)
- Routine eye exams
- Most dental care, such as cleaning, fillings, extractions, and dentures
- Routine foot care, except for those with systemic conditions like diabetes or neuropathy
- Cosmetic surgery
- Homemaker services
- Meals on Wheels
- Private duty nursing
- Services that are not reasonable and necessary

Part B Costs and Claims – Beneficiary Costs

Along with the monthly premium, Part B beneficiary cost-sharing charges generally are the:

- Annual deductible; a certain amount paid first in Medicare approved charges. The deductible adjusts each year to account for inflation in Medicare spending.[3]
- 20% coinsurance charge; 20% of Medicare's approved amount
- Excess charge
    - Physicians who do not "accept assignment" can bill for no more than 115% of Medicare's approved amount. This is called the Limiting Charge, or Excess Charge.

[3] Annual cost-sharing amounts are available in the appendix under 2016 Medicare Premium and Cost-Sharing Amounts.

  - The Limiting Charge does not apply to all Part B providers. DME suppliers who do not accept assignment, for example, can bill the patient for the entire difference between the approved amount and the actual charge for an item.
- Part B Premium
  - The standard Part B premium.
  - *IRMAA (Income Related Monthly Adjustment Amount)* Higher-income beneficiaries will pay higher premiums for Part B and prescription drug coverage. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

After the beneficiary meets the annual Part B deductible, Medicare Part B typically pays 80% of the approved amount for physician, DME, ambulance and other covered services, and the beneficiary owes 20% of the approved amount (the Part B coinsurance charge). But there are some exceptions to the usual 20% coinsurance charge.

Medicare bases its payment for physicians and many other providers on national "fee schedules" that CMS adjusts for differences in costs among the nation's geographic areas. CMS also adjusts its fee schedule payments to address cost increases.

Exceptions to Part B Cost-Sharing Norms

Outpatient hospital coinsurance charges and beneficiary costs for preventive and screening services often depart from the usual Part B cost-sharing rules. Under the Outpatient Prospective Payment System (OPPS), patient coinsurance charges often exceed 20% of Medicare's approved charge. The copayment for a single service can't be more than the amount of the inpatient hospital deductible.

Part B Billing and Claims

Most Part B providers, including physicians, must submit claims for services and items directly to the A/B Medicare Administrative Contractor (A/B MAC). Medical equipment, prosthetics, and supply providers send their claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MAC). Afterwards, the payment contractors send a Part B *Medicare Summary Notice* to the patient (normally every three months) that explains its coverage decision(s) and the patient's share of the costs. Keep in mind that providers have one calendar year from the date of service to submit claims in Original Medicare.

Because nearly all providers submit claims to Medicare, it is unlikely that you will ever help a client complete a Medicare claim form officially called the Beneficiary Request for Medicare Payment Form 1490S. But, it may come up in connection with covered care in Canada and Mexico, or when a provider refuses in rare cases to submit a claim to Medicare.

Assignment

Providers who accept assignment agree to accept Medicare's approved amount as payment in full. The term itself means that a patient assigns her claim on Medicare's payment over to the provider. When that happens, Medicare pays the provider directly. Providers can only bill the patient for the annual deductible and the coinsurance charge. While physicians have the option to accept assignment, many agree to accept assignment in all cases. They are called "Medicare Participating Physicians." In recent years, physicians nationwide have accepted assignment on nearly 99 percent of their claims.

When providers do not accept assignment, they can bill the patient for more than the Medicare approved amount and ask for full payment at the time they give the service. Medicare then pays the patient, not the provider. Thus, the patient must take steps to pay the provider if they did not pay up front for the service.

Medicare requires some Part B providers to accept assignment in all cases. The mandatory assignment rule applies to:

- Ambulance suppliers
- Outpatient hospital facilities
- Ambulatory Surgical Centers
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Outpatient physical, occupational, and speech therapy providers
- Clinical laboratories

The law requires providers and suppliers to submit claims on behalf of Medicare beneficiaries for both assigned and unassigned claims. Since October 2003, Medicare in most cases also requires doctors, suppliers, and other providers to submit claims electronically to the Carriers and MACs.

Beneficiary Financial Liability Protections: Waiver of Liability

When Medicare denies payment for services because they are not reasonable and necessary in an individual case, under certain conditions the patient is not liable for the bill. Under this "waiver of liability" rule, the provider cannot collect payment from the patient. The rule does not apply to services that Medicare excludes from coverage (for example, cosmetic surgery and non-covered services or procedures that CMS describes in a National Coverage Determination, or NCD), or to services that Medicare denies for technical reasons as when a claim does not meet all of the coverage requirements.

When does waiver of liability apply? It applies when the beneficiary did not know or could not be expected to know, that Medicare would deny coverage for the services because they are:

- Not reasonable and necessary
- Custodial
- Not intermittent skilled nursing care (for home health)
- Given to a non-homebound person (for home health)

When Medicare waives liability for a patient on a denied claim, the provider is liable for the bill unless he or she could not be expected to know that Medicare would deny coverage. Thus, providers have an incentive to notify patients in writing when there is any doubt that Medicare will cover a service or item. These notices are called *Notice of Medicare Provider Non-Coverage* and *Advance Beneficiary Notices* (ABNs). Note that if both patient and provider did not know that Medicare might deny payment, Medicare pays the provider for the service.

A patient generally is not liable for the charges on a denied claim if a provider does not give her proper written notice. This means that providers must clearly describe the services or items in question and explain why they think the services are not reasonable and necessary in light of Medicare coverage rules. If a provider gives a blank ABN to your client and bills her for non-covered services, appeal the denial and send a copy of the improperly completed form along with the appeal request.

How do you find out if Medicare waived your client's liability for non-covered services? Look at the MSN. If Medicare's approved amount is $0.00, a separate note will say, "It appears that you did not know that Medicare would not pay for this service, so Medicare does not hold you liable."

Without a written notice, Medicare assumes that a beneficiary could not know about the chance of a claim denial, and it waives the beneficiary's liability to pay the claim. But if a physician or other health care

provider gave an ABN that properly explains why Medicare might deny coverage, Medicare assumes that the beneficiary has notice about the chance of a denial. The provider then is free to bill the beneficiary for the unpaid bill.

An *Advance Beneficiary Notice (ABN)* is a standard CMS form that, when a provider completes it properly, gives written notice to a patient that Medicare may not pay for a service or item. Medicare guidelines instruct providers to use ABNs only when there is a legitimate doubt about the medical necessity of a service or item. Providers should not give them to everyone. Here are some key points about ABNs:

- Medicare considers a patient who receives a properly completed ABN to know that the service or item would not be covered if Medicare later denies payment on the claim.
- The practical effect of an ABN is to shift financial liability for a denied claim from the provider to the patient.
- After issuing an ABN, the provider must submit the bill to Medicare for an official coverage decision if the patient decides to receive the services or items and asks the provider to bill Medicare.

Laboratories may give ABNs to patients because Medicare often denies payment for tests when the diagnosis does not fit the procedure. The problem arises because physicians order tests when they are not yet sure of the patient's diagnosis, or when they want to rule out a condition. When your clients face coverage denials for lab tests, they can either ask the lab to resubmit the claim with additional information from the physician or appeal the denial.

> **Example:** It is not appropriate for a laboratory to give an ABN to a patient who has a condition that clearly makes a lab test medically necessary. For example, a test for warfarin (Coumadin) levels in a patient's blood typically would be reasonable and necessary for someone who has a mitral heart valve replacement.

Ambulance Transportation and ABNs

CMS does not expect ambulance providers to issue Advance Beneficiary Notices (ABNs) to beneficiaries in some cases where Medicare is likely to deny payment. There are two main reasons for this. The first is that Medicare does not want providers to ask beneficiaries to sign ABNs when they are in an emergency situation or under great duress, that is, where someone would feel forced to sign the form. Medicare's concern is that a beneficiary will not be able to make an informed decision under such conditions.

The second reason why ambulance providers do not issue ABNs when Medicare is likely to deny payment, in both emergency and non-emergency situations, involves the "technical denial" problem. CMS views any denial where a patient could be transported safely by other means, or for mileage beyond the nearest appropriate facility, as technical denials instead of medical necessity denials. CMS guidance says that the waiver of liability and ABN rules (above) apply only to medical necessity denials where Medicare decides that a covered service is not reasonable and necessary in a particular case. But with technical denials for ambulance services, CMS reasons that the ABN rules do not apply because the law never allows transport to a facility other than the nearest appropriate facility. Thus, providers need not issue an ABN when there is no medical necessity determination to be made because Medicare excludes a service from coverage.

Private Contracts

The law allows Medicare beneficiaries and physicians to enter private written contracts in which the physician agrees to provide services and the beneficiary agrees to pay whatever the physician charges.

Providers who enter private contracts cannot receive Medicare payments for two years. Neither the provider nor the beneficiary can submit the claim to Medicare or to a Medicare supplement (Medigap) insurance plan, meaning that the beneficiary pays the entire bill out-of-pocket. Physicians, however, cannot require beneficiaries to enter a private contract in emergency situations. Physicians who enter private contracts must forgo Medicare payments for all Medicare patients for two years.

Other Things You Should Know About Medical Services Available

Coverage of Second Opinions

Sometimes your doctor may recommend surgery for the treatment of a medical problem. Because even minor surgery involves some risk, you may want to get the opinion of another doctor before making a decision.

If the second doctor doesn't agree with the first, you may feel confused about what to do. In that case, you may want to do the following:

- Talk more about your condition with your first doctor
- Talk to a third doctor (Medicare helps pay for a third opinion) Getting a second opinion doesn't mean you have to change doctors. You decide which doctor you want to do your surgery.

Medicare Part B helps pay for a second opinion just as it helps pay for other doctors' services that are medically necessary. If you have Medicare Part B and are in the Original Medicare Plan,

- Medicare pays 80% of the Medicare-approved amount for a second opinion.
- Your share is usually 20% of the Medicare-approved amount after you have paid your yearly Part B deductible. The Part B deductible may increase each year.
- If the second opinion doesn't agree with the first, Medicare pays 80% of the Medicare-approved amount for a third opinion.
- If you decide to have the surgery, Medicare Part B covers the doctor's services, and Medicare Part A (Hospital Insurance) covers other hospital services.

If you are in a Medicare Health Plan (MA), you have the right to get a second opinion. Some MA plans such as HMOs will only help pay for a second opinion if you first get a referral from your primary care doctor. (A referral is a written OK). After you get a referral, you must get the second opinion from the doctor named in the referral. If you want to get a second opinion from a doctor who doesn't belong to your plan, talk to your plan first. In some cases, HMO plans will help pay for this. If your plan won't pay, you could still get the second opinion from the doctor who doesn't belong to your plan, but you would have to pay the full cost. Call your plan for more information.

If you are in a Medicare Preferred Provider Organization (PPO) or a Medicare Private Fee-for-Service Plan, your plan will help pay for a second opinion. You don't need a referral. If you are in a PPO, you may have to pay more if you get a second opinion from a doctor who doesn't belong to your plan.

If you belong to any of the above plans, and the first two opinions are different, these plans will help pay for a third opinion. Call your plan for more information.

Financial Liability Protection—Part B

Under the Original Medicare plan, there are protections under both Medicare Part A and Medicare Part B for beneficiary if Medicare decides that they received care that was not medically necessary or that is not covered by Medicare.

Limitation on Liability

In certain cases, even if Medicare denies your claim, you will not be held responsible for paying the doctor or other health care provider. These cases fall under the "limitation on liability" (wavier of liability) provision of the Medicare law. This limitation on liability applies only when the following three requirements are met:

- The services are furnished by an institutional provider, such as a hospital, skilled nursing facility, or home health agency that participates in Medicare, or by a doctor or other supplier who "accepts assignment."
    - Medicare denied the claim for one of the following reasons:
        - The care provided was custodial care.
        - The care was not "reasonable and necessary" under Medicare program standards for diagnosis and treatment.
        - For home health services, the patient was not homebound or did not require skilled nursing care on an intermittent basis.
        - The only reason for the denial is that, in error, the beneficiary was placed in a Skilled Nursing Facility bed that was not approved by Medicare.
- The beneficiary did not know, or could not reasonably be expected to know, that Medicare does not cover the services given. (For example, the beneficiary did not know because they did not receive a written notice, Advance Beneficiary Notice – ABN.)

In certain situations, Medicare law will protect the beneficiary from paying for doctor services provided on a non-assigned or assigned basis that are denied because they are "not reasonable or necessary." If the doctor knows or should know that Medicare will not pay for the service, the doctor is required to give the beneficiary written notice in advance that tells them why Medicare will not pay for it. If they do not get this written notice, they will not have to pay for the service or they may be entitled to a refund from the doctor.

Advance Beneficiary Notice of Noncoverage (ABN)

There are two situations where a doctor or health care provider must give a written notice (called an Advance Beneficiary Notice of Noncoverage – ABN), in advance, that the care **MAY NOT** be paid by Medicare:

1. Before the doctor or provider gives you a service that they believe Medicare doesn't consider medically necessary;
2. When they know or believe that Medicare will not pay for the service.

If the beneficiary is not given an ABN before they receive the service, they are not responsible for paying for the service. But if they do receive a written notice, sign an agreement, receive the service and Medicare does not pay for the service, the beneficiary must pay for it.

An Advance Beneficiary Notice is for use by the provider *before* service is given. It **protects** the provider and **informs** the beneficiary.

CMS Website to read Beneficiary Notices:

http://www.cms.hhs.gov/BNI/01_overview.asp

Medicare Outpatient Observation Notice Form (MOON)

Beginning on March 8, 2017, hospitals and critical access hospitals must provide the Medicare Outpatient Observation Notice (MOON) to Medicare beneficiaries receiving observation services as an outpatient for more than 24 hours. This notice educates Medicare beneficiaries on the effect of outpatient status, particularly as it pertains to cost-sharing requirements and skilled nursing facility (SNF) eligibility. The MOON must be provided no later than 36 hours from the time the beneficiary begins receiving outpatient observation services (or, if sooner, upon release). The MOON must be accompanied by an oral explanation of the information in the form and must be signed by the beneficiary or the beneficiary's representative. Failure to provide the MOON to applicable beneficiaries is considered a violation of the hospital's Medicare provider agreement and could result in termination of the hospital's Medicare provider agreement.

http://www.cms.hhs.gov/BNI/01_overview.asp

Illegal Practices

Medicare beneficiaries need to be aware that these practices are specifically prohibited by federal law:

Waiver of excess charges

A physician asks/requires beneficiary sign a waiver agreeing to pay for more than the fee schedule amount.

Retainer

A physician asks/requires a retainer be paid before accepting a Medicare beneficiary as a patient.

TO REPORT ANY OF THESE ACTIVITIES or ANY Medicare Fraud, Abuse, and Health Care Error:

Kansas SMP - 1-800-432-3535

Chapter 5
MEDICARE PART C (Medicare Advantage)

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Medicare Part C (Medicare Advantage)

Medicare Advantage is a system for delivering Medicare benefits to beneficiaries who enroll in plans offered by private health insurance organizations. Private Medicare plans agree to coordinate the care received by beneficiaries and reduce costs by emphasizing prevention and limiting the use of services. The Original Medicare program, in contrast, typically pays for care on a fee-for-service basis.

Eligible beneficiaries must choose to enroll in a MA plan. That is, eligible beneficiaries must enroll in a MA plan during an applicable enrollment period, and generally agree to stay in the plan for a calendar year, in order to receive coverage through the Medicare Advantage program. After enrollment in a MA plan takes effect, beneficiaries typically must receive all of the care according to plan rules, respecting provider network, prior authorization, and other limits that plans may use to control spending.

The Centers for Medicare and Medicaid Services (CMS) pays private MA plans a fixed amount per beneficiary to provide care. The amount CMS pays to the plans is not directly related to the quantity or cost of health services they deliver. This payment method is called capitation. It contrasts with Original Medicare's fee-for-service system in which Medicare pays physicians and other healthcare providers for each service they provide to Medicare beneficiaries.

In 2018, an average of 34% of Medicare beneficiaries were enrolled in Medicare Advantage plans. Since enrollment into a Medicare Advantage plan changes fundamental aspects of how Medicare beneficiaries receive their health care, it is more important than ever for people to have access to timely, accurate, and useable information about these plans before they enroll. SHIPs have an important role in providing thorough counseling and information to Medicare beneficiaries about all their Medicare options so that they can make informed decisions about their benefits.

Types of Plans

In order to receive health coverage through a Medicare Advantage (MA) plan, beneficiaries need to enroll in an available plan. While all MA plans are set up under the Medicare Part C program, the law allows plan sponsors to take very different approaches to structures for coverage, provider networks, and payment. Plan sponsors offer several types of plans. These include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service (PFFS) plans, Special Needs Plans, and PACE plans. This section provides in-depth descriptions of the different MA plans available across the country.

Medicare Advantage plans are offered in a specific geographical area, with exceptions for some employer/union sponsored MA plans that have retirees living in different areas. Generally, beneficiaries must live within a plan's service area to be considered eligible for enrollment in the MA plan. A service area may be as small as one county or as large as multiple MA regions. Within a MA plan's service area, the plan must provide all enrollees an identical package of benefits with an identical cost-sharing structure.

Health Maintenance Organizations (HMOs)

Health Maintenance Organizations (HMOs) are a type of Coordinated Care Plan (CCP) that operates through a network of health care providers. HMOs contract with hospitals, physicians, laboratories, and other providers to create their provider networks. Plans may offer incentives to network providers to help in the effort to contain costs or to meet certain quality of care standards. Most HMOs require people who enroll in the plan to choose a primary care provider (PCP). The PCP is often a physician who is expected to act as a gatekeeper to health care services. HMO plan members, or "enrollees," generally must contact

their PCP to obtain referrals to see specialists or to receive some services, such as expensive diagnostic procedures. Many HMOs also require prior approval for elective surgeries and post-acute care admissions, for example, to rehabilitation hospitals. HMOs cannot, however, require enrollees to obtain referrals for emergency medical care or urgently needed care, though most plans expect enrollees to contact the plan within a certain time frame after receiving such care. Each HMO can have different provider networks and different rules for referrals and prior approval, so it is important to understand the specifics of a plan before enrolling in one.

In HMO plans, enrollees usually must obtain health care services through network providers. The HMO will not cover services that plan enrollees obtain when they see physicians or go to hospitals or other providers outside of the network (except for necessary emergency or urgent care).

Some HMO plans have developed a more lenient approach, called a Point of Service (POS) benefit option. The HMO-POS benefit allows enrollees to obtain certain health care services without following the plan's standard network or prior authorization rules. Often, services obtained through the POS benefit will cost an enrollee more than services provided according to the standard rules. HMO plans with a POS benefit may limit the POS portion of the benefit to specific services or to a fixed dollar benefit amount. As with all MA plans, it is important to understand the POS benefit, if offered, before enrolling in an HMO plan.

HMO plans may or may not offer Medicare Part D drug coverage through the HMO, although most do. ***Enrollees in HMO plans with no Medicare drug coverage (MA-only) may not enroll in a stand-alone Prescription Drug Plan (PDP).*** Enrollees who select an HMO plan with Medicare drug coverage (MA-PD) must accept the drug coverage portion of the plan.

Preferred Provider Organizations (PPOs)

Preferred Provider Organizations (PPOs) are a type of Coordinated Care Plan that operates through a network of health care providers. Unlike HMOs, PPOs generally pay for out-of-network care. Also, they do not require enrollees to choose a primary care provider (PCP) nor do they require referrals to see specialists or receive certain types of health services. Enrollees in PPOs usually pay lower cost-sharing amounts for services provided by the PPO's network of "preferred" health care providers. Even in routine circumstances, PPOs provide coverage for services received out-of-network, but cost-sharing (deductibles and copayments) is generally higher for out-of-network care.

A Regional Preferred Provider Organization (RPPO) is a type of PPO plan that offers coverage throughout one of the 26 CMS-established MA regions. These plans are the result of the government's effort to expand and support Coordinated Care Plans even in rural areas. By contrast, other PPOs (local PPOs) provide a benefit package to a service area of only one or more counties. RPPOs offer a number of incentives and changes from local PPOs, including a standard benefit package (that includes a set premium) across the region, an annual out-of-pocket limit, or "cap," on enrollee out-of-pocket cost-sharing, and a combined Part A and Part B deductible. Furthermore, the health care provider network of RPPOs is spread throughout the MA region, providing access to more health care providers across a broader area than local PPOs and most HMOs.

PPO plans may or may not offer Medicare drug coverage. ***Enrollees in PPO plans without Medicare drug coverage (MA-only) may not enroll in a stand-alone Prescription Drug Plan (PDP).*** Enrollees who select a PPO plan with Medicare drug coverage (MA-PD) must accept the drug coverage portion of the plan.

Special Needs Plans (SNPs)

- Special Needs Plans (SNPs) are a type of Coordinated Care Plan (HMO or PPO) that exclusively provides coverage for beneficiaries with special medical needs or health care situations. Special Needs Plans must offer Medicare Part D drug coverage. A SNP may serve one of the following three subgroups of Medicare beneficiaries:

- Institutionalized individuals
  - Those residing in or expected to reside for 90 days or longer in a long-term care facility (including skilled nursing facility (SNF), nursing facility (NF), intermediate care facility (ICF), or inpatient psychiatric facility)
  - Those living in the community but requiring an equivalent level of care (LOC) to those residing in a long-term care facility
- Dual-eligible individuals
  - Those entitled to Medical Assistance under a state plan under Title XIX (Medicaid)
  - Some SNPs may enroll all or a portion of dual-eligible beneficiaries, including those with Medicaid and those in Medicare Savings Programs
- Individuals with a chronic or disabling condition
  - These plans must be designed to serve 15 severe and chronic conditions:
    - Chronic alcohol and other drug dependence
    - Autoimmune disorders—including polyarteritis nodosa, polymyalgia rheumatica, polymyositis, rheumatoid arthritis, and systemic lupus erythematosus
    - Cancer excluding pre-cancer conditions
    - Cardiovascular disorders—including cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorder
    - Chronic heart failure
    - Dementia
    - Diabetes mellitus
    - End-stage liver disease
    - End-stage renal disease (ESRD) requiring dialysis. (While Medicare rules generally do not allow Medicare beneficiaries with end-stage renal disease (ESRD) to join MA plans, CMS has the ability to waive the ESRD enrollment exclusion for Special Needs Plans.)
    - Severe hematologic blood disorders—including aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplatic syndrome, sickle-cell disease (excluding sickle-cell trait), and chronic venous thromboembolic disorder
    - HIV/AIDS
    - Chronic lung disorders—including asthma, chronic bronchitis, emphysema, pulmonary fibrosis, and pulmonary hypertension
    - Chronic and disabling mental health conditions—including bipolar disorders, major depressive disorders, paranoid disorder, schizophrenia, and schizoaffective disorder
    - Neurologic disorders—including amyotrophic lateral sclerosis (ALS), epilepsy, extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington's disease, multiple sclerosis, parkinson's disease, polyneuropathy, spinal stenosis, and stroke-related neurologic deficit
    - Stroke

- SNPs also must apply one of the following structures:
  - The plan may target one chronic condition from the list of approved chronic conditions (see above).
  - The plan may target a group of commonly co-morbid and clinically linked chronic conditions from a list of approved common multi-condition groupings in which the eligible beneficiary has at least one condition. The groupings include diabetes mellitus and chronic heart failure; chronic heart failure and cardiovascular disorders; diabetes mellitus and cardiovascular disorders; diabetes mellitus, chronic heart failure, and cardiovascular disorders; and stroke and cardiovascular disorders.
  - The plan may target a plan-designed grouping of multiple chronic conditions from the list of approved chronic conditions in which the eligible beneficiary has all conditions

Private Fee-for-Service (PFFS) Plans

Private Fee-for-Service (PFFS) Plans are a type of Medicare Advantage (MA) plan that is very different from Coordinated Care Plans. Beneficiaries don't need to choose a primary care doctor in PFFS Plans. PFFS plans resemble Original Medicare in that the plans pay providers for each service they deliver to plan enrollees. They are also similar in that enrollees are not limited to a network of health care providers and do not need referrals to see a specialist. On the other hand, unlike Original Medicare, PFFS plans set their own payment rates for health care providers. Thus, enrollees may see any provider who agrees to accept the plan's payment terms, but CMS does not require providers to accept these terms. Because of this, it is critical to know that any Medicare provider, including physicians, home health agencies, and equipment suppliers, **may choose to accept, or *not accept*, the terms of the PFFS plan each time a patient visits the provider**. This means that enrollees cannot trust that their preferred doctors and hospitals will remain PFFS providers even if they received covered services through these providers previously.

Starting in 2011, non-employer/non-union PFFS plans that are operating in areas with more than one MA network-based plan must meet the access standards of other MA network-based plans. Some PFFS Plans contract with a network of providers who agree to always treat you even if you've never seen them before. Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before. For each service you get, make sure your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan's payment terms. In an emergency, doctors, hospitals, and other providers must treat you. You only need to pay the copayment or coinsurance amount allowed by the plan for the type(s) of service you get at the time of the service.

Private Fee-for-Service plans may or may not offer Medicare drug coverage through the PFFS. Unlike many other types of MA plans, enrollees in PFFS plans without Medicare drug coverage (PFFS-only) may enroll in a stand-alone Prescription Drug Plan (PDP).

Medicare Medical Savings Account (MSA) Plans

A Medicare MSA Plan is a consumer-directed Medicare Advantage Plan. These plans are similar to Health Savings Account Plans available outside of Medicare. You can choose your health care services and providers.

Medicare MSA Plans have 2 parts. They combine a high-deductible insurance plan with a medical savings account that you can use to pay for your health care costs.

High-deductible health plan: The first part is a special type of high-deductible Medicare Advantage Plan (Part C). The plan will only begin to cover your costs once you meet a high yearly Deductible, which varies by plan.

Medical Savings Account (MSA): The second part is a special type of savings account. The Medicare MSA Plan deposits money into your account. You can use money from this savings account to pay your health care costs before you meet the deductible. Medicare MSA plans cover the Medicare services that all Medicare Advantage Plans must cover.

Medicare MSA Plans do not cover Medicare Part D prescription drugs. If you join a Medicare MSA Plan and need drug coverage, you'll have to join a Medicare Prescription Drug Plan.

Programs for All-Inclusive Care for the Elderly (PACE)

The Program for All-Inclusive Care for the Elderly (PACE) is a model that provides community-based medical, psychosocial, long-term care, and chronic care to frail older adults. An interdisciplinary team manages participants' care to keep them out of nursing homes as long as possible by providing adult day center and home-based care services. PACE is a Medicare Health Plan, but not a Medicare Advantage Plan.

To qualify for PACE services, an individual must be age 55 or older, certified by the state to need nursing home care, have the ability to live in the community safely and live within a PACE service area. PACE programs receive monthly Medicare and Medicaid capitation payments for each qualifying participant, and those who are not eligible for these benefits must privately pay the capitation amount. Capitation allows PACE programs to provide a variety of services, even some that Medicare or Medicaid may not typically cover, through a determined monthly payment for each individual.

PACE delivers most of its services from a day health center which members attend several times a week. The day health center provides primary medical care, physical, occupational and recreational therapies, personal care, social services, and transportation to and from the center. Home-based services often supplement the center-based services.

Eligibility and Enrollment

Given the many choices that Medicare beneficiaries face in terms of receiving their health insurance and drug coverage, it is essential for SHICK counselors to help clients assess if a Medicare Advantage (MA) plan will meet their health insurance needs. The first step in that process is to determine if a client is eligible to enroll in a MA plan. Here are three key questions counselors should ask to assess a client's eligibility for enrolling in a MA plan.

- **Is your client enrolled in Medicare?** Generally, to be eligible to enroll in a Medicare Advantage plan, a Medicare beneficiary must be enrolled in both Medicare Part A and Part B.
- **Does your client have end-stage renal disease (ESRD)?** Except in certain circumstances, beneficiaries may not be medically determined to have end-stage renal disease (ESRD) at the time of enrolling in a MA plan. Individuals who develop ESRD while enrolled in a MA plan may continue to be enrolled in the plan. Beneficiaries who have ESRD may also enroll in a Special Needs Plan (SNP) that is open for enrollment to those with ESRD.
- **Does your client live in the MA plan's service area?** Beneficiaries must permanently reside in a Medicare Advantage plan's service area to be able to enroll in the plan. Service areas differ among the various types of MA plans. Service areas may be no larger than a few counties in a metropolitan area or

they may encompass an entire state or a multi-state region. Since provider network rules vary by plan as well as by plan type, it is especially important for beneficiaries who live out of a plan's service area for some part of the year to consider this factor.

When eligible beneficiaries decide to join a MA plan, they must complete an enrollment form to elect, or enroll in, a MA plan. It is very important to note that Medicare beneficiaries who choose to enroll in a Medicare Advantage plan remain "in Medicare." Often beneficiaries think that they are leaving Medicare when they join a MA plan. Counselors may need to address the sources of this confusion, which may include marketing materials and a MA plan's use of its own membership card instead of a beneficiary's regular Medicare card. While MA coverage through a private plan replaces the Part A Hospital Insurance and Part B Supplemental Medical Insurance that provide coverage to beneficiaries in Original Medicare, MA enrollees retain the rights of all Medicare beneficiaries, including the right to return to Original Medicare.

Finally, except for beneficiaries enrolled in Medicare Medical Savings Account (MSA) plans and those enrolled in Private-Fee-for-Service (PFFS) plans and Cost plans that do not offer qualified prescription drug coverage, individuals may not be enrolled into both a MA plan and a stand-alone Medicare Prescription Drug Plan (PDP) at the same time.

Deciding to Enroll in a MA Plan

MA plans may help some Medicare beneficiaries lower their out-of-pocket spending and gain access to benefits beyond those in Original Medicare.

SHICK counselors provide a unique and essential service for clients when guiding them through a process to reach sound decisions about MA plan enrollment. To continue the assessment process that began with determining eligibility, counselors should learn as much as possible about a client's interest in particular MA plans. Here are some likely reasons for that interest:

- **Low premiums**: Some MA plans have very low monthly premiums. When compared to the cost of Medicare Supplement (Medigap) insurance policies or retiree group health plans, some of your clients could save several hundreds of dollars annually on insurance premiums by enrolling in a MA plan. The prospect of lower monthly health insurance premiums alone motivates many people to consider MA plans.
- **Extra Benefits**: Most MA plans offer benefits that the Original Medicare program excludes from coverage. Typically, these extra benefits can include routine dental and vision care.
- **Simplicity**: MA plans often combine the benefits that Original Medicare and Medicare Part D make available, along with some features of supplement insurance, in a complete package with one monthly premium. Some people prefer this to Original Medicare in which beneficiaries often pay separate premiums for Medigap insurance and Part D prescription drug benefits. Many MA plans also use set copayment amounts, such as $10 or $20 for each physician visit instead of Original Medicare's less predictable Part B 20% coinsurance charge.
- **An Affordable Alternative to Medicare Supplement Insurance**: Because MA plans cover some of the benefit gaps in Original Medicare, and because they are billed as a modern insurance option with more "advantages," some of your clients may believe that MA plans take the place of Original Medicare and supplement insurance, or that the MA plans and Medigap insurance are equivalent. This is a

misimpression that SHICK counselors must address with patience and the use of case examples that illustrate how the out-of-pocket costs in MA plans and Medigap insurance differ.

After taking some time to listen to the reasons for a client's interest in a MA plan, it is important next for counselors to address several factors that beneficiaries should consider before joining a Medicare Advantage plan. Here are some considerations:

- **Plan Rules**: Enrollees in MA plans must follow the rules of the Medicare Advantage plan to receive coverage and payment. For example, a common rule in Medicare HMOs is one that requires the use of network providers, including doctors, hospitals, and diagnostic facilities. Another common rule in HMOs requires patients to get referrals to see specialists. Many MA plans, including HMOs and Private Fee-for-Service (PFFS) plans, also have prior authorization or prior notification rules that apply, for example, to medical equipment and elective surgery. Enrollees who do not follow their MA plan's rules may be responsible for the entire cost of care.
- **Lock-In**: Beneficiaries who opt to join a MA plan should understand the concept of lock-in. Individuals may make changes only during limited enrollment periods (e.g., the OEP and MA OEP). Once an enrollment choice is effective, most beneficiaries are "locked-in" to their selected plan for the remainder of the plan year. This lock-in feature does not apply to beneficiaries who have a SEP.
- **Out-of-Pocket Costs**: Since many Medicare beneficiaries have moderate incomes, it is tempting for some people to compare MA plans and Original Medicare with a Medigap policy by premiums alone. But the true cost of a MA plan includes the monthly premium plus the cost-sharing charges for various services. MA plans set their own cost structure, so a plan could offer a low monthly premium and offset it by charging more for individual covered services. While MA plans commonly use defined copayments for inpatient hospital and physician services, many use percentage-based coinsurance charges for outpatient hospital care and medical equipment and supplies. In some plans, beneficiaries owe out-of-pocket 20% of the cost for outpatient surgery and other treatments. In contrast, those in Original Medicare may purchase a Medigap policy that pays all of the beneficiary's cost-sharing for inpatient and outpatient hospital services, and the entire coinsurance charge for medical equipment and supplies.
- **Beneficiary Liability for Cost-Sharing**: MA plan members must be prepared to cover the plan's out-of-pocket costs with their own income or financial resources. Thus, it is critical for people to examine a MA plan's cost-sharing structure and for counselors to show through case examples how the cost-sharing system works, before your clients enroll in a MA plan.
- **Access to Providers**: Some MA plans have health care provider networks with restricted access to "out-of-network" providers. Provider networks are common in Medicare HMOs and PPOs. Some HMO and PPO plans' networks are very large, while others are more limited. Medicare PFFS plans, on the other hand, make payments to any health care provider who is willing to accept the plan's payment terms. Doctors, hospitals, and other service providers can pick and choose among the PFFS plans whose payments they will accept. With respect to providers, counselors should encourage clients to think about a MA plan's ability to ensure access to the hospitals, doctors, home health agencies, and diagnostic centers they prefer to use.
- **Peace of Mind**: Some people who enroll in MA plans face surprisingly large out-of-pocket costs when an unexpected illness or accident requires a series of outpatient hospital visits for treatment or rehabilitation. Others are stunned when an out-of-town diagnostic center does not accept a MA plan's

payments, leaving them to foot the entire bill for expensive procedures. To promote peace of mind, counselors can help clients weigh the benefit of a MA plan's potential savings with some of its inherent uncertainties and risks. With clients who are "on the fence," counselors should recall that those who enroll in MA plans can return to Original Medicare during an annual Open Enrollment Period (OEP), the MA Open Enrollment Period (MA OEP), or a Special Enrollment Period (SEP). In limited cases, clients have special rights to return to Original Medicare and purchase Medigap insurance.

CMS has an online tool that provides information about Medicare Advantage plans, called the Medicare Plan Finder. It is available at http://www.medicare.gov/. Coverage and cost information about each plan is located in the Medicare Plan Finder by clicking on the plan's name. Through this online tool, SHICK counselors can help beneficiaries narrow the list of available MA plans in their state. The tool allows you to further limit the list of MA plans in a state with additional screening criteria—including but not limited to:

- Plans that charge no more than a certain monthly premium and/or deductible
- Plans that allow an enrollee to visit any doctor and other coverage options
- Plan Star Rating

While the Medicare Plan Finder gives a lot of information about the coverage and cost features in MA plans in summary and detailed forms, even the detailed information may not provide all of the specifics that a client needs to make an informed decision, such as contracted providers. Thus, further research may be required. Typically, you can find more information about a MA plan through its website or toll-free number.

The Medicare website also has a comparison tool for Medigap policies available in the state. Since beneficiaries sometimes enroll in a Medicare Advantage plan as an alternative to buying Medigap insurance, this tool does provide a method to evaluate both sets of options.

Enrollment Periods and Effective Dates

CMS does not allow continuous open enrollment for the Medicare Advantage program. While some low-income beneficiaries may make enrollment changes more often, most beneficiaries have limited time frames to enroll in, disenroll from, or switch MA plans. Most people who enroll in MA plans are "locked in" to their plans for a calendar year. Beneficiaries must complete an enrollment form to elect, or enroll in, a MA plan.

There are three enrollment period categories: initial, yearly, and special enrollment. A beneficiary's first chance to enroll in Medicare, and thus to choose a Medicare Advantage plan, is called the Initial Enrollment Period (IEP). The IEP often coordinates with a beneficiary's Part D Initial Enrollment Period (IEP). Yearly scheduled enrollment periods (including the annual Open Enrollment Period and MA Open Enrollment Period) are set times of year when the law permits beneficiaries to make changes to their Medicare coverage. Special Enrollment Periods (SEPs) enable beneficiaries with special situations to make plan changes outside of initial or yearly opportunities. For example, SEPs permit beneficiaries who move out of a plan's service area or who lose other health coverage to make changes to their Medicare benefits.

Initial Coverage Election Period (IEP)

The Initial Coverage Election Period (IEP) is the seven-month time frame during which a person who is newly eligible for Medicare (enrolled in both Medicare Part A and Part B) may choose to enroll in a Medicare Advantage plan for the first time. The IEP begins three months before entitlement to both Part A

and Part B and ends either on the last day for the beneficiary's Part B initial enrollment period or the last day of the month preceding entitlement to both Part A and Part B, whichever is later.

Generally, a person becomes eligible for Medicare on the first day of the month of his or her 65th birthday or the 25th month of disability. Part B enrollment may not occur upon entitlement to Part A for a variety of reasons; thus, the IEP typically coordinates with Part B entitlement or enrollment.

Yearly Opportunities for Enrollment: OEP and MA OEP

The MMA permits Medicare beneficiaries to make changes to their Medicare enrollment during the annual Open Enrollment (or Election) Period (OEP) each year. Medicare Advantage-eligible beneficiaries may use the OEP as an opportunity to enroll in or disenroll from a MA plan. They can use the OEP to switch from one MA plan to another or to leave the MA program for Original Medicare. The OEP runs from October 15 through December 7 each year. The new coverage choice becomes effective on January 1 of the following year. Beneficiaries who make more than one enrollment choice during the OEP will be enrolled only into the plan with the latest date of application. This means that beneficiaries can change their minds throughout the OEP. While this may be helpful for some individuals, keep in mind that unscrupulous plan sales agents can undo the results of a counseling session with SHICK's clients. Note that employer/union sponsored MA group plans need not conform to the OEP rules that apply to other MA plans.

The OEP is also a chance for all Medicare beneficiaries to enroll in or disenroll from a Medicare drug plan. A decision to enroll in or disenroll from Medicare drug coverage during the OEP is effective for the following calendar year, beginning on January 1. Only beneficiaries who have a Special Enrollment Period (SEP) opportunity may change their Medicare drug plan enrollment during the plan year.

Medicare Advantage Open Enrollment Period (MA OEP)

The Medicare Advantage open enrollment period (MA OEP) takes place from January 1st through March 31st annually. This OEP allows individuals enrolled in an MA plan, including newly MA-eligible individuals, to make a one-time election to go to another MA plan or Original Medicare. Individuals using the MA OEP to make a change may make a coordinating change to add or drop Part D coverage. An MA organization has the option to voluntarily close one or more of its MA plans to MA OEP enrollment requests. If an MA plan is closed for MA OEP enrollments, then it is closed to all individuals in the entire plan service area who are making MA OEP enrollment requests. All MA plans must accept MA OEP disenrollment requests, regardless of whether or not it is open for enrollment. Individuals with enrollment in Original Medicare or other Medicare health plan types, such as cost plans, are not able use the MA OEP to enroll in an MA plan, regardless of whether or not they have Part D.

The types of changes beneficiaries can make during the MA OEP are listed in the table below. An enrollment choice made during the MA OEP is in effect for the entire remaining calendar year starting on the effective date of coverage, unless a beneficiary has a SEP opportunity.

Important: If the beneficiary disenrolls from a Medicare private health plan (Medicare Advantage), federal law does not give the beneficiary the right of guarantee issue to buy a Medigap plan.

Type of Coverage on January 1	Allowed During MA OEP
MA-PD MA-only	• MA-PD • MA-only • Original Medicare + PDP • Original Medicare w/o PDP
Original Medicare only or with a PDP	• No changes allowed

Another OEP enrollment opportunity, called the OEPI, exists for people in institutions. The OEPI is a continuous enrollment period for all Medicare beneficiaries who move into, reside in, or move out of an institution. The OEPI permits them to make unlimited changes to their MA or Original Medicare enrollment. For the purpose of the OEPI, the term "institutionalized" includes those residing in the following facilities:

- Skilled nursing facilities (SNFs)
- Nursing facilities (NFs)
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Psychiatric hospitals
- Rehabilitation hospitals
- Long-term care hospitals
- Swing-bed hospitals

Special Enrollment (Election) Periods

Special Enrollment (Election) Periods (SEPs) enable Medicare beneficiaries to make certain enrollment changes in several special situations. As a SHICK counselor, it is important to keep in mind that these SEP opportunities exist because they may enable some of your clients to make changes in their MA enrollment outside of the OEP and MA OEP.

CMS's enrollment guidance describes a SEP this way:

> Special election periods constitute periods outside of the usual IEP, OEP, or MA OEP when an individual may elect a plan or change his or her current plan election…. Depending on the nature of the particular special election period, an individual may:
>
> - Discontinue an enrollment in a MA plan and enroll in Original Medicare
> - Switch from Original Medicare to a MA plan
> - Switch from one MA plan to another MA plan

Certain SEPs are limited to an enrollment or disenrollment request. If the individual disenrolls from (or is disenrolled from) the MA plan and changes to Original Medicare, the individual may subsequently elect a new MA plan within the SEP time frame. Once the individual has elected the new MA plan, the SEP ends for that individual even if the time frame for the SEP is still in effect. **In other words, the SEP for the individual ends when the individual elects a new MA plan or when the SEP time frame ends, whichever comes first, unless specified otherwise within an SEP.**

In addition to MA-specific SEPs, there are certain other SEPs that correspond to Prescription Drug Plans (PDPs).

Change in Residence

Two circumstances give persons the right to a SEP for a change in residence. This includes those who have a change in permanent residence that places them outside of their MA plan's service area and those who have new MA and/or Part D plans available as a result of a change in permanent residence.

This SEP has certain notice procedures. For people who notify their plan in advance of their move, their SEP begins the month before the move and continues for two months. For those who give notice of the move upon moving or afterwards, the SEP begins upon notification and continues for two months.

When individuals do not notify their plan of their move, and the plan learns from CMS or otherwise that they have lived outside of their plan's service area for more than six months, their SEP begins in the sixth month and continues through the eighth month after the move. Persons may request that the effective dates of their SEP enrollments to be up to three months after the notification but not earlier than the date of the move.

Contract Violation

MA plan enrollees who demonstrate to CMS that the MA organization violated a material provision of its contract or materially misrepresented the plan during marketing have a SEP opportunity to change to another MA plan or to Original Medicare. SHICK can help plan enrollees submit requests for Contract Violation SEPs to their CMS Regional Office. CMS will process some of these enrollment requests as retroactive disenrollments/enrollments. The SEP begins upon CMS's determination of the violation and continues subject to the discretion of CMS.

Non-Renewals or Terminations

People whose plans end due to non-renewal on January 1 of a plan year have a SEP from October 1 of the prior year to January 31 of the following year. CMS requires these plans to give 90 days' notice to enrollees. The effective date of the enrollment may be on January 1, or February 1, but not before the plan receives the enrollment request.

For enrollees of plans that terminate their contracts, their SEP begins two months before the termination effective date and ends one month past the termination effective date. These plans are required to give 60 days' notice to enrollees. The effective date of the enrollment may be the month after notice is given until two months after the termination effective date.

For enrollees of plans whose contracts CMS terminates, their SEP begins one month before the termination effective date and ends two months past that date. CMS requires these plans to give a 30-day notice to enrollees. The effective date of the enrollment may be up to three months after the month of termination but not before the plan receives the enrollment request.

Exceptional Conditions

- **SEP EGHP**: Medicare beneficiaries who have access to an Employer/Union Group Health Plan (EGHP) have a SEP to elect a MA plan or vice versa during the period of time when the EGHP allows plan changes. The effective date of the enrollment may be up to three months after the request for enrollment or disenrollment but not before the plan receives the request.
- **Disenrollment Connected to a CMS Sanction**: If CMS sanctions a MA organization and enrollees disenroll due to the issue that led to the sanction, CMS may authorize a SEP on a case-by-case basis for those enrollees.

- **PACE Enrollees**: MA enrollees may disenroll at any time to join a PACE program. Those who disenroll from PACE have a SEP for up to two months after the disenrollment during which they may join a MA plan.
- **Dual-Eligible and LIS-eligible Beneficiaries**: Beneficiaries can join, switch, or drop Medicare prescription drug coverage onetime per calendar quarter between January through September. The effective date of the change is the first of the month following the request for the change. They can also make a change from October 15–December 7, and the change will take effect on January 1.
- **Trial Period SEP**: People who drop a Medigap policy to enroll in a MA plan for the first time are entitled to a guaranteed right to purchase their own Medigap policy back or buy a new one, if the one they had is not available, within the "trial period," usually twelve months. The Trial Period SEP permits them to disenroll from a MA plan at any time during this trial period to return to Original Medicare and to purchase the Medigap policy. The SEP begins upon disenrollment from the MA plan and continues for two additional months, with an effective date depending on the situation.
- **Retroactive ESRD Entitlement**
- **Retroactive Medicare Entitlement**
- **Part D Coordinating**: These SEPs permit eligible persons to make an election into or out of an MA-PD plan (or as it applies below).
  - **Involuntary Loss of Creditable Coverage**: Medicare beneficiaries who experience an involuntary loss of creditable coverage or a reduction in such coverage that makes it no longer creditable have a SEP to permit enrollment into a Part D plan (including an MA-PD plan). The SEP begins upon notification of the loss (or reduction) and ends two months after the loss (or reduction) or the notice, whichever is later. The effective date is the first of the month following the request or may be up to three months prospective.
  - **Not Informed of Creditable Coverage**: Those not adequately informed of a loss of (or that they never had) creditable coverage have a SEP to enroll in a Part D plan (including an MA-PD plan). Established on a case-by-case basis, this SEP begins upon approval from CMS and continues for two additional months.
  - **Error by Federal Employee**: On a case-by-case basis, CMS may grant a SEP to those whose enrollment or non-enrollment in a Part D plan (including an MA-PD plan) is not valid due to the action, inaction, or error of a Federal employee. This SEP begins upon approval from CMS and continues for two additional months. SHIPs can help plan enrollees submit requests to their CMS Regional Office.
  - **Disabled Medicare Beneficiary Turning 65**: Beneficiaries eligible for Medicare due to a disability have an additional IEP for Part D upon turning 65. The coordinating SEP with this IEP may be used to disenroll from an MA-only or MA-PD plan and return to Original Medicare, or to enroll in an MA-only plan (regardless of whether the Part D IEP to enroll in a PDP is used). The SEP begins and ends concurrently with the additional Part D IEP.
- **Beneficiaries Losing Special Needs Status**: Those enrolled in a Special Needs Plan (SNP) who no longer meet the specific special needs status are eligible for a SEP. The SEP begins upon the change in status and continues for three more months.
- **Beneficiaries no longer eligible for Medicaid or LIS upon Losing LIS**: Beneficiaries can join a Medicare Advantage or Medicare Prescription Drug Plan, switch from their current plan to another Medicare Advantage or Medicare Prescription Drug Plan, drop their Medicare Advantage Plan and return to Original Medicare, or drop their Medicare prescription drug coverage. The effective date of the change

would be the first of the month following the request for the change. Their chance to change lasts for 3 full months from either the date they are no longer eligible or notified, whichever is later.

- **Enrollment in a Chronic Care SNP**: A SEP exists for individuals who qualify for a Chronic Care Special Needs Plan (SNP) to enroll in an SNP. The SEP applies to all beneficiaries who qualify for these SNPs and ends upon enrollment into a plan.
- **Beneficiaries Who Require a New Chronic Care SNP**: An additional SEP exists for beneficiaries currently enrolled in a Chronic Care SNP who require a new SNP due to a new chronic care focus. The SEP ends upon enrollment into the new SNP.
- **Disenrollment from Part D to Enroll in or Maintain Creditable Coverage**: Any enrollee in a Part D plan (including PDPs and MA-PDs) may disenroll at any time from the plan to obtain or maintain other creditable coverage. The effective date of disenrollment would be the first of the month following the request. This SEP permits those leaving MA-PD plans also to enroll in an MA-only plan.
- **Beneficiaries who are released from jail**. Beneficiaries who are released from jail have a SEP to join a MA plan or Part D plan for two full months after the month they are released from jail.

SEP65

Beneficiaries who enroll in a MA plan (excluding an MSA plan) during their Initial Enrollment Period for Part B (the seven months around their 65th birthday) have a SEP65 to try out the Medicare Advantage program. These individuals may disenroll from the MA plan into Original Medicare at any time during the first twelve months of enrollment in the MA plan. They have a guaranteed issue right to any Medigap policy (not just plans A, B, D, G, K, or L).

5-Star SEP

Under the 5-Star Special Enrollment Period, a beneficiary can join or switch to a 5-Star MA plan (with or without drug coverage) or a 5-Star PDP in their service area. This SEP is from December 8 through November 30 of the next year, with an effective date of the first of month following the enrollment request. It can only be used to enroll in plans given an overall 5-star rating for the current calendar year. The Star rating is from the ratings on the Plan Finder. Beneficiaries can only use the 5-star SEP one time during the year. If the beneficiary joins an MA-only plan which allows a stand-alone PDP, they also have a coordinating Part D SEP and can join a PDP for the same month. The PDP doesn't have to be a 5-star plan. However, if they are switching from one MA-only plan to another MA-only plan, they do not have an SEP to switch PDPs.

How to Enroll in a MA Plan

Beneficiaries eligible for the Part D low-income subsidy, and thus have auto or facilitated enrollment, may occasionally be auto or facilitated enrolled into a Medicare Advantage plan with drug coverage. This process only occurs in certain exceptional instances when a beneficiary is enrolled into an MA-only plan upon becoming eligible for the LIS. At that point, these beneficiaries would be facilitated into MA-PD plans to ensure their access to Medicare drug coverage.

Who Can Help a Medicare Beneficiary Enroll?

In most cases, Medicare beneficiaries themselves must complete applications to enroll in MA plans. CMS's MA Enrollment and Disenrollment Guidance explains that anyone other than the beneficiary who completes an enrollment request must state that he or she has the legal authority under state law to execute the enrollment.

NOTE: SHICK counselors who assist clients with enrollment generally do not have the legal authority to make health care decisions on behalf of a Medicare beneficiary. Instead, SHICK counselors who help clients with Medicare Advantage plan enrollment are merely facilitating the process. Counselors can avoid problems by making sure that they do not indicate that they represent their clients, or sign enrollment forms on a client's behalf.

Plan Must Provide Certain Information to Enrollee

Prior to the effective date of enrollment (or within 10 calendar days of enrolling) a MA plan must provide all enrollees with the following documents:

- A copy of the enrollment form, where applicable
- A notice acknowledging receipt of the completed enrollment election showing the effective date of coverage
- Proof of health insurance coverage, including, where applicable, the data necessary to access prescription drug benefits

Materials must explain the following information to new enrollees:

- The costs associated with the MA plan, including but not limited to the premium, coinsurance, copayments, or fees and the amount that the plan contributes to the Medicare premium and deductible, if applicable.
- The lock-in requirement, including an acknowledgement from enrollees that they understand about the plan's provider network requirements.
- The effective date of coverage and steps to take to obtain services prior to the receipt of an ID card, if necessary.

Disenrollment

Medicare beneficiaries who are currently enrolled in a Medicare Advantage plan may only disenroll from that plan during certain periods: the annual Open Enrollment Period (OEP) from October 15 through December 7; during the MA Open Enrollment Period (MA OEP) from January 1 through March 31; and any applicable Special Enrollment Period (SEP).

There are a few ways for a Medicare beneficiary to disenroll from a MA plan:

- By enrolling in another plan
- By sending or faxing a signed written notice to the MA organization
- By requesting disenrollment online to the MA organization (if the MA organization offers this option)
- By calling 1-800-MEDICARE

CMS's disenrollment policy guidance states that "if a member verbally requests disenrollment from the MA plan, the MA organization must instruct the member to make the request in one of the ways described above. […] The disenrollment request must be dated when it is initially received at the MA organization's business offices."

The effective date of most disenrollment requests is the first of the month following the request for disenrollment. There are certain exceptions to this rule based on the enrollment period during which enrollees request the disenrollment. Plans must send written acknowledgement of the disenrollment request to the enrollee within ten days of the request.

MA plans may also process involuntary disenrollments in certain circumstances. Examples of situations where plans have the option to disenroll individuals include the following:

- Failure to pay premiums timely
- Engaging in disruptive behavior
- Providing fraudulent information to the plan

There are also certain situations when CMS requires a plan to process an involuntary disenrollment:

- Moving out of a MA plan's service area
- Losing entitlement to Medicare Part A and/or Part B
- Losing special needs status, for Special Needs Plans
- Death
- Plan terminating or discontinuing

Post-Enrollment Actions

Even after a beneficiary requests enrollment or disenrollment, there are certain changes that may be made related to the enrollment or disenrollment.

Cancellations

Both enrollment and disenrollment requests may be cancelled before the effective date of the change. Those wishing to request such a cancellation must request this directly from the MA organization.

Reinstatements

Enrollment in a MA plan may be reinstated if a disenrollment was processed and the disenrollment was not legally valid. CMS processes reinstatements on a case-by-case basis, but common reasons for reinstatements include the following circumstances:

- Disenrollment due to mistaken death indicator
- Disenrollment due to mistaken loss of Medicare Part A or Part B
- Mistaken disenrollment

Retroactive Enrollments

If a MA organization does not process a valid request for enrollment within the appropriate time frame, then CMS may perform a retroactive enrollment.

Retroactive Disenrollments

If an enrollment in a MA plan was never legally valid or if a beneficiary makes a valid disenrollment request and it is not processed, a retroactive disenrollment may be performed by CMS. Enrollments that are not legally valid could include the following:

- An incomplete enrollment request
- An attempted enrollment for an individual who did not meet eligibility requirements at the time of enrollment
- If the member or his/her legal representative did not intend to enroll in the MA organization. Evidence of a lack of intent to enroll could include:
    - An enrollment form signed by the individual when a legal representative should have signed,
    - A request by the individual for cancellation of enrollment before the effective date,

- An enrollment in a supplemental insurance program after enrolling in the MA plan, or
- Receiving services out-of-network after enrolling in a MA plan.

Coverage of Benefits and Access to Services

Basic Benefits

Generally, the law requires Medicare Advantage plans to cover, at a minimum, all Original Medicare-covered services, except hospice care. This means that MA plans must provide coverage of all Part A and Part B services by furnishing these services directly or through payment arrangements with providers of certain services. MA organizations must submit to CMS their coverage of benefits package before CMS approves the MA plan.

Before approving a MA organization to offer a MA plan to beneficiaries, CMS reviews the proposal to ensure that the plan meets the following conditions:

- Medicare-covered services are provided and meet CMS guidelines under Original Medicare
- Cost-sharing structure does not discriminate against beneficiaries, promote discrimination, discourage enrollment, encourage disenrollment, steer certain subsets of beneficiaries to the plan, inhibit access to services, or design cost-sharing differentials that limit choices
- Benefits meet other MA program requirements

As with Original Medicare, coverage of services depends on several conditions:

- The service must meet a benefit category
- The service must not be specifically excluded from coverage
- The item or services must be considered “reasonable and necessary”

CMS’s policy guidance provides this information about the term “reasonable and necessary”:

> Section 1862(a)(1)(A) of the Act states that, subject to certain limitations, no payment may be made for expenses incurred for items or services that are not “reasonable and necessary” for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.

Medicare Advantage Organizations must abide by National Coverage Determinations, general Medicare coverage guidelines, and written coverage decisions of local Medicare Administrative Contractors (MACs). In the absence of national or local coverage determinations, Medicare Advantage organizations may follow the coverage policies of other MA organizations, or make their own coverage determinations and provide a rationale for the decision. While MA plans must provide coverage for all Medicare-covered services, they may use their flexibility to encourage cost-effective use of these services.

Supplemental Benefits and Guidelines

Coverage of supplemental benefits by a Medicare Advantage plan falls into two categories—mandatory supplemental benefits and optional supplemental benefits.

Mandatory Supplemental Benefits

These benefits include services not covered by Original Medicare (excluding Medicare prescription drug coverage) that some MA plans may offer to all enrollees as an automatic part of the MA plan’s package. If a MA plan offers mandatory supplemental benefits, all enrollees in that plan must accept these benefits.

MA plans submit their mandatory supplemental benefits to CMS as part of the benefits package that CMS reviews before it approves the plan.

MA plan enrollees pay for these benefits through the MA plan's premium and cost sharing. The MA plan may use rebate dollars to pay for a part of or all mandatory supplemental benefits.

Examples of mandatory supplemental benefits include:

- Coverage for emergencies outside the United States
- Annual physical examinations
- Routine hearing and vision examinations
- No three-day prior hospital stay before Skilled Nursing Facility (SNF) admission
- Acupuncture
- Transportation to plan provider appointments
- Point of Service (POS) option in Medicare HMOs

Optional Supplemental Benefits

These benefits include services not covered by Original Medicare (excluding Medicare drug coverage) that a MA plan offers as an option to all enrollees. If enrollees opt to take these benefits, they must pay the full cost of the coverage, typically through an extra premium. The optional supplemental benefits must be offered to all beneficiaries equally upon enrolling in the MA plan and for a set time afterwards. Plan enrollees may voluntarily drop this coverage at any time during the plan year by giving notice to the plan.

Examples of optional supplemental benefits packages include:

- Dental care that covers visits, x-rays, and semi-annual cleanings
- Vision care that covers optometry visits, eyeglasses, or contact lenses
- Hearing care that covers audiology tests and the partial costs of hearing aids
- Point of Service (POS) option in Medicare HMOs

Design of Supplemental Benefits

While MA plans have significant flexibility in designing their benefits packages, they must follow certain guidelines for their supplemental benefits package:

- All benefits generally must be health-related. Health-related means that the primary purpose of the item or service is to prevent, cure, or diminish an illness or injury that is actually present or expected to occur in the future. If the primary purpose of the item or service is comfort, cosmetic, or daily maintenance then it may not be classified as a health benefit.
    - Beginning in 2019, MA plans are now allowed to offer some non-health related supplemental benefits, though the number of plans offering these benefits are still limited.
- All benefits must be offered in the same way to all enrollees.
- All benefits must be priced in the bid to CMS.
- All benefits must be specified in the appropriate marketing vehicles.

Value-Added Items and Services (VAIS)

Value-Added Items and Services (VAIS) are items and services that do not meet the definition of benefits. MA organizations may not use Medicare program dollars to pay for VAIS, and the cost associated with these items and services must be intrinsically administrative for CMS to consider them VAIS.

There are certain rules associated with plans offering VAIS:

- VAIS must be offered for the entire contract year
- VAIS must be offered in the same way to all enrollees
- Plans must maintain the privacy and confidentiality of enrollee records
- Plans must comply with applicable HIPAA laws
- Plans must comply with relevant fraud and abuse laws

Examples of VAIS include:

- Fitness programs
- Health club memberships or membership discounts
- Discounts on items such as nutritional supplements
- Meals on Wheels following hospital discharge

Service Areas

Medicare Advantage plans have a specific geographic area that CMS approves with some exceptions for retiree group MA plans. According to CMS's policy guidance:

> The basic requirement of service area is that each MA plan offered by a MA organization must be offered to all beneficiaries in a MA plan's service area with a uniform benefit package and uniform cost-sharing arrangements.

Beneficiaries must live within a plan's service area to be able to enroll in the MA plan. A service area may be as small as one county or as large as multiple MA regions. A regional MA plan (like a Regional PPO plan) must have a service area that encompasses the entire MA region. (Nationally, there are 26 MA regions. Kansas is in Region 18 with Oklahoma.) Within a MA plan's service area, the plan must provide all enrollees an identical package of benefits with an identical cost-sharing structure.

The following features are affected by a MA plan's service area:

- **Access Requirements**: a MA plan's service area defines the geographic area in which a coordinated care plan's covered services must be available and accessible.
- **Eligibility**: a MA plan's service area determines which Medicare beneficiaries are permitted to enroll in the plan. Other than Special Needs Plans (which may restrict their enrollment to certain populations of beneficiaries), MA plans must allow any eligible Medicare beneficiary residing in a plan's service area to enroll in that plan during an applicable enrollment period.
- **Payment Rate**: a MA plan's service area determines CMS's payment rate to the MA plan. CMS pays MA plans a set amount of money per beneficiary who enrolls in the plan. Several factors affect the set amount, including, for example, the plan's service area and the health status of enrollees.
- **Required Benefits**: a MA plan's service area sometimes determines which benefits must be covered by the plan. All benefits offered by MA plans in a service area must be uniform throughout

the service area; so the service area will establish, to some extent, the benefits that a MA plan must offer.

- **Urgently-Needed Services**: a MA plan's service area determines the boundaries beyond which a coordinated care plan must cover urgently-needed services.

Disclosure Requirements

MA plans can be most beneficial to enrollees who are able to understand and follow the plans' rules for receiving covered services and benefits. To achieve this end, plans are required to provide certain information to enrollees at specific times during a plan contract year.

Upon Enrollment and Annually Thereafter

MA plans must provide the following information to all plan enrollees upon enrollment and annually thereafter:

- Service area: The MA plan's service area and enrollment continuation area, if relevant
- Benefits: The MA plan's benefits, including conditions and limitations and the premiums and cost-sharing related to these benefits
- Access: Information about the MA plan's network providers, out-of-network coverage, and POS option (if applicable)
- Out-of-area coverage: The MA plan's rules for coverage of services outside of the plan's service area
- Emergency coverage: The MA plan's coverage of emergency services, including what constitutes an emergency, appropriate use of emergency services, process and procedures for obtaining these services, and locations where emergency services can be obtained
- Supplemental benefits: The MA plan's mandatory and optional supplemental benefits (if applicable) and the premiums for those benefits
- Prior authorization and review rules: The MA plan's prior authorization rules that must be met to ensure the plan provides coverage for the services
- Grievance and appeals procedures
- Quality Improvement program: Except for PFFS and MSA plans, a description of the required Quality Improvement program
- Catastrophic caps and single deductible: Plans' information about their out-of-pocket limit (also known as "catastrophic stop-loss coverage") and combined Medicare deductible (if applicable)
- Disenrollment rights and responsibilities

Upon Request

All beneficiaries eligible to enroll in a MA plan have a right to receive the following information from MA plans:

- Original Medicare-covered benefits: Information about Part A and Part B covered benefits, including cost-sharing
- Enrollment procedure: Information and instructions for potential enrollees on how to enroll in the MA plan
- Rights: Information about grievance and appeal procedures and the right to be protected from discrimination

- Potential for contract termination: Information about potential changes to a MA plan, including contract termination, non-renewal of a contract, or a reduction in a plan's service area
- Benefits: The MA plan's benefits, including conditions and limitations, the premiums and cost-sharing related to these benefits, out-of-pocket limits, out-of-network coverage policies, and coverage of emergency and urgently-needed care
- Premiums: Information about any monthly basic premium, any monthly supplemental premium, and any reduction in the Part B premium
- Plan's service area
- Quality and performance indicators: To the extent they are available, information about the following indicators: disenrollment rates, enrollee satisfaction, health outcomes, plan-level appeal data, and record of plan compliance
- Supplemental benefits: The MA plan's mandatory and optional supplemental benefits (if applicable) and the terms, conditions, and premiums for those benefits
- Utilization management techniques
- Aggregated number and disposition of disputes: Information about submissions for plan grievances and appeals
- Physician compensation methods
- Financial information: Information on the financial condition of the MA organization

Ensuring Continuity of Care

All MA organizations must show they have met standards to ensure continuity of care for enrollees. MA organizations must meet the following requirements, among others, to satisfy CMS's expectation that the plan is ready and able to secure continuity of care for enrollees:

- The MA plan must describe its method for coordinating care, including which services are coordinated, under which circumstances they are coordinated, methods of coordination, and who coordinates the care.
- The MA plan must provide enrollees with a source of primary care.
- The MA plan must integrate services with community and social service programs through contracts or otherwise.
- The MA plan must establish processes that ensure effective and continuous patient care and quality review, including an initial health assessment for all new enrollees, an enrollee health record that is maintained, and a proper exchange of clinical information throughout the network of providers.
- The MA plan must use practices to inform enrollees of preferred follow-up care, training methods for self-care, and other health care promotion.
- The MA plan must have set treatment regimes to address common barriers to compliance for enrollees.

Access and Availability Rules for Coordinated Care Plans

Coordinated Care Plans (CCPs), such as HMOs and PPOs, also are required to demonstrate they have met access and availability standards for enrollees. MA organizations must meet the following requirements to obtain CMS approval for the plan sponsors:

- The CCP must maintain and monitor a network of providers that is sufficient to provide adequate access to covered services to meet the needs of all enrollees. The plan must maintain a provider network that is distributed throughout the service area to ensure enrollees must not travel unreasonable distances to receive care. Unreasonable distance is understood to be an average travel time of 30 minutes for commonly used services. Acceptable travel times may be longer for less common services or in rural areas.
- The CCP must establish standards for timeliness of access to care. This means that adequate numbers of providers are available all day, every day, for medically necessary service.
- The CCP must maintain a cohort of primary care providers (PCPs) from which enrollees may select a personal PCP.
- The CCP must provide access to necessary specialists. Female enrollees should have direct access to women's health specialists. If a MA plan's network of specialists does not sufficiently serve the plan's enrollees, the MA plan must arrange for care outside of the network to meet the needs of enrollees.
- The CCP must establish medical necessity determination standards, including coverage rules, practice guidelines, payment policies, and utilization management.
- The CCP must ensure that it provides coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services as required.
- The CCP must have criteria for chronic care improvement programs, including the identification of enrollees appropriate for such programs and systems for monitoring enrollees' participation in such programs.

Relationship to Drug Coverage

Drug coverage under the Medicare Advantage program falls into several categories: Part B drug coverage, Part D drug coverage, and over-the-counter drug coverage. Medicare Part A provides coverage for some drugs received during a Medicare-covered inpatient hospital stay.

Part B Original Medicare Drug Coverage

Since Medicare Part D drug coverage took effect on January 1, 2006, all Part B-covered drugs and biologicals continue to be covered through Original Medicare. Thus, MA plans cover Part B drugs and biologicals outside of their Part D drug benefit because the plans must cover the benefits in Part A and Part B of Original Medicare.

Some examples of Part B-covered drugs and biologicals are:

- Injectable drugs that are considered "not usually self-administered" and are given to beneficiaries in connection with physician services
- Drugs that beneficiaries take through durable medical equipment authorized by a MA plan
- Clotting factors for beneficiaries diagnosed with certain blood clotting disorders
- Immunosuppressive drugs following a Medicare-covered organ transplant
- Injectable osteoporosis drugs for beneficiaries who have had bone fractures related to post-menopausal osteoporosis
- Antigens
- Certain oral anti-cancer drugs
- Certain anti-nausea drugs

- Injectable erythropoietin for beneficiaries who have end-stage renal disease (ESRD) and related anemia

Part D Medicare Drug Coverage

There are different rules that govern whether Medicare Advantage plans offer Part D benefits as a MA plan with drug coverage (MA-PD). All Medicare Advantage organizations offering coordinated care plans (e.g., HMOs and PPOs) in a service area must offer at least one MA-PD plan within that area. This rule affects both local and regional coordinated care plans. All Special Needs Plans, a type of coordinated care plan, are required to provide prescription drug coverage.

Private Fee-for-Service (PFFS) plans, Medicare Medical Savings Accounts (MSAs), and Program for All-Inclusive Care for the Elderly (PACE) are not coordinated care plans. Medicare law does not place the same requirements on them as it does on coordinated care plans. PFFS plans are not required to provide drug coverage, and therefore many PFFS plans exist as MA-only plans. Also, MSA plans are prohibited from offering drug coverage, so all MSA plans are MA-only plans. Like Special Needs Plans, however, PACE plans must provide prescription drug coverage to all enrollees.

Generally, Medicare beneficiaries who want drug coverage and the benefits of a Medicare Advantage plan must enroll in a MA plan with Part D prescription drug coverage (MA-PD). An exception applies to beneficiaries who are enrolled in certain types of MA plans that do not offer drug coverage, including some PFFS plans, and all Medical Savings Account (MSA) plans. The MMA permits people who are enrolled in a PFFS, Cost, or MSA plan without Part D drug coverage, to enroll in a stand-alone Prescription Drug Plan (PDP) to receive prescription drug coverage. Otherwise beneficiaries who enroll in MA coordinated care plans that do not offer Part D drug coverage may not enroll in stand-alone PDPs.

Monthly Premiums

All Medicare beneficiaries have costs associated with their Medicare coverage, whether they are in Original Medicare or Medicare Advantage. The costs of a Medicare Advantage (MA) plan, though, can be different from those in Original Medicare.

Beneficiaries in MA plans must continue to pay the Medicare Part B premium.

The plan may have an additional premium, sometimes called a Part C premium. It covers the Medicare Part A and Part B benefits as well as any mandatory supplemental benefits. Enrollees pay the plan's Part C premium in addition to the Part B premium. Low monthly Part C plan premiums attract many Medicare beneficiaries to the Medicare Advantage program in the first place. Many MA plans eliminate the Part C premium entirely. SHICK counselors can help their clients make sound MA enrollment decisions by showing them how to balance a plan's low premiums with its other out-of-pocket costs.

Some Medicare Advantage plans may offer optional supplemental benefits to their enrollees. Only those enrollees who choose this optional coverage must pay an extra premium to receive the benefits. Optional benefits packages are similar to "riders" in other kinds of insurance. Medicare Advantage plans cannot use rebate dollars to reduce the actual costs of the optional supplemental premium.

Costs for Health Care Services

Federal law gives Medicare Advantage (MA) plans flexibility to create cost-sharing structures that differ from Original Medicare's. MA plans may use percentage coinsurance charges, fixed copayment charges, or a combination of the two, depending on the service. Keep in mind that plans can change their cost-sharing

structures and payment amounts yearly. CMS requires plans to notify plan members of these changes through an "Annual Notice of Change," or ANOC.

While beneficiaries in Original Medicare may purchase a Medigap policy to pay for some of the out-of-pocket costs—or gaps—in Original Medicare, the law prohibits Medigap policies from coordinating with MA plans. At this time, there are no Medicare-approved policies, like a Medigap, to cover the out-of-pocket costs for Medicare Advantage enrollees. Enrollees in MA plans must be prepared to pay out-of-pocket for any and all deductibles, copayments, and coinsurance amounts. In 2011, CMS implemented regulations making total out-of-pocket spending more predictable by requiring annual spending caps for all MA plans. The caps limit plan members' financial exposure to set dollar amounts. After a person reaches a spending cap, the MA plan covers the full cost of care for the rest of the year.

Billing for Services

Medicare Advantage billing is a process very similar to other commercial health insurance products. When a MA plan enrollee receives a covered service, the health care provider collects the copayment, if applicable, from the enrollee. Then the provider submits the claim to the plan. If the MA plan agrees to cover the service, the plan sends the provider a payment. If the MA plan declines to cover the service, the plan notifies the provider. It issues a written Notice of Denial of Payment to explain the reasons for its denial. In such cases, the provider may bill the enrollee for the full cost of the service. An enrollee who disagrees with a plan's coverage denial (i.e., a plan's "organization determination") may initate the appeals process.

Medicare Advantage plans may have restrictions on certain health services. For example, they may require enrollees to receive prior authorization for some services. If the physician requests prior approval for such a service and the MA plan denies the request, the plan issues a written Notice of Denial of Medical Coverage to explain its decision. When this happens, enrollees have a few options. First, they can start the appeals process. Second, they may file a grievance with the MA plan. Third, the physician may provide more information to meet the plan's coverage requirements.

The prior authorization process is quite different from the way that beneficiaries in Original Medicare receive covered services. In Original Medicare, the beneficiary receives a service from a Medicare provider. At that point, Medicare decides whether the service is covered. If the service is not covered, the beneficiary may pay the bill or appeal the denial if he believes Medicare should have covered the service. In Medicare Advantage, an enrollee may have to request coverage for a service before receiving it. If the plan denies coverage the enrollee may pay out-of-pocket for the service or start an appeal. The key difference between these two delivery mechanisms is that under Original Medicare a beneficiary may have to appeal to receive payment for a service received. Under Medicare Advantage a beneficiary may have to appeal to receive the service itself.

In Original Medicare, beneficiaries receive a Medicare Summary Notice (MSN) every three months if Medicare has paid a claim on their behalf. The MSN outlines all of the services a beneficiary received, how much Medicare paid for the service, and the amount providers may bill the beneficiary for each service. Medicare Advantage does not have an official, standard, system like the MSN for providing notice to enrollees about services they received. CMS instead expects plans to "give the beneficiary prompt notice of acceptance or denial of claims in a format specified by CMS." Most plans send an Explanation of Benefits (EOB) after they have paid for a service. For denials, they issue a form captioned *Notice of Denial of Payment*.

Low-Income Assistance

Some Medicare beneficiaries with limited income receive benefits from the state Medicaid program to pay some of the out-of-pocket costs associated with Medicare coverage. There are several levels of assistance, including full Medicaid benefits and the different categories of Medicare Savings Programs (MSPs).

Medicare beneficiaries who qualify for full Medicaid benefits are known as full dual-eligible beneficiaries (or "full duals"). Because full duals have few, if any, out-of-pocket expenses associated with their Medicare and Medicaid coverage, most of them have coverage through Original Medicare. However, some full dual beneficiaries may choose to enroll in a MA plan.

Some Medicare beneficiaries may qualify for the Medicare Savings Program called "Qualified Medicare Beneficiary," or QMB. Similar to the full dual-eligible beneficiaries, those with QMB have lower out-of-pocket costs associated with their Medicare coverage, and most of them have coverage through Original Medicare. However, some QMBs may choose to enroll in a Medicare Advantage plan.

Both full duals and QMBs receive assistance from Medicaid to pay for certain costs associated with Medicare Advantage plans. These costs include:

- Medicare premiums
- Deductibles
- Coinsurance and copayments (except for Part D copayments)

Enrollment of full duals and QMBs into some Medicare Advantage (MA) plans can be problematic. Not all MA plans have a contract in place with the state Medicaid office. Without such a contract, payment to providers for services received by enrollees may not occur as it should. When these beneficiaries receive covered services from a provider, the provider bills the MA plan for the services. If the plan does not have a contract with Medicaid, the claim is not always submitted by the provider to Medicaid for payment. The provider then may end up billing the beneficiary for the copayment charges that, for other Medicare beneficiaries, would be associated with the service**. Many times beneficiaries pay out-of-pocket for these charges, not realizing that they are protected by law from being charged these cost-sharing amounts and that Medicaid should cover these costs.**

Marketing Overview – Medicare Advantage and Medicare Part D

The Centers for Medicare & Medicaid Services (CMS) has set Marketing Guidelines for Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs). Providers, such as pharmacies and all other entities that contract with MA plans, must also follow a set of Marketing Guidelines. Congress took steps in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 to address several problematic marketing activities. MIPPA and related CMS rules and guidance deal with unsolicited contacts with Medicare beneficiaries, providing meals to prospective enrollees, and the use of unlicensed sales agents. CMS also issued new guidance on co-branding, appointments to market MA plans to prospective enrollees, and agent and broker compensation. The entire list of requirements is available at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html.

It is important for SHICK counselors and Medicare beneficiaries to recognize and report to CMS activities or behaviors that do not meet the Marketing Guidelines.

Marketing for the next plan year may not begin until MA organizations and Medicare drug plan sponsors receive notice from CMS that they have an approved contract to offer in the coming year, but not before October 1 of the current year. Prior to this marketing period, plans may only provide educational material or presentations to eligible Medicare beneficiaries, that is, with no intent to enroll potential members.

Co-Branding with Providers or Downstream Entities

Plans are prohibited from displaying the names and/or logos of co-branded providers on the Plan's member identification card, unless the provider names and/or logos are related to a member's selection of a specific provider/provider organization, (e.g., physicians, hospitals). Part D Sponsors are prohibited from displaying the names and/or logos of co-branded providers/pharmacies on the Part D Sponsor's member identification card.

Plans/Part D Sponsors that choose to co-brand with providers/pharmacies must include on marketing materials (other than ID cards) the appropriate disclaimer. Neither the Plan/Part D Sponsor nor its co-branding providers/pharmacies, whether through marketing materials or other communications, may imply that the co-branding partner is endorsed by CMS, or that its products or services are Medicare-approved. Co-branded marketing materials must be submitted to CMS by the Plan/Part D Sponsor.

Cross-Selling

A CMS rule prohibits MA and Part D drug plans and their representatives from marketing non-health care related products (such as annuities and life insurance) to prospective plan enrollees during sales activities or presentations. The rule's purpose is to prevent confusion that Medicare health plans and non-health related financial products are part of the same package. Plans may, however, sell non-health related products on inbound calls when a beneficiary asks for information about them.

Marketing Materials

All materials used in promoting and selling a MA plan or a Medicare drug plan and for enrollment are subject to CMS rules and restrictions on marketing. Separate CMS rules govern the materials that plans use for different phases of the marketing process.

- Advertising
- Advertising, as governed by CMS rules, includes the following methods:
    - Television ads
    - Radio ads
    - Banner ads
    - Outdoor advertising
    - Print ads
    - Internet advertising
    - Direct mail (including enrollment forms or materials)

Pre-Enrollment Materials

CMS has a specific set of rules to govern the marketing materials that MA organizations and Medicare drug plans use prior to enrollment. These are called "pre-enrollment materials."

Language Requirements

MA and Medicare drug plans must include certain statements in all pre-enrollment materials. These language requirements fall into the following specific categories:

- Lock-In Statement/Access Information: This statement must be used by MA plans that limit access to providers (i.e., a coordinated care plan's provider network). Pre-enrollment materials must indicate that enrollees must use plan providers for routine care. These materials must state that neither Medicare nor the MA plan will cover routine care received outside of the plan's network.
- Benefit and Plan Premium Information: Pre-enrollment materials must include the specifics of coverage and cost information, including:
    - Part B premium payment
    - Annual limits on benefits
    - Annual monetary limits
    - Major exclusions and limitations
    - Reference to the plan's customer service phone number
- Enrollment Limitations: Sponsors must include a statement indicating that beneficiaries may enroll in a plan only during specific times of the year.
- Network Limitations: Medicare drug plans must explain the requirement that enrollees use network pharmacies, except under non-routine circumstances when they could not reasonably use network pharmacies.
- Alternative Formats: Pre-enrollment materials must indicate when a MA or Medicare Drug plan has beneficiary materials in alternative formats (e.g., Braille, languages other than English, audio, or large print).
- Claim Forms and Paperwork: Materials addressing claim forms and paperwork may not state the plan has "no paperwork" or "no claim forms," but the materials may say, "virtually no paperwork" or "hardly any paperwork."

Summary of Benefits

The Summary of Benefits (SB) is the main means that a MA organization or Medicare Drug Plan uses to provide current enrollees and eligible individuals wide-ranging information about a plan's structure, coverage, benefits, and costs.

The SB is a standardized document with four sections:

- An introduction and beneficiary information: This section includes standard language that applies to all MA organizations and Medicare Drug Plans and must be included verbatim in the SB.
- A benefit comparison matrix: This section of the SB includes a chart of benefits offered by the MA or Drug plan. The benefits included on the chart are pulled from a list of commonly available benefits.
- An optional free-form text area: This section includes information about the plan's benefits not included elsewhere in the SB.
- Special Needs Plans (SNPs) for dual-eligible beneficiaries must provide each prospective enrollee a written statement describing
    - Benefits the individual is entitled to under Medicaid
    - Cost-sharing protections the individual is entitled to under Medicaid
    - Which of these benefits and cost-sharing protections are covered under the SNP

Dual-Eligible Outreach

MA organizations have the option to conduct outreach to enrollees about the Medicaid and Medicare Savings Programs (MSPs) which assist Medicare beneficiaries who qualify for the programs with some health care costs. MA organizations providing such outreach programs must submit plans to CMS for approval.

If a MA organization chooses to provide such outreach to enrollees, it must follow CMS-established guidance to be effective and to protect enrollees. MA plans must:

- Provide outreach for all levels of assistance
- Clarify that providing financial information is optional
- Clarify that MSPs are part of the Medicaid program
- Confirm the plan will protect the privacy of information provided to the plan
- Explain that the plan's initial assessment of eligibility is not final; the State Medicaid Agency makes the final determination
- Provide follow up information for enrollees that the MA plan determines are not eligible for assistance
- Adequately train staff to conduct outreach
- Provide alternate sources of information for assistance
- Ensure privacy guidelines are followed
- Coordinate with CMS's regional offices

MA plans providing such outreach may:

- Conduct outreach to a portion of enrollees rather than the entire enrollee population
- Provide hands-on assistance to the enrollee in completing applications
- File an Authorization of Representative form to help enrollees apply for assistance with the state
- Follow up with enrollees who do not respond to initial attempts to contact for such outreach
- Assist enrollees to reapply for benefits when necessary
- Subcontract outreach to another entity

MA plans providing outreach to enrollees may not:

- Solicit potential enrollees door-to-door or through other means of direct contact including cold calls, without an enrollee initiating the contact
- Share private financial information with other entities not involved in the outreach process
- Use enrollees' financial information for any purpose other than to provide an initial screening for assistance programs
- Continue to contact enrollees who have refused outreach assistance
- Imply to enrollees that the plan has final authority to decide eligibility for such programs

Marketing Review

With few exceptions, MA plans and Medicare drug plan sponsors must submit all of their marketing materials to CMS for review and approval prior to use.

Special Guidelines

Requirements for Marketing to Populations with Special Needs

Organizations offering MA and Medicare drug plans must make marketing materials available in any language spoken as a primary language by more than ten percent of residents within a plan's service area. Plans also must provide a service through their toll-free call centers to assist beneficiaries who speak a language other than English.

Plans must accommodate enrollees with visual impairment by providing appropriate basic enrollee information materials. Any Medicare beneficiary eligible to enroll in a MA or Medicare drug plan, including those with disabilities, must have appropriate assistance from the plan to access information.

Plans must submit materials in languages other than English (including Braille) with an English translation as well as a signed and certified letter to demonstrate that the translation is suitable.

Anti-Discrimination

The law prohibits Medicare Advantage organizations and Medicare drug plan sponsors from discriminating on the basis of:

- Race
- Ethnicity
- Religion
- Gender
- Sexual Orientation
- Health Status
- Geographic Location

With a few exceptions, a plan's services must be offered to all enrollees in the plan. A few examples of these exceptions include gender-specific services and certain services for those with specific diagnoses.

Promotional Activities

CMS has established specific rules about many aspects of MA and Medicare drug plan promotion. It is important to note that CMS guidance issued in September 2008 clarified a distinction between "educational events" and "marketing (or sales) events." Several important restrictions on sales activities apply to plans involved in educational events. CMS's marketing rules, designed to protect beneficiaries from undue sales pressure and misleading information, apply to the following activities:

Nominal Gifts

Plans may provide small gifts of nominal value ($15 retail) to potential enrollees who attend a marketing or sales presentation. Plans must provide any nominal gift to any eligible beneficiary and cannot make the gift conditional on enrollment in the plan. Plans advertising any free gifts must include disclaimers that there is no obligation to enroll in the plan. Medicare rules prohibit plans from using cash, charitable contributions, gift certificates, and gift cards as nominal gifts.

Drawings/Prizes/Giveaways

Any prize offered to potential enrollees at marketing or sales presentations may not be used to coerce beneficiaries to enroll in a specific MA or Medicare drug plan. A plan may offer a larger drawing, prize, or giveaway with a value greater than $15, but any attendee of the function (not only beneficiaries) must be eligible to win.

Hold Time Messages

An MA plan or Medicare drug plan may use health-related information as part of the messages played while on hold with the plan's toll-free call center. Information may not be presented during these messages about non-health related services, for example, other lines of insurance.

Referral Programs

Plans may offer small, nominal gifts to plan members who refer potential enrollees to the plan. The rules limit these gifts to one per year for any plan member, and are subject to the same limitations as other nominal gifts (e.g., retail value less than $15). Plans may solicit such referrals from their enrollees during the year.

Educational Events

MA and Medicare drug plans cannot engage in sales activities, including the distribution of marketing materials or the collection of plan applications, at educational events. Typically, educational events include health information fairs and other state or community-sponsored events that the event sponsors promote as being educational in nature. MA and Medicare drug plans and other organizations may sponsor educational events. According to CMS, the purpose of an educational event is to provide objective information about the Medicare program and issues such as wellness and prevention. CMS guidance says that the plans should not use educational events to steer or attempt to steer beneficiaries "to a specific or limited number of plans."

Organizations that sponsor or participate in educational events must add a notice on advertising materials saying that the event is "educational only and information regarding the plan will not be available." In contrast to educational events, sales events are those that have the purpose of marketing to potential members or steering potential members to a specific or limited number of plans.

Health Fairs and Health Promotion Events

MA organizations or Part D plan sponsors may take part in health fairs either as a sole-sponsor or as a co-sponsor. At sole-sponsor events, such plans may offer door prizes, or similar items, with a value less than $15. At multiple-sponsor events, plans may exceed the $15 limit if they contribute to a larger prize offered by multiple contributors. CMS prohibits sales presentations and enrollment at health fairs and health promotion events.

CMS-Sponsored Health Information Fairs

CMS is required to sponsor informational events about MA and Part D plans. The agency permits MA plans and Part D plans to participate. At these health fairs, plans may assist in planning, distribute information and applications, have a booth, distribute nominal gifts, contribute funding to the cost of the fair, and market multiple lines of business. CMS does not, however, permit plans to make sales presentations, collect enrollment forms, collect names or addresses of beneficiaries, compare benefits to other plans, use third-party materials, or provide gifts larger than $15.

Meals and Light Snacks

CMS rules prohibit MA and Part D prescription drug plans from providing or subsidizing meals for potential enrollees and current enrollees at marketing events, that is events at which someone discusses plan benefits or distributes plan materials. The prohibition on subsidizing meals means that plans cannot give restaurant gift cards or gift certificates to beneficiaries, regardless of the gift's value.

Plans and their representatives may, however, provide refreshments and light snacks at marketing events. CMS guidance suggests that foods such as fruit, nuts, cookies, crackers, and cheese, are acceptable as light snacks. In addition, the rules allow plans to provide meals to beneficiaries at educational events.

Provider Promotional Activities

Providers may be involved in some activities to promote MA and Part D plans. This section refers to providers, including pharmacists, pharmacies, physicians, hospitals, and long-term care facilities.

Providers in the Health Care Setting

- Providers may have general discussions with beneficiaries about potential plan options.
- Providers may make available marketing materials to their patients as long as they make them available for all MA plans with which a provider participates.
- Providers cannot accept enrollment applications.
- Providers may not persuade beneficiaries to join a MA plan.
- Providers may not offer anything to a beneficiary in return for enrolling in a MA plan.
- Providers may refer their patients to other sources of information, including SHICK.

Plans in the Health Care Setting

- MA and Part D plans may not conduct sales activities in health care settings, except in common areas such as hospital and nursing home cafeterias, community or recreational rooms, or conference rooms.
- Plans cannot conduct sales presentations and distribute or accept enrollment applications in areas where patients primarily receive health care services, including waiting rooms, exam rooms, hospital patient rooms, dialysis center, and pharmacy counter areas.
- Plans may not mislead or pressure beneficiaries into participating in the presentation.
- Plans may only schedule marketing appointments with long-term care nursing facility residents when a beneficiary requests it.

Provider Affiliations

- Providers may announce new affiliations for specific MA and Part D plans through general advertising.

- Any materials found within the provider's location that list a provider's MA or Part D plan affiliations must include all such plans.

Health Fairs

- Providers may distribute marketing materials (not including MA or Part D enrollment applications) at health fairs.
- Providers may present general education about MA and Part D plans at health fairs.

Agent and Broker Guidance

People employed by or contracting with a Medicare Advantage organization or Part D sponsor are governed by a set of rules concerning their behavior and activities. The organization employing or contracting such sales agents is responsible for the activities of these agents. State insurance departments also regulate agents and brokers. This means that agents are subject both to plan and state oversight. One variable in this arrangement is that the effectiveness of oversight often depends on the strength of a state's insurance department.

No person marketing a MA or Part D plan may choose to market to or selectively enroll healthier beneficiaries. This discriminatory practice is called "cherry picking" and is not allowed in the marketing of MA or PDP plans.

Licensed and Trained Marketing Representatives

CMS requires MA and Part D plans to use only those agents, brokers, and sales representatives who are licensed, certified, or registered under state law to market their products. CMS further expects plan sponsors to follow a state's appointment process to inform the state insurance regulators of the representatives they have appointed to market plans on their behalf, as well as to report the termination of any agents or brokers. In addition, plan sponsors must ensure each year that brokers and agents who sell Medicare products are trained on Medicare rules, regulations, specific plan details, and that they pass a test with a score of 100%.

Agent and Broker Compensation

CMS is aware that MA and Part D plans offer compensation to agents and brokers who market these plans to beneficiaries, and that some plans' compensation structures have led to "churning," a prohibited sales practice in which an agent or broker enrolls a beneficiary in a new MA or Part D plan each year to take advantage of higher first year commissions. While compensation structures may differ among types of plans (e.g., MA versus MA-PD), Medicare law now requires plans to create compensation systems that create incentives for agents and brokers to enroll beneficiaries in the MA or Part D plan that best meets their health care needs. In short, compensation systems that create incentives for agents or brokers to move beneficiaries between different MA and/or PDP plans are prohibited. CMS rules limit agent or broker compensation for a beneficiary's annual renewal in a MA or Part D plan to half the compensation paid for the beneficiary's first year as a plan member. The rule also requires that compensation paid to agents and brokers reflect fair market value based on commissions paid in past years (with inflation adjustments allowed). CMS will review the plans' compensation structures annually, and plans cannot change their commission rates or compensation structures without CMS approval.

Scope of Appointments (Sales Meetings) with Beneficiaries

MA and Part D drug plans' sales representatives, including agents and brokers, may not market any health care related product during an individual marketing appointment beyond the scope of topics that the beneficiary agrees to discuss. This rule requires plans and their sales representatives to document, in advance of a personal sales meeting, the scope of the beneficiary's interest in discussing different MA and Part D plan options. The rule applies to marketing appointments with both current and prospective plan members. CMS expects plans to confirm that a beneficiary wants to talk about stand-alone Part D prescription drug plans or Medicare Advantage plans, or both. Plans may document a beneficiary's consent through a signed appointment form, a recording, and other verifiable means.

Marketing through Unsolicited Contacts

CMS rules prohibit MA and Part D plans from making unsolicited contact with prospective enrollees outside of advertised educational or marketing events. The rules apply to both door-to-door and telephone marketing activities.

Door-to-Door Solicitation

MA organizations and Medicare Part D sponsors cannot market their plans door-to-door without a beneficiary's invitation to do so. Similarly, agents and brokers cannot visit or call beneficiaries who attended an event unless the beneficiary gave permission for the follow-up contact at the event.

Unsolicited Email Policy

Generally, MA and Part D organizations may not send unsolicited emails to beneficiaries. If beneficiaries request email from a plan, the organization is permitted to do so.

Outbound Marketing Calls

Rules prohibit MA and Part D plans and their sales representatives from making outbound calls to potential enrollees, without the beneficiary first initiating the contact. Plans may not conduct or allow unsolicited contacts under the guise of selling another product such as Medicare Supplement policies, a needs assessment, or a review of Medicare coverage options to which CMS's unsolicited contact rules do not directly apply. The prohibition on outbound calls does not apply, however, to Medicare Supplement marketing. Thus, the plan sponsors must walk a fine line because the rules allow sales representatives to make outbound calls specifically to market Medicare Supplement policies and to discuss MA and Part D products if the beneficiary expresses an interest in them.

CMS, however, allows plans to contact beneficiaries who are already plan members to discuss other products. In the same way, agents and brokers may contact beneficiaries who they previously enrolled in a MA or Part D plan to discuss plan issues and to market other plan options. Agents also can initiate phone calls to confirm an appointment to which a beneficiary has already agreed. Otherwise, agents cannot make unsolicited phone calls to other beneficiaries or plan members, and plans cannot make unsolicited contacts with former plan members who have disenrolled or with current members who are in the process of disenrolling voluntarily.

Enrollment via Inbound Telephone

MA organizations and Part D plan sponsors may not enroll beneficiaries during outbound calls (telemarketing). Furthermore, they cannot transfer outbound calls to inbound lines to proceed with

enrollment. During an appropriate enrollment call, the plan may not collect (or request) credit card or bank account numbers.

Beneficiaries who would like to enroll in a MA or Part D plan during an appropriate enrollment period may call the plan directly to do so.

IMPORTANT REMINDERS

People in Medicare Advantage plans are:

- Still in Medicare program
- Still have Medicare rights and protections
- Still get all regular Medicare-covered services
- May get extra benefits like routine vision, hearing, dental care
- May be able to get prescription drug coverage

Chapter 6
MEDICARE PART D

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MEDICARE PART D

The Medicare Modernization Act (MMA) of 2003 created the Medicare Part D prescription drug program, with coverage first available in 2006. The MMA's main purpose is to provide prescription drug coverage to Medicare beneficiaries through private insurance companies called plan sponsors. People with Medicare Part A, Part B, or both, are eligible to join a Part D drug plan of some kind.

Plan Sponsors

There are two ways to get Medicare drug coverage through these plan sponsors:

- Through stand-alone Prescription Drug Plans (PDPs).
- Through a Medicare Advantage (MA) plan, or health plan, that operates under Medicare Part C.

The Standard Benefit Design

The federal government does not sponsor its own standard benefit drug plan. Rather, the MMA establishes a standard prescription drug coverage benefit design. The standard coverage design has an annual deductible, a 25% coinsurance amount, and a coverage gap which are established by law. Some plan sponsors offer a Part D drug plan that conforms exactly to the standard coverage model. The MMA also allows Part D plan sponsors to use the standard coverage design as a baseline for other Part D drug plans with many different coverage features. These include plans that are actuarially equivalent to the standard coverage benefit but have tiered copayments instead of the 25% coinsurance charge. Some plan sponsors also offer Part D plans, called alternative prescription drug coverage, that go beyond the coverage of standard plans. The plan sponsors, within broad guidelines, set the premiums, cost-sharing amounts, and coverage limits for their Part D plans. The Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicare, approves these private drug plans for inclusion in the Part D program using the standard coverage model as a baseline for coverage.

Access to Drugs

The MMA requires all Part D drug plans to provide access to medically necessary medications including generic and brand name drugs. Under Medicare rules, Part D drug plan formularies must cover at least two drugs within each diagnostic or therapeutic class. Many plans actually cover more than two drugs in each class, though most plans do not have open formularies that cover all possible prescription medications.

The MMA specifically excludes some drugs from Part D coverage. Part D plans do not cover prescription drugs that are covered by Medicare Part A or Part B, such as chemotherapy drugs. Other drugs that are generally excluded from Part D coverage are located in the section on formularies.

Creditable Coverage and Late Enrollment Penalties

Enrolling in the Part D program is voluntary. The MMA established defined time frames when beneficiaries can enroll in and/or disenroll from a Part D drug plan. A decision not to join a Part D plan during an available enrollment period may result in late enrollment penalties added to the monthly premium for those who do not have existing creditable coverage. Creditable coverage is drug coverage that is financially equal to or better than Medicare's standard drug benefit. This means people without creditable coverage who are eligible to join a Part D drug plan but choose not to do so may pay higher monthly premiums when they eventually sign up. In contrast, people with creditable coverage can keep their current coverage without penalty if they join a Part D drug plan later.

Low-Income Subsidy or Extra Help

For people with limited financial means, the MMA established the low-income subsidy (LIS) or "Extra Help" program to help pay the premiums and other out-of-pocket costs connected with the Part D plans. The LIS is available for Medicare beneficiaries receiving Medicaid benefits, for those enrolled in one of the Medicare Savings Programs (MSPs), and for those whose monthly income is at or below 150% of the Federal Poverty Level (FPL). All who meet the income criteria must meet also certain guidelines in countable assets from all sources. The Social Security Administration (SSA) processes applications for the LIS program. When beneficiaries are found eligible for the LIS program, Medicare directly pays their drug plans for some or all of their Part D costs, including premiums, deductibles, and coinsurance charges or copayments.

Types of Drug Plans - Two Main Categories

The Part D prescription drug benefit is available only through Medicare-approved plans from private insurance companies called "plan sponsors." The MMA authorizes the plan sponsors to offer two major types of Medicare Part D drug plans. These are Prescription Drug Plans (PDPs) and Medicare Advantage plans with Part D (MA-PDs). The law gives plan sponsors significant room to design PDPs and MA-PDs with varied cost-sharing and formulary features. This section describes the two main types of plans and some of the variations federal law allows.

Prescription Drug Plans (PDPs)

PDPs are stand-alone plans that offer only prescription drug benefits under Medicare.

- Generally, beneficiaries remain in Original (traditional, fee-for-service) Medicare for their Part A and Part B coverage.

Medicare Advantage Plans with Part D (MA-PDs)

- MA-PDs offer a Part D prescription drug benefit along with other Medicare-covered benefits including physician, hospital, diagnostic, home health care, and durable medical equipment services, through contracted provider networks. Beneficiaries still must pay their Part B premiums and they do have Medicare. Enrolling in Medicare Advantage essentially is an alternative to Original Medicare. The MA-PD delivers Medicare benefits and serves as a primary insurer.

Plan Variations

Standard and Alternative Coverage Designs

Guidelines for the four varieties of Medicare Part D plans are set forth in CMS's *Medicare Prescription Drug Benefit Manual (PDBM)* – https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html.

1. ***Defined Standard*** prescription drug coverage benefit design. CMS approves all other drug plan benefit designs based on the value of this standard, defined coverage.
2. ***Actuarially Equivalent*** standard plan. Both this plan and the defined standard plan have the same annual deductible. The main difference between these two types is the actuarially equivalent plans have tiered copayments rather than a 25% coinsurance charge. In its *PBDM*, CMS refers to both of these standard designs as "basic" drug benefit types.
3. ***Basic Alternative*** plan. The basic alternative plans must be equal in value to standard plans but may have lower deductibles and different cost-sharing structures.

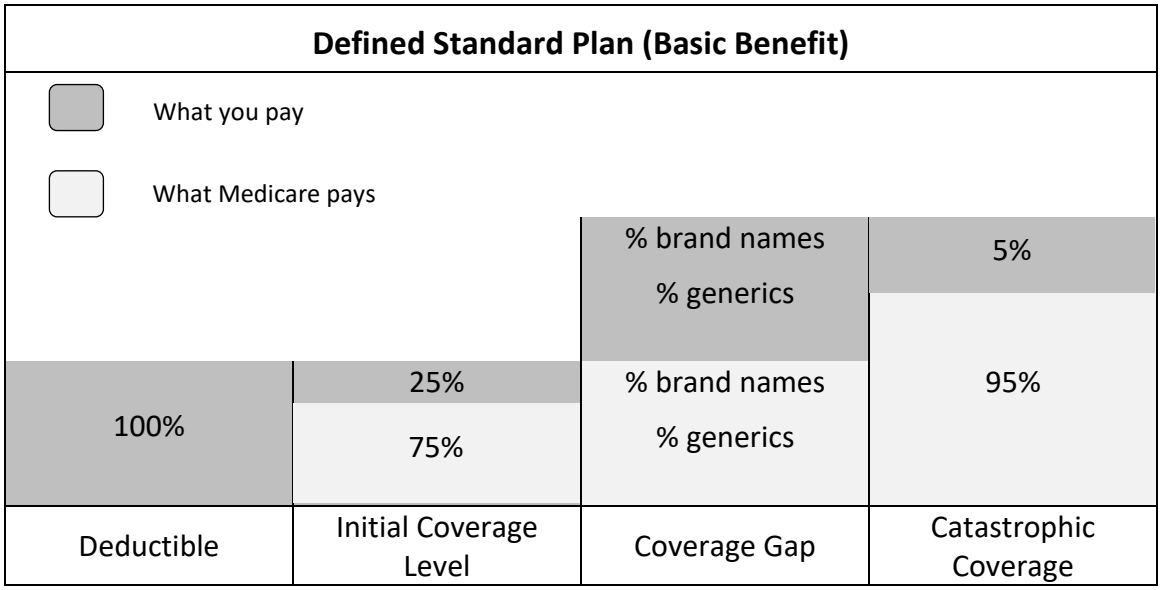
4. ***Enhanced Alternative*** plan. This plan has supplemental benefits that may include reduced cost-sharing amounts and broader formularies. Monthly premiums for alternative and enhanced plans are sometimes higher than those for standard plans.

The drug plans themselves vary considerably in terms of monthly premiums and cost-sharing structures—some use set copayments and others have percentage-based coinsurance charges. It is important to note that many specific features of these plans change from year to year, including the premiums, annual deductible, and coverage limits. Plan sponsors also can alter the cost-sharing structures, the scope of their formularies, and their cost-control systems. CMS and the plan sponsors agree to their Part D contracts on an annual basis.

Defined Standard Plan (Basic Benefit)[4]

The MMA defines the costs of the standard benefit as a plan with:

- A monthly premium
- An annual deductible
- A 25% coinsurance for the cost of covered drugs up to an initial coverage limit
- A coverage gap ("doughnut hole") in costs for covered drugs
- Catastrophic coverage where the beneficiary pays the greater of 5% coinsurance or a copay for a generic or preferred drug and a higher copay for other drugs for the rest of the year



Actuarially Equivalent Standard Plan (Basic Benefit)

The MMA defines the costs of the actuarially equivalent standard benefit as a plan with:

- A monthly premium
- An annual deductible
- A cost-sharing structure that may have flat copayments instead of a 25% coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to the initial coverage limit
- A coverage gap ("doughnut hole") in costs for covered drugs

[4] Annual cost-sharing amounts are available in the appendix under *Annual Medicare Premium and Cost-Sharing Amounts*.

- Catastrophic coverage where the beneficiary pays the greater of 5% coinsurance or a copay for a generic or preferred drug and a higher copay for other drugs for the rest of the year

Basic Alternative Plan (Basic Benefit)

The MMA defines the costs of the basic alternative benefit as a plan with:

- A monthly premium
- A reduced or eliminated annual deductible
- A cost-sharing structure that may have flat copayments instead of a 25% coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to an initial coverage limit.
- A coverage gap ("doughnut hole") in costs for covered drugs. If the initial coverage limit is raised, the coverage gap will be smaller in these plans
- Catastrophic coverage where the beneficiary pays the greater of 5% coinsurance or a copay for a generic or preferred drug and a higher copay for other drugs for the rest of the year

Enhanced Alternative Plan (Enhanced Benefit)

The MMA defines the costs and coverage of the enhanced alternative benefit as a plan with:

- A monthly premium
- A reduced or eliminated annual deductible
- A cost-sharing structure that may have flat copayments instead of a 25% coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to an initial coverage limit.
- If included, a coverage gap ("doughnut hole") in costs for covered drugs. If the initial coverage limit is raised, the coverage gap will be smaller in these plans. Some enhanced alternative plans will offer some coverage throughout the coverage gap
- Catastrophic coverage where the beneficiary pays the greater of 5% coinsurance or a copay for a generic or preferred drug and a higher copay for other drugs for the rest of the year
- Formularies may be broader, and may cover drugs that are generally excluded from Part D coverage

When counseling clients about which type of plan to choose, it is important to understand the major differences between these four Part D plan designs. This information about each plan is available each year on the Landscape of Plans. Note that the *Medicare Prescription Drug Plan Finder* (Plan Finder), available at http://www.medicare.gov, does not distinguish plans in this way.

Eligibility and Enrollment

Given all the choices available for Medicare prescription drug coverage, it is essential for SHICK counselors to help clients determine whether they can enroll, whether they want to enroll, how to enroll, and when to enroll in a Medicare drug plan. The first step in the process is to ask if your client is enrolled in Medicare. Anyone who has Medicare Part A and/or Part B is eligible for a Part D plan.

Deciding to Enroll in a Part D Plan

Everyone who is eligible for Part D has a choice to make about whether to enroll in a Part D drug plan. That choice depends largely on whether they have other health insurance that covers prescription drugs. For clients who currently have no coverage for prescription drugs, enrolling in Part D can save them money

over a period of time. On the other hand, clients who already have prescription drug coverage face a different set of options based on if and how their current coverage works with Part D.

It is important for all Medicare beneficiaries to make informed decisions about their drug coverage. Medicare beneficiaries with the following types of coverage have special considerations:

- Retiree or union coverage
- Veterans Administration (VA) and/or TRICARE for Life
- Federal Employee Health Benefit Program (FEHBP)
- Medicaid
- Medicare Savings Programs (QMB, LMB, ELMB)

Creditable Coverage

- For beneficiaries with existing insurance coverage for prescription drugs, it is important to learn if that coverage is "creditable." Creditable coverage means that the insurance benefit is as good as—or better than—the coverage in Medicare's basic benefit.
- The drug coverage in many retiree or union health plans, TRICARE for Life, the VA, and the Federal Employee Health Benefit Program (FEHBP) is creditable coverage. The drug coverage in three standardized Medigap insurance policies (Plans H, I, and J) sold between 1992 and 2004 is not creditable, but the drug coverage in some Medigap policies that pre-date 1992 is creditable. Similarly, the drug coverage in some Medigap policies sold through 2005 in Massachusetts, Minnesota, and Wisconsin is creditable. If the policy was issued before 1992 (or before 2006 in the three states), contact the benefits administrator at the insurance company to ask whether the benefit is considered creditable.
- The MMA requires insurers to notify people annually about the creditable status of their health plans. This notice may be an official letter, or it may appear in a health plan update, such as a newsletter. It is important for your clients who have creditable coverage to keep these notices in a safe place for possible future reference. Another way to get information on creditable coverage is to call the benefits office for the retiree health plan.
- People who have creditable coverage for prescription drugs do not need to enroll in a Part D drug plan, perhaps ever. It is also important to know that some people who have creditable coverage through an employer or union health plan could permanently lose their retiree health benefits if they enroll in a Part D drug plan. Under the terms of some group insurance contracts, retirees may lose all of their health benefits and forfeit their creditable coverage (along with spousal coverage) by enrolling in other coverage, like a Medicare drug plan.

Late Enrollment Penalty (LEP)

CMS charges a late enrollment penalty to Part D-eligible beneficiaries when they do not have a Part D plan or creditable coverage. The penalty is assessed if and when these beneficiaries enroll in Part D. CMS calculates the penalty based on the number of months an eligible beneficiary was not enrolled in Part D or other creditable coverage.

Some people choose not to enroll in Part D because they have no prescription drug costs now, or they are overwhelmed by the process. Because of the potential for penalties, it is very important for you and your clients to know whether their current coverage is creditable. One group exempt from the penalty is those eligible for the low-income subsidy—they will not have a late enrollment penalty.

ENROLLMENT: CONSIDER THE THREE Cs

Coverage – What are the beneficiary's drug needs NOW? Medicare drug plans cover generic and brand-name drugs. All plans must cover the same categories of drugs, but plans can choose which specific drugs they will cover in each drug category. Beneficiaries should check to see which plans cover their prescription drugs.

Cost – What will the beneficiary pay out-of-pocket, including premiums? Monthly premiums and beneficiaries' share of the cost of prescriptions will vary depending on which plan they choose. If they have limited income and resources, they may qualify for extra help from Medicare in paying their drug plan costs.

Convenience – What pharmacies does the beneficiary want to use? Do they honor the plan that has the coverage the beneficiary needs at a cost he/she can afford? Drug plans must contract with pharmacies in each area. Beneficiaries should check with the plan to make sure the pharmacies in the plan are convenient to them. Some plans will also allow them to get their prescriptions through the mail.

How to Select a Plan

There are many factors to consider for beneficiaries who decide to enroll in a Part D plan. Dozens of plans are available in most areas of the country. SHIPs use a number of factors to help narrow down the list of possible plans for each person they assist. This keeps the process more manageable and also helps beneficiaries choose a plan because the list of appropriate plans is often a good deal shorter than the list of all plans. To help them choose the most appropriate plan, bear in mind the following categories:

Access to Needed Drugs

One factor to consider when selecting a Part D drug plan is the extent to which the plan provides coverage for needed drugs. It is important to compare the beneficiary's prescribed medications to Part D plans' formularies (i.e., lists of covered drugs). Because many Part D plans are available to most beneficiaries, using the formulary to narrow down that list of plans is a helpful practice.

After filtering out Part D plans that do not include all of a beneficiary's medications on their formularies, there are other factors to consider related to the formulary. Specifically, Part D plans may apply utilization management tools to certain drugs on their formularies. Some examples of these tools include prior authorization, step therapy, and quantity limits. Since utilization management may make it more difficult for enrollees to access their needed prescriptions, it is important to consider this factor when comparing the plans' formularies.

Access to Pharmacies

Another factor to consider is the plans' pharmacy networks. It is important to check if a beneficiary's preferred pharmacy is in the plan's network, and if not, to make sure that convenient alternatives exist. Plan networks are important because Part D plans will not pay for prescriptions at non-network pharmacies, except in emergencies. A drug plan's network pharmacies may change from year to year. Some drug plans also have "preferred pharmacies" within the network that offer lower prices than other network pharmacies.

Other pharmacy access concerns include alternative methods of getting prescriptions. Many plans offer a mail-order program, though the law does not require it. All plans must allow access to home infusion pharmacies and to long-term care (LTC) pharmacies for those who reside in LTC facilities.

Plan Costs

Most beneficiaries will consider costs and prices when selecting a Part D plan. The total yearly costs of being enrolled in a Part D plan depend on the monthly premium, annual deductible, copayments or coinsurance for each drug, and any drug costs that the beneficiary will owe in the coverage gap. Monthly premiums range significantly. Deductibles will also range in cost annually. A deductible is the amount that an enrollee must spend out-of-pocket on formulary drugs before the plan begins to pay its share of the costs for each prescription filled. Finally, the Plan Finder lists the cost of each drug covered by Part D plans.

Beneficiaries who qualify for LIS have different cost considerations. Most of these beneficiaries have access to premium-free plans with no annual deductible, reduced or eliminated cost-sharing for each drug, and no coverage gap. Remember, though, that plan formularies will vary, so not all premium-free plans are appropriate for all LIS beneficiaries.

Other Considerations

Beneficiaries in the process of selecting appropriate Part D plans may consider other factors before enrolling in a plan. One consideration for these beneficiaries is service area. A plan's service area includes the counties, states, regions, or territories in which an enrollee may use the plan. Some plans are national, meaning their service area is nationwide. Others are regional and have geographic limitations on their pharmacy networks.

Another factor beneficiaries consider is the quality information that CMS makes available about each plan. The Plan Finder shows quality information for the following categories: drug plan customer service, member complaints and staying with drug plan, member experience with drug plan, and drug pricing and patient safety. These quality measures offer beneficiaries a source of objective information which they can use to compare plans.

An additional factor for beneficiaries to understand is the concept of lock-in. Beneficiaries who opt to join Part D plans should understand that after enrollment, they may have only limited opportunities to make changes to their coverage. Once an enrollment choice is effective, most beneficiaries are "locked-in" to their selected plan for the remainder of the plan year. This lock-in feature does not apply to beneficiaries who have a Special Enrollment Period.

Enrollment Periods

The MMA does not allow most beneficiaries to enroll in or disenroll from Part D plans at any time. Most beneficiaries have limited time frames to enroll in, disenroll from, or switch Part D plans. Two notable exceptions are beneficiaries who qualify for LIS and beneficiaries living in long-term care facilities. Beneficiaries with LIS may make quarterly changes. Beneficiaries in LTC facilities may make monthly plan enrollment changes.

There are three enrollment period categories: initial, annual, and special. A beneficiary's first chance to enroll in Medicare, and thus to join a Medicare drug plan, is called the Initial Enrollment Period (IEP). The yearly scheduled enrollment period, annual Open Enrollment Period (OEP), is a set time of year when the law permits beneficiaries to change their Part D plans. Special Enrollment Periods (SEPs) enable beneficiaries under specific circumstances to make plan changes outside of initial or yearly opportunities. SEPs are designed, for example, to permit beneficiaries who move out of a plan's service area or into a long-term care facility to make changes.

Initial Enrollment Period (IEP)

Generally, an individual becomes eligible for Medicare on the first day of the month of the individual's 65th birthday or the 25th month of disability. The three months before, the month during, and the three months after this eligibility date are known as the Part B Initial Enrollment Period (IEP). This time frame is also the IEP for Part D benefits. Beneficiaries who do not enroll in a Medicare drug plan during their IEP generally will not be able to enroll in a plan until the following annual Open Enrollment Period (OEP), unless they qualify for a special enrollment period, or SEP. Note that if a beneficiary does not have creditable drug coverage and does not enroll in a Medicare drug plan during the IEP, he will likely have a late enrollment penalty added to his Medicare drug plan's premium if and when he enrolls.

Initial enrollment for Medicare works differently for some people with disabilities. For those with end-stage renal disease (ESRD), beneficiaries must file a written application for those benefits when they become eligible. Those who have had a kidney transplant and those who have had kidney dialysis for three months are entitled to Medicare Part A. Part D eligibility begins upon entitlement to or enrollment in Medicare Part A and/or Part B. Thus, upon filing an application for Medicare Part A coverage, beneficiaries are entitled to enroll in a Part D plan.

Part D eligibility and enrollment for those with Lou Gehrig's disease (amyotrophic lateral sclerosis, ALS) is more similar to the process for those with disabilities. The 24-month waiting period that applies to most beneficiaries with disabilities does not apply to those with ALS. These individuals have a 5-month waiting period; their Part A coverage begins on the sixth month of the ALS disability. Thus, these beneficiaries have seven months of a Part D IEP. Their IEP begins in the second month of ALS disability and continues to three months past the month their Part A benefits begin.

Yearly Opportunity for Enrollment: AEP

Beneficiaries who already are enrolled in Medicare may enroll in a plan, change plans, or disenroll from their current plan during the annual Open Enrollment Period (OEP). The OEP runs from October 15 through December 7 each year. A decision to enroll or disenroll during the OEP is effective usually for the entire calendar year starting on January 1. Beneficiaries who make more than one enrollment choice during the OEP will be enrolled only into the plan with the latest date of application. This means that beneficiaries can change their minds throughout the OEP. While this may be helpful for some individuals, keep in mind that other insurance sales agents can undo a plan selection made during an earlier SHICK counseling session with a client.

Special Enrollment Periods (SEPs)

Special Enrollment Periods (SEPs) enable Medicare beneficiaries to make Part D plan enrollment changes in special situations. Special enrollment periods constitute periods outside of the usual IEP for Part D or AEP when an individual may elect a plan or change his or her current plan election. There are various types of SEPs, including SEPs for dual-eligible individuals, for individuals whose current plan terminates, for individuals who change residence and for individuals who meet exceptional conditions.

Change in Residence

Beneficiaries have the right to a SEP under the four following circumstances related to a change in residence:

- Those with a change in permanent residence that places them outside of their Part D plan's service area
- Those with new Part D and/or MA plans available due to a change in permanent residence
- Those not eligible for Part D because they have been living outside of the U.S. and have returned to the U.S.
- Those not eligible for Part D because they were incarcerated (in jail) and are now released

This SEP has certain notice procedures. For people who notify their plan in advance of their move, their SEP begins the month before the move and continues for two months. For those who give notice of the move upon moving or afterwards, the SEP begins upon notification and continues for two months. People may request for the effective date of this SEP enrollment to be up to three months after they notify their plan but not earlier than the date of the move.

There are other procedures for those who do not notify their plans of their moves. If the plan learns from CMS (or otherwise) that an enrollee has lived outside of the plan's service areas for more than six months, the enrollee's SEP begins upon discovery of that move and continues for two months after the move.

Dual-Eligible Beneficiaries and Upon Losing Dual-Eligibility

All dual-eligible beneficiaries (including those with both Medicare and Medicaid and those who are in Medicare Savings Programs) have a SEP that begins upon becoming dual-eligible and ends up to two months after losing such eligibility. This SEP allows beneficiaries to enroll in or disenroll from Part D plans, including PDPs and MA-PD plans. The beneficiary is limited to a onetime per calendar quarter election between January through September (three opportunities to change plans). The effective date of the change is the first of the month following the request for the change.

Contract Violation

Part D plan enrollees who demonstrate to CMS that the PDP sponsor violated a material provision of its contract or materially misrepresented the plan during marketing have a SEP opportunity to change to another Part D plan. The SEP begins upon CMS's determination of the violation and continues subject to the discretion of CMS. CMS also may approve retroactive disenrollment in these cases, depending on the severity of the situation. In considering cases for retroactive disenrollment, CMS will consider certain factors in each case.

Non-Renewals or Terminations

Beneficiaries whose plans end due to non-renewal on January 1 of a plan year have a SEP from October 1 to January 31 of the next year. In these circumstances, CMS requires these plans to give a 90-day notice to enrollees. The effective date of the enrollment may be on January 1, or February 1, but not before the plan receives the enrollment request.

For enrollees of plans that terminate their contracts, their SEP begins two months before the termination effective date and ends one month past the termination effective date. These plans are required to give a 60-day notice to enrollees. The effective date of the enrollment may be the month after notice is given until two months after the termination effective date.

For enrollees of plans whose contracts CMS terminates, their SEP begins one month before the termination effective date and ends two months past that date. CMS requires these plans to give a 30-day notice to enrollees. The effective date of the enrollment may be up to three months after the month of termination but not before the plan receives the enrollment request.

Involuntary Loss of Creditable Coverage

Beneficiaries who involuntarily lose creditable prescription drug coverage are eligible for a SEP. An involuntary loss includes a reduction in the amount or type of coverage that makes it no longer creditable. A loss of coverage because an individual failed to pay premiums does not constitute an involuntary loss.

This SEP permits enrollment in a PDP and begins with the month in which the individual is advised of the loss of creditable coverage and ends two months after either the loss (or reduction) occurs or the individual received the notice, whichever is later. The effective date of this SEP may be the first of the month after the request or, at the beneficiary's request, may be no more than two months from the end of the SEP.

Not Adequately Informed about Creditable Coverage

Those not adequately informed of a loss of (or that they never had) creditable coverage have a SEP to enroll in a Part D plan (including an MA-PD plan). Established on a case-by-case basis, this SEP begins upon approval from CMS and continues for two additional months.

Error by a Federal Employee

On a case-by-case basis, CMS may grant a SEP to those whose enrollment or non-enrollment in a Part D plan (including an MA-PD plan) is not valid due to the action, inaction, or error of a federal employee, including customer service representatives (CSRs) at 1-800-MEDICARE. This SEP begins upon approval from CMS and continues for two additional months.

5-Star SEP

Under the 5-Star Special Enrollment Period, a beneficiary can join or switch to a 5-Star MA plan (with or without drug coverage) or a 5-Star PDP in their service area. The time frame for this SEP is December 8 through November 30 of the next year, with an effective date of the first of month following the enrollment request. It can only be used to enroll in plans given an overall 5-star rating for the current calendar year. The Star rating is from the ratings on the Plan Finder. Beneficiaries can only use the 5-star SEP one time during the year. If the beneficiary joins an MA-only plan which allows a stand-alone PDP, they also have a coordinating Part D SEP and can join a PDP for the same month. The PDP doesn't have to be a 5-star plan. However, if they are switching from one MA-only plan to another MA-only plan, they do not have an SEP to switch PDPs.

Exceptional Conditions

- **SEP EGHP:** Medicare beneficiaries who have access to an Employer/Union Group Health Plan (EGHP) have a SEP to elect a Part D plan or vice versa during the period of time when the EGHP allows plan changes. The effective date of the enrollment may be up to three months after the request for enrollment or disenrollment but not before the plan receives the request.
- **Disenrollment Connected to a CMS Sanction:** If CMS sanctions a Part D plan sponsor and enrollees disenroll due to the issue that led to the sanction, CMS may authorize a SEP on a case-by-case basis for those enrollees.
- **PACE Enrollees:** Part D plan enrollees may disenroll at any time to join a PACE plan. Those who disenroll from PACE have a SEP for up to two months after the disenrollment during which they may join Original Medicare and a PDP or an MA plan.

- **Trial Period SEP:** People who drop a Medigap policy to enroll in a Medicare Advantage plan for the first time are entitled to a guaranteed right to return to the Medigap policy they had or if the policy they had is not available, to purchase another Medigap policy within the "trial period," usually 12 months. The Trial Period SEP permits them to disenroll from an MA plan at any time during this trial period to return to Original Medicare and to purchase the Medigap policy and a PDP. The SEP begins upon disenrollment from the MA plan and continues for two additional months, with an effective date depending on the situation.
- **Retroactive ESRD Entitlement**
- **Retroactive Medicare Entitlement**
- **SEP for Institutionalized Individuals:** Beneficiaries who move into, reside in, or move out of a long-term care (LTC) facility have a SEP that begins upon moving into the LTC facility and lasts through up to two months after moving out of the facility.
- **SEP for Individuals Who Enroll in Part B during the Part B General Enrollment Period (GEP):** Those individuals who are not entitled to premium-free Part A and who enroll in Part B during the GEP (January – March). The SEP begins April 1 and ends June 30, with an effective date of July 1.
- **Beneficiaries Losing Special Needs Status:** Those enrolled in a Special Needs Plan (SNP) who no longer meet the specific special needs status are eligible for a SEP. The SEP begins upon the change in status and continues for three more months.
- **Enrollment in a Chronic Care SNP:** A SEP exists for individuals who qualify for a Chronic Care Special Needs Plan (SNP) to enroll in an SNP. The SEP applies to all beneficiaries who qualify for these SNPs and ends upon enrollment in a plan.
- **Beneficiaries no longer eligible for Medicaid or LIS upon Losing LIS**: Beneficiaries can join a Medicare Advantage or Medicare Prescription Drug Plan, switch from their current plan to another Medicare Advantage or Medicare Prescription Drug Plan, drop their Medicare Advantage Plan and return to Original Medicare, or drop their Medicare prescription drug coverage. The effective date of the change would be the first of the month following the request for the change. Their chance to change lasts for 3 full months from either the date they are no longer eligible or notified, whichever is later.
- **Disenrollment from Part D to Enroll in or Maintain Creditable Coverage:** Any enrollee in a Part D plan (including PDPs and MA-PDs) may disenroll at any time from the plan to obtain or maintain other creditable coverage (such as TRICARE or VA coverage). The effective date of disenrollment would be the first of the month following the request. This SEP permits those leaving MA-PD plans also to enroll in an MA-only plan.

How to Enroll

After beneficiaries determine they are eligible for the Part D drug benefit, decide to enroll in a plan during an available enrollment period, and choose an appropriate plan, the next step is to start the process of enrolling. There are several ways to enroll in a Part D drug plan. These include mailing an enrollment form to the plan sponsor, enrolling online, enrolling by phone, and enrolling with a sales representative.

CMS makes it fairly easy for beneficiaries to compare and enroll in Part D plans on the Plan Finder located online at http://www.medicare.gov.

Who Can Help a Medicare Beneficiary Enroll?

In most cases a Medicare beneficiary must complete the application to enroll in a Medicare drug plan. CMS's PDP Guidance on Eligibility, Enrollment and Disenrollment explains that anyone other than the

beneficiary who completes an enrollment request must state that he or she has the legal authority under state law to execute the enrollment and that the documentary proof of such legal authority will be made available to CMS or the plan upon request.

SHICK counselors who assist Medicare beneficiaries with enrollment generally do not have the legal authority to make health care decisions on behalf of a Medicare beneficiary. SHICK counselors who assist beneficiaries with Part D plan enrollment are merely facilitating the process. ***Counselors can avoid problems by making sure that they do not indicate that they represent their clients or sign enrollment forms on a client's behalf unless the client is unable to write.*** If clients are not able to write, counselors should follow the standard rules for such cases. This means that the client should make an "X" in the signature box and the witness should write "By" and his name and address with a short description of reason the patient cannot sign.

Disenrolling and Switching

Most Medicare beneficiaries who currently are enrolled in a Part D drug plan may only disenroll from that plan during certain periods: the OEP from October 15 through December 7, certain situations during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 through February 14, and applicable SEPs. Generally, once an enrollment choice is effective, most beneficiaries are "locked-in" to their selected plan for the remainder of the plan year.

There are a few ways for a Medicare beneficiary to disenroll from a Part D plan:

- By enrolling in another plan
- By giving or faxing a signed written notice to the PDP sponsor
- By requesting disenrollment online to the PDP sponsor (if the sponsor offers this option)
- By calling 1-800-MEDICARE

Annual Open Enrollment Period (OEP)

During the OEP, Medicare beneficiaries can make only one choice among two options affecting their drug plan enrollment. They either can enroll in a different Part D plan (PDP or MA-PD) or disenroll from their current plan. Enrolling in a different Part D plan effectively switches the beneficiary from one plan to the other.

Medicare Advantage Open Enrollment Period (MA OEP)

A separate yearly open enrollment period for changes related to Medicare Advantage plans is called the Medicare Advantage Open Enrollment Period (MA OEP). It lasts from January 1 to March 31 each year. During the MA OEP, Medicare beneficiaries currently enrolled in a MA-PD or a MA-only have an opportunity to change their Medicare Advantage plan coverage. Enrollment in an MSA plan does not qualify beneficiaries for the MA OEP. Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage. Any change made during the MA OEP takes effect on the first of the following month.

Special Enrollment Period (SEP)

During any applicable SEP, a beneficiary may disenroll from a Part D plan. Beneficiaries need only enroll in a new Part D plan to be disenrolled from a previous one. A disenrollment during the SEP does not prevent a beneficiary from subsequently enrolling in another plan as long as the SEP's timeframe has not expired. The length of an SEP varies according to the situation. People who move out of their drug plan's service

area, for example, can have a SEP of up to four months. In contrast, people who move out of a certain type of nursing facility have a SEP that lasts up to two months after discharge.

MA Plans and Part D

Generally, Medicare beneficiaries who want drug coverage and the benefits of a Medicare Advantage plan must select an MA plan that offers Part D prescription drug coverage (MA-PD). This rule is absolute for all coordinated care plans (i.e., HMOs, PPOs, and SNPs). Those beneficiaries enrolled in coordinated care plans who want Part D coverage must enroll in coordinated care plans that have a Part D component—an MA-PD plan. This means that enrollees in coordinated care plans without Part D coverage—MA-only plans—will not have access to drug coverage through Medicare. Furthermore, Special Needs Plans (SNPs) must provide Part D coverage. Thus, all SNPs are MA-PDs, and enrollees have access to Medicare drug coverage through their SNPs.

An exception applies to beneficiaries who are enrolled in certain types of MA plans that do not provide drug coverage, including some PFFS plans and all Medical Savings Account (MSA) plans. Private Fee-for-Service plans may or may not have Part D coverage. For those PFFS plans that are MA-PDs, enrollees must take the Part D coverage that comes with the plan. For those PFFS plans that do not offer drug coverage, enrollees may also enroll in stand-alone Prescription Drug Plans (PDPs) to receive Part D coverage. Additionally, MSA plans are not permitted to offer drug coverage, so enrollees in these plans also may enroll in stand-alone PDP plans.

Costs and Prices

Beneficiaries enrolled in both types of Part D plans—PDPs and MA-PDs—will have costs associated with enrollment in those plans. The costs will differ from beneficiary to beneficiary and from plan to plan.

Those who qualify for the low-income subsidy (LIS) receive assistance from Medicare to help cover some or all of these costs that others pay out-of-pocket. ***Throughout this section, for the sake of simplicity, the costs and prices discussed will apply to those beneficiaries who do not qualify for LIS.***

Beneficiary Cost-Sharing

Beneficiaries who are enrolled in Part D plans almost always have cost-sharing responsibilities. These costs generally include the monthly premium, an annual deductible, and copayments or coinsurance for each prescription filled. Above a certain level of out-of-pocket spending, beneficiaries also will have costs in the coverage gap, also known as the “donut hole.” Once beneficiaries have spent to another set level, costs are minimal as there is a level of catastrophic coverage in the Part D plan design.

Monthly Premiums

A premium is a set amount of money beneficiaries must pay each month to a Part D plan in order to be enrolled in a plan. Monthly premium amounts range widely. Plans with higher premiums sometimes offer enhanced benefits, such as a broader formulary with more access to brand-name medications or coverage for some drugs in the coverage gap.

Beneficiaries have several options to pay the monthly premium to their plan. They can choose to pay the premium directly to the plan by check, money order, a savings or checking account deduction, or electronic payment by phone or through the Internet by using credit cards. Beneficiaries may also elect to have the premium deducted from their Social Security checks. ***Data transfers from the drug plans to CMS***

and then to SSA can take a few months to process, which can result in up to three months of premiums taken out of a Social Security check at once.

IRMAA (Income Related Monthly Adjustment Amount) Beginning 2011, the Affordable Care Act required Part D enrollees whose incomes exceed the same thresholds that apply to Part B enrollees to pay an income-related monthly adjustment amount, in addition to their Part D plan premium.[5]

Annual Deductible

A deductible is the amount a beneficiary owes out-of-pocket before the drug plan starts to pay for medications on its formulary. The allowed deductible amount increases each year. Plan deductibles range from $0 to an amount which changes each year, depending on the type of plan. Some plans have a structure in which certain tiers of their formularies are exempt from the deductible. For example, a plan could allow enrollees to pay reduced cost-sharing for generic drugs, but brand-name drugs are full price until the enrollee reaches the deductible.

Copayments and Coinsurance Amounts

After plan enrollees spend the full amount of a plan's deductible, they enter the period of coverage known as the "initial coverage period." During the initial coverage period, Part D plans charge either a copayment or coinsurance amount for each medication that enrollees fill at pharmacies. Each plan sponsor sets the copayment or coinsurance amount, and the amount differs according to the drug plan's design. Typically, beneficiaries pay this out-of-pocket cost at the time they receive each filled prescription.

Copayments are a flat-rate amount, such as $5 or $25, charged to beneficiaries for each prescription. Coinsurance charges are based on a percentage of the total negotiated price of a prescription, such as 25% (as in the case of a basic standard plan). Negotiated prices are the costs for prescription drugs agreed upon through direct negotiation between the Part D sponsor or an intermediary contracting organization, such as a pharmacy benefit manager (PBM), and the pharmaceutical manufacturer. In effect, the negotiated price is the amount paid by Part D plans to pharmacies for each prescription drug filled by a plan enrollee.

True Out-of-Pocket (TrOOP) Costs

True Out-of-Pocket (TrOOP) costs are those that a beneficiary incurs in the course of paying the cost-sharing amounts for covered drugs under a Medicare Part D drug plan. Plans calculate these costs for each enrollee to determine which level of coverage to provide (i.e., deductible, initial coverage period, coverage gap, or catastrophic coverage). TrOOP includes the total amount of any annual deductible paid plus the price paid for each formulary prescription filled. ***Note that the monthly premium does not count towards TrOOP costs.***

It is important for SHICK counselors to understand the relationship between TrOOP costs and the initial coverage limit and catastrophic coverage. As beneficiaries incur costs under their Part D plans, they move closer to the initial coverage limit.

After plan enrollees reach the initial coverage limit measured by total drug spending, they enter the coverage level known as the coverage gap. During the coverage gap, beneficiaries must pay the negotiated price for covered drugs minus a discount on brand name drugs or generics.

Important Note about TrOOP:

[5] Annual cost-sharing amounts are available in the appendix under *Annual Medicare Premium and Cost-Sharing Amounts*.

The total amount spent in the gap on plan-covered drug costs includes: the drug costs paid by the beneficiary and the discount on brand-name drugs paid by the drug manufacturer.

The remaining discount paid by the Part D plan for covered-brand name drugs and the discount on covered-generic drugs while in the Coverage Gap do not count toward TrOOP.

When the amount spent on Plan-covered drugs reaches the catastrophic limit, the beneficiary reaches the catastrophic coverage threshold. Beneficiaries with catastrophic coverage pay the greater of five percent of the plans' negotiated drug costs or lower copayments for generics and preferred brand-name drugs and a higher copayment for other brand-name drugs for the remainder of the calendar year. The Part D plan covers 95% or the balance of the cost.

Beneficiaries with LIS also incur TrOOP costs. Their TrOOP includes the amount Medicare pays for formulary drugs for LIS beneficiaries in Part D plans. For those with LIS, Part D plans use TrOOP to determine the point when beneficiaries enter catastrophic coverage. The catastrophic limit is the same for all enrollees in Part D plans.

A plan must send a statement, called an "Explanation of Benefits" (EOB), to every enrollee at the end of each month showing how much the plan and the enrollee have paid in TrOOP costs. Part D plans are responsible for calculating and reporting TrOOP costs.

TrOOP costs for each Part D enrollee follow enrollees throughout the plan year. If a beneficiary switches Part D plans, his TrOOP costs are transferred to the new Part D plan. For this reason, beneficiaries cannot switch Part D plans to "reset" their TrOOP costs and avoid the coverage gap. Because TrOOP follows Part D enrollees from plan to plan, there is no way to "game the system."

Certain out-of-pocket expenses count towards TrOOP costs, and other out-of-pocket spending does not count.

TrOOP Includes	**TrOOP Does NOT Include**
Out-of-pocket expenses including the annual deductible and all coinsurance and copayment amounts for drugs on the plan's formulary	Monthly premiums paid to the plan
Spending from health savings accounts (HSAs), flexible spending accounts (FSAs), and medical savings accounts (MSAs)	Amount paid by other insurance plans in addition to the beneficiary's Part D coverage (e.g., an employer or retiree group plan's drug benefit, VA, or TRICARE)
Contributions or payments for drugs on the plan's formulary paid by friends or relatives on a beneficiary's behalf	Amount paid by Medicaid or by state programs that receive federal or public funds
Contributions or payments for drugs on the plan's formulary paid by certain charitable foundations on a beneficiary's behalf	Amount spent for prescription drugs that are non-Part D drugs or that are not on the plan's formulary (unless the enrollee received a formulary exception for a drug)
Unadvertised, individualized waivers or reductions of plan cost-sharing amounts by pharmacies due to a beneficiary's inability to pay	Amount spent for prescription drugs that are purchased from a pharmacy that is not in the pharmacy network of the plan (except for drugs received due to a plan's out-of-network policy)
Payments by Qualified State Pharmaceutical	Total cost of a drug that a private Patient

TrOOP Includes	TrOOP Does NOT Include
Assistance Programs (SPAPs)* (not available in Kansas)	Assistance Program (PAP) provides to a beneficiary
Copayments paid by beneficiaries who use private Patient Assistance Programs (PAPs) to cover Part D drugs that are on their plan's formulary	Copayments paid by beneficiaries who use private Patient Assistance Programs (PAPs) to cover Part D drugs that are not on their plan's formulary

Late Enrollment Penalty

The late enrollment penalty (LEP) affects those without Part D or creditable coverage who delay enrolling in a Medicare drug plan. Creditable coverage is insurance coverage that is at least equal to or better than the coverage in the Part D basic benefit. Generally beneficiaries without creditable coverage for more than 63 days will face an LEP if they decide to enroll in a Part D plan at a later date.

Most beneficiaries who do not have creditable coverage and delay enrolling in a Part D plan will owe an LEP. The penalty is added to their plan's monthly premium. The penalty will continue as long as they are enrolled in a Part D plan and, for many, this means that they will pay the penalty for the rest of their lives. Plans are not permitted to charge an LEP to beneficiaries with LIS.

The penalty is calculated as one percent of the Part D base beneficiary premium for each month the beneficiary does not have creditable coverage and is not enrolled in Part D plan.

Another category of beneficiaries will not face an LEP, in one specific situation. The under-65 Medicare population, like all Medicare beneficiaries, who are not enrolled either in Part D or in creditable coverage for more than 63 days have an LEP if they later choose to enroll in Part D. These beneficiaries receive a new Initial Enrollment Period (IEP) upon turning 65. With the new IEP comes an exemption from past or current LEP. The exemption is in effect for beneficiaries who were paying an LEP as well as those who never enrolled in Part D and otherwise would have an LEP. The subsequent IEP, in effect, erases any previous record of months without creditable coverage.

Penalty Calculation

The LEP is not calculated as a percentage of the premium of the enrollee's chosen drug plan. The penalty amount will change each year because CMS calculates the penalty based on the Part D base beneficiary premium for a current calendar year. The final amount is rounded to the nearest $.10 and added to the monthly premium of the plan that the beneficiary selects. See the chart below for information on calculating the LEP.

(18%)	**x**	**$34.10**	**=**	**$6.20**	**+**	**$20.00**	**=**	**$26.20**
1% x 18 months (the number of months without creditable coverage)		Base Beneficiary premium amount		Penalty amount		Monthly premium		Total Monthly premium including the penalty

Help for Low-Income Beneficiaries

Eligibility

Medicare beneficiaries with limited income and resources have access to substantial financial help with the costs of Part D. A program called the low-income subsidy (LIS), or "Extra Help," provides this assistance

to beneficiaries with limited means. The subsidy helps to pay a portion of Part D plans' costs— including the monthly premium, the annual deductible, and copayments or coinsurance amounts for covered drugs. The MMA sets forth several subsidy levels that differ based on the amount of a beneficiary's income and resources (or assets).

The Social Security Administration (SSA) manages the following processes related to the low-income subsidy:

- Provides general information to the public about LIS
- Supplies applications for LIS
- Makes LIS eligibility determinations for Medicare beneficiaries who apply for LIS. SSA works in conjunction with CMS on the LIS program. In short, CMS is responsible for administering the program, while SSA makes determinations about who is eligible for the program.

In general, LIS is available to Medicare beneficiaries whose:

- Income is below 150% of the federal poverty level (FPL)
- Resources (sometimes called assets) amounts are lower. There are two levels of allowable resources.
- The amounts are listed in the appendix under *Annual Medicare Premium and Cost-Sharing Amounts*.
- Also note that SSA does not count all sources of income and resources when determining eligibility for LIS.

SSA and CMS also work with state Medicaid agencies to determine LIS eligibility for another group of Medicare beneficiaries—individuals who qualify for Medicaid or for a Medicare Savings Program (MSP). These beneficiaries are considered "deemed eligible" and will automatically receive the subsidy. All other individuals must apply in order to receive the subsidy. Except in limited circumstances, those who are eligible for LIS receive the subsidy at least throughout the calendar year.

Countable and Excluded Income

The degree of help available to low-income beneficiaries depends in part on the amount of income they receive. In general, SSA uses Supplemental Security Income (SSI) rules to calculate countable income in determining if beneficiaries meet the income limits for the low-income subsidies. Common sources of countable income are:

- Social Security benefits
- Railroad Retirement benefits
- Pensions or annuities (including veterans' pensions)
- Alimony
- Rental income (net)
- Workers compensation
- Wages (gross) or earnings from self-employment (net)

If beneficiaries receive Social Security benefits for a disability or blindness and have work-related expenses that are not reimbursable by their employers, these expenses will be deducted before earned income is counted. Some sources of income do not count in LIS eligibility determinations. They include food stamps, home energy assistance, stipends paid to ACTION program volunteers (e.g., Senior Companion Program workers), some victim compensation payments (e.g., war reparations), and some tribal payments to Native

Americans. More details about countable income are available in the Social Security booklet, *A Guide to SSI for Groups and Organizations.*

Countable and Excluded Resources

The amount of help available to low-income beneficiaries also depends on their resources or assets. Only certain resources count in determining eligibility for the Extra Help program. Some examples of countable resources are:

- Bank accounts (checking, savings or certificates of deposits or CDs)
- Stocks, bonds, savings bonds, mutual funds, individual retirement accounts (IRAs)
- Cash at any other financial institution or at home
- Real estate other than a primary home

Other resources, such as the beneficiary's primary home or a car, do not count in determining one's eligibility for LIS. These excluded resources include:

- Cash value of a life insurance policy
- Property one needs for self-support, such as rental property
- Jewelry and home furnishings
- Burial spaces owned by a beneficiary and spouse

Beneficiaries can exclude from their countable resources up to $1,500 per person that they designate for funeral and burial expenses.

Applying for Low-Income Subsidy: Who Needs to Apply and Who Does Not?

Some low-income beneficiaries do not need to apply for LIS (Extra Help) because they are "deemed eligible." Other low-income beneficiaries must apply.

Individuals who are deemed eligible for the Extra Help and do not need to apply include those Medicare beneficiaries who receive Medicaid benefits, including full and partial benefits. Individuals with Medicare and full Medicaid benefits are referred to as "full duals," in that they are enrolled in both programs and are eligible for Medicaid's full set of benefits. Full-duals also include residents of nursing facilities who are on Medicare and Medicaid and Medicare beneficiaries who reside in the community and are enrolled in a Medicaid Home and Community-Based Services (HCBS) waiver program. This also includes SSI recipients who automatically receive full Medicaid benefits.

Medicare beneficiaries who are enrolled in one of three Medicare Savings Programs (MSPs) sometimes are referred to as "partial duals." The state, through its Medicaid program, pays at least the Part B premiums for beneficiaries enrolled in the Qualified Medicare Beneficiaries (QMB), Low-income Beneficiaries (LMB), and Expanded Low-income Beneficiaries (ELMB) programs. For those in the QMB programs, the state also covers Medicare's deductibles and coinsurance costs.

Medicare beneficiaries who must apply for the extra help are those with limited financial means but who are not a full or partial dual. All beneficiaries who think they may be eligible for the extra help can apply, but only those who meet the income and resource limits will be found eligible.

Levels of Low-Income Subsidy

There are different levels of subsidies that depend on eligible beneficiaries' income and resources. The descriptions below use the standard federal poverty level (FPL) for individuals living in the 48 contiguous

states and the District of Columbia. Income amounts are slightly higher for those living in Alaska and Hawaii.

The descriptions below refer to the benchmark premium. CMS calculates the benchmark premium each year using premium and enrollment information for all plans with enrollment in the past year. CMS uses the following premium amounts for plans:

- The total monthly premium for standard plans
- The portion of enhanced plans' premiums attributed to standard Part D coverage
- The monthly prescription drug beneficiary premiums for MA-PD plans

CMS calculates the average of these amounts and uses actual enrollment information to weight the average. This weighted average is called the "benchmark subsidy." Each year, CMS calculates the benchmark for each plan region. Those with the full premium subsidy do not have to pay a monthly premium if they enroll in standard plans with premiums below this benchmark amount.

Full Dual-Eligible (Medicare and Full Medicaid) with Income up to 100% FPL

Full dual-eligible beneficiaries who reside in the community and have income within these requirements receive the following subsidies:

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
- Those who enroll in a standard plan with a premium above the benchmark amount must pay a portion of the premium
- Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Do not pay an annual deductible
- Pay a low copay for generic and preferred brand prescription drugs and a slightly higher copay for all other drugs on the plan's formulary
- After beneficiaries in this group reach the out-of-pocket threshold, all prescription drugs on the plan's formulary are free

Full Dual-Eligible (Medicare and Full Medicaid) with Income above 100% FPL and Partial Dual-Eligible with Income up to 135% FPL

Beneficiaries who reside in the community and have income within these requirements receive the following subsidies:

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
    - Those who enroll in a standard plan with a premium above the benchmark amount must pay a portion of the premium
    - Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Do not pay an annual deductible
- Pay a higher copay than full-dual eligible for generic and preferred brand prescription drugs and again a slightly higher copay for all other drugs on the plan's formulary
- Pay nothing for all prescription drugs on the formulary, after reaching the out-of-pocket threshold

Institutionalized and HCBS Beneficiaries

Special LIS rules apply for full-duals who reside in certain long-term care (LTC) facilities including: skilled nursing facilities, nursing facilities, inpatient psychiatric hospitals, and intermediate care facilities that are residential facilities for developmentally disabled adults (called "ICF/MRs"). Regardless of their income, Medicare beneficiaries who receive full Medicaid benefits and reside in these LTC facilities receive maximum subsidies, and therefore do not incur any out-of-pocket costs for prescription drugs on their plans' formularies. They do not pay monthly premiums, annual deductibles, or copayments for their prescriptions. Medicaid Home and Community-Based Services (HCBS) waiver recipients also have no copays.

Residents of assisted living facilities, group homes, and board and care homes may qualify for LIS but are subject to some cost-sharing in line with their income and resources.

Non-Deemed

Income up to 135% FPL

These beneficiaries have applied for and been approved for LIS by SSA. There are two subsidy levels available for beneficiaries within this income range depending upon the amount of their countable resources.

Fewer Resources

Beneficiaries in this income group have a lower resource level and:

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
    - Those who enroll in a standard plan with a premium above the benchmark amount must pay a portion of the premium
    - Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Do not pay an annual deductible
- Pay a higher copay than full-dual eligible for generic and preferred brand prescription drugs and again a slightly higher copay for all other drugs on the plan's formulary
- Pay nothing for all prescription drugs on the formulary, after reaching the out-of-pocket threshold

More Resources

Beneficiaries in this income group have a higher countable resource level (assets):

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
- Those who enroll in a standard plan with a premium above the benchmark must pay a portion of the premium
- Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Have an annual deductible, unless their plan has a lower deductible. In that case, they would pay the plan's deductible, which could be as low as $0
- Pay a coinsurance of 15% for each prescription drug on the plan's formulary

- Pay a low copay for generic and preferred brand prescription drugs and a slightly higher copay for all other drugs on the plan's formulary, after reaching the out-of-pocket threshold

Income between 135% FPL and 150% FPL

Beneficiaries whose countable income is between 135% and 150% of FPL (see chart below) and who have countable resources (assets) no higher than the maximum allowable resources are eligible for a subsidy. Beneficiaries who meet these income and asset requirements receive the following subsidies:

- Medicare pays a portion of the monthly premium based on their income:
  - Those with income between 135% and 140% FPL receive a premium subsidy of 75% of the benchmark premium
  - Those with income between 140% and 145% FPL receive a premium subsidy of 50% of the benchmark premium
  - Those with income between 145% and 150% FPL receive a premium subsidy of 25% of the benchmark premium
- Have an annual deductible, unless their plan has a lower deductible. They would pay the plan's lower deductible, or $0 in plans with no deductible
- Pay a coinsurance of 15% for each prescription drug on the plan's formulary
- Pay a low copay for generic and preferred brand prescription drugs and a slightly higher copay for all other drugs on the plan's formulary, after reaching the out-of-pocket threshold

How Do Beneficiaries Apply for LIS?

Those beneficiaries who are not deemed eligible and want to apply for Extra Help must complete an application in order for SSA to make an eligibility determination. Beneficiaries can access the SSA application in four ways:

- Go to the SSA website at http://www.ssa.gov and complete the application online
- Call SSA at 1-800-772-1213 and ask a customer service representative to send an application through the mail
- Call SSA at 1-800-772-1213 and ask a customer service representative to help them complete the application over the phone
- Go to a local SSA office and pick up an application form SSA Form 1020

Once paper applications are complete, they must be mailed to the Social Security Administration. The application comes with a self-addressed, postage-paid envelope.

SSA verifies elements of eligibility (e.g., income, resources, residency, and Medicare entitlement) by comparing the information on the application form to Social Security records and records from other federal agencies, including CMS. SSA asks applicants to submit proof of income or resources in limited circumstances. Two examples of such instances are if there are discrepancies between the information on the application and the government records or if applicants report ownership of non-home real property.

Who Can Help Beneficiaries Complete the Application?

Three categories of helpers, called personal representatives, may act on behalf of beneficiaries for the purpose of applying for LIS. These include:

- Those asked to help (such as a family member or friend)
- Those authorized by state or other law

- Someone acting responsibly on behalf of an "incapacitated" beneficiary

CMS expressly declined to limit "acting responsibly" in any way, stating that it assumes the good intentions of everyone who wants to help get people into the LIS program. Also, SHICK counselors are able to help beneficiaries complete applications.

How Long Does SSA Take to Process an Application?

The law does not require the SSA to process applications and notify applicants about subsidy determinations in any particular time frame. The SSA states only that applications remain "in effect" until a decision is reached regarding subsidy eligibility and has further indicated that it expects routine processing time to be two to three weeks.

What Rights Do Beneficiaries Have if Their Subsidy Applications Are Denied?

The SSA has an appeal process that low-income beneficiaries can use if they disagree with a decision to deny, reduce, or discontinue the LIS. Beneficiaries who wish to appeal a decision by SSA must complete a form called Appeal of Determination for Help with Medicare Prescription Drug Plan Costs

Eligible for Low-Income Subsidy: What Happens Next

Beneficiaries who qualify for LIS must be enrolled into Part D plans to receive the subsidy. An automatic system processes enrollments for all beneficiaries with LIS (those who are deemed and those who apply) into Part D plans if they do not enroll in plans on their own. This system turns a two-step process of LIS application and Part D enrollment (for those who apply), or automatic eligibility and enrollment (for those who are deemed) into one step. While these systems may not operate flawlessly, they are critical to the success of Part D and LIS. If all beneficiaries had to apply for LIS and subsequently enroll in Part D, it is quite likely that enrollment would be far lower than it is.

Most beneficiaries who are deemed eligible are automatically enrolled into a Part D plan if they do not enroll on their own. They receive a yellow letter from CMS notifying them of the auto-enrollment process, unless they have creditable coverage through a retiree plan. If they do have creditable coverage through a retiree plan that is receiving a credit from CMS for their enrollment, these beneficiaries will not be automatically enrolled in a Part D plan. They will receive a white letter explaining this process.

Limited Income Newly Eligible Transition (LI NET) Program

The Limited Income Newly Eligible Transition (LI NET) program is administered by Humana and offers those with the low-income subsidy (LIS) immediate, but temporary, access to prescription drug coverage. LI NET provides this coverage for beneficiaries who qualify for Extra Help and go to a pharmacy to have a prescription filled, but are not enrolled in Medicare drug plans.

The LI NET program serves three functions:

1. When full dual-eligible beneficiaries have some period of retroactive eligibility with no Part D plan, the LI NET plan through Humana provides retroactive coverage of their prescription drugs. The LI NET program then auto-enrolls these beneficiaries prospectively into a standard Part D plan with a premium below the regional benchmark. Keep in mind that the LI NET auto-enrollment process applies to full benefit dual-eligibles and to Medicare beneficiaries and people with SSI who do not have Medicaid but who are entitled to retroactive Part D coverage.

2. All beneficiaries with the low-income subsidy (LIS) who are not enrolled in a Part D plan are eligible to use the LI NET plan for immediate coverage of their prescription drugs at the pharmacy. Beneficiaries must provide evidence of their eligibility for the LIS. Other than the group eligible for LI NET auto-enrollment, all other beneficiaries with LIS will still have access to the existing facilitated enrollment process.
3. Finally, the LI NET program also provides retroactive reimbursement for out-of-pocket expenses paid by beneficiaries with LIS who were not enrolled in a Part D plan at the time of the expenses.

Humana has established a toll-free number for assistance with the LI NET program. This number is 1-800-783-1307.

Medicaid's Role with Non-Part D Drugs

The MMA specifically excludes some drugs from Part D coverage. Part D plans do not cover prescription drugs that are covered by Medicare Part A or Part B, such as some chemotherapy drugs. Other drugs that are generally excluded from Part D coverage are listed in the section on formularies. Some Part D plans with enhanced benefit designs, however, may provide coverage for some of the drugs in these categories.

A state's Medicaid program may cover some of these excluded drugs or Part D drugs that are not on Medicare drug plan formularies for full dual-eligible beneficiaries, including residents of nursing facilities and recipients of HCBS waivers. To access specific information about which non-Part D drugs state Medicaid programs are covering for full-dual beneficiaries, check with your state Medicaid agency.

Redeterminations and Redeeming

Agencies reassess eligibility for the LIS on a regular basis. This process involves three agencies: the SSA, CMS, and the state Medicaid agency (KDHE). The agency that initially determined a beneficiary's eligibility for the LIS is responsible for reassessing their eligibility for the following calendar year.

Redetermination: SSA uses a process called "redetermination" to assess the continued eligibility of LIS recipients who applied for and were found eligible for LIS through the SSA.

Redeeming: CMS reviews the eligibility status of all beneficiaries who were deemed eligible for LIS (in the previous calendar year) because they receive Medicaid benefits (full or partial) or Supplemental Security Income (SSI) benefits.

SSA Redeterminations

The Social Security Administration (SSA) conducts three types of redeterminations:

- Initial
- Cyclical
- Subsidy changing events (SCE)

The following SSA redetermination processes only pertain to beneficiaries who applied for the LIS (or Extra Help) through the SSA.

Initial Redeterminations

To redetermine eligibility the next year, the SSA selects a group of beneficiaries who were eligible for Extra Help during the previous year and who the SSA believes have experienced a change in their circumstances that may have affected their eligibility for extra help. These beneficiaries receive a redetermination form in the mail in September. The form, Social Security Administration Review of Your Eligibility for Extra Help

(SSA-1026), must be completed and returned within 30 days of receipt, **even if nothing has changed**. If the beneficiary does not complete and return the form, SSA may terminate his eligibility for Extra Help, effective January 1 of the following year.

Cyclical Redeterminations

Each year the SSA also will select a random group of Extra Help recipients for redetermination to evaluate their eligibility for the next year. These beneficiaries receive a redetermination form in the mail in September. The form is the same form sent to those selected for the initial redetermination. Beneficiaries must respond to the form within 30 days of receipt, **even if nothing has changed**. If a beneficiary does not complete and return the form, SSA may terminate their eligibility for Extra Help, effective January 1 of the following year.

Subsidy Changing Event (SCE) Redeterminations

Beneficiaries with LIS who experience subsidy-changing events — including marriage, divorce, separation, annulment, and death of spouse — must report the event to SSA. Upon notification, SSA sends these beneficiaries a special SCE redetermination form. Beneficiaries are required to complete and submit the form within 90 days of receipt. Beneficiaries who do not respond will no longer receive Extra Help. For those that do respond, their Extra Help status will reflect the change the month after SSA receives the completed form.

Beneficiaries may appeal a reduction or termination of their subsidy. According to SSA, “It may be more advantageous to the individual to file an appeal than to file a new application. This is because the individual may lose one or more months of Part D subsidy by filing a new application. An appeal would preserve the retroactivity of the subsidy while a new application would not” (20 CFR 418.3605 - 418.3680). Beneficiaries should use the SSA appeals form for this process.

Redeeming

Based on data that state Medicaid agencies send to CMS, individuals with Medicare and Medicaid are deemed eligible for the LIS. These beneficiaries automatically qualify for LIS, and therefore, do not need to complete an application. CMS redeems for the following year all individuals who were full or partial duals in or after July of the current year.

Starting each year in July, state Medicaid agencies begin sending transmissions to CMS containing data on all dual-eligible beneficiaries. Individuals whose data is transmitted to CMS automatically are redeemed eligible for LIS for the following year.

If their LIS status has not changed, they will not receive any notice informing them that they will continue to receive Extra Help in the following year. If they remain LIS eligible, but a change in their finances requires a change to their subsidy amount, they will receive an orange letter from CMS. The letter explains that although they still qualify for the Extra Help in the next year, their costs will change as of January 1.

Some people who were deemed eligible for LIS in the current year will not be deemed eligible for the following year because they no longer qualify for Medicaid. These beneficiaries receive a grey letter from CMS in September. The letter explains that they will not automatically receive Extra Help to pay for their Part D costs effective January 1. The letter explains they can apply for the LIS through the SSA. It also contains an application for the LIS with a postage-paid envelope.

Individuals who receive this letter include Medicare beneficiaries who:

- No longer qualify for full Medicaid benefits
- Are no longer eligible for a Medicare Savings Program (MSP)
- No longer receive Supplemental Security Income (SSI) and do not qualify for Medicaid

Anyone who receives the grey letter and subsequently re-qualifies for Medicaid would be redeemed for the LIS for the following year.

Part D Plan Reassignment by CMS

In the fall of each year, CMS reassigns certain groups of Medicare beneficiaries who are eligible for LIS into Part D plans for the coming year. Typically, CMS reassigns two groups of Medicare beneficiaries who were deemed eligible for the Extra Help in the past year and will continue to be deemed eligible in the following year:

- Medicare beneficiaries with the full subsidy who stayed in the plan into which they were auto-assigned by CMS, and their plan premium for the following year is more than the regional low-income premium subsidy benchmark.
- Medicare beneficiaries with the full subsidy whose plans are leaving the Medicare program in the following year.

Some Part D plans that were LIS benchmark plans in the past year will have a premium above the following year's regional LIS benchmark. As a result, full LIS recipients would be responsible to pay a portion of the plan premium if they remain in such plans. Therefore, CMS reassigns certain LIS-eligible individuals to different Part D plans with premiums that are at or below the regional LIS benchmark for their area. Specifically, CMS reassigns only those full subsidy LIS beneficiaries who accepted their auto-assigned plans.

By early November, reassigned Medicare beneficiaries should receive blue letters from CMS with information about their reassignment. Those who are reassigned because their plan is leaving the Medicare program will receive Version 1 of the blue letter. Those who are reassigned because their current, assigned plan's premium will be above the next year's regional LIS benchmark will receive Version 2 of the blue letter.

Notably absent from those reassigned are all full subsidy LIS beneficiaries who enrolled in plans other than the one to which they were auto-assigned. CMS will not reassign these Medicare beneficiaries who were deemed eligible but switched plans. CMS refers to this group of beneficiaries as "choosers." CMS does not reassign one other group of LIS beneficiaries—those with partial LIS subsidy (which includes those with LIS who are charged a deductible).

These beneficiaries, the "choosers," should receive a tan letter from CMS by early November informing them that they will owe a portion of the premium if they remain in their plans.

Prescription Drug Assistance Programs and Medicare Part D

Generally two types of prescription drug assistance programs are available to help Medicare beneficiaries with limited financial resources access their medications:

- State Pharmaceutical Assistance Programs (SPAPs) – not available in Kansas
- Private Pharmaceutical Assistance Programs (PAPs)

Beneficiaries must meet certain eligibility criteria to qualify for the benefits offered under these programs. These programs coordinate their benefits with Part D in different ways.

State Pharmaceutical Assistance Programs (SPAPs) (Not Available in Kansas)

State Pharmaceutical Assistance Programs (SPAPs) provide assistance with prescription drug costs to some beneficiaries with limited financial resources. Eligibility criteria vary from program to program. The MMA allows SPAPs to wrap-around Medicare Part D coverage and fill in coverage gaps for medications that are either:

- Not covered by an individual's PDP or MA-PD plan
- Excluded by law
- Cost prohibitive while someone is in the coverage gap ("doughnut hole")

Beneficiaries may still pay a portion of the cost for each of their medications even with Part D and SPAP coverage.

All other forms of drug coverage, including Part D, are primary to coverage provided by an SPAP. That is, an SPAP will only cover medications after any other drug coverage is applied to the cost of that drug. Additionally, payments made by some SPAPs to cover drugs that are on the plan's formulary, but are needed during the coverage gap, count towards TrOOP for the Part D plan. Only payments from qualified SPAPs count towards TrOOP.

Private Pharmaceutical Assistance Programs (PAPs)

Some private pharmaceutical companies offer their products to low-income individuals for free or reduced prices through pharmaceutical assistance programs (PAPs) and drug discount programs. Due to Medicare Part D coverage, many of these programs either no longer offer their services to Medicare beneficiaries who are eligible for or enrolled in a Medicare Part D plan, or require some attempts to have the Part D plan pay for a medication before they will assist a beneficiary. There is a separate application process for each medication. This process varies from company to company.

PAPs are not comprehensive insurance plans and therefore are not considered creditable coverage. Some programs may provide only one free sample or supply of a medication; others may provide ongoing assistance. The application process sometimes requires the participation of a physician who will receive and administer or deliver the drug to her patient.

It is important to know that the total cost of the drug that a PAP provides to a beneficiary in the coverage gap does not count towards True Out-Of-Pocket costs (TrOOP). Therefore, assistance from a PAP extends the time that a beneficiary spends in the coverage gap, and, hence, delays the Part D catastrophic benefit. However, if a beneficiary must pay a copayment or coinsurance amount to receive a PAP-provided medication, the copayment or coinsurance amount counts towards TrOOP if the medication is on the plan's formulary.

Access to Drugs and Formularies

Each Part D plan has a network of pharmacies from which enrollees routinely can access their Part D drugs. Additionally, each Part D plan covers the prescription drugs that it places on a formulary, or list of covered drugs. Formularies may vary greatly among the plans. Plans also may encourage enrollees to use certain drugs on their formularies in an effort to control costs. All of these factors may affect a beneficiary's access to prescription drugs, and thus are important to consider when selecting a plan.

Pharmacy Networks

The Part D plans vary in the extent of their pharmacy networks. A pharmacy network is a group of pharmacies under contract with a Part D plan to provide its enrollees access to prescription drugs.

In addition to network pharmacies, some drug plans also designate preferred pharmacies that offer the lowest prices and out-of-pocket costs among all the plan's network pharmacies. The Plan Finder lists all network pharmacies by name and location and further notes those which are preferred pharmacies. It is important to learn if a beneficiary's pharmacy of choice is in the plan's network, and if it is not, to make sure that convenient alternatives exist. Because the drug plans renew their contracts annually, network pharmacies may change from year to year.

A Medicare drug plan may not pay for prescriptions at pharmacies that are not in the plan's network. Exceptions apply, however, in emergencies and some other situations. CMS requires Part D plans to ensure that their enrollees have adequate access to covered drugs at out-of-network pharmacies when someone "cannot be reasonably expected to obtain covered drugs at a network pharmacy, or when such access is not routine." Thus, CMS expects the drug plans to cover prescriptions filled at out-of-network pharmacies when a plan enrollee loses his or her covered drugs or becomes ill, needs a covered drug, and cannot get to a network pharmacy.

Similarly, drug plans should cover prescriptions that a hospital or clinic-based pharmacy fills when someone is an emergency or outpatient surgery patient. Since Medicare Part B covers these types of hospital and clinic visits, Part D covers the prescriptions received during those visits. Many hospital-affiliated pharmacies are not in the network of Part D plans, so this type of coverage would be provided by the plan's out-of-network policy. Since the plan's negotiated price for a drug is often less than the price charged by a hospital pharmacy, beneficiaries should keep in mind that that they will have to pay the difference between the two prices.

It is also important to know that the MMA allows pharmacies to waive or reduce the cost-sharing amount (i.e., copayment, coinsurance) for beneficiaries who are otherwise unable to afford their prescription drugs. Pharmacies, however, cannot do this on a routine basis. The amount the pharmacy pays counts toward the beneficiary's true out-of-pocket costs (TrOOP).

Formularies

Medicare drug plans use formularies—that is, comprehensive lists of the drugs they cover—to define their drug benefits. The MMA allows each drug plan to develop its own formulary within certain limits. CMS reviews formularies to make sure that they comply with federal law. It evaluates the formularies to ensure adequate access to medically necessary drugs and to make sure that no formulary excludes drugs in such a way as to discourage particular groups from joining a plan. For example, CMS would not approve a formulary if it did not include insulin and oral anti-glycemic agents, as such a formulary would discriminate against people with diabetes.

The MMA requires all Part D drug plans to provide access to medically necessary medications including generic and brand-name drugs. Plans' formularies must include at least two drugs in each treatment category and class that a drug plan sponsor designates, although CMS may require plans to include more than two drugs for some categories and classes. Medicare rules require the plans to cover all drugs in six categories. CMS refers to these classes as "classes of clinical concern."

- Anti-neoplastics (anti-cancer drugs)
- Anti-convulsants

- Antidepressants
- Antipsychotics
- Immunosuppressants
- Anti-retrovirals

CMS established the requirement for plans to cover all drugs and dosage forms within these six classes with only limited exceptions. Those exceptions include:

- Multi-source brands of the identical molecular structure
- Extended release products when the immediate-release product is included
- Products that have the same active ingredient or moiety
- Dosage forms that do not provide a unique route of administration (e.g., tablets and capsules versus tablets and transdermals)

Drugs Excluded from Part D Coverage

Aside from requiring coverage for drugs in certain categories, the MMA specifically excludes some drugs from Part D coverage. Part D plans do not cover prescription drugs when they are covered by Medicare Part A or Part B, including some chemotherapy drugs. Other drugs that the law generally excludes from Part D coverage are:

- Drugs prescribed for anorexia, weight loss, or weight gain (except drugs used to treat AIDS wasting and cachexia due to chronic disease)
- Drugs prescribed to relieve the symptoms of coughs and colds. This exclusion does not include medications used to treat a cough that results from a medical condition that is not a cold or cough.
- Prescription vitamins and minerals, with the exception of prenatal vitamins and fluoride. Vitamin D analogs such as calcitriol, doxercalciferol, paricalcitol, and dihydrotachysterol are not considered prescription vitamins. Prescription niacin products, such as Niaspan and Niacor are Part D drugs and are not considered vitamins.
- Over-the-counter drugs, with the exception of insulin
- Prescription drugs to promote hair growth
- Fertility drugs
- Cosmetic drugs. Drugs taken to treat psoriasis, acne, rosacea, or vitiligo are not considered cosmetic.
- Drugs that must be monitored by testing services that only the manufacturer provides, such as certain anti-psychotic medications
- Sexual or erectile dysfunction (ED) drugs, when prescribed for the treatment of sexual or erectile dysfunction

Formulary Changes

Part D plans can change their formularies within certain limits. Medicare drug plans may only change the therapeutic categories and classes in their formularies once each year. These changes must occur between plan years. That is, a plan can change the categories and classes on its formulary for the next plan year, but the change cannot be effective prior to January 1 of the next year.

Medicare drug plans typically may not remove drugs from their formularies at any time during the plan year. A few exceptions to this general rule exist. First, Part D drugs may be removed from formularies when the Food and Drug Administration (FDA) pronounces a Part D drug unsafe. Plans may also remove drugs from formularies if the manufacturer removes the Part D drug from the market.

Medicare drug plans also may not make any change in cost-sharing status of formulary drugs from the start of the Annual Enrollment Period to ***60 days after the beginning of the plan year***. Plans also must provide a 60-day notice to affected beneficiaries including those who are currently taking a drug that is removed from the formulary or whose costs are changing because of a shift in a drug's tier placement. If the plan does not provide prior notice, it must authorize a 60-day fill of the drug and provide notice at the point of sale.

Part D plans usually must follow these general rules about mid-year formulary changes:

- Plans may remove or place in a higher tier brand-name drugs when generic or multi-source brand name equivalents enter the market.
- Plans may remove non-Part D drugs included on their formularies by mistake.
- Plans may add utilization management tools based on new FDA warnings.
- Plans may remove drugs based on new FDA market withdrawal notice.
- Plans may remove or place in a higher tier drugs based on new clinical guidelines or recommendations. An example is following CDC's recommendation against using older antivirals for treatment and prevention of the flu.
- Plans may add utilization management tools in the following cases:
    - To respond to other approved formulary changes. One example is adding prior authorization to a brand name drug when a generic version is on the market.
    - To help determine B vs. D coverage
    - To promote the safe utilization of a Part D drug based upon new clinical guidelines or information----------

Medically Accepted Indications and Off-Label Use

Part D plans must ensure that physicians and other health providers prescribe Part D covered drugs for medically accepted indications. In some cases, providers prescribe drugs for a purpose other than the one originally approved by the FDA. This is called an "off-label use" of the drug. Sometimes physicians prescribe a drug to treat a medically accepted indication that is an off-label use. CMS does not require Part D plans to approve off-label use but does expect them to refer to common medical practice in determining that a prescribed drug effectively deals with a medically accepted indication.

Because plans can differ in their decisions about medically accepted indications, it is important to check with a plan about its policies for approving off-label use. One plan, for example, may consider peer-reviewed literature in deciding on an acceptable use, while another may limit its consideration to the uses described in a CMS-approved drug compendium. Plans may deny coverage for off-label drug use for lack of medical necessity. If the client's physician is willing to help make the case that an off-label use is within common medical practice, SHICK counselors can assist their clients to appeal these coverage denials.

Cost-Containment Strategies

The Part D program relies on competition among drug plans and limits on the use of some covered drugs, often called utilization management tools, to help contain costs and control government spending on the prescription drug program.

Price Competition

The federal government does not regulate the drug prices that plan sponsors charge in the Medicare Part D program. Part D plan sponsors individually negotiate prices with drug manufacturers. Thus, drug prices

vary from plan to plan. The plans' negotiated drug costs affect the length of time it takes enrollees to reach the initial coverage limit, as well as the prices they pay for drugs once in the coverage gap.

Utilization Management Tools

Along with price competition, the MMA allows drug plans to control costs through drug utilization management systems that may have an impact on a beneficiary's ability to access prescribed medications. The common elements in these utilization management systems are:

- Cost tiers
- Prior authorization
- Step therapy
- Quantity limits

As a SHICK counselor, keep in mind that even though a drug plan lists a client's medication as a covered drug on its formulary, a utilization management tool may restrict access to that drug. It may be necessary to ask the prescribing physician to make the case to the plan that your client's medical condition creates a medical need for the drug. When a Part D plan uses a utilization management tool to deny coverage for a formulary drug that your client needs, SHIPs can play an important role in assisting through the exceptions or redetermination appeals processes.

Cost Tiers

Many plan sponsors assign the covered drugs on a plan's formulary to different cost-sharing tiers. The MMA allows plan sponsors to design plans with as many as six tiers, though plans more commonly have three or four. Plans usually assign generic drugs to a low cost-sharing tier. For example, a plan's copayments for generic furosemide and brand-name Lasix might be $5 and $40, respectively. The smaller copayment in the lower tier works as an incentive for beneficiaries to select less costly drugs instead of the more expensive alternatives placed in higher tiers.

Prior Authorization

Prior authorization requires an added step in filling a prescription. Plans typically use prior authorization requirements to control the use of higher cost medications. The MMA gives plan sponsors considerable latitude to design their prior authorization systems. The plans can use different forms and may ask physicians to provide more or less documentation to establish the need for a drug. Thus, it may be easier for prescribing physicians to secure prior authorization in one plan as opposed to another. SHICK counselors may be able to help clients with information about the exceptions and appeals process following an unsuccessful request from the plan for prior authorization.

Step Therapy

Step therapy is a cost-control method that requires beneficiaries to use a less expensive medication, long-established as effective in treating a condition, before moving on to the next "step" in the process, involving a higher cost or newer, brand-name drug. Drug plans that require step therapy for a particular drug will not pay for the more expensive drugs, in the second and third steps, until the beneficiary tries the less expensive first step, and it proves to be ineffective or harmful. When beneficiaries have already tried the less expensive drug unsuccessfully, the doctor should contact the drug plan to request an exception.

Quantity Limits

Plans may limit the amount of medication that they pay for over a certain period of time. The Kaiser Family Foundation reported that quantity limits are the most common utilization management tool that national

PDPs use with ten frequently prescribed brand-name drugs. It is not unusual to find plans only paying for a limited supply of a brand-name medication, even though a physician prescribes more.

The MMA allows Part D plans to use any of these cost-containment strategies. SHICK counselors can expect that their clients will encounter one or more of them as potential road-blocks to access their prescribed drugs. Thus, it is important for clients to understand their rights, and know how to exercise them, when a drug plan's cost-control requirements impede needed care.

Medication Therapy Management Programs (MTMPs)

All Part D plans (including MA-PD plans) must offer a Medication Therapy Management Program (MTMP) to eligible enrollees. MTM programs are intended to reduce the risk of adverse medication events and improve medication use by participants.

Transition Policies

All Part D drug plans have transition policies through which enrollees sometimes can obtain a temporary fill of their prescription drugs. Transition policies cover new Medicare beneficiaries' enrollment in Part D plans, a switch from one Part D plan to another, level of care changes affecting long-term care facility residents, and formulary changes from one contract year to the next affecting current plan enrollees.

When a transition policy is in effect, a Part D plan must cover an enrollee's prescription drugs even if they are not on the plan's formulary. While CMS has set forth minimum transition policy requirements to address the needs of new and current drug plan enrollees, the agency allows plans to craft their own transition policies. Because the policies may vary from plan to plan, with some exceeding the minimum requirements, it is important for your clients to check with their drug plans to learn how the transition policies might affect them.

New Enrollees

Under the MMA, Part D plans must offer a transition process for beneficiaries who are either enrolling in a Part D plan for the first time (i.e., new Medicare beneficiaries and beneficiaries who recently lost creditable coverage) or are enrolling in a different plan. This includes beneficiaries who are joining a Part D plan through a Special Enrollment Period (SEP). Under the transition process, plans must provide new enrollees with a temporary, 30-day supply of a non-formulary drug, including a drug dispensed under a utilization management restriction (e.g., prior approval) that they were taking before enrolling in new Part D plans. Plans may choose to extend the 30-day supply for new enrollees, but at a minimum they must provide a 30-day supply. Plans must cover this temporary supply, or transition fill, when beneficiaries go to pharmacies to fill prescribed medications within 90 days of drug coverage becoming effective.

The transition process also is an opportunity for enrollees to work with their physicians to find alternative drugs on the plan's formulary or to file an exception to request coverage for the drug. Medicare rules require plans to give new enrollees a written notice that states that they must either switch to a therapeutically equivalent drug that is on formulary or request an exception from the plan to continue taking the drug for the remainder of the calendar year. Plans work with pharmacies to distribute the notice to enrollees when they receive a transition fill. In the event that a prescription is not filled and such a notice is not distributed, it is best to contact the plan for further information on the plan's reasons for denying coverage and the appropriate next steps. The transition letter should explain the reason that the plan is providing a temporary fill, e.g., that the drug is not on the formulary or that the plan places a utilization management restriction on the drug.

Current Enrollees

CMS expects Part D plans to have a meaningful transition process in place for current plan enrollees whose drugs are no longer on the plan's formulary in the change from one contract year to the next. CMS expects plans to select one of two options.

1. Plans can provide for current enrollees a transition process that is consistent with the process for new enrollees. Under this option, CMS requires plans to provide enrollees with a temporary supply of the requested prescription drug (where it is not medically contraindicated) and with written notice that states how they must either switch to a drug that is on the plan's formulary or request an exception to continue taking the drug.
2. Alternatively, plans can establish and implement a transition process for current enrollees prior to the start of a new contract year (January 1, in most cases). This option requires plans to prospectively transition current enrollees to a therapeutically equivalent drug on the formulary or complete requests for formulary and cost-sharing exceptions before prior to the start of a new contract year. If a plan does neither, it must provide a temporary fill until the beneficiary has transitioned to a new drug on the formulary or until it has granted an exception.

Marketing

The rules governing marketing Medicare Part D are the same as those for Medicare Part C, Medicare Advantage. Please refer to Chapter 5, Marketing Overview – Medicare Advantage and Medicare Part D section.

Chapter 7
MEDICARE SUPPLEMENT (MEDIGAP) INSURANCE

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Medicare Supplement (Medigap) Insurance

Medicare Supplement insurance is health insurance sold by private insurance companies that fill some of the cost and benefit "gaps" in the Original Medicare program. The official name for these policies is "Medicare Supplement Insurance," but it is often referred to as Medigap Insurance. State insurance departments regulate the companies and agents that sell this insurance.

Before 1990, Medigap insurance policies were not standardized in many states. As a result, it was hard for consumers to compare one plan to another as to how well they filled Medicare's gaps. Since 1991, insurance companies in most states must sell Medigap insurance policies that conform to minimum standards set by the National Association of Insurance Commissioners (NAIC). Massachusetts, Minnesota, and Wisconsin had their own Medigap standardization laws in place before the NAIC developed its national model law and regulation and are exempt from the NAIC rules. From 1991 to 2005, the NAIC model had 10 standard Medigap plans lettered A-J. The Medicare Modernization Act of 2003 added plans K and L to the array of standard plans. Plans K and L took effect on January 1, 2006, the same day that Medicare began its Part D prescription drug program.

A revised NAIC model law and rule took effect on June 1, 2010. After that date, insurers can no longer sell some of the 10 original standardized Medigap plans (E, H, I, J, and high deductible J) because, when Medigap drug benefits were removed from plans H, I, and J in 2006, the result was that the plans duplicated other plans. The revised NAIC model also eliminated the preventive care, at-home recovery, and 80% payment for excess charge benefits. This is because, with changes in Original Medicare's coverage and claims procedures, they are now outdated.

Since Congress authorized the model law in 1990, the NAIC refers to the plans issued under the old model rules as "1990 plans." These plans will remain in effect as long as their policy holders pay premiums. They may, however, become more expensive over time as the number of policy holders declines.

The revised NAIC model also created two new Medigap plans, M and N, and added a new hospice cost-sharing benefit to the core benefit of all plans that take effect on June 1, 2010. The revised NAIC model law calls the 11 Medigap policies (A, B, C, D, F, high deductible F, G, K, L, M, and N) that conform to the new rules "2010 plans."

Here are some key points about Medigap insurance that apply to both the 1990 and 2010 plans:

- Beneficiaries who have Original Medicare and a Medigap policy have access to most hospitals, physicians, and other providers in the country.
- Medigap coverage is tied to Original Medicare's coverage. If Medicare approves payment on a claim, so does the Medigap policy. If Medicare denies a claim, generally so does the Medigap policy.
- A person generally must have Medicare Part A and Part B to purchase a Medigap policy.
- Medigap policies do not work with Medicare Advantage plans, that is, Medicare HMOs, PPOs, Private-Fee-for-Service (PFFS) plans, Special Need Plans, and Medicare Savings Accounts (MSA). Medicare Advantage plan members should not buy Medigap insurance.
- Many companies have "crossover claim" agreements with Medicare. Medicare shares its coverage and payment information electronically with the Medigap insurer. The company in turn automatically pays its share of the claim. When providers accept assignment, this enables bills to be paid in full with no paperwork for the beneficiary.

- Insurance companies are not required to sell all standard plans, but they must offer Plan A and either Plan C or Plan F if they want to sell any of the others.

Covered Gaps and the Basic Benefit

Each of the standard Medigap policies covers the same gaps regardless of the company that sells it. Thus, for example, Medigap Plan C from Mutual of Omaha covers exactly the same gaps as Plan C from Golden Rule. This means that SHICK counselors and their clients can make "apples to apples" comparisons among the standard policies. Prices for Medigap insurance tend to increase based on the number of gaps the policies fill. Plan A which covers a basic, or core, benefit is usually the cheapest.

Medigap policies are designed to cover some or all of these gaps in Original Medicare: [6]

- Part A deductible per benefit period
- Part A hospital daily coinsurance
- No hospital coverage after 150 days in a benefit period
- No psychiatric hospital coverage after 190 days in a lifetime
- SNF daily coinsurance charge
- Hospice coinsurance charges for palliative medications and respite care
- First three pints of blood
- Part B annual deductible
- Part B coinsurance charge (20% of the approved amount in most cases, but more for many outpatient hospital services, and for outpatient mental health)
- Part B excess charge (the difference between Medicare's approved amount and Medicare's 15% limiting charge for physician services)
- Emergency care received outside the U.S.A.

The basic, or core, benefit includes coverage for the:

- Part A inpatient hospital coinsurance charges
- 365 days of hospitalization after Medicare coverage ends (starting on the 151st medically necessary inpatient hospital day in a Part A benefit period)
- Hospice coinsurance charges for palliative medications and respite care
- Preventive care coinsurance
- Part B 20% coinsurance charge
- First three pints of blood

Explanation of Basic and Additional Benefits

Part A Deductible (All Plans except A)

Medicare will pay for the first 60 days of hospitalization in a benefit period after the beneficiary pays a "deductible." This benefit pays the full deductible amount each time it is charged to the beneficiary. It is included in all policies except Plan A, although on Plans K, L, & M, only a varying percentage is covered. The amount usually goes up each year, and the deductible is charged on the basis of a benefits period rather than a calendar year.

[6] Medicare cost-sharing can be found in the Appendix under Annual Medicare Premium and Cost-Sharing Amounts/

Part B Deductible (Plans C & F)

Medicare has an annual deductible for Part B covered services. This amount of Medicare-approved Part B charges each year is the responsibility of the beneficiary. This benefit pays the deductible each year.

It may cost as much in premium as the maximum benefit you can receive because the insurance company will pay out the maximum benefit for most insured.

Starting January 1, 2020, Medigap plans sold to new people with Medicare won't be allowed to cover the Part B deductible. Because of this, Plans C and F will no longer be available to people new to Medicare starting on January 1, 2020. If you already have either of these two plans (or the high deductible version of Plan F) or are covered by one of these plans before January 1, 2020, you'll be able to keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans.

Skilled Nursing Facility Coinsurance (All Plans except A & B)

Medicare covers only approved skilled nursing care in a Medicare approved facility. These benefits are available when you satisfy the guidelines as defined by Medicare. This type of care is usually for a very limited number of days.

All standardized policies except A & B include the "Skilled Nursing Facility Coinsurance Benefits" that pays the actual billed charges up to the Medicare coinsurance amount for days 21-100. Standardized Policies cannot pay benefits beyond 100 days. The average stay in skilled care is well below 100 days.

Excess Charges (Plans F & G)

One of the gaps in Medicare is medical charges that are in "excess" of approved amounts. Physicians who don't accept assignment (non-participating physicians) can charge more than the approved amounts. However, the patient cannot be held liable for charges greater than the 15% "excess" over the fee schedule amount.

A policy that covers the deductibles, the 20% coinsurance (in the basic benefits), and the 100% of excess charges does essentially pay 100% of costs as long as the service is Medicare approved.

Foreign Travel Emergency (Plans C, D, F, G, M, & N)

Medicare covers you only while in the United States and its possessions (Guam, Puerto Rico, and Virgin Islands). If someone is traveling outside the covered areas, Medicare will not pay for health care (except in rare emergency situations when the nearest care is across the border in Canada or Mexico.)

Covered Cost under This Benefit

- Only for emergency care needed immediately because of an injury or an illness of sudden and unexpected onset
- Care must begin during the first 60 consecutive days of each trip outside the U.S.
- $250 calendar year deductible
- $50,000 lifetime maximum
- 80% of billed charges paid for Medicare eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country.

Medigap Modernization

Beginning June 1, 2010, insurance companies must offer Medigap policies that comply with a new set of Medigap standards. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the states to adopt a revised NAIC model for Medigap modernization that had been in development since 2005. States enacted legislation and adopted regulations in 2009 to give effect to the revised model standards. Companies began selling policies that comply with the new standards in June 2010.

The revised model eliminated some policies altogether. After June 2010, companies no longer sell Medigap Plans H, I, J, and high-deductible Plan J because, since they no longer offer the former limited prescription drug benefit, they now duplicate other plans. The new rules also eliminated Plan E because its 80% coverage of the Part B excess charge is not needed.

The revised model also eliminated some benefits from all Medigap plans. Companies no longer offer the at-home recovery, preventive care, and 80% of excess charges benefit. Given changes in Medicare since 1990, these benefits are outdated and little used.

Two new Medigap policies—Plans M and N—joined Plans A, B, C, D, F, high deductible F, G, K, and L. Plan M includes the basic benefit, 50% coverage for the Part A deductible, full coverage for the Part B coinsurance charge, and foreign travel emergency coverage. Plan N includes the basic benefit, full coverage for the Part A deductible, coverage for the Part B coinsurance charge, except for a $20 copayment for office visits and a $50 copayment for emergency room visits, and foreign travel emergency coverage.

The Standard Medigap Insurance Policies (June 1, 2010)

Medigap Plan A covers only the core benefit. The other Medigap plans build on this core benefit to cover different combinations of coverage gaps. Keep in mind that the basic benefit does not include coverage for the Part A inpatient hospital deductible or the Part B annual deductible. Several of the 1990 and 2010 plans, however, cover the Part A deductible in full. Note that Plans K, L, M, and N take a slightly different approach to covering the features of the basic benefit. Here are the main features of the standard Medicare Supplement Insurance (Medigap) policies:

- Plan A covers the basic benefit. It does not cover the Part A or Part B deductibles, the Part A SNF daily coinsurance charge, foreign travel emergencies, or Part B excess charges.
- Plan B covers the basic benefit and the Part A inpatient hospital deductible. It does not cover the Part A SNF daily coinsurance charge, the Part B deductible, foreign travel emergencies, or the Part B excess charges.
- Plan C covers the basic benefit, the Part A inpatient hospital deductible, the Part B deductible, the SNF daily coinsurance charge, and foreign travel emergencies. It does not cover the Part B excess charge.
- Plan D covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies.
- Plan F covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, the Part B deductible, and 100% of the Part B excess charge. Note that physicians in the United States accept assignment in 99% of the cases, meaning that very few doctors bill for the excess charge. Other Part B providers, such as medical

equipment suppliers, may bill for excess charges more often. Some companies offer a high deductible Plan F with an annual deductible.

- Plan G covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, and 100% of the Part B excess charge. It does not cover the Part B deductible.
- Plan K covers 100% of the Part A inpatient hospital coinsurance charges but it departs from the basic benefit by paying 50% (not 100%) of Part B coinsurance charges. It also covers 50% of the Part A inpatient hospital deductible and the SNF daily coinsurance charge. It has an annual out-of-pocket cap and is adjusted each year for inflation.
- Plan L covers 100% of the Part A inpatient hospital coinsurance charges but it departs from the basic benefit by paying 75% (not 100%) of Part B coinsurance charges. It also covers 75% of the Part A inpatient hospital deductible and the SNF daily coinsurance charge. It has an annual out-of-pocket cap and also is adjusted each year for inflation.
- Plan M covers 100% of the Part A inpatient hospital coinsurance charges and 50% of the Part A deductible. It also fully covers the SNF daily coinsurance charge.
- Plan N covers 100% of the Part A inpatient hospital coinsurance charges and 100% of the Part A deductible. It fully covers the SNF daily coinsurance charge. This plan covers the 20% coinsurance charge for most Part B services (e.g., ambulance and outpatient hospital services), except for physician office visits and emergency room (ER) visits. The policy holder is responsible for $20 copayments for office visits and $50 copayments for ER visits.

1990 Plans no longer sold

While these plans are no longer being sold, you may counsel beneficiaries who still have one of these policies in force.

- Plan E (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, and preventive services that Medicare Part B does not cover (e.g., an annual physical examination).
- Plan H (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge and foreign travel emergencies. It is almost identical to Plan D, except that it has no at-home recovery benefit. Before 2006, this policy had a limited prescription drug benefit.
- Plan I (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, the at-home recovery benefit, and 100% of the Part B excess charge. It does not cover the Part B deductible. Before 2006, this policy had a limited prescription drug benefit.
- Plan J (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, the at-home recovery benefit, the preventive care benefit (e.g., for annual physical examinations), the Part B deductible, and 100% of the Part B excess charge. Before 2006, this policy had a limited prescription drug benefit. Some companies offer a high deductible Plan J with an annual deductible.

- If you encounter a beneficiary with H, I, or J that still includes drug coverage, you will need to consider their options carefully as this drug coverage is not creditable.

Other Policy Options

- Medicare Select Policies: Some insurance companies also offer "Medicare Select" policies for Medigap Plans. Medicare Select policies cover the same gaps as regular plans, except that they require beneficiaries to the use certain providers, typically hospitals, in non-emergency situations. Select policies usually cost less than regular policies.
- High Deductible Plans F: The law allows insurance companies to sell Medigap plan F with a high deductible option. After the beneficiary pays the annual deductible, the policies start to fill the same gaps as the regular plans F. CMS updates the deductible amount each year based on the consumer price index. The monthly premiums for high deductible policies are also usually less than those for regular policies.

Uncovered Gaps in Original Medicare

There are some gaps in Original Medicare that the standard plans cannot fill. Foremost among the gaps is prescription drug coverage.

Other gaps in Original Medicare include:

- SNF coverage after 100 days in a benefit period
- Private duty nursing
- Hearing aids
- Dentures and dental implants
- Eyeglasses (except for cataracts)
- Custodial care

Many people cover these additional gaps out-of-pocket. Some, however, purchase other types of insurance, such as long-term care insurance to help with the costs of custodial level care in nursing facilities and at home. Some buy dental insurance to help pay for dental care. These "other" gaps are among the main reasons that Medicare beneficiaries pay on average about 18 percent of their total health and long-term care costs out-of-pocket.

The Cost of Medigap Insurance

Because each standard policy must cover the same benefits, the main point of comparison between one insurance company and another is price. Generally, Plan A is the least expensive plan among an insurance company's array of Medigap insurance policies. Policies that fill more coverage gaps usually cost more. Policies with a guaranteed issue feature also tend to cost more. But insurers set their own prices for Medigap policies and monthly premiums vary from company to company, sometimes dramatically. The range in monthly premiums for Medigap insurance can be from as low as $60 to more than $400. It really pays to shop around.

A number of factors contribute to the difference in pricing among companies for the same insurance policy. One factor is the number of people the company insures. If it insures a large number of Medicare beneficiaries, it may be easier to spread the cost of insurance around. Another factor is the approach the company takes to marketing and customer service. Some use local agents for sales and service. Others rely on direct mail and toll-free customer service lines.

Insurance companies also use different methods to set or "rate" their prices. When buying a Medigap policy, it is good to know which method the company uses because it may have a big impact on future premium costs. The three most common rating methods are:

- Issue-age rating where the premium is based on the beneficiary's age at the time the company issued the policy. Premiums generally are lowest for people in the 65 to 69 age group and will not increase as they get older, although premiums tend to rise due to inflation.
- Attained-age rating where the premium is based on a beneficiary's current age and goes up with age. Premiums start out fairly low but increase over time.
- Community rating where the premium is the same for everyone who has the Medigap policy regardless of age. (Kansas does not have any community-rated policies.)

Most insurance companies use one of the age-rating methods to set their premiums. Relatively few use the community rating method.

The Kansas Insurance Department publishes a Medigap insurance cost comparison guide. It's a great tool for evaluating insurance options. These guides enable your clients to compare the coverage and cost of different Medigap policies. If you're helping someone from another state, check the SHIP or insurance department website for state-specific guide premium comparisons.

One important service that SHICK counselors provide is helping clients compare the cost of Medigap insurance with the cost of Medicare Advantage (MA) plans. Many MA plans have very low monthly premiums, including some with no premiums at all. But comparing Medigap insurance and MA plans on premium prices alone can lead to problems. It is also important for people to understand where the potential for out-of-pocket costs exists.

Example: *Glenn is new to Medicare. As he decides about enrolling in a Medicare Advantage plan, he asks about the difference in price between Medigap Plan C and a Medicare PPO. The monthly premium for the Medigap policy is $170 ($2,040 annually). The monthly premium for the Medicare PPO is $50 ($600 annually). Glenn wants to make sure, however, that he has good coverage for cancer care because the illness runs in his family. With Medigap Plan C, if he needs hospital outpatient services and chemotherapy drugs, he would have no additional out-of-pocket costs. Plan C covers all the coinsurance charges. But with the Medicare PPO, he would owe 20% of the cost of chemotherapy drugs with the potential for many thousands of dollars in out-of-pocket costs that would add to the cost of the PPO's low premiums.*

Consumer Rights and Protections

Medicare beneficiaries have several important consumer rights when purchasing Medigap insurance. Some of the main protections are:

Open enrollment and guaranteed issue rights for new Medicare beneficiaries: In Kansas, all people with Medicare have a six-month Medigap open enrollment period after they become eligible for Medicare and enroll in Medicare Part B. This also protects older workers when they first enroll in Part B at a later date. A beneficiary has the right to purchase any Medigap policy during this frame. Insurance companies must issue the policy and cannot turn down the applicant on the basis of poor health status.

Guaranteed issue and open enrollment for people under 65: Kansas requires insurance companies to sell all types of Medigap policies to Medicare beneficiaries who are under age 65, including those with disabilities. The companies must issue the policies regardless of age or health status. Beginning in 2020, guaranteed issue plans will be one of the following six policies: A, B, D, G, K, or L.

Guaranteed issue rights for those who lose coverage: Medicare beneficiaries who lose their coverage from a Medicare Advantage plan when they move away from the plan's service area, or those who lose coverage when an employer or union group plan ends, have a right to enroll in one of six Medigap policies (A, B, D, G, K, or L) during a 63-day window after their previous coverage ends.

- **Losing Medicare Advantage (MA) coverage**
  - MA terminates or stops providing care in the area.
  - Beneficiary moves outside the MA service area.
  - Beneficiary leaves the plan because it failed to meet its required obligations to them.
  - The beneficiary is eligible to return to Original Medicare and purchase a Medigap policy, A, B, D, G, K or L from any company selling these policies.
- **Medicare Advantage/Medicare Select Trial Right**
  - The beneficiary initially enrolls in an MA plan or Medicare Select plan when they first become eligible for Medicare and decide within the first 12 months they do not like it, they can go to Original Medicare, and they have the right to purchase any Medigap policy from any insurance company selling these policies.
  - if the beneficiary decides to try an MA plan or Medicare Select, they drop their Medigap coverage, and then decide they don't like the MA, they may return to Original Medicare if they meet these requirements:
    - This must be the first time they are enrolled in an MA plan or Medicare Select plan;
    - They must decide to leave the plan within one year after joining;
    - If they meet these requirements, they will return to their original Medigap policy, if it is still offered, or choose from policies A, B, D, G, K, or L.
- **Employer Group Health Plan Benefits**
  If the beneficiary is enrolled as an employee, retiree, or dependent under a group health plan and the plan terminates their health benefits they have the right to purchase a Medigap policy (A, B, D, G, K or L) from any insurance company selling these policies.
- **Medigap Insurance Coverage**
  If the beneficiary loses their Medigap insurance coverage due to one of these reasons:
  - Insurance company is insolvent or goes bankrupt.
  - Involuntary termination of coverage or enrollment.
  - Company substantially violates material provision of the policy
  - Representative of company materially misrepresents policy provisions in marketing the policy.
  - The beneficiary is eligible to return to Original Medicare and purchase a Medicare supplement policy, A, B, D, G, K or L from any company selling these policies.
- **Medicaid eligibility**
  If the beneficiary loses their eligibility for health benefits under Title XIX of the Social Security Act (Medicaid), the beneficiary is eligible to purchase any Medigap policy from any company selling these policies in Kansas.

Guaranteed Renewability: Insurance companies cannot cancel Medigap insurance policies except for failure to pay premiums. Older policies (prior to 1992) may allow the company to refuse to renew on an individual basis.

- If a supplement is canceled due to non-payment of premium, it shall be reinstated in the event of lapse, if the insurer provides proof of cognitive impairment or the loss of functional capacity within five months after termination. The beneficiary (or their representative) may pay past due premium

and keep the policy in force. The standard of proof of cognitive impairment of loss of functional capacity shall be established by clinical diagnosis by a person licensed to practice medicine and surgery and qualified to make such diagnosis.

Prohibited marketing practices: It is against the law for an insurance company or agent to sell duplicate Medigap policies, to sell a Medigap policy to someone who has Medicaid (with some exceptions), and to use high-pressure sales tactics.

Other Policy Features & Limitations

30-Day Free Look

Kansas requires a minimum 30-day "free look" period for Medigap insurance beginning when the policy is received by the insured. If the policy is reviewed and returned to the insurer during the free look period, a full premium refund must be given. Policies should be returned with a letter of explanation directly to the insurer's home office using certified mail. To verify the date of receipt, keep the envelope in which the policy was received, and keep a copy of all correspondence. For practical purposes, the date of receipt is considered to be the postmark date plus 7-10 days.

Suspension during Medicaid or QMB Eligibility

In some situations, eligibility for Medicaid or QMB assistance may be for a short period only. Under these circumstances a suspension provision enables the insured to immediately return to using the Medigap policy without having to go through the application process and possible denial because of health conditions.

Suspending (Freezing) a Medigap Policy

- When a policyholder or certificate holder is entitled to Medicaid or QMB, the benefits and premium may be suspended at the request of the insured for a period not to exceed 24 months. The insured must notify the company within 90 days after the date they become entitled to Medicaid/QMB coverage and explain why they want their policy suspended. Upon receiving the notice, the company must return that portion of the premium applicable to the period of Medicaid/QMB eligibility.
- When a policyholder or certificate holder loses Medicaid or QMB, his/her insurance coverage can automatically be reinstated (effective with the termination date) if the company is notified within 90 days and pays the premium attributable to the period.
- There can be no pre-existing condition waiting period when the policy is reinstated. Coverage must be equivalent to coverage in effect before the date it was suspended. Premiums must be paid back to the date the policy is reinstated, which is the date Medicaid or QMB ends.

Underwriting

Underwriting is the process through which insurance companies decide whether to issue insurance to an applicant. Each company has its own guidelines for underwriting. Some companies are very conservative and insure only relatively low-risk individuals. Other companies will insure people with a higher potential risk because of health problems. A higher risk usually requires a higher premiums rate.

Underwriting may be limited to asking health-related questions on an application, or it may entail a thorough review of an individual's medical history including obtaining copies of medical records from the applicant's physicians. There is no limit on how far back into one's medical history the insurance company

can search while they are doing underwriting. Conditions for which the applicant has received no advice or treatment in the six months before a policy's effective date cannot be considered pre-existing for any required waiting period.

Pre-Existing Conditions Limitations

Some people who know or suspect that they might require medical treatment in the future attempt to purchase health insurance to defray the cost of that future treatment. This form of "adverse selection" may involve fraudulently concealing information from an application or may occur because basic insurance principles are not understood. One of the ways companies defend against this form of adverse selection by applicants in poor health is the pre-existing condition exclusion or waiting period. There is no limit on what health history is considered for underwriting purposes as earlier described; however, there is a limit on how long benefits can be denied for pre-existing conditions once a policy has been issued.

Pre-Existing Condition Defined

Under the Kansas insurance code, "a pre-existing condition is one for which medical advice was given or treatment was recommended by or received from a physician within the six months before the effective date of coverage." Treatment for this definition includes prescription medication. The waiting period for a Medicare supplement policy cannot exceed six months after the policy becomes effective.

Waiting Period for Pre-existing Conditions

Limits can apply only to those conditions identified as pre-existing, according to the definition above. Benefit payments on a claim can be denied for treatment of pre-existing medical condition for up to six months after the effective date of a health insurance policy. During the waiting period, any eligible claims for conditions that are not pre-existing will be paid.

The six-month time frame before and after policy issue is the maximum allowed. A company can use a shorter time period or have no limitation for pre-existing conditions. Obviously, an accident that occurs after a policy is issued could not be a pre-existing condition.

Credit for Pre-Existing Conditions

If you have a Medigap policy and you replace it with another Medigap policy, you get up to six months "credit" for the time you were covered by the old policy. The company cannot refuse to cover pre-existing conditions if you have at least six months of "creditable coverage." Creditable coverage includes:

- Group health plan (like an employer plan);
- Health insurance policy;
- Medicare Part A or Part B;
- Medicaid;
- Medical program of the Indian Health Service or tribal organization;
- A Healthcare Marketplace plan;
- TRICARE (health care program for military dependents & retirees);
- Federal Employees Health Benefit Plan;
- Public health plan; or
- Health plan under the Peace Corp Act.

Coordination of Benefits

The Medigap Policy and Medicare

Medigap insurance always coordinates with Medicare. This means Medicare pays first (is primary), and the Medigap policy helps pay amounts not paid by Medicare. If a claim is not approved for Medicare coverage, the Medigap policy usually does not cover the claim unless the policy specifically includes a benefit in addition to Medicare-approved coverage.

The Medigap Policy & Other Health Insurance

Medigap policies are not allowed to coordinate benefits with other health insurance (except for Medicare). In other words, the Medigap policy will pay its normal benefits regardless of any other insurance you may have.

Group Health Insurance Policies

Common types of group health insurance policies are employer-provided retirement policies, accident policies, and specific-disease policies (such as a plan that pays in case of cancer or stroke).

Group insurance policies are **allowed to have a coordination of benefits** provision. This provision allows them to reduce their benefits if another group insurance plan or Medicare pays benefits. The result may be that the **group** policy ends up paying little or nothing on the claim.

More than One Medicare Supplement Policy

It is against the law for an insurance company or agent to knowingly sell a Medigap policy to someone who already has a Medigap policy, unless the new one is to replace the old one. Applications ask if the applicant has another Medigap policy or if it is the intent to replace coverage currently in force. If the applicant indicates coverage is in force and there is no intent to terminate the current coverage, the insurance company will not issue the policy.

If you had a supplement policy prior to 1991, it is possible for you to have two supplements. However, after 1991, you can only have ONE Medigap policy. If someone does have multiple Medicare supplement policies, each policy must pay full benefits due. Claims should be filed separately for each policy.

Other Health Insurance Policies

The law allows the sale of additional insurance policies such as hospital indemnity, cancer, stroke, and accident even though benefits may duplicate benefits from Medicare. However, such policies must pay all benefits due regardless of any payments the insured receives from other coverage.

A disclosure statement explaining possible duplication of benefits must be provided to the applicant along with the application.

Consumer Protection

The manner in which insurance companies and agents conduct the business of selling insurance and the design and use of written material is substantially regulated by federal and state laws and regulations. Any violation of those laws and regulations may be addressed in a written complaint which, upon investigation by the Kansas Insurance Department, may lead to fines, restriction on future activity, or loss of the right to do business in the state.

Sales Materials

Outline of Coverage

This must be provided to the client at the time of solicitation. It shows the features of each plan being offered and includes premium information.

Acknowledgement of Non-duplication

This must be provided at the time of **application** (or issuance if a mail order policy). The agent, or insurance company for a direct mail sale, must offer to review all health insurance policies for a client. Both the client and agent must sign the "Acknowledgement of Non-duplication" which states that the offer to review had been made and that the intended sale will not duplicate other benefits to which the client is entitled.

Replacement Notice

This must be provided at the time of application (or policy delivery if a mail order policy) when a Medigap policy being purchased will be replacing another Medigap policy. The replacement notice must be signed by the client and agent, and it must state that the client intends to terminate existing coverage. The agent must indicate why the replacement policy is being purchase (additional benefits; lower premiums, but no change in benefits, fewer benefits and lower premium; or other).

Questionable Behavior of Insurance Agents

The Kansas Insurance Department (KID) has rules and regulations regarding what is required and expected on the part of agents as they sell insurance. KID has enforcement authority through the Agents and Brokers Division, which licenses all agents selling insurance in Kansas. Any questionable behavior of an agent can be passed along to this division at any time and it will be put in the file of the agent and if necessary, disciplinary action will be taken.

To take administrative action of any kind, KID needs the person observing the behavior to **file a written complaint** with the department including the name of the agent and the company that he/she represents. The formal complaint must be signed by the person who has observed the questionable behavior.

WARNING! It is important to remember that any personal views on a particular agent or company are just that - personal views. Expressing such a view in public is contrary to the most basic principle of the SHICK program - **"unbiased"** assistance. This is also a fundamental principle of the Kansas Insurance Department and the Kansas Department for Aging and Disability Services. Any prejudicial statements made that are not based on administrative action taken specifically by the department toward certain individuals is strictly prohibited.

KID takes its role of supervising agents very seriously because it has a direct relationship with regard to protecting Kansas insurance consumers. Any information about any agent forwarded to KID is always helpful. Formal complaints are even more helpful because they can then investigate the matter.

Be a Wise Consumer

Shop Around

Decide which of the 10 standardized policies best meets your needs. Then shop around for price, customer service, and financial stability. Group insurance is not necessarily less expensive than individual coverage.

Remember - You Have an Open Enrollment

During the first six months a person is enrolled in Medicare Part B, *whether 65 or under 65 (in Kansas)*, all insurance companies must accept the person for Medigap coverage under any policy currently being

marketed. Past health history may not be considered. If the beneficiary waits until after the open enrollment period, they may be refused coverage under some policies if they do not meet the company's insurability requirements.

Companies May Have a Waiting Period (Up to six months)

Pre-existing conditions would not be covered during the waiting period. If you have pre-existing conditions, look for a company that does not have a waiting period.

Does the Person with Medicare have Creditable Coverage?

If the answer is yes, there is no need to worry about the pre-existing condition waiting period – but first they must understand creditable coverage AND not have a gap of more than 63 days without coverage.

The Phrase "No Medical Examination Required" may be misleading

The beneficiary might not have to go to a physician for an exam, but medical statements they make on the application could prevent them from getting coverage after their open enrollment period.

Take Time

A beneficiary should not feel pressured into buying a policy if they have questions or concerns. They should involve a friend or relative whose judgment they can trust. If they need more time, tell the agent to return at some future date. They should not fall for the age-old excuse, "I'm only going to be in town today, so you had better buy now."

Generally, it takes at least 30 days to be approved

They are not insured by a new Medigap policy on the day they apply for it.

A policy should be delivered within a reasonable time (usually within 30 days after application)

If they haven't received the policy or had their check returned in 30 days, contact the company and obtain in writing the reason for delay. If problems continue, contact the Kansas Insurance Department.

Consider carefully before replacing a policy with a new one

The beneficiary should not cancel a policy until they have been accepted by the new insurer and have policy in hand.

Do not pay with cash

They should/can pay by check, money order, or bank draft payable to the insurance company only, not the agent. They should completely fill in the check before presenting it to the agent.

If they are eligible for Medicaid, generally, they do not need a Medigap policy

There are exceptions to this. To find out if they are eligible for Medicaid or if they are a Qualified Medicare Beneficiary (QMB) or a Low Income Beneficiary (LMB), ask the beneficiary or the KanCare Clearinghouse.

Use Their 30-Day "Free Look" Period

The beneficiary should review their new Medigap policy and get a premium refund if they decide not to take the coverage.

Refunds Aren't Available After the "Free Look" Period

Insurance companies are not required to return an unused premium if the beneficiary decides to drop the policy before its next premium due date, but after the free look period has passed. If an agent tries to sell

them a new policy saying they can get a premium refund for their current policy, report the agent to the Kansas Insurance Department.

Medigap Policies Are Not Sold by Federal or State Governments

Advertising or suggesting that a policy is government sponsored is illegal. These practices should be reported to the Kansas Insurance Department.

Complete the Application Carefully

Before the beneficiary signs an application, they should read the health information recorded by the agent. They should not sign it until all health information is presented correctly. If they leave out medical information requested, the insurer could deny coverage for that condition or cancel their policy.

Review Retiree Policies Carefully

The beneficiary should carefully compare benefits and cost of retiree plans before replacing a retiree benefit with a Medigap policy. It will be necessary to have a copy of the outline of coverage to make this comparison. It may be necessary to call the Employer's Plan or Human Resources Administrator. Without this information, it is not possible to make an accurate comparison.

Outline of Coverage

An Outline of Coverage must be provided at the time of solicitation. When presented by an agent, an acknowledgment of receipt of such outline shall be obtained. This is often in the form of a question on the application requiring a yes or no answer.

The information that must be included and the format in which it must be presented are spelled out in the insurance regulations. In general, an Outline of Coverage will have the following:

- An illustration of premium information with all possible premiums for the prospective applicant.
- Disclosures about other aspects of the policy and how coverage will be administered.
- Charts displaying the features of each benefit plan being offered.

Remember - All Medigap Insurance is Guaranteed Renewable

The insurance company cannot refuse to renew a policy unless the beneficiary does not pay the premiums or they submitted false information on the application.

Remember - Lapsed Premium Due to Cognitive Impairments or Loss of Functional Capacity Can Be Reinstated

Collections of lapsed premiums will be allowed (possibly up to five months) if there is clinical diagnosis of proof of cognitive impairment or loss of functional capacity.

Chapter 8
CLAIMS & APPEALS

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CLAIMS & APPEALS

If you're in Original Medicare, doctors and suppliers are required by law to file Medicare claims for covered services and supplies you get. Find out which doctors in your area accept assignment.

If you have a Medicare Advantage Plan, these plans don't have to file claims because Medicare pays these private insurance companies a set amount every month.

It is the responsibility of the beneficiary to supply the provider with correct information. Incorrect information delays the whole process and may result in denial of payment.

Be sure the provider has the following information:

- Correct Medicare number
- Correct name exactly as it is shown on the Medicare card
- Current address and telephone number

Kansas Medicare Part A and Part B Claims (A/B MAC) - Wisconsin Physicians Services (WPS).

To contact, call 1-800-MEDICARE

Hospitals

- Participating hospitals always accept assignment. They handle all paperwork and deal directly with the A/B MAC (Medicare Administrative Contractor.)
- Hospitals also file all private insurance and receive those reimbursements.
  Exception: Indemnity policies pay fixed dollar amounts per day directly to the policyholder.
- The beneficiary should not pay a hospital bill until the hospital receives payment from Medicare and insurance.
  Note: Hospitals may send monthly bills or statements until the hospital is paid. To avoid problems, the beneficiary must inform the hospital of his/her intentions.
- The beneficiary may receive a Medicare Summary Notice, describing days used and the deductible payment.
  Note: A request may be made for an itemized hospital bill, but the beneficiary is never informed as to what Medicare actually pays on that hospital claims.
- No one should pay any hospital or provider based on the Medicare Summary Notice. Wait for a bill from the hospital.

Skilled Nursing Facilities

- Skilled nursing facilities also file claims for patients and accept assignment. The patient must have been in a skilled Medicare certified facility and/or in a Medicare participating bed.
- Payments are limited by Medicare's requirements; the facility will know if patient qualifies for payment.
- A "Medicare Summary Notice" is used to inform beneficiaries of benefits used. As with the hospital, that patient is not told what Medicare pays the facility.

Kansas Home Health & Hospice MAC – Highmark Medicare Services.

To contact, call 1-800-MEDICARE.

Home Health Agencies

- Home Health Agencies file claims for the patient and takes assignment. Medicare pays 100% for eligible services.
- The A/B MAC does not send a statement; the beneficiary can request a Medicare Summary Notice.

Hospice

- Hospice files claims for patient and takes assignment. Medicare pays 100% for eligible services.
- The A/B MAC does not send a statement; the beneficiary can request a Medicare Summary Notice.

Kansas Durable Medical Equipment MAC – Noridian Administrative Services, LLC

To contact, call 1-800-MEDICARE

Doctors, Suppliers, and Other Providers

Even if they do not take assignment, doctors, suppliers, and other providers of Part B services and supplies must submit Medicare claims. Medicare allows them up to 12 months to file the claims, but most of them do it electronically within a short period of time.

Contact 1-800-MEDICARE with problems or questions regarding claims. Always have the Medicare Summary Notice (MSN) as a reference when making these calls.

Carrier (Railroad Retirement eligible) - Palmetto Government Benefits Administrators

Railroad Retirement System

Claims are submitted to the United Health Insurance Company office. Regional offices are listed in Your Medicare Handbook for Railroad Retirement Beneficiaries, which is available at any Railroad Retirement office. To contact, call 1-800-MEDICARE.

Claims for Services Received Outside the State

Claims for services incurred outside the state must be submitted to the intermediary or carrier in the state where the service was provided or where the bill originated.

Filing Your Own Claims

According to federal law, a person with Medicare cannot file their own claims – it is the responsibility of the Medicare provider to file all claims, whether or not they believe that the claim will be paid. **In very rare cases, a beneficiary may need to file a claim on their own.**

Medicare claims must be filed no later than 12 months (or 1 full calendar year) after the date when the services were provided. If a claim isn't filed within this time limit, Medicare can't pay its share. For example, if the beneficiary sees their doctor on March 22, 2015, the Medicare claim for that visit must be filed no later than March 22, 2016. The beneficiary should check the MSN they receive in the mail every three months to make sure claims are being filed timely. If the claims aren't being filed timely:

1. The beneficiary should contact the Doctor or Supplier and ask them to file a claim.
2. If they don't file a claim, the beneficiary should call 1-800-MEDICARE and ask for the exact time limit for filing a Medicare claim for the service or supply received. If it's close to the end of the time limit and the doctor or supplier still hasn't filed the claim, the beneficiary should file the claim.
3. Detailed instructions and a form can be found at https://www.medicare.gov/claims-and-appeals/file-a-claim/file-a-claim.html.

Medicare Summary Notice (MSN)

(Formerly the Explanation of Medicare Benefits - EOMB) - When the claim is paid, the beneficiary may be sent a Medicare Summary Notice (MSN) from the A/B MAC.

The MSN shows the billed amount and the Medicare approved amount. It shows what the co-payment is and what Medicare is paying. If the annual deductible had not been met, that would also be shown. The notice gives the address and toll-free number for contacting the carrier.

Another Option to Access Your Information

MyMedicare.gov

MyMedicare.gov, www.MyMedicare.gov, is an online way to get personalized Medicare information. If they provide an email address when they register, Medicare will email their user ID and a temporary password ("pattern") right away. When they login they will be immediately prompted to change their password to protect their personal information. Once online they can do the following on this site,

- Track health care claims
- Check Part B deductible status
- View eligibility information
- Track usage of preventive services
- Find a Medicare health or prescription drug plan or search for a new one and track their drug costs

The tool allows them to keep all their Medicare information in one convenient place. For example, they may want to see when a claim gets paid by Medicare, or they may want to track how much they've spent out-of-pocket towards their Part B deductible (what you pay before Medicare begins to pay its share).

MyMedicare.gov can even track which Medicare preventive services they have used each year and remind them of those services they are eligible to have but haven't used. For example, Medicare covers preventive services like screening mammograms, prostate cancer screenings, and flu shots. On mymedicare.gov they will get reminders about taking advantage of these benefits.

There is also a "My Drug Costs" tab to organize and keep track of their prescription drug costs and spending.

Mymedicare.gov also includes:

- A glossary of the terms used by Medicare on the site.
- A Spanish version of mymedicare.gov.
- Easier viewing of your Medicare claims online.
- A printer friendly format for claims.

For more information about Medicare, visit www.medicare.gov on the web. Or, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Due Process Rights

All Medicare beneficiaries have "due process" or procedural rights when Medicare or its payment contractors deny payment for covered services, and when providers decide to discharge a patient or discontinue covered services. These due process rights include:

- Written notice
- The right to reconsideration by someone who was not involved in the first decision
- The right to a hearing when a certain amount of money is at stake
- The right to judicial review when a certain amount of money is at stake

Other Medicare Appeal Rules

Medicare adjusts the amounts in controversy for Administrative Law Judges (ALJ) hearings and judicial review to reflect inflation in medical costs.

Medicare regulations allow physicians, equipment suppliers, and other service providers to appeal a denial of an initial determination. This creates the potential for both the beneficiary and the provider to request a redetermination for the same denial. Regulations also enable providers and suppliers to use an informal "reopening" procedure to correct minor mistakes or omissions, coding errors for example, with the MAC rather than go through the formal appeals process.

National and Local Coverage Determinations

CMS has National Coverage Determinations (NCDs) that describe the circumstances and conditions of Medicare coverage for specific medical services, procedures, or devices. It is important to know that the terms of these NCDs control Medicare coverage decisions nationwide. NCDs generally outline the conditions under which CMS considers a service, procedure, or device to be covered—or not covered—under the "reasonable and necessary" language of the Medicare law. For example, chelation therapy for atherosclerosis is the subject of an NCD which instructs Medicare's payment contractors not to cover the procedure because its safety and effectiveness are in question.

Once published, an NCD is binding on all Medicare payment contractors including A/B MACs, DME-MACs, Home Health and Hospice MACs, Quality Improvement Organizations (QIOs), Program Safeguard Contractors (PSCs), and Medicare Advantage Organizations. NCDs are also binding on Administrative Law Judges (ALJ) during the claim appeal process.

Coverage denials based on NCDs differ from denials that simply involve a decision that a procedure, such as a diagnostic test, is not reasonable and necessary in an individual case. When NCDs state that Medicare does not cover the use of a procedure for a specific medical indication, CMS effectively excludes that use from program coverage. As a result, NCD coverage denials have two very important consequences. One is that Medicare's financial liability (waiver of liability) protections for beneficiaries do not apply in these cases. The other is that a beneficiary can bypass the general appeals process described above and use a special procedure to challenge the NCD by appealing directly to the DHHS Departmental Appeals Board (DAB).

A Local Coverage Determination (LCD) is a decision by a Medicare administrative contractor (MAC) whether to cover a particular service on a MAC-wide basis in accord with the reasonable and necessary language in the Medicare law. An LCD is binding on the Medicare payment contractor and the QIC at the first and second levels of the appeals process described above. An LCD, however, does not bind the decision of an ALJ.

What is an Appeal?

An appeal is the action a beneficiary can take if they disagree with a coverage or payment decision made by Medicare, a Medicare health plan, or a Medicare Prescription Drug Plan. A beneficiary can file an appeal if Medicare or the plan does one of these:

- Denies a request for a health care service, supply, or prescription that the beneficiary thinks they should be able to get
- Denies a request for payment for health care or a prescription drug already received
- Denies a request to change the amount that must be paid for a prescription drug

A beneficiary can also appeal if they are already getting coverage and Medicare or the plan stops paying.

They can also appeal if Medicare or the plan stops providing or paying for all or part of an item or service they think they still need.

The appeals process has five levels. If the beneficiary disagrees with the decision made at any level of the process, they can generally go to the next level. At each level, they'll be given instructions in the decision letter on how to move to the next level of appeal.

Original Medicare Appeals Process

Level 1: Redetermination by the company that handles claims for Medicare
Level 2: Reconsideration by a Qualified Independent Contractor (QIC)
Level 3: Hearing before an Administrative Law Judge (ALJ)
Level 4: Review by the Medicare Appeals Council (Appeals Council)
Level 5: Judicial review by a federal district court

Medicare Advantage Appeals Process

Level 1: Health Plan Reconsideration
Level 2: Independent Review Entities (IRE) Reconsideration
Level 3: Hearing before an Administrative Law Judge (ALJ)
Level 4: Review by the Medicare Appeals Council (Appeals Council)
Level 5: Judicial review by a federal district court

Part D Appeals Process

Level 1: MA-PD/PDP Redetermination
Level 2: Part D Independent Review Entities (IRE) Reconsideration
Level 3: Hearing before an Administrative Law Judge (ALJ)
Level 4: Review by the Medicare Appeals Council (Appeals Council)
Level 5: Judicial review by a federal district court

The first two levels of each appeal process are different, but the final three levels are the same. However, each Appeals process may have different time limits. There is also a standard process and expedited process under each appeal timeline. Flow charts of each process can be found in the Appendix under Chapter 14.

Detailed information about each appeal process can be found in the CMS publication, Medicare Appeals, available at http://www.medicare.gov/Pubs/pdf/11525.pdf.

Original Medicare Coverage Decision Notices

As you work with clients, be aware of these four kinds of coverage and payment notices in Original Medicare. All notices contain information about the next step that a beneficiary can take to request a coverage decision or appeal. The next steps may vary, depending on the notice.

- **Medicare Summary Notices (MSN)**
  After a provider, like a home health agency, physician, or ambulance company, submits a claim for payment to Medicare, the MAC makes a coverage and payment decision detailed in an MSN. The MSN is Medicare's official "initial determination" on a claim for coverage and payment. Medicare sends MSNs to beneficiaries every three months. If the MSN shows that Medicare denied coverage and payment, the beneficiary, her representative, or the provider can look to the instructions on the MSN to request a redetermination.

- **Inpatient Hospital Notices**
  Acute care hospitals issue *An Important Message from Medicare about Your Rights (IM)* to all Medicare patients at the time of admission and may reissue the *IM* before the patient's discharge. If a beneficiary disagrees with the proposed discharge, they can ask the BFCC-QIO to make an expedited determination of the need for a longer hospital stay. Soon after a beneficiary makes this request, the hospital must deliver a *Detailed Notice of Discharge (DND)*.

- **Service Termination Notices**
  Skilled nursing facilities (SNFs), home health agencies, comprehensive outpatient rehabilitation facilities (CORFs), and hospices must give written notice to beneficiaries before they end Medicare-covered services or discharge a beneficiary from their care. This standard notice of a decision to terminate services is called a *Notice of Medicare Provider Non-Coverage*. This notice is <u>not</u> an official initial determination or Medicare coverage decision. It merely states the provider's opinion that the beneficiary no longer meets Medicare's coverage rules for the service. This notice must give the:
  - Patient at least two days' notice of the proposed end of services.
  - Date that coverage of services ends.
  - Date that the beneficiary's financial liability for continued services starts.
  - Notice of the right to an expedited determination by the Quality Improvement Organization (QIO).

- **Advance Beneficiary Notices (ABN)**
  Medicare Part A and Part B health care providers may issue ABNs. CMS has a general ABN for use by physicians, DME suppliers, laboratories, and hospices. Home health agencies and skilled nursing facilities use other ABNs. Because ABNs are not official Medicare coverage determinations, there is nothing to appeal unless the provider submits a claim. After receiving an ABN, a patient has the right to ask a provider to submit a claim to Medicare. If the Medicare payment contractor then issues an MSN showing that it denied payment on the claim for lack of medical necessity, a beneficiary can start the appeal process by requesting a redetermination.

The Appeals Process – Original Medicare

Level 1: Redetermination

The beneficiary, a representative, or a physician must send a written request for a redetermination to the MAC within 120 days of receiving the MSN with its denial notice. Those with good cause can request an

extension. The written request can take the form of a letter, a copy of the MSN with the words "Please Review" written on it, or a CMS *Redetermination Request* form.

In the redetermination process, a person who was not involved in the initial decision reviews the claim for improper coding, missing documentation, and additional information from the provider or patient. Redetermination notices explain the facts, policies, and law that underlie the Medicare payment contractor's redetermination decision. The MAC has 60 days to make its redetermination decision.

Level 2: Reconsideration

The deadline for filing a request for reconsideration is 180 days after receipt of the MAC's adverse redetermination decision. Those with good cause can ask for an extension.

You can send a *Reconsideration Request* to the Qualified Independent Contractor (QIC) named on the redetermination notice. CMS contracts with four regional QICs for Part A and Part B, and a national QIC for Durable Medical Equipment, Prosthetic, and Supply (DMEPOS) appeals. The QICs are:

- Part A west region: Maximus Federal Services, Inc., http://www.medicarepartaappeals.com/
- Part A east region: C2C Innovative Solutions, Inc., https://www.c2cinc.com/QIC-Part-A-East
- Part B north region: C2C Innovative Solutions, Inc., http://www.c2cinc.com/QICPartBNorth.aspx
- Part B south region: C2C Innovative Solutions, Inc., http://www.c2cinc.com/QICPartBSouth.aspx
- DMEPOS-National: C2C Innovative Solutions, Inc., http://www.c2cinc.com/QICDME.aspx

In its reconsideration, the QIC conducts a review of the medical record considering CMS manual guidelines and coverage determinations. There is no face-to-face meeting with a decision maker at this stage. The QIC must issue a written reconsideration decision, explaining its rationale, within 60 days.

Level 3: ALJ Hearings

A beneficiary, a beneficiary's representative, or a physician who receives an unfavorable reconsidered determination from the QIC has a right to a hearing with an Administrative Law Judge (ALJ) if a minimum amount of money is at stake. The amount in controversy is the amount of money involved with the denied services. In other words, the amount in controversy is the total projected value of the denied services or benefits. Enrollees having more than one denied claim may combine their claims to meet the threshold amount in controversy, if needed, as long as all the claims have followed the proper procedures.

Beneficiaries (or the representative or physician) may request an ALJ hearing only in writing and according to the instructions found in the QIC's reconsideration notice. The request for an ALJ hearing must be made within 60 days of notice of the QIC's unfavorable reconsidered determination. As with requests for reconsideration, those with good cause may be granted an extension past this 60-day time frame.

Most ALJ hearings take place using video-teleconferencing (VTC) facilities. The ALJ hearing is a beneficiary's first chance to meet face-to-face (to the extent that VTC technology allows) with a decision-maker. It provides a chance to ask and answer questions, and to bring in witnesses, such as a physician.

Administrative Law Judges work for the Office of Medicare Hearings and Appeals (OMHA). Like CMS, OMHA is an agency within the federal department of Health and Human Services. For more information about ALJ hearings, including relevant forms, internal procedures, and FAQs, visit OMHA's website at http://www.hhs.gov/omha/index.html.

Level 4: Medicare Appeals Council (MAC) Review

Any of the relevant parties who disagree with an adverse ALJ hearing decision (including case dismissal) may ask the Medicare Appeals Council (MAC) to review the case. The MAC has the option to grant or decline each request for review. In response to each case, the MAC may issue a final decision or a dismissal or return the case to the ALJ with instructions. The MAC may initiate its own review of any ALJ hearing decision or dismissal. When it does so, the MAC must notify all relevant parties.

Beneficiaries, their representatives, physicians, or CMS may request MAC review only in writing. If CMS requests the MAC review, it must provide notice to the beneficiary. The request for a MAC review must be made within 60 days of receipt of the ALJ hearing decision or dismissal. As with other steps in the appeals process, those with good cause may be granted an extension past this 60-day time frame.

The MAC uses the following criteria to either grant or decline cases submitted for review:

- Does there appear to be an abuse of discretion by the ALJ?
- Is there an error of law?
- Are the actions, findings, or conclusions of the ALJ not supported by substantial evidence?
- Is there a broad policy or procedural issue that may affect the public interest?

Level 5: Judicial Review

Any of the relevant parties who disagree with a hearing decision (including case dismissal) may request a federal district court to review the ALJ decision if the MAC declined to review the case or affirmed an adverse ALJ decision, and if the amount in controversy is a minimum amount.

To start the judicial review process, the relevant party must file a civil action in a district court in the judicial district where the beneficiary lives.

Expedited Determinations and Reconsideration in Original Medicare

Right to an Expedited Determination

If a beneficiary receives a *Notice of Medicare Provider Non-Coverage* service termination notice from a home health agency, hospice, skilled nursing facility, or Comprehensive Outpatient Rehabilitation Facility (CORF), they have a right to an expedited determination by the Medicare Quality Improvement Organization (QIO). In Kansas, the Beneficiary and Family Centered Care (BFCC)-QIO is KEPRO - https://www.keprogio.com/, 1-855-408-8557.

Expedited Determination Procedures

A beneficiary must ask the BFCC-QIO for an expedited determination, by telephone or in writing, by noon of the day following receipt of the provider's service termination notice. The *Notice of Medicare Provider Non-Coverage* has instructions on how to reach the BFCC-QIO. The beneficiary or her representative must be available to answer questions for, or provide information to, the BFCC-QIO staff. The beneficiary may submit evidence to the BFCC-QIO.

When it makes an expedited determination about a provider's decision to terminate services, the BFCC-QIO:

- Must immediately notify the provider about the request.
- Determines if the termination notice is valid.
- Examines the medical record and determines if a physician certified that a significant health risk exists for the patient.

- Must seek the beneficiary's views.
- Gives the provider a chance to explain why the termination or discharge is appropriate.
- Notifies the beneficiary, her physician, and the provider of its decision generally within two days of receiving the expedited determination request.
- May initially notify the parties by telephone but must follow up with a written notice. The notice must give the date on which the beneficiary becomes liable for the cost of continued services and describe her right to an expedited reconsideration.

When a beneficiary requests an expedited determination, Medicare coverage continues until the BFCC-QIO completes the determination process. A provider may not bill the beneficiary for the disputed services until then. If the patient decides to pay for ongoing care after coverage termination, they can ask the provider to submit a claim to Medicare. This is called a "demand bill." If Medicare denies payment, the patient can request a redetermination.

Inpatient Hospital Notices and Expedited Procedures

An acute care hospital must give *An Important Message from Medicare about Your Rights (IM)* to all Medicare patients at the time of admission and again no later than two days before a proposed discharge. The *IM* describes a beneficiary's right to an independent review when they disagree with a proposed discharge. If a beneficiary disagrees with a hospital's discharge decision, he or someone on his behalf should call the BFCC-QIO no later than the planned discharge date to request a quick review.

Instructions for this process and the BFCC-QIO's toll-free phone number should appear on the Important Message from Medicare. After a person requests the BFCC-QIO review, the hospital must give the patient a *Detailed Notice of Discharge* that contains specific information about the Medicare coverage policies upon which the hospital has based its decision.

To receive an official expedited coverage determination, the patient must call the BFCC-QIO no later than noon of the proposed day of discharge. Medicare requires the BFCC-QIO to issue a written decision within one day of receiving all the information it needs to decide. If the QIO decides that the patient is ready to be discharged, Medicare covers the hospital stay until noon of the day after the BFCC-QIO gives notice of its decision.

If the patient disagrees with the BFCC-QIO's decision, he may request expedited reconsideration of the BFCC-QIO's decision by noon of the next calendar (not working) day. The Qualified Independent Contractor (QIC) reviews the case and issues a decision within 72 hours.

Medicare Advantage Grievances and Appeals

All Medicare beneficiaries enrolled in Medicare Advantage (MA) plans have the right to a review of adverse coverage decisions that the plans make regarding health services. Thus, all organizations offering MA plans must have procedures in place for enrollees to exercise their rights. These rights fall into three main categories:

- Grievance: A complaint or dispute that describes an enrollee's dissatisfaction with the way the MA plan provides health care services, regardless of whether a remedy exists.
- Organization Determination: A determination an MA plan makes regarding
    - Payment for certain out-of-network services received by an enrollee
    - Payment for health services the enrollee believes are Medicare-covered

  - Discontinuation of services the enrollee believes are medically necessary
  - Failure of a plan to provide services in a timely manner such that an enrollee's health would be adversely affected
- Appeal: The process that enables independent review of adverse organization determinations. The process has up to five levels of review, from reconsideration by the MA plan to judicial review.

Grievances

All Medicare Advantage plans must have processes in place to hear and resolve grievances filed by MA plan enrollees. Here are several examples of situations that MA plans should process as grievances:

- Complaints about copayment amounts
- Complaints about an enrollee's involuntary disenrollment
- Complaints about a change in premiums or cost-sharing amounts from one contract year to the next
- Complaints about wait-times on the plan's toll-free number for members
- Complaints about the quality of care of services provided
- Complaints about aspects of care, including a provider's inappropriate behavior or failure to respect an enrollee's rights
- Complaints about timeliness of services provided

CMS requires that MA grievance procedures include the following elements:

- MA plans must accept information and evidence about grievances orally and in writing up to *60 days* after the event
- MA plans must use a model notice or an approved variation to notify enrollees of their right to file an expedited grievance
- MA plans must respond within 24 hours to expedited grievances when:
  - The MA plan extends the time frame to make an organization determination or reconsideration
  - The MA plan refuses to grant a request for an expedited organization determination or reconsideration
- MA plans must act promptly and appropriately within a time frame suitable to the enrollee's case but no later than 30 days from the date of receipt of the grievance
- MA plans must transmit grievances to the appropriate level of the MA organization in a timely manner
- MA plans must provide the results of their investigation to all concerned parties within a time frame suitable to the enrollee's case but no later than 30 days from the date the grievance is filed with the MA plan
- MA plans must provide prompt notice if the plan needs a 14-day extension to process a grievance
- MA plans must document the need for such extensions and explain how it is in the enrollee's best interest
- MA plans must track and maintain records of receipt and resolution of all grievances
- All plans must disclose grievance data to Medicare beneficiaries upon request

All enrollees in an MA plan are entitled to receive written materials about the plan's grievance procedures. These materials must be made available to enrollees upon enrollment, at the time of involuntary disenrollment (if applicable), annually, and upon request. Plans must make written information available

about enrollees' right to file expedited grievances when plans deny the enrollees' requests for expedited appeal or an organization determination or when the MA plan takes an extension on an organization determination or appeal.

Organization Determinations

All Medicare Advantage plans must have processes in place to make timely decisions regarding the coverage or costs of all basic, mandatory supplemental, and optional supplemental services provided by an MA plan. Plans must issue organization determinations when enrollees request them as in the case, for example, of a request to approve coverage for a skilled nursing facility stay to receive physical therapy.

The following are examples of situations that MA plans treat as organization determinations:

- Payment for temporarily out-of-area renal dialysis services
- Payment for emergency services, post-stabilization care, or urgently needed services,
- Payment for other health services the enrollee believes are covered by Medicare or should have been covered by the MA plan
- Refusal to authorize, provide, or pay for services the enrollee believes should be covered by the MA plan, including supplemental benefits
- Discontinuation or reduction of a service the enrollee believes is medically necessary and should continue
- Failure to approve, furnish, arrange, or pay for health care services in a timely manner
- Failure to provide an enrollee with timely notice of an adverse determination, with a negative effect on the enrollee's health

Any decision made by an MA plan within the above categories constitutes an organization determination. Enrollees who disagree with an unfavorable organization determination can start the appeals process after they receive a written denial notice from the plan. The notice should contain information about appeal rights along with contact phone numbers and addresses.

Standard Time Frames

When an enrollee or her physician asks an MA plan to approve coverage for a service or item prior to its delivery, MA plans must make organization determinations and provide written notice of the decision within 14 days of receiving the request. Under certain conditions, a plan may extend this standard time frame up to 14 additional calendar days. These exceptional conditions could include an enrollee's request for the extension or the plan's need for additional information or documents. Any granted extension must be sent in writing to the enrollee; this notice must include information about filing a grievance with the plan regarding the extension.

When MA plans deny an enrollee's or provider's requests for payment for services or items already received, they have 60 days to make an organization determination and provide notice of the payment decision.

Written Notification

When an MA plan denies a request to approve a service or item for coverage, it issues a form called a Notice of Denial of Medical Coverage. Plans should use the NDMC to describe the service or item and explain the reasons for denying the request. When a plan denies a request for payment for services

already received, it issues a form called a Notice of Denial of Payment. The NDP should describe the claim, show the date of service, name the provider, and state the reasons for the denial.

Plans must deliver these denial notices within appropriate time frames for the beneficiary to act, if necessary. Therefore, CMS expects plans to provide written notice via fax, hand delivery, or mail, depending on the situation.

CMS rules state that these notices must include at least the following information:

- The specific reason for denial, taking into consideration the enrollee's medical condition, any disabilities, and language needs
- Notice of the right to a reconsideration (standard and expedited) and the right to appoint a representative
- For health service denials, descriptions of the processes to request both standard and expedited reconsiderations, time frames for both processes, the conditions for obtaining an expedited reconsideration, and information about the appeals process
- For payment denials, descriptions of the process of a standard reconsideration, time frames for the process, and information about the appeals process
- The right to submit additional evidence

If an MA plan fails to give notice in a timely manner, CMS considers this an adverse organization determination. Enrollees may appeal the failure to provide notice just as with any other denial of coverage or payment.

Expedited Organization Determinations

Under certain circumstances, enrollees or their physicians may ask an MA plan to provide an organization determination more quickly than the standard time frame. This process is called an expedited organization determination. If an enrollee or his physician believes that waiting for the standard time frame for an organization determination would place the enrollee's life, health, or ability to regain maximum function in serious jeopardy, the enrollee (or his physician) may request an expedited organization determination. The request to expedite an organization determination may be oral or written.

If an enrollee's provider makes an appropriate request to expedite (that is, the enrollee's life, health, or ability to regain maximum function is in jeopardy), the MA plan must approve the request to expedite. If the enrollee makes the request to expedite, the MA plan must determine if his health status meets the serious jeopardy test before it expedites the organization determination. Under the expedited organization determination process, an MA plan must provide notice of its decision as soon as the enrollee's health condition requires, but not later than 72 hours after receiving the request. Note that only the enrollee, the enrollee's representative, or the enrollee's physician may request an expedited organization determination (provided it does not involve a request for a payment for services rendered).

If an MA plan denies the enrollee's request to expedite the organization determination, the plan must process the decision as a standard organization determination. In these situations, the plan must provide prompt oral notice of the decision to process the determination under the standard time frame. Within three days of the decision to process as a standard determination, the plan must provide written notice to the enrollee that:

- Explains the standard time frame
- Describes the process of filing an expedited grievance

- Further explains the right to resubmit the request to expedite (including information about the potential role of the enrollee's provider)

Appeals

MA plan enrollees have the right to appeal any unfavorable organization determination that an MA plan makes regarding coverage for health services or payments. An unfavorable determination does not automatically trigger an appeal. Someone must start the appeal process with a request for reconsideration. An enrollee or another party can make the request. Other parties who may request a standard appeal on behalf of an enrollee include:

- The enrollee's representative
- Someone asked by the enrollee to make the request
- The legal representative of the enrollee
- Another provider or entity with an appealable interest in the proceeding

Any enrollee may have a representative who can assist with the appeal. There are two types of representatives—appointed and authorized. An authorized representative (e.g., an individual with Durable Power of Attorney or a health care proxy) has the authority to act on behalf of an enrollee under State or other applicable laws. An appointed representative is an individual (e.g., a relative, friend, advocate, or attorney) appointed by the enrollee or other party who assists an enrollee in all the plan's processes. To become an appointed representative, the enrollee and the representative must sign a completed *Appointment of Representative* form (Form CMS-1696). Both types of representative have the same rights and responsibilities as the enrollee in terms of the entire appeals process. Further, a representative may:

- Receive information about an enrollee's claim or grievance
- Submit evidence
- Make statements of fact and law
- Make any request, or give or receive any notice about the appeal or grievance proceedings

Level 1: Reconsiderations

The first step of the appeals process is called a "reconsideration." As mentioned above, the reconsideration does not happen automatically. An enrollee (or his representative) must ask the plan to reconsider its original organization determination as communicated in a Notice of Denial of Medicare Coverage (NDMC) or a Notice of Denial of Payment (NDP). You or your doctor must file a written standard request, unless your plan allows you to file a service request over the phone, by fax, or by email. Your plan's address is listed in your plan materials and on the organization determination notice.

Follow the directions in the "Notice of Denial of Medical Coverage" or the "Notice of Denial of Payment" you got with your unfavorable decision to request a reconsideration from your plan. Your written reconsideration request should include the following:

- Your name, address, and the Medicare number (health insurance claim number (HICN)) shown on your Medicare card.
- The items or services for which you're requesting a reconsideration and the dates of service.
- Your signature. If you've appointed a representative, include the name and signature of your representative. For more information on appointing a representative, see Section 2.

You should also include any other information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

Your plan will respond to your request for an appeal within the timeframes below:

- Standard service request—30 days
- Payment request—60 days
- Fast request—72 hours

Your request will be a fast request if your plan determines, or your doctor tells your plan, that your life or health may be at risk by waiting for a standard decision.

The timeframe for completing standard service and fast requests may be extended by up to 14 days. The timeframe may be extended if, for example, your plan needs more information to decide about the case, and the extension is in your best interest.

If the plan decides against you (fully or partially), your appeal is automatically sent to level 2.

Level 2: Part C Qualified Independent Contractor and Reconsidered Determinations

The Independent Review Entity (IRE) that reviews MA plans' unfavorable reconsideration decisions is called a Qualified Independent Contractor (QIC). Maximus Federal Services (formerly Maximus CHDR-Center for Health Dispute Resolutions) is the QIC under contract with CMS to review Medicare Advantage coverage and payment denials. It issues a "reconsidered determination" at this second level in the Medicare Advantage appeals process. In conducting its review, Maximus refers to Medicare coverage policies and to its own Medicare Advantage Reconsideration Process Manual. Once an MA plan forwards its unfavorable reconsideration decision to Maximus, the QIC must adhere to the same time frames established for MA plan reconsiderations, whether standard or expedited.

Maximus must notify all relevant parties (including the enrollee, any representative, the physician, and the MA plan) of the decision it makes. The decision notice must:

- Be written in understandable language
- Be written in a manner that considers the medical conditions, disabilities, and special language needs of the enrollee
- Provide the reasoning for the decision
- Provide information about the next step in the appeals process (i.e., the ALJ hearing), in the case of an adverse decision and if the amount in controversy is met (see below)

If Maximus reverses the MA plan's coverage denial under standard review procedures, the plan must authorize or provide the service as soon as the enrollee's health requires, but not later than 14 days from the date the plan receives notice from Maximus that it reversed the plan's reconsidered decision. If instead Maximus reverses the MA plan's coverage denial under expedited review procedures, the plan must authorize or provide the services to the enrollee as soon as the enrollee's health requires, but not later than 72 hours from the date the plan receives notice from Maximus that it reversed the plan's reconsidered decision. Finally, if Maximus reverses an MA plan's reconsidered decision to deny a payment request, the plan must pay for the services no later than 30 days from the date it receives notice of the reversal.

Quality Improvement Organizations (QIO)

When an MA plan terminates coverage of an inpatient hospital stay, or when the plan or a contracting provider terminates pre-authorized skilled nursing facility (SNF), home health agency, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, a special expedited review procedure exists. An IRE known as a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), under contract with CMS to review quality of care issues, performs the specialized review. The BFCC-QIO review procedure bypasses the MA plan's reconsideration process (described above) when an appeal request to the BFCC-QIO meets a tight deadline. For information on the BFCC-QIO in your state, beneficiaries can either check the coverage termination notice or call 1-800-MEDICARE.

When an SNF, home health agency, or CORF believes that the care it is currently providing to an MA plan enrollee no longer meets Medicare coverage criteria, it often will give a Notice of Medicare Non-Coverage to the person. SNF, HHA, and CORF service providers must deliver the notice to the enrollee, on the MA plan's behalf, at least two days before the termination of services. Valid delivery means that the enrollee must be able to understand the notice's purpose to sign for receipt of it. Other notice protections apply to incompetent persons in institutions.

The NOMNC gives an ending date for the services and has instructions on how to ask the QIO for an immediate appeal. The key to this special review procedure is to make the review request—by calling the BFCC-QIO—as soon as possible, but no later than noon of the day before the service termination is due to take effect. The NOMNC must contain the BFCC-QIO's name and phone number. The notice also informs the enrollee that they may have to pay for services after the termination date if the BFCC-QIO agrees that Medicare no longer covers the services. If a person misses the deadline for requesting an immediate appeal with the BFCC-QIO, they may still ask her MA plan for an expedited reconsideration.

Level 3 through Level 5

The last three levels of Appeal for Medicare Advantage Plans are the same as for Original Medicare. (See page 8-13 for more details.)

Giving Effect to Decisions from ALJ, MAC, and Judicial Review

If an ALJ, the MAC, or a federal court reverses an MA plan's coverage or payment denial, the MA plan must authorize, provide payment for, or provide the service as soon as the enrollee's health requires, but not later than 60 days from the date the plan receives notice of the decision to reverse the plan's original decision.

Part D Grievances, Coverage Determinations, and Appeals

Because each Medicare drug plan has a different formulary, as well as different rules regarding access to drugs, some enrollees may have problems getting all their prescriptions filled through their Part D plans. The MMA establishes specific rules and processes for beneficiaries who are having difficulty obtaining their prescriptions. Understanding the reasons for the plan's denial of coverage and learning what to do about it are important steps in obtaining a drug from the Part D plan.

Grievances

All Medicare drug plans must have processes in place to hear and resolve grievances filed by Part D plan enrollees. Here are several examples of situations that Part D plans should process as grievances:

- Complaints about copayment amounts

- Complaints about an enrollee's enrollment or disenrollment
- Complaints about a change in premiums or cost-sharing amounts from one contract year to the next
- Complaints about wait times on the plan's toll-free number for members
- Complaints about the quality of care or benefits provided
- Complaints about the plan's written communications
- Complaints about timeliness of services provided

CMS requires that Part D grievance procedures include the following elements:

- Plans must accept information and evidence about grievances orally and in writing up to at least 60 days after the event.
- Plans must accept any information or evidence concerning the grievance.
- Plans must respond within 24 hours to expedited grievances related to a plan's refusal to grant a request for an expedited coverage determination or an expedited redetermination if the enrollee has not yet received the drug at issue
- Plans must transmit in a timely manner all grievances to the appropriate decision-makers
- Plans must take prompt, appropriate action, including a full investigation of complaints
- Plans must notify results of their investigations to all concerned parties, as expeditiously as the enrollee's case requires, but no later than 30 days after the plan receives the oral or written grievance
- Plans must inform enrollees of the results of the grievance as follows:
    - Plans must respond in writing to those grievances submitted in writing
    - Plans may respond either orally or in writing to grievances submitted orally, unless the enrollee requests a written response.
    - Plans must be responded to in writing to all grievances related to quality of care, regardless of how the grievance is filed. The response also must include information about the enrollee's right to file a written complaint with the QIO.
- Plans must have procedures for tracking and maintaining records about the receipt and disposition of grievances. They also must disclose grievance data to Medicare enrollees upon request.

All enrollees in Part D plan are entitled to receive written materials about the plan's grievance procedures. Plans must make written information available about enrollees' right to file expedited grievances when plans deny the enrollees' requests for expedited appeal or organization determination or when the Part D plan takes an extension on a coverage determination or appeal.

Coverage Determinations

A coverage determination is a decision by a Medicare drug plan about whether or not to cover a prescribed medication under the Part D program. In most cases, drug plans determine that prescribed medications are medically necessary and approve coverage. But a plan may decide not to cover a drug for several reasons:

- The drug is not on the plan's formulary.
- The plan determines the drug to be not medically necessary.
- The plan restricts coverage to a specific dosage of the drug.
- The drug is subject to prior authorization, step therapy, or another utilization management restriction.

- The drug is covered under Medicare Part A or Part B.
- An out-of-network pharmacy furnishes the drug.
- The plan sponsor determines that the drug is excluded from Part D coverage.

These types of coverage determinations are generally made by the plan behind the scenes, and do not require an enrollee to take action to receive a coverage determination. There is, however, a type of coverage determination—called an exception—that only occurs after an enrollee takes action. When a beneficiary files a request for a formulary exception with the plan, the plan's decision about whether to grant the exception is also a coverage determination.

If a plan denies coverage for a prescription drug at the pharmacy counter, the beneficiary, an appointed representative, or the beneficiary's physician may request a coverage determination. An appointed representative is a person asked by a beneficiary to assist in the coverage determination process. To become an appointed representative, this person can complete a standard CMS form (https://www.cms.gov/cmsforms/downloads/cms1696.pdf). The form is valid for one year after it is signed, and must be submitted with each request for a coverage determination. Because the MMA gives physicians the authority to request a coverage determination on behalf of a beneficiary, it is not necessary for the physician to be an appointed representative.

Medicare drug plans make coverage determinations on standard and expedited time frames. When someone requests a standard coverage determination, the Part D plan must make its decision and respond to the beneficiary and the prescribing physician (if the physician requested the coverage determination) within 72 hours after receiving the request. If the plan denies coverage for the prescribed medication, the plan must give the beneficiary a written notice describing the reason for the denial along with instructions to appeal the adverse coverage determination.

A drug plan will make an expedited coverage determination if the physician believes that a delay will place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests are completed according to the plan's rules, usually by phone or fax. The plan must respond to the beneficiary and physician within 24 hours.

Exceptions

A significant portion of coverage determinations are requests for exceptions. Part D plan enrollees have the right to request two different types of exceptions from their drug plans, one for coverage of a non-formulary drug (formulary exception) and the other for a reduction in the cost-sharing amount for a formulary drug (tiering exception). Beneficiaries may not request both types of exceptions for the same drug.

If a plan has a separate tier for generic drugs, an enrollee cannot request an exception to reduce the copayment of a brand-name drug to that of a generic drug. If the plan decides to cover the drug or reduce the cost-sharing amount, the exception lasts for the remainder of the plan year. If an enrollee remains in the same plan for the next year, the plan can decide anew about an exception for the drug. The plan may require the enrollee to submit a new exception request for the coming plan year. Note that Medicare rules do not require the drug plans to process an enrollee's exception request until the prescribing physician provides the plan with an oral or written supporting statement.

Formulary Exceptions

Exceptions that fall under this category include requests for:

- A drug that is not on the plan's formulary
- A drug that is on the plan's formulary, but not in the dosage or form prescribed by the physician
- A drug with a utilization management restriction (i.e., step therapy, prior approval, quantity limit)

Cost-Sharing (Tiering) Exceptions

Beneficiaries may request exceptions to lower their cost-sharing amounts for non-preferred, brand-name drugs. Plans with cost-sharing tiers assign some medications to a more costly non-preferred drug tier and others to a more affordable, preferred status tier. Beneficiaries who cannot take the preferred drug in a class or category may request an exception to lower the cost-sharing amount of their non-preferred drug to that of the preferred group.

Part D Appeals Process

When a coverage determination is unfavorable, or "adverse," the enrollee may appeal the drug plan's decision. There are five steps in the appeals process. In each step, beneficiaries must make their request for further action within 60 days of receiving notice of the prior, unfavorable response.

Level 1. Redetermination

A redetermination is a request for the Part D drug plan to revisit an unfavorable coverage determination. A request for a standard redetermination must be decided by the plan within seven days. If the beneficiary's request must be expedited, the plan must make a decision within 72 hours of receiving the request.

Level 2. Reconsideration

When the drug plan gives an adverse decision on a redetermination request, reconsideration is the next step in the appeals process. This step is a request to the Part D Qualified Independent Contractor (QIC), a Medicare contractor also known as an Independent Review Entity (IRE), to review the Part D plan's adverse redetermination decision. The Part D QIC must decide on standard reconsideration requests within seven days and within 72 hours of receiving an expedited reconsideration request.

The Part D QIC is Maximus Federal Services, http://www.medicarepartdappeals.com/.

Level 3 through Level 5

Again, the last three levels of Appeal for Medicare Part D Plans are the same as for Original Medicare. (See page 8-13 for more details.)

As this section illustrates, there are specific rules and processes set forth by the MMA for beneficiaries who are having difficulty obtaining their prescriptions. Some beneficiaries may be able to resolve their access issue relatively easily, while others may need to take a series of steps to hopefully resolve their issue.

Chapter 9
OTHER HEALTH INSURANCE

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OTHER HEALTH INSURANCE

There is a wide variety of options available for health insurance coverage other than just Medicare, Medigap, and Medicare Advantage. Other insurance can be available from an employer, the government, or a private insurance company. Sometimes the policies are group policies and sometimes they are individual policies.

Employer-Sponsored Insurance Options Supplement Medicare

What They Cover

Employer-sponsored health plans generally offer retirees 65 years and older broad coverage. Typical employer plans assist in paying Medicare coinsurance and deductibles for basic medical services, including hospital, physician, laboratory, and X-ray services. Plans may also cover prescription drugs, a major expense for some senior citizens, and plans may cap a retiree's liability through an out-of-pocket limit. Some plans also cover routine vision, hearing and dental care.

Financial Limits

The employer-sponsored plans commonly apply financial limits to their benefits. These include deductibles, coinsurance, and lifetime maximum benefits.

Some plans also include out-of-pocket maximums, or catastrophic benefits, and these plans will pay some or all covered expenses for the beneficiary after the out-of-pocket maximum is reached, up to the policy maximum.

Types of Plans

The predominant types of employer-sponsored plans are network plans, such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs). Fewer and fewer employers are offering a conventional fee-for-service plan and more and more employees are choosing one of the network plans.

Three Methods of Integrating Employer-Sponsored Benefits with Medicare

For most retirees 65 and over, Medicare is their primary health insurer; employer-sponsored plans are secondary sources. Employer-sponsored plans exhibit three methods of integrating benefits with Medicare: carve-out, exclusion, and coordination of benefits: *For each example use the following amounts shown here: $1,000.00 Claim –Medicare allows $1,000.00 – Medicare Pays $800.00*

Carve-Out

This employer-sponsored plan calculates what the plan would pay without Medicare coverage, then Medicare benefits are subtracted from the employer-sponsored plan amount, and the plan pays the remaining amount, if any.

Example:	*Plan looks at total charges:*	*$1,000.00*
	Plan "carves out" out amount paid by Medicare	*800.00*
	Plan looks at balance as eligible amount:	*$ 200.00*
	Plan imposes applicable deductible and co-pay:	*x 80%*
	Payment:	*$ 160.00*

Exclusion

Under exclusion, Medicare benefits are subtracted from the total that the plan would pay and employer-sponsored plan benefits are calculated on the remainder.

Example:	*Company determines amount plan would pay without Medicare:*	*$800.00*
	Subtract the amount paid by Medicare:	*-800.00*
	Plan pays the difference:	*-0-*

Coordination of Benefits

Under coordination of benefits, the plan pays the difference between Medicare payments and the actual charges, up to the amount the plan would have paid in the absence of Medicare.

Example:	*Plan looks at balance after Medicare pays:*	*$200.00*
	Plan compares that with the amount it would Pay without Medicare:	*$800.00*
	Plan pays the lesser amount:	*$200.00*

Federal Retirement Insurance

Federal health insurance can be continued for federal government employees when they retire. This insurance is secondary to Medicare. The federal government offers over 100 different plans (including managed care plans) to different types of federal workers.

Also, for these retirees ONLY, Medicare Part B may not be as critical even for fee-for-service plan enrollees and is NOT required.

For enrollment questions, contact the **U.S. Office of Personnel Management,** Health Benefits Branch, **1-888-767-6738.**

State Retirement Insurance

If a state employee meets the retirement guidelines set by the State of Kansas, he/she may continue the coverage after retirement by paying the required premium.

State Employees with Medicare and State Retirees should look to the Department of Health and Environment, Division of Health Care Finance, for guidance in coordinating Medicare and their state insurance coverage.

They can be contacted at: 785-296-1715 OR Visit their website at: http://www.kdheks.gov/hcf/sehp

Special Considerations

If a retiree has an employer-sponsored plan available, it can be his or her best option. However, because some companies have reduced the coverage offered retirees and this trend is expected to continue, this source of supplemental insurance is not secure.

People with Medicare need to compare their employer's health insurance with a standard Medigap policy. Only one will be needed: a Medigap policy or an employer-sponsored plan.

ASK THESE QUESTIONS:

- ✓ Is the employer stable, or is the plan likely to be terminated or benefits cut due to financial pressures on the employer?
- ✓ Does the plan have a low lifetime maximum benefit? If so, how much has been used?
- ✓ Does the plan have an open enrollment period?
- ✓ Does the plan require the retired person to use only certain providers in a limited geographical area; can the retired person take the benefit along if he/she decides to move to a different part of the state or country?

Private Insurance

Specific-Disease Policy

A specific disease policy provides coverage only for the specific disease or diseases named in the policy. A common type is cancer insurance. This type of plan does not provide basic health coverage.

These policies generally pay a fixed dollar amount for each day of hospitalization or outpatient treatment for the specified disease. Some policies help pay for certain surgical procedures or provide a first-occurrence payment if the insured is diagnosed with the covered disease.

The coverage is in addition to Medicare coverage. Cancer policies may cover some expenses not approved by Medicare. For example, some policies provide coverage such as transportation, food, and lodging costs. There is no standardization of specific-disease policies. Since coverage varies widely, premium costs also vary widely.

For a cancer policy, there is only a ten day “free look” period. Review the policy carefully. It is important for the policyholder to weigh the costs against the benefits. The value of the specific-disease policy depends on the chance that the insured will get the disease(s) the policy covers.

Hospital Indemnity Policies

A hospital indemnity policy pays a fixed dollar amount directly to the policyholder, such as $100, for each day of hospitalization. There are several drawbacks. It pays only if the insured is hospitalized, and it does not provide protection against large medical bills outside the hospital stay. Amounts paid usually are a small percentage of the policyholder’s costs, and the fixed payments often do not keep pace with inflation. There are restrictions on when the coverage begins and a maximum amount the policy pays.

Amounts paid are in addition to what is paid by other insurance, and the money can be spent in any way. However, it is no substitute for a comprehensive Medicare coverage and should only be considered when the individual already has good general health coverage and can afford the additional cost each month.

Long-Term Care Policies

This type of coverage as well as other financial options to pay for all types of long-term care expenses is addressed in detail in Chapter 10 of this Handbook.

Group Travel Insurance

Medicare does not cover medical expenses incurred while traveling in a foreign country. If your Medigap policy does not cover foreign travel emergencies, a group travel policy may be purchased from a travel agent. Benefits are limited and may include the following:

- Accident medical coverage ($2,500, $5,000 or $10,000)
- Sickness (such as $50/day)
- Medical evacuation coverage (up to $25,000)

Premiums may be based on the option selected, length of the trip, and/or cost of the trip.

Other Group Plans

Other group plans may be sponsored by an employee group, union, trade association, or other association, such as a senior citizen organization. These group plans may provide significant benefits for active workers and retirees which supplement Medicare. They may pay for:

- Medicare deductible and co-payments
- Prescription drugs
- World-wide coverage
- Expenses not paid by Medicare

COBRA Continuation Coverage

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1985. COBRA contains provisions giving certain former employees, retirees, spouses, and dependent children the right to temporary continuation of health coverage at group rates for a period of time beyond a "qualifying event." While COBRA is usually not available to persons who are entitled to Medicare, it does apply to workers or dependents who are not Medicare entitled.

Types of Plans Covered

The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. It applies to plans in the private sector and those sponsored by state and local government and certain church-related organizations.

Medical Benefits

Qualified beneficiaries must be offered benefits *identical* to those received immediately before qualifying for continuation coverage. Medical benefits available to COBRA beneficiaries may include:

- Inpatient and outpatient hospital care
- Physician care
- Surgery and other major medical benefits
- Prescription drugs
- Other medical benefits, such as dental and vision care

Qualifying Events

"Qualifying events" are certain types of events that would cause, except for COBRA continuation coverage, an individual to lose health coverage. The type of qualifying event will determine who the qualified

beneficiaries are and the required amount of time that a plan must offer the health coverage to those under COBRA. A plan, at its discretion, may provide longer periods of continuation of coverage.

The types of qualifying events for employees are:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the number of hours of employment

The types of qualifying events for **spouses and dependent** children are:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the number of hours of employment
- Covered employees becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee
- Loss of "dependent child" status under the plan rules

Duration of Coverage

COBRA beneficiaries generally are eligible to pay for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Coverage begins on the date that coverage would otherwise have been lost by reason of a qualifying event and can end when:

- The last day of maximum coverage is reached
- Premiums are not paid on a timely basis
- The employer ceases to maintain any group health plan
- Coverage is obtained with another employer health plan that does not contain any waiting period for pre-existing conditions
- **A beneficiary is entitled to Medicare benefits**

Special rules for disabled individuals may extend the maximum periods of coverage.

Cost Considerations

Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer formerly paid a part of the premium. It is ordinarily less expensive, though, than individual health coverage.

Information on COBRA benefits may be obtained by calling the **U.S. Department of Labor**, Pension and Welfare Benefits Administration, at **1-866-4-USA-DOL** TTY: 1-877-889-5627. On the Internet: http://www.dol.gov/dol/topic/health-plans/cobra.htm

Veterans Benefits

Veterans and spouses of veterans should contact the Veterans Administration (VA) to learn about health care options that are available to them.

General Information

The veteran can have both Medicare and Veterans benefits. The veteran must choose which program to use for medical treatment each time services are needed. Medicare cannot pay for the same service or supplies paid for by the VA. Nor can the VA pay for the same service or supplies paid for by Medicare.

You do not always have to go to a VA hospital or to a doctor who is affiliated with the VA for the VA to pay for your care.

If the Veteran Chooses to Use VA Benefits

If the veteran chooses to use their veteran's benefits, Medicare generally cannot pay for the services they get. Medicare *cannot* pay for the services you get from VA hospitals or other VA facilities.

If the Veteran Chooses to Use Medicare Benefits

If the veteran chooses to use their Medicare benefits, Medicare can pay for Medicare-covered services they get from hospitals and doctors not affiliated with the VA – as long as the VA will not be paying for the same services.

When Medicare and VA Can Each Help Pay

If the VA authorizes the veteran to get hospital services in a hospital that is not a VA hospital, but does not pay for all the services received during the stay, Medicare can pay for Medicare-covered services for which the VA does not pay. For example, if the VA authorizes a five-day stay and you remain in the hospital for 10 days, Medicare can pay for the Medicare-covered services you get during the five days not authorized by the VA.

VA Copayments: Sometimes Medicare Can Help Pay

The VA charges copayments to some veterans with non-service-connected conditions. The veterans who are charged copayments are those at or above a certain income. Sometimes, Medicare can pay part, or all, of this copayment amount.

- Medicare *cannot* pay copayments for services furnished by VA hospitals and facilities.
- Medicare *may be able* to pay all or part of the copayment, if the VA charges a copayment for VA authorized care by a doctor of hospital not affiliated with VA.

If there are questions about whether the VA or Medicare should pay for doctor services and other medical services, contact the Medicare Administrative Contractor (MAC) that pays Medicare claims in Kansas. If there are questions about whether the VA or Medicare should pay for hospital services or services furnished by other facilities, ask the provider of services to contact the MAC.

Should a Veteran Purchase Medicare Part B?

A veteran may think that Medicare Part B is an unnecessary expense. However, it is important to keep in mind that it may not always be geographically possible or convenient to travel to a VA facility to seek medical care. Also, without Medicare Part B, the veteran may incur unanticipated expenses.

Veteran Drug Benefit

A veteran may qualify for the VA Drug benefit. A veteran may have both the VA Drug benefit and a Medicare Part D Prescription Drug plan - these plans DO NOT Coordinate.

The VA Drug benefit is CREDITABLE COVERAGE.

VA on the Internet: www.va.gov

Or For more information about VA policies on nonservice-connected veterans and health insurance, contact your nearest VA MEDICAL FACILITY

The Veterans Administration Regional Office*

5500 East Kellogg

Wichita, KS 67218-1698

1-800-827-1000

Kansas VA Medical Centers

VA Eastern Kansas Health Care System - Dwight D. Eisenhower VA Medical Center
4101 S. 4th Street
Leavenworth, KS 66048-5055
Phone: (913) 682-2000 or (800) 952-8387

VA Eastern Kansas Health Care System - Colmery-O'Neil VA Medical Center
2200 SW Gage Boulevard
Topeka, KS 66622
Phone: (785) 350-3111 or (800) 574-8387
Fax: (785) 350-4336

Robert J. Dole Department of Veterans Affairs Medical and Regional Office Center
5500 E. Kellogg
Wichita, KS 67218
Phone: (316) 687-2221 or (888) 878-6881
Fax: (316) 651-3666

Toll-Free Numbers for Contacting the VA

VA Benefits:	1-800-827-1000
Education (GI Bill)	1-888-442-4551
Health Care Benefits	1-877-222-8387
Income Verification and Means Testing	1-800-929-8387
Mammography Helpline	1-888-492-7844
Special Issues - Gulf War/Agent Orange/Project Shad/ Mustard Agents and Lewisite/Ionizing Radiation	1-800-749-8387
Status of Headstones and Markers	1-800-697-6947
Telecommunications Device for the Deaf (TDD)	1-800-829-4833

TRICARE for Life & TRICARE Senior Pharmacy

TRICARE is a health benefits program for all seven uniformed services: The Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration. It provides medical, dental, and hospital benefits for dependents of active duty service personnel, and for retired service personnel and their dependents prior to age 65. Previously, at age 65 they become eligible for Medicare and their TRICARE benefits end. The spouse or dependent of a person who has turned 65, but who is not yet 65 him/herself, is eligible for TRICARE benefits, and may continue under this plan until age 65.

"This Act extends TRICARE health care and pharmacy benefits to Medicare-eligible retirees of the Uniformed Services, their families' members and survivors. Under the law, pharmacy benefits are effective on April 1, 2001, and the rest of TRICARE health care benefits are effective on October 1, 2001" – from the Office of the Assistant Secretary of Defense Health Affairs

Medical Benefits

Effective October 1, 2001; all Medicare-eligible military beneficiaries became eligible for TFL benefits. The law requires that ***ALL*** Medicare-eligible beneficiaries, regardless of age, ***MUST*** be enrolled in Medicare Part B to receive these benefits.

How does TFL coordinate with Medicare?

- Services covered by both Medicare and TRICARE - Medicare will pay the provider, and then TFL will pay the Medicare deductible and copayment. Nationwide, 93% of providers accept Medicare, so this will cover the vast majority of cases.
- Services covered by Medicare but not TRICARE – The beneficiary will be liable for Medicare copayments, but (by law) the provider's charges cannot exceed 115% of the Medicare Approved Amount. For example, a Medicare procedure not covered by TRICARE is Medicare's limited chiropractic care benefit. In such a case, Medicare would pay 80% of the bill or the Medicare Approved Amount, whichever is less. The beneficiary would pay the remaining 20% copayment plus the 15% in excess charges, if any.
- Service covered by neither Medicare nor TRICARE. The beneficiary is responsible for the cost of non-covered services, e.g., routine dental care, hearing aids, eyeglasses and long-term custodial care.
- Services by TRICARE but not Medicare. The beneficiary is responsible for paying the standard TRICARE copayments. The new annual retiree family catastrophic cap (CATCAP) limits their maximum out-of-pocket cost for TRICARE-allowable medical expenses in any fiscal year to $3,000. If the beneficiary has met the amounts for TRICARE deductibles and copayments, TRICARE will pay 100% of allowable charges for the rest of that fiscal year.

There are five main situations when TRICARE covers a service that Medicare does not:

- Prescription Drugs - see the TRICARE Senior Pharmacy (TSRx) Program
- Inpatient hospitalization when the Medicare benefit is exhausted - from the 151st day on, TFL becomes the first payer indefinitely. The beneficiary pays a 20% copayment when using TRICARE network hospitals and 25% when using non-network hospitals. If the beneficiary pays $3,000 in family TRICARE

deductibles and copayments, TRICARE's CATCAP protection kicks in and TFL pays 100% of TRICARE-allowable costs for the remainder of the fiscal year.

- Skilled Nursing (Facility) Care without at least 3 days prior hospitalization. TRICARE becomes the primary payer and pays 75% of allowable charges. The beneficiary pays the TRICARE deductible and copayments of 25%, up to the annual $3,000 CATCAP.
- Care for individuals residing in foreign countries. Medicare-eligible beneficiaries living in foreign countries still must enroll in Medicare Part B to use TFL. TRICARE will be the first payer for all covered services. In this case, you pay the $150 annual TRICARE deductible ($300 per family) plus 25% copayments, up to the $3,000 CATCAP, plus any excess charges over the TRICARE-allowed amount.

Did you know? "Dual-eligible" is the term used to describe a TRICARE beneficiary who is entitled to Medicare.

Myth: TFL is only for TRICARE beneficiaries who are 65 years of age or older.

Fact: TFL is for all TRICARE beneficiaries who are entitled to Medicare because of a disability, end stage renal disease, or age.

See the TFL website for more detailed information - http://www.tricare.mil

Pharmacy Benefits - Tricare Senior Pharmacy (TSRx)

Effective April 1, 2001 - TRICARE beneficiaries who are 65 and over are receiving the same pharmacy benefit as retirees who are under 65. This includes access to prescription drugs not only at military treatment facilities, but also at retail pharmacies and through the Department of Defense national mail service program. TRICARE Senior Pharmacy & the Medicare Part D Prescription Drug coverage do coordinate - The TRICARE Drug benefit is CREDITABLE COVERAGE.

- If the beneficiary was 65 prior to April 1, 2001, the law states they automatically qualified for the benefit whether or not they had purchased Medicare Part B.
- If the beneficiary turns 65 after April 1, 2001, the law mandates that they ***MUST*** be enrolled in Medicare Part B to receive the TRICARE pharmacy benefit.

Retirees with questions? Call 1-877-DOD-MEDS (1-877-363-6337) OR http://www.tricare.mil/pharmacy

CHAMPVA

CHAMPVA, Civilian Health and Medical Program of the Department of Veterans Affairs, is a federal health benefits program administered by the Department of Veterans Affairs. CHAMPVA is a Fee-for-Service (indemnity plan) program. It provides reimbursement for most medical expenses - inpatient, outpatient, mental health, prescription medication, skilled nursing care, and durable medical equipment (DME). There is a very limited adjunct dental benefit that requires preauthorization.

CHAMPVA bases its benefit structure on the CHAMPUS/TRICARE Standard option. There are ***no other*** ties between the programs. CHAMPVA is administered by the Department of Veterans Affairs Health Administration Center in Denver, Colorado and is ***only*** for family members of 100% permanently and totally disabled veterans (not retired).

Who is Eligible for CHAMPVA?

Who is eligible for CHAMPVA:

- When a reservist is on active duty or active duty for training

- Note: When the reservist turns age 62, and receives a retired status, the reservist and eligible family members become TRICARE eligible.

CHAMPVA provides coverage to the spouse or widow(er) and to the children of a veteran who:

- is rated permanently and totally disabled due to a service-connected disability, and the dependents are not otherwise eligible for Department of Defense (DoD) TRICARE benefits.
- was rated permanently and totally disabled due to a service-connected condition at the time of death, and the dependents are not otherwise eligible for DoD TRICARE benefits
- died of a service-connected disability, and the dependents are not otherwise eligible for DoD TRICARE benefits.
- died on active duty, and the dependents are not otherwise eligible for DoD TRICARE benefits. In most cases, the dependents of service members who die while on active duty are covered under DoD TRICARE. Dependents are generally TRICARE eligible except in the case of a widow/er who remarries.

CHAMPVA eligibility can be impacted by changes such as marriage, divorce from the sponsor, or eligibility for Medicare or TRICARE. Changes in status should be reported immediately to CHAMPVA, ATTN: Eligibility Unit, P.O. Box 469028, Denver, CO 80246-9028 or call (800) 733-8387.

CHAMPVA and Medicare

When payment for covered services and supplies may be made under both Medicare and CHAMPVA, Medicare is the primary payer. For health care services covered under both plans, you often have no out of pocket expenses.

To get view more information online go to http://www.va.gov/hac/forbeneficiaries/champva/champva.asp or call (800) 733-8387 - Monday-Friday 8:05 AM - 7:30 PM Eastern Time

Coordination of Benefits

The purposes of the coordination of benefits (COB) program are to identify the health benefits available to a Medicare beneficiary, and to coordinate the payment process to prevent mistaken payment of Medicare benefits. It also enables Part D sponsors to correctly determine which payments are eligible true out-of-pocket (TrOOP) costs.

Medicare eligibility data is shared with other payers and Medicare-paid claims are transmitted to supplemental insurers for secondary payment. An agreement must be in place between the Centers for Medicare & Medicaid Services (CMS) Benefits Coordination & Recovery Center (BCRC) and private insurance companies for the contractor to automatically cross over medical claims. In the absence of an agreement, the person with Medicare is required to coordinate secondary or supplemental payment of benefits with any other insurers he or she may have in addition to Medicare. Plans are ensured that the amount paid in dual coverage situations doesn't exceed 100% of the total claim, avoiding duplicate payments.

The BCRC initiates an investigation when it learns that a person has other insurance. The investigation determines whether Medicare or the other insurance has primary responsibility for meeting the beneficiary's health care costs. The goal of these MSP information-gathering activities is to quickly identify MSP situations, ensuring correct payments by the responsible parties.

- Plans are ensured that the amount paid in dual coverage situations does not exceed 100% of the total claim, avoiding duplicate payments.
- Under the Medicare Modernization Act (MMA), the meaning of COB expanded further:
  - Requires tracking of true out-of-pocket (TrOOP) costs, or "incurred costs" for people who enroll in Medicare prescription drug coverage. Tracking TrOOP determines when a person becomes eligible for catastrophic coverage. The COB process provides Part D plans with information they can use to calculate their members' TrOOP costs.
  - The law also introduced new ways to improve communication among multiple service providers for enhanced payment oversight, preventing mistaken payment of Medicare benefits and protecting the Medicare Trust Fund. Coordination of benefits results in higher quality services for people with Medicare, and a more sound healthcare system.
- Coordination of Benefits relies on multiple databases maintained by multiple stakeholders, including Federal and state programs, plans that offer health insurance and/or prescription coverage, pharmacy networks, and a variety of assistance programs available for special situations and/or conditions.
- A key data source is the IRS/SSA/CMS Data Match. The law requires the Internal Revenue Service (IRS), the Social Security Administration (SSA), and CMS to share information about Medicare beneficiaries and their spouses. The Data Match identifies situations where another payer is primary to Medicare.
- In addition, CMS has entered into Voluntary Data Sharing Agreements with numerous Fortune 500 companies and other large employers. These agreements allow employers and CMS to send and receive group health plan enrollment information electronically. By law, employers are required to complete a questionnaire on the group health plan that Medicare-eligible workers and their spouses choose. Where discrepancies occur in the Voluntary Data Sharing Agreements, employers can provide enrollment/disenrollment documentation. This ensures the integrity of the Medicare program and has saved the Medicare Trust Funds more than $3.5 billion.

Benefits Coordination & Recovery Center (BCRC)

The Medicare Secondary Payer (MSP) program is in place to ensure that Medicare is aware of situations where it should not be the primary, or first, payer of claims. If a beneficiary has Medicare and other health insurance, Coordination of Benefits (COB) rules decide which entity pays first. There are a variety of methods and programs used to identify situations in which Medicare beneficiaries have other insurance that is primary to Medicare. Activities related to the collection, management, and reporting of other insurance coverage for Medicare beneficiaries is performed by the Benefits Coordination & Recovery Center (BCRC).

Contact the BCRC to:

- Report employment changes, or any other insurance coverage information.
- Report a liability, auto/no-fault, or workers' compensation case.
- Ask general Medicare Secondary Payer (MSP) questions/concerns.
- Ask questions regarding Medicare Secondary Development (MSP) letters and questionnaires.

BCRC Customer Service Representatives are available to assist you Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627

Medicare as a Secondary Payer

- Medicare Secondary Payer (MSP) law mandates that certain types of insurance pay health care bills first and that Medicare pay second.

- Other insurance that may pay first includes group health plan insurance, no-fault insurance, liability insurance, workers' compensation, and the Federal Black Lung Program. We will discuss each of these situations in more detail later.
- Medicare is primary in the absence of other primary insurance coverage.
- In most cases, except the situations just mentioned, Medicare is also primary for prescription drug coverage.

Other Possible Health Care Payers

- No-fault or liability insurance
- Workers' compensation
- Federal Black Lung Program
- COBRA continuation coverage
- Employer/union/retiree group health plans
    - Federal Employee Health Benefits Program
    - Military coverage through veterans' benefits
        - VA
        - TRICARE for Life

No-fault insurance

No-fault insurance is insurance that pays for health care services resulting from personal injury or damage to someone's property regardless of who is at fault for causing it. Types of no-fault insurance include the following:

- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

Medicare is the secondary payer where no-fault insurance is available. Medicare generally will not pay for medical expenses covered by no-fault insurance. However, Medicare may pay for medical expenses if the claim is denied for reasons other than not being a proper claim. Medicare will make payment only to the extent that the services are covered under Medicare. Also, if the no-fault insurance does not pay promptly (usually within 120 days), Medicare may make a conditional payment. A conditional payment is a payment for which Medicare has the right to seek recovery.

The money that Medicare used for the conditional payment must be repaid to Medicare when the no-fault insurance settlement is reached. If Medicare makes a conditional payment and the person with Medicare later resolves the insurance claim, Medicare will seek to recover the conditional payment from the person. He or she is responsible for making sure that Medicare gets repaid for the conditional payment.

Liability Insurance

Liability insurance is coverage that protects a party against claims based on negligence, inappropriate action, or inaction that results in injury to someone or damage to property. Liability insurance includes, but is not limited to

- Homeowner's liability insurance
- Automobile liability insurance
- Product liability insurance
- Malpractice liability insurance

- Uninsured motorist liability insurance
- Underinsured motorist liability insurance

Medicare is the secondary payer in cases where liability insurance is available. If health care professionals find that the services they gave an individual can be paid by a liability insurer, they must attempt to collect from that insurer before billing Medicare. Medicare may make a conditional payment if the liability insurer will not pay promptly, usually within 120 days. When the liability insurer pays, Medicare recovers its conditional primary payment. Medicare will only pay to the extent services are covered under Medicare.

Workers' Compensation

Medicare generally will not pay for an injury or illness/disease covered by workers' compensation. If all or part of a claim is denied by workers' compensation on the grounds that it is not covered by workers' compensation, a claim may be filed with Medicare. Medicare may pay a claim that relates to a medical service or product covered by Medicare if the claim is not covered by workers' compensation.

Federal Black Lung Program

Some people with Medicare can get Federal Black Lung Program medical benefits for services related to lung disease and other conditions caused by coal mining. Medicare doesn't pay for health services covered under this program. Black lung claims are considered workers' compensation claims. All claims for services that relate to a diagnosis of black lung disease are referred to the Division of Coal Mine Workers' Compensation in the U.S. Department of Labor.

When Medicare is Primary

For most people with Medicare, Medicare is their primary payer, meaning Medicare pays first on their health care claims. Some situations where Medicare is the primary payer include:

- Medicare is the sole source of medical, hospital, or drug coverage
- Medigap policy or other privately purchased insurance policy **is not** related to current employment (This type of policy covers amounts not covered by Medicare)
- Coverage through Medicaid and Medicare (dual-eligible beneficiaries), with no other coverage that could be primary to Medicare
- Retiree coverage, in most cases (To know how a plan works with Medicare, check the plan's benefits booklet or plan description provided by the employer or union, or call the benefits administrator)
- Health care services provided by Indian Health Service (IHS)
- TRICARE for Life
- Coverage under COBRA, with one exception, End-Stage Renal Disease (ESRD)

When Medicare is Secondary

Some people with Medicare have other insurance or coverage that must pay individual benefits before Medicare pays its co-share. This applies no matter how the person receives benefits from Medicare, whether from Original Medicare or a Medicare Advantage Plan. Let's take a look at situations in which Medicare is the secondary payer.

According to law, Medicare is generally the secondary payer in the following situations:

- Working Aged and EGHP – A person age 65 or older who has Medicare and who is also covered through an Employer Group Health Plan and either the person or their spouse is actively employed – including self-employed) in a firm with 20 or more employees; or if the employer is part of a

multi-employer group health plan where at least one employer in the plan has 20 or more employees.

- Disability and EGHP – If a person with Medicare based on disability (under age 65) is covered through his or her current employer or a spouse's current employer in a large firm with 100 or more employees.
- ESRD and EGHP – If a person with Medicare based on ESRD is covered by an Employer Group Health Plan of any size, the group health plan is primary for an initial 30-month coordination period, after which Medicare becomes primary. The EGHP coverage does not need to be based on the current employment of the person, spouse, or family member.

Medicare is also the secondary payer in most non-group health plan situations involving

- Workers' Compensation – The person with Medicare is covered under Worker' Compensation and the illness or injury is job-related.
- Black Lung – The person with Medicare has black lung disease and is covered under the Federal Black Lung Program.
- No-fault/liability – The person with Medicare received health care that may be covered by no-fault or liability insurance, such as in the case of an automobile accident, injury in a public place, or malpractice.

Medicare Secondary Payer Recovery Portal

The Medicare Secondary Payer Recovery Portal (MSPRP) is a web-based tool designed to assist in the resolution of Liability Insurance, No-Fault Insurance, and Workers' Compensation Medicare recovery cases. The MSPRP gives the beneficiary the ability to access and update certain case specific information online.

The MSPRP provides you with the following features and related benefits:

1. Submit a Proof of Representation or Consent to Release documentation
2. Request conditional payment information:
    - Request an updated conditional payment amount
    - Request a copy of a current conditional payment letter
3. Dispute claims included in a conditional payment letter:
    - View the claims listed on the conditional payment letter and dispute unrelated claims
    - Upload documentation to support the claim dispute
4. Submit case settlement information:
    - Input settlement information and upload a copy of the settlement documentation

How to Access the MSPRP

Beneficiaries will access the MSPRP through the MyMedicare.Gov Web site. They will login to their MyMedicare account via the MyMedicare.gov Web site. This Web site can be accessed from the My Medicare.Gov link found in the Related Links section near the bottom of the page. The beneficiary will enter their established Login ID and Password for that application in the Secure Sign In section of the web page. They can access the MSPRP in two different ways:

- Click the [Case ID] in the "Payment Details" box on the MyMedicare page of the case they would like to access.

Click the [Go to MSPRP] button.

Chapter 10
LONG-TERM CARE OPTIONS

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LONG-TERM CARE

Long-term care differs from traditional medical care. While medical care services rehabilitate or correct certain medical problems, long-term care services help a person maintain his or her lifestyle. LTC refers to any form of help (e.g., assistance or supervision) that an individual requires for taking care of basic activities of daily living (ADLs), such as bathing, eating, dressing, toileting, and transferring. A person can receive LTC in many different settings, not just in a nursing home.

People may need LTC services because they experienced a gradual or sudden inability to care for themselves. This can occur due to an accident or a sudden illness. Also, as life expectancy continues to increase, more people may need LTC services due to the gradual decline in capacity associated with the aging process.

Definitions

ADL - Activities of Daily Living – these are routine activities that people do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking), and continence. An individual's ability to perform ADLs is important for determining what type of long-term care (e.g. nursing-home care or home care) and coverage the individual needs (i.e. Medicare, Medicaid or long-term care insurance).

Custodial Care – Non-medical care that helps individuals with his or her activities of daily living, preparation of special diets and self-administration of medication not requiring constant attention of medical personnel. Providers of custodial care are not required to undergo medical training.

Settings for Receiving Long-Term Care (LTC)

People can receive LTC in their homes or communities, not just in long-term care facilities like nursing homes. Many prefer to age in place and receive LTC services at home or in the community. Some benefits of receiving care in the community include easier access to family and friends, some of whom may also serve as caregivers. Another benefit is the comfort of remaining in a familiar environment without having to adapt to new surroundings. More and more, individuals opt to remain at home for many reasons. Among them is the fact that the national average cost of home-based LTC services can be significantly less than the cost of a nursing home.

Here are some of the settings where a person can receive LTC services:

- Home/Community-Based Settings
- Adult Day Care and Social Day Care Programs
- Home Health Agencies
- Private Homes/Apartments
- Respite Centers
- Facility-Based
    - Long-Term Care Hospitals
    - Skilled Nursing Facilities (SNFs)
    - Nursing Homes
    - Adult Foster Care
    - Personal Care Homes (also called Retirement Homes or Board Homes)
    - Domiciliary Homes (also called Assisted Living Residences)
    - Continuing Care Retirement Communities (CCRCs)

What Does Medicare Cover?

The Original Medicare program does not pay for custodial level care if that is the only care that a beneficiary needs. It also is important for those with Medigap (Medicare Supplement) insurance to know that these policies do not offer supplemental LTC insurance coverage. Similarly, beneficiaries enrolled in Medicare Advantage (MA) plans typically will find that they have no additional coverage for LTC services. Nevertheless, services at the custodial care level, such as help with cooking and cleaning, are what many people need.

Medicare has three post-acute care benefits that may provide some long-term care services to some beneficiaries:

- **Skilled Nursing Facility (SNF) Care**: Medicare pays for 100 days of SNF care in a benefit period. It covers 100% of the cost for the first 20 days, and the beneficiary owes a coinsurance charge for each day after the 21st day. To qualify for coverage in the Original Medicare program, the SNF stay must follow an inpatient hospital stay of at least three days in length and the beneficiary must receive skilled nursing or rehabilitation services on a daily basis.
- **Home Health Care***:* Medicare pays 100% for home health care for beneficiaries who are homebound and need rehabilitation care or skilled nursing services on a part-time or intermittent basis. There is no limit on the number of covered days for home health care as long as the beneficiary remains homebound and receives a skilled service (such as a nursing visit) at least once in a 60-day period. Medicare also covers the services of home health aides that include help with some activities of daily living, such as bathing, for beneficiaries who receive skilled services.
- **Long-Term Care Hospitals (LTCH**): Since 1999, Medicare has certified some facilities to operate as long-term care hospitals (LTCH). Their average inpatient length of stay must be 25 days or longer. These hospitals typically provide post-acute extended medical and rehabilitative care for patients whose conditions are complex and who may have more than one acute or chronic condition. They provide services such as rehabilitation, respiratory therapy, cancer treatment, head trauma care, and pain management.
    - For purposes of covered days in a benefit period, Medicare treats LTCHs the same as acute care and rehabilitation hospitals. The number of days spent in a LTCH count toward Medicare's 150 covered inpatient hospital days in a benefit period. Where they exist, LTCHs provide an alternative to skilled nursing facilities for some patients.

Who Pays for Long-Term Care?

Medicare may cover some long-term care costs, but that coverage is limited in nature and generally approved for short periods of time. The balance is paid by Medicaid, private pay, or long-term care insurance.

National Spending for Long-Term Services & Support (LTSS), by payer (2016)

21.8%	Medicare
42.2%	Medicaid
6.3%	Other public assistance
15.6%	Out-of-pocket
7.5%	Private insurance
6.5%	Other private funding

Source: CRS analysis of National Health Expenditure Account data obtained from the Centers for Medicare & Medicaid Services, Office of the Actuary, prepared November 2017. https://fas.org/sgp/crs/misc/IF10343.pdf

Long-Term Care Insurance

Long-term care insurance (LTCI) is designed to help pay the costs of long-term care (LTC) services that Medicare and other types of health insurance do not cover. It also protects assets that a beneficiary would otherwise use to pay for long-term care. In 2015, the average cost of care for a nursing home was approximately $60,225 a year. It is important for people to plan for their LTC needs, and to decide how LTCI fits into their plans.

Who Needs Long-Term Care Insurance (LTCI)?

LTCI is one way to finance long-term care services that one might need in the future. However, it is not for everyone.

Generally, many people do not have assets with high enough value to justify spending expensive monthly LTCI premiums to protect them. Aside from the cost of LTCI, many people are not sure about how to assess their future needs. What are the chances of needing long-term care services? What is the risk involved? Others may not be sure when to buy LTCI. Does it make sense to wait a little longer to buy since premiums increase with a person's age? Some may not be sure what the phrase "significant amount of assets" means. At what point does it make sense to insure against exhausting one's assets? These questions cause many people to waver when deciding to purchase LTCI.

Typically, LTCI is geared toward middle-class, middle-aged individuals, whose assets could easily be exhausted by a one-year stay in a nursing home. A general rule is that if a person's annual income is more than $25,000 (single) and they have more than $80,000 in liquid assets, LTCI may be a cost-effective insurance option.

Another point to keep in mind is that the risk of developing chronic medical conditions increases with age. Insurance companies use medical underwriting questions to screen for chronic conditions. Most companies will not sell LTCI to people who have potentially costly health problems. LTCI premiums also increase with age at purchase.

Another point to remember, **unlike Medicare supplement insurance, LTC insurance is *not standardized***. It is a good idea to become educated about the various features of long-term insurance, decide what policy features suit your situation and then shop for a policy.

How Does Long-Term Care Insurance (LTCI) Work?

LTCI is one way to help pay for the LTC services that Medicare excludes from coverage. The alternative is for Medicare beneficiaries who need only a custodial level care or help with ADLs to rely on family or friends to provide the care or to pay out-of-pocket to cover the cost of the care.

LTCI Policies

There are several types of LTCI policies available to consumers. Companies sell policies on an individual and group basis, often through employers. Most LTCI policies have some common features: conditions of coverage, daily payments, and a maximum benefit. Consumers may be able to buy additional benefits, such as inflation protection.

Insurers selling LTCI will screen applicants for existing medical conditions before issuing a policy. The companies decide to accept or reject the "insurance risk" and then set a premium based on a medical underwriting assessment that may include such factors as age, gender, lifestyle, and family history.

LTCI Policy Basics

LTCI policies provide benefits according to an "Outline of Coverage" that summarizes a policy's key benefits, terms, and conditions. Consumers can use Outlines of Coverage to compare the benefits of two or more policies. State law requires companies to give Outline of Coverage to any person who requests one. The Outline of coverage must describe the terms under which a person can return the policy for a refund and when the company may change premiums. It also must describe the policy's key benefits, exclusions, and limitations, and explain any provisions for inflation. Here are some important LTCI policy features that consumers should review carefully when they read an Outline of Coverage:

- **Benefit Triggers**: Insurance companies use conditions of coverage called "triggers" to decide when a consumer is eligible to receive benefits. Most policy triggers involve an inability to perform ADLs (the number of ADLs can vary among policies), a cognitive impairment, a doctor's signed Certificate of Medical Necessity, and with some older LTCI policies, prior hospitalization.
- **Pre-Existing Condition Waiting Period**: This is the waiting period before a policy will pay for care related to a health condition that the consumer had when applying for the policy. Insurance companies cannot limit coverage for pre-existing conditions for more than six months.
- **Plan of Care**: Most companies will require a Plan of Care before paying benefits. The Plan of Care is a document written by the consumer's health care providers that prescribes the LTC needed, including the (1) necessity of care, (2) type of care, and (3) frequency and length of care.
- **Elimination, Deductible, or Waiting Periods:** The amount of time a company waits to start benefit payments after a consumer's need for LTC services "triggers" her eligibility for payments. These periods may last up to 100 days. Usually, a longer elimination period corresponds to a lower premium.
- **Exclusions**: There are certain medical, mental, or other conditions that a LTCI policy may not cover. State law may allow exclusions for:
  - Mental and emotional disorders or diseases (other than Alzheimer's disease or related disorders)
  - Alcoholism or drug addiction
  - Attempted suicide or intentionally self-inflicted injuries

LTCI Policy Payments

When a person's need for LTC services has "triggered" the policy's benefits and the elimination (or waiting) period has passed, the consumer receives coverage as with other types of insurance. The company pays on claims for LTC as providers deliver services. The payment amounts depend on the scope of benefits that the consumer chose when purchasing the policy. The main features in LTCI policies that are the source of different payment amounts are:

- **Daily Benefit Amount**: A daily benefit amount (DBA) is a specified dollar amount that is the most a company will pay per day for covered services. The consumer is responsible for any costs of care above that amount. Policies often have different DBAs for home care and nursing facility care. Thus, before choosing a DBA, consumers should learn how much home-based and facility-based services cost in their community. LTC service costs vary between different areas and providers. Most policies pay DBAs ranging from $50 to $500 a day. Generally, a higher DBA corresponds to a higher policy premium.

- **Duration of Benefits or Maximum Benefit Limit:** Most policies limit the total benefit they pay over the life of a policy. Insurance companies usually referred to this feature as the "duration of benefits." Companies usually sell policies with total payments measured in one-year increments. The duration of benefits can be one year to a lifetime. Most people buy policies with benefit limits of two to five years. Generally, policies with longer maximum benefit periods cost more.
- **Benefits Paid Limit**: While most LTCI policies pay expenses up to the DBA selected, some policies have a weekly or monthly limit. This is important because most people who receive care at home do not receive the same amount of care each day. This feature allows consumers to spend more money on care on those days when they might not have any family to provide care and spend less or nothing on days when family care is available. A weekly or monthly limit approach may result in greater coverage for home care costs than with a daily benefit limit.
- **Benefit Payout Method**: Insurers pay LTCI policy benefits in two ways: indemnity or expense-incurred. With an indemnity payment, the company pays the dollar amount of the policy's DBA regardless of the actual cost of LTC services on that day. With an expense-incurred payment, the policy may pay less than the DBA if the actual cost of care is lower. For example, if the DBA is $100 and care costs only $80, the policy pays $80.
- **Inflation Protection Rider**: While the cost of nursing home or home health care increases each year, LTCI benefit payments remain the same without inflation protection. An inflation protection feature usually adds an extra 5% to the daily benefit amount, compounded annually.
- **Premium Payment**: People can pay LTCI premiums in several ways: monthly, quarterly, semi-annually, or annually. Some companies have "10 Pay" or "20 Pay" programs in which an insured person pays premiums for 10 or 20 years until the policy is paid in full. The other special payment option is "65 Pay," where an individual pays premiums up to age 65 when the policy is paid in full.
- **Tax-Qualified/Non-Tax Qualified**: Under a HIPAA provision, some LTCI policies may meet certain federal standards which allow insured persons to deduct premiums as a medical expense. In some cases, policyholders can include all or a part of the premium as a federal income tax deduction and may not be required to pay federal taxes on the policy's benefit payments. Tax qualifications vary by state and policy. Non-tax qualified policies do not meet the requirements of a partnership policy. For more information on "partnership policies," see section on PLTC.
- **Pooled Benefits or Joint Policie**s: Couples might consider buying a joint LTCI policy that covers both people and has a lower premium than buying two separate policies. At the very least, couples should ask about discounts when buying more than one LTCI policy from the same company.

Other Factors to Consider when evaluating LTCI Policies

- **Age**: Most companies typically will not sell a policy to an individual under age 18 or over age 85. Some may limit the amount of insurance that someone can buy when they reach age 80. In addition, age usually determines premium amounts: the younger the buyer, the lower the premium; the older the buyer, the higher the premium.
- **Premium**: Companies base their premiums on the age at purchase and the scope of the policy's benefits. Consumers should weigh carefully how well they can afford a policy's premium. A general rule is that a LTCI policy premium should be no more than seven percent of a person's or a couple's annual income.
- **Pre-Existing Conditions**: The law allows companies to underwrite a consumer's risk, meaning that they can look at health, lifestyle, and family history before deciding to issue a policy. Companies usually

charge higher premiums for higher-risk individuals. Others may refuse to issue a policy altogether if the individual is likely to need covered services in the near future.

- **Gender**: Some companies view women as higher risk than men because they have longer life expectancies, tend to outlive their spouses (who may have provided LTC services as caregivers) and are therefore more likely to need LTC services.
- **Financial Ratings Companies**: Several companies rate insurance companies on their financial condition and "claims paying ability." The rating scales typically use a grade system (e.g., A++), although different companies use different scales. Before buying a LTCI policy, advise consumers to check an insurance company's current standing. The Kansas Insurance Department website connects consumers with these ratings for companies who sell Long-Term Care Insurance in Kansas.

To protect themselves, consumers should be aware of tactics that some agents may use to sell LTCI policies that include:

- **"Churning" people between LTCI plans**. This occurs when an agent sells someone a LTCI policy and then, a few years later, returns to sell another policy. The agent may market it as a "new and better" policy. Insurance agents typically receive higher commissions in the first year that a policy is in force. "Churning" someone into a new policy yields more money for the agent. SHIP counselors should help clients make sure before switching to a new policy that it is actually better than the old one.
- Some agents may use a policy's lack of clarity to a consumer's detriment. Remind your clients to ask about a policy's terms and definitions. This ensures that the policy will cover the kind of services that your clients prefer and that are available in your community. If the terms are not entirely clear, people should ask agents to provide written explanations before deciding to purchase a policy. Agents must not pressure consumers into purchasing policies they do not understand.
- Remind your clients never to pay premiums with cash, and always to make checks payable to the insurance company, not the agent.

Consumer Protections

State insurance departments require companies to make sure that their LTCI policies contain certain consumer protections. Encourage your clients to keep them in mind when buying a LTCI policy. The protections include:

- **Outline of Coverage**: All insurance companies must provide a Long-Term Care Insurance Outline of Coverage complete with an explanation of benefits, terms, and conditions, limitations and exclusions contained in a policy.
- **30-Day Free Look Period**: Consumers have a no obligation, 30-day free "look period" in which they can decide to cancel a policy and receive a full refund of any premiums they paid.
- **Inflation Protection**: This policy option provides increased benefit levels to help cover the cost of expected increases in the price of LTC services. For example, a $100 DBA that increases by a simple 5% each year will go up $5 a year, and would be $200 in 20 years. If compounded, the benefit would be $265 in 20 years. By law, insurance companies must offer this option.
- **Guaranteed Renewable**: Guaranteed renewable means that the insurance company cannot cancel a policy or make any changes to the policy's provisions, except for failing to pay premiums.

What Else Do I Need to Consider When Purchasing a Policy?

There are a few other optional features in LTCI that a consumer may want to consider when buying a policy. These options usually cost more in premiums and not all companies may offer them. They include:

- **Alternative Plan of Care**: Insurance companies may agree to pay for a service that the policy's terms do not specify among its covered benefits.
- **Bed Hold**: If a nursing home resident goes to the hospital, some policies will pay to hold her bed in the nursing facility for a specified number of days.
- **Caregiver Training**: This benefit pays to train an informal (unpaid) caregiver to care for a person in her home. This training provides information on how to give safe and appropriate personal care.
- **Domestic Partner Coverage**: This option provides LTC coverage to people who have filed as domestic partners with a government agency, reside in the same residence, and have an exclusive mutual commitment to share the responsibility for each other's welfare and financial obligations.
- **Durable Medical Equipment**: This option provides assistance in obtaining durable medical equipment such as a wheelchair, lift chair, or walker. Note that Medicare Part B covers DME and supplies for Medicare beneficiaries in their homes.
- **Emergency Response System**: This policy option helps obtain an emergency response system.
- **Hospice Benefit**: This option will cover services furnished by a hospice facility for the care or management of a terminal illness. Note that Medicare Part A has a hospice benefit for Medicare beneficiaries whose life expectancy is six months or less.
- **Nonforfeiture Benefits**: This feature enables a consumer who can no longer afford to pay the LTCI premium to have the policy pay a portion of benefits.
- **Restoration of Benefits**: Some policies restore benefits to the original maximum amounts after a period—often 180 days—during which the insured person goes without treatment or services paid by the policy. For example, if a policy has a maximum benefit of three years and the consumer has used one year, if the person does not use LTC services for six months the company automatically restores the maximum benefit to the original three years.
- **Shared Care (also called Spousal Benefit Transfer)**: This provision allows an insured spouse to receive benefits under the other spouse's policy when she reaches the maximum lifetime benefit in her own policy.
- **Survivorship Benefit**: If both spouses have LTCI policies with the same insurance company, when one spouse dies, no more premiums will be due on the surviving spouse's policy as long as no claims were paid by either policy during the first 10 years of concurrent coverage. This provision makes it easier for a surviving spouse to continue to maintain coverage even when her financial situation declines after her spouse's death.
- **Waiver of Premium**: This policy provision relieves the insured of paying the premiums after the policy starts to pay benefits. Some companies automatically include this benefit in their policies. Others offer it as a rider at additional cost.

Partnerships for Long-Term Care (PLTC)

The Partnership for Long-Term Care (PLTC) is a public-private program between state Medicaid programs and private LTCI companies. Its purpose is to encourage more people to buy LTCI, and thereby reduce or eliminate the burden on Medicaid to pay for long-term care services. As with individual and group LTCI policies, PLTC is aimed at middle-income individuals who want to plan for possible long-term care needs, have considerable assets to protect, and can afford the premiums. PLTC policies, or "partnership policies," protect assets and enable access to Medicaid's LTC benefits, including nursing facility care, without requiring the policyholder to impoverish themselves.

Through the PLTC, individuals can purchase policies that meet the program's requirements. When the policy's benefits are exhausted, policyholders are eligible for Medicaid to help pay for LTC services, without depleting all of their remaining assets. It is important to keep in mind that participants must meet other Medicaid eligibility requirements as defined by their state programs.

Kansas Partnership for Long-Term Care

The Long-Term Care Partnership Program now available in Kansas offers a way for Kansans to protect their assets if they ever need to apply for Medicaid services.

How are Assets Protected?

Kansas uses the dollar-for-dollar model, in which the value of the assets protected is equal to the amount of insurance coverage purchased. For example, an individual who buys a policy with a maximum benefit of $100,000 could protect $100,000 of assets. After the policy's payments reach the maximum benefit, Medicaid then covers LTC services.

There are some other key components to a LTCI Partnership policy.

- **Inflation Protection**: Federal law requires partnership policies to incorporate some type of inflation protection depending on the age of the policyholder at the time of purchase.
- **Reciprocity**: Federal rules allow policyholders to purchase a policy in one state, move to another state, and receive asset protection from the new state's Medicaid program. Most reciprocity agreements are still in development and are likely to vary from state to state.
- **Tax-Qualified**: This feature allows individuals to receive certain tax advantages when buying a PLTC policy. Partnership policies are required to be tax-qualified policies.

Frequently Asked Questions about the Partnership for Long-Term Care

Q: What is the Kansas Partnership for Long-Term Care?

A: The Kansas Partnership for Long-Term Care is an initiative involving the State of Kansas and private insurance companies to encourage the private funding of long-term care. If a person purchases qualified long-term care insurance and ultimately uses the benefits under the policy, he or she can keep assets equal to the benefits received if that person applies and is approved for Medicaid.

Q: What are the requirements for a person to be covered under the partnership program?

A: Requirements of the program are these: The policy must have been issued after April 1, 2007; the insured must have been a Kansas citizen at the time of issue; the policy must be tax qualified; the policy must contain certain consumer protection provisions; the policy must provide minimum inflation protection—compound annual inflation protection if issued to a person under 61, annual inflation protection if issued to a person between 61 and 76.

Q: Would a Partnership policy purchased in another state be accepted in Kansas?

A: Kansas has elected to grant the asset disregard program to policyholders who purchased Partnership Policies in other states. The Partnership anticipates that Kansas Partnership Policies will be transferable to other states with Partnership Programs.

To learn more about the KS Partnership for LTC & the companies selling these policies in Kansas go to http://www.ksinsurance.org/ltc-partnership-site/index.htm or call the Kansas Insurance Department. Brochures are available upon request.

Resources for Long-Term Care Insurance (LTCI) Counseling

Self-Assessment Tool

Individuals must make the decision to purchase LTCI when they are still relatively healthy. People need to know (1) if their financial situation requires they will need LTCI, and (2) if they will be able to afford it. Here are some guidelines that your clients can use to help sort out whether or not they should consider LTCI as a financing option.

LTCI may be appropriate if a person answers "yes" to most of the following questions:

- Do you have family history of medical conditions? Do you anticipate the need for long-term care services?
- Do you have significant assets to protect? Do you have more than $80,000 in liquid assets (not including car or home)? Is your annual income more than $25,000-$35,000 (single) or $35,000-$50,000 (couple)?
- Do you want to pass along your assets to your heirs or others who survive you?
- Do you want to insure yourself against the cost of long-term care services rather than plan to pay for care out-of-pocket with your income and liquid assets?
- Can you afford the insurance premiums (i.e. up to $2,000 annually) in addition to all your current bills?
- Do you want more choices regarding the type of LTC you hope to receive?
- Do you want to protect family members or friends from having to provide care?

LTCI may NOT be appropriate if a person can answer "yes" to most of these questions:

- Do you have few or no assets?
- Would you have to stop paying other bills in order to pay the insurance premiums?
- Is your only income from Social Security or Supplemental Security Income (SSI)?
- Do you already qualify for Medicaid?

LTCI may not be appropriate for individuals who have more than enough assets (i.e., over $1 million) to be self-insured.

Expect LTCI policy premiums to increase over time. Companies can raise premiums if their losses justify a price increase, or whenever changes in the law increase the cost of doing business. Nevertheless, insurance companies can only revise premium rates on a "class" basis and not single out an individual.

Where to Learn More

For general information on long-term care insurance, see:

- *Kansas Long-Term Care Insurance and Shopper's Guide* available through Kansas Insurance Department, http://www.ksinsurance.org or call 1-8900-432-2484
- *Long-Term Care Insurance: Is it Right for You?* is a fact sheet available on AARP's Web site, http://www.aarp.org.
- Visit the National Clearinghouse for Long-Term Care Information Web site, administered by the Administration on Aging (AoA), at http://www.longtermcare.gov/LTC/Main_Site/index.aspx for consumer-friendly information and resources to help with future long-term care planning.
- For more information on LTCHs, see CMS's *What are Long-Term Care Hospitals?* fact sheet at http://www.medicare.gov/publications/pubs/pdf/11347.pdf.

Alternatives to Long Term Care Insurance

Reverse Mortgage

Use of Home Equity – No Health Screening, for Older People

- Loan against your home, provides you cash for its value without selling it
    - Access to home equity for homeowner's age 62+
- Unlike other loans, you do not make monthly repayments
- Loan does not have to be repaid as long as the borrower lives in the home
- Loan is repaid when you die, sell the house or permanently move out of it
- Borrower retains title and ownership
- Borrower is responsible for taxes and repairs

To Consider:

- ***CRITICAL*** to use a HUD (US Department of Housing and Urban Development) Certified Reverse Mortgage Counselor (list at www.hud.gov)
    - Funds can be used to purchase LTC insurance or pay for care
- Loans do not adjust for inflation
- LTC costs may exceed the amount received through the reverse mortgage
- May be difficult for married couple to support LTC insurance for both with amount available from reverse mortgage
- Homeowner will still require funds to pay for taxes, repairs, and maintenance
- Heirs can retain home by repaying reverse mortgage
- Heirs can "keep the difference" if the home's sale price exceeds the loan balance at the time the loan is repaid

Reverse Mortgage Annuity

Use of Home Equity – No Health Screening, for Older People

- An annuity is purchased with a portion of the loan amount
- Annuity continues if borrower sells home or moves
- Available on a limited basis

To Consider:

- Same as a reverse mortgage
- May include additional charges
- Tax implications

Sell Home

Uses Home Equity – No Health Screening

- Home can be used to pay for LTC by selling it
- Option not for everyone

To Consider:

- Unable to pass home to heirs
- Proceeds may be insufficient to cover LTC expenses
- Market conditions

Leaseback

Uses Home Equity – No Health Screening

- Investor purchases home
- Seller rents the home on a long-term lease
- Investor possesses property once seller stops living there

To Consider:

- Home may stay in family
- Potential taxes on proceeds
- May lose public assistance

Accelerated Death Benefit

Uses Life Insurance – Poor Health

- Death benefit cash advance, tax free
- Qualification due to poor health condition
- Amount of funds based on contract provisions and health condition (2% of face amount for nursing home, 1% for home care)

To Consider:

- More limited benefits than typical LTC insurance
- Little or no death benefit for survivors
- Need to maintain premium payments
- May affect Medicaid eligibility

Life Settlement

Uses Life Insurance – Older People

- Insurance policy is sold for present value
    - Females age 74+, males age 70+
- Use of the proceeds is unrestricted

To Consider:

- Can fund LTC costs or insurance
- May have nothing left for beneficiaries
- Health not an issue
- Tax liabilities

Viatical Settlements

Uses Life Insurance – Poor Health

- Life insurance policy sold to a third party for a fraction (50% or more) of the death benefit (proceeds are tax-free)
- Must be terminally ill

To Consider:

- Available to someone who would not qualify for LTC insurance
- Settlement may be insufficient to cover LTC expenses
- Survivors would not receive any proceeds
- >50% of applicants are declined

Single Pay Life/LTC Policies

Uses Life Insurance

- Funded through lump sum payment
- Pays for LTC expenses and has a death benefit

To Consider:

- Large lump sum needed for meaningful LTC benefit
- If care needed in early years, benefit may be insufficient
- Planning for inflation is difficult, requires additional payments

Chapter 11
MEDICAID AND OTHER ASSISTANCE

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MEDICAID AND OTHER ASSISTANCE

This chapter is a brief summary of the rules, laws, and eligibility guidelines for Medicaid and other assistance programs. As a SHICK Counselor, you are not responsible for determining if a client is or is not eligible for assistance, **nor should you even hint at giving legal or financial advice**.

This information is intended to increase your awareness and understanding of programs for which a client might qualify and appropriate referral agencies to which a client may be directed.

Some clients will be reluctant to discuss financial matters or to deal with certain bureaucratic agencies. As a SHICK Counselor, you do not have the right to discuss a client's situation with anyone without the client's permission.

Medicaid

Medicaid is the name of the health care program for people receiving TAF (Temporary Assistance for Families) and certain low-income people who are also blind, aged, or disabled. It is a joint federal-state medical assistance program. It's a program that pays medical bills for low-income people who can't afford the costs of medical care. Medicaid pays benefits for covered services only when they are medically necessary.

Medicaid is a Federal program but is state regulated. All states must provide medical services to certain low-income people who are also blind, aged, or disabled. These services are mandated under federal law. Since it is a joint federal-state medical assistance program that pays medical bills for low-income people who can't afford the costs of medical care, states may provide other services in addition to those mandated.

What is KanCare?

KanCare is the program through which the State of Kansas administers Medicaid. Launched in January 2013, KanCare is delivering whole-person, integrated care to more than 415,000 people across the state. Kansas has contracted with three health plans, or managed care organizations (MCOs), to coordinate health care for all people enrolled in Medicaid.

The Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the State of Kansas. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance abuse, as well as operates the state hospitals and institutions. Each Medicaid consumer is assigned to one of the KanCare health plans. Consumers in KanCare receive all the same services provided under the previous Medicaid delivery system, plus additional services. The inclusion of services provided through the Home and Community Based Services waiver for consumers with intellectual or developmental disabilities (I/DD) became part of KanCare in February 2014. In addition to the services that were available to Medicaid consumers prior to 2013, the three health plans offer new services to their members, such as preventative dental care for adults, heart/lung transplants and bariatric surgery.

Consumers have the option during open enrollment season once per year to change to a different KanCare health plan if they prefer to do so. Open enrollment season corresponds with the anniversary month of enrollment in the program.

All pre-2013 Medicaid services are now provided through the KanCare health plans. These include physical health services such as doctor appointments and hospital visits, behavioral health services, dental and vision care, pharmacy, transportation, and nursing facility care. All the services offered through the State's Home and Community Based Services waivers are part of KanCare. The HealthWave and HealthConnect Kansas programs have ended, and all of those services are now provided through the KanCare health plans.

KanCare health plans are required to coordinate all of the different types of care a consumer receives. The goals of the KanCare program are to improve overall health outcomes while slowing the rate of cost growth over time. This will be accomplished by providing the right care, in the right amount, in the right setting, at the right time. The health plans focus on ensuring that consumers receive the preventive services and screenings they need and ongoing help with managing chronic conditions.

From www.KanCare.ks.gov

Medicaid Eligibility

Medicaid is for 1) people receiving TAF and 2) the aged (65 and older), blind, and disabled. There are limits on the amount of assets (resources) and income which an individual can have in order to be eligible for Medicaid. Unlike Medicare, Medicaid does not require that the applicant earn work credits through Social Security to qualify.

Older or disabled adults who received Supplemental Security Income (SSI) from the SSA are automatically eligible for Medicaid but must make an application for assistance with KanCare. Each state establishes its own process for handling Medicaid applications.

Those who do not receive SSI payments will likely have to meet a spenddown and must not have more than $2,000 in assets for a single individual or $3,000 for a married couple.

How does a person apply?

A beneficiary can apply for assistance through KanCare online or with a paper application. Information and applications are available at http://www.kancare.ks.gov/apply.htm. The KanCare Clearinghouse processes KanCare applications.

- ✓ If you have questions you can contact the KanCare Clearinghouse toll free at 1-800-792-4884.
- ✓ Write your name and/or social security number on each document you want to send. Include the confirmation number from your application if you have it.
    - Mail or fax copies of documents to the KanCare Clearinghouse at:
      KanCare Clearinghouse
      P.O. Box 3599
      Topeka, KS 66601,
      Fax application to 1-844-264-6285.

Dual-Eligible (DE)

Dual-eligibles are persons who qualify, in some way, for both Medicare and Medicaid coverage.

Medically Needy or Medicaid with a Spenddown – Seniors and People with Disabilities

Persons with higher income may qualify for Medically Needy coverage. Single persons must have less than $2000 in assets. Married couples must have less than $3000 in assets.

A spenddown works like an insurance deductible. Persons must incur medical costs equal to the spenddown before Medicaid will pay. When a person meets his or her spenddown, Medicaid will pay. The spenddown is usually figured for a six-month base period. The person's income is used to find their spenddown amount. The protected income limit for the elderly and people with disabilities is $495.00 for one or two people and $500 for three people. For adults, only the income of the person needing coverage and their spouse is used. Almost every person has a different spenddown amount.

How does a Spenddown Work?

Medical expenses paid by the client are used to "spend down" to the Medicaid income limit. Medicaid will then pay for expenses incurred during the period that the client did not use to meet the spenddown. The spenddown is the individual's responsibility and is calculated based on a six-month period.

The eligibility worker determines the amount of the spenddown amount and sends a letter to you. A medical card is sent for each person included on the application. The medical card will not pay any bills until the spenddown amount is met. Past due and owing medical bills (incurred before the first date of spenddown period and still owed during the spenddown period) can be submitted for all persons that are on the program to meet the spenddown. Bills for the person on the spenddown (during the spenddown period) must be filed electronically by the provider; show them the medical card so they can file the bill. When medical care is needed and the medical provider (doctor, dentist) does not accept Kansas Medicaid copies of the bills incurred during the spenddown period can be sent in. When all of the bills added together meet the spenddown amount, the medical card can be used for all the rest of the medical bills during the 6-month spenddown period.

Medical expenses that can be used for a spenddown include:

- Health Insurance and Medicare premiums
- Prescription drugs
- Dental care expenses including dentures
- Physicians services
- Hospital costs
- Nursing home expenses
- Home health care expenses
- Some over-the-counter drugs ONLY if prescribed by a doctor
- Medical transportation costs
- Eye doctors and eyeglasses
- Some medical equipment including hearing aids

Income

Income is counted in the month it is received. Some income is not counted and only KanCare economic assistance specialists can determine if a person meets income limits.

Countable Income

All income is counted unless specifically excluded. This includes the following:

- Wages
- Social Security
- Veterans retirement income and disability pensions

- Private pensions
- Income from investments
- Payments or donations by a third party for basic needs (food, shelter, and clothing)
- Lump sum payment such as an inheritance (Counted as income in the month it is received, any remaining at the beginning of the next month becomes a resource.)

Excluded (Non-Counted Income)

- Food stamps, rent subsidies, energy assistance
- Food, clothing, etc. from private non-profit agencies
- Loans

Monthly Income Deductions

- First $20 of all *monthly* income is deducted.
- First $65/*monthly* of all earned income is deducted.
- One-half of remaining earned income is deducted.

Resource Limits

Not all resources are counted toward Medicaid limits, many important ones are exempt. Some people deplete resources the Medicaid system would allow them to keep. This loss happens because people do not have the correct information and do not have appropriate professional advice.

Countable Resources

- Cash
- Savings and checking accounts
- Stocks, bonds, and CDs
- Real and personal property (other than home and one car)
- Trusts
- Life insurance if the face value is greater than $1500. Only the cash value of such a policy is counted.

Exempt Resources

- Primary residence and land that it sits on (if contiguous) regardless of value (if person or spouse is residing there or if there is intent to return)
- Household and personal property unless of unusual value
- One automobile (regardless of value)
- Life insurance if face value is $1500 or less
- Burial funds of reasonable value (one of the following):
    - Irrevocable burial trust or prepaid burial contract up to $3000
    - Separate, identified accounts up to $1500
    - Burial plots and markers for client and all immediate family members
    - Pre-purchased burial merchandise (casket, vault, etc.)

Medicare Supplement Suspension

Since Medicaid and QMB provide the benefits that a Medicare supplement policy would provide, a Medicare supplement policy is unnecessary. However, because an individual can lose eligibility for Medicaid or QMB, he/she can place a Medicare supplement policy on suspension for up to 24 months rather than canceling the policy.

The request for suspension must be made by the policyholder within 90 days of becoming Medicaid or QMB eligible. During the suspension period, the beneficiary will owe no premiums; the policy will pay no benefits. If the recipient loses eligibility in Medicaid or QMB, the policy can be reinstated with full coverage. Reinstatement must be done within 90 days of the loss of eligibility; premiums must be paid back to the date the policy is reinstated, which is the date Medicaid or QMB ends.

Any insurance company who fails to comply with these requirements is subject to stiff monetary penalties. Problems should be reported to the Kansas Insurance Department.

Other options that might be available:

- Keep Supplement policy in force… (it is needed to meet a spend down)
- Drop it, Use Medicare Rights & Protections of Guarantee Issue later if the person with Medicare & Medicaid loses entitlement to Title XIX

Medicare Savings Programs

Applications must be made through KanCare.

Qualified Medicare Beneficiary - (QMB)

QMB is for those who are entitled to Medicare Part A and almost meet eligibility limits (income and resources) for SSI Medicaid.

- **Income Limit** = 100% of federal poverty level + $20 (SSI income disregard)
- **Resource Limit** – Exempt resources are not counted.
  Lower Resources level
- **Benefits** – Medicaid pays
  - Medicare Part A & B Premiums
  - Medicare Part A & B Deductibles
  - Medicare Part A & B Coinsurance Amounts
  - Medicare Part D Premiums & Deductibles

  The benefits are not as broad as under Medicaid. Only Medicare eligible services are covered. **Because of the benefits, there is no need for a Medicare supplement insurance policy if a person has QMB.**
- **Effective date**
  The effective date is the first of the month after approval. Benefits are not retroactive.

Low-Income Medicare Beneficiary - (LMB)

LMB is for those who are just above the income limit for QMB. Again, application must be made through KanCare.

- **Income Limit for LMB** – 120% of federal poverty level + $20 (SSI income disregard) An LMB beneficiary may be working toward a spend down.
- **Resource Limit for LMB**—Exempt resources are not counted.
  Lower Resource level
- **Benefit**
  Medicaid pays the Medicare Part B premium. The premium is no longer deducted from the Social Security check.
- **Effective Date**
  The effective date is the first of the month of application. Benefits can also be retroactive for three months if the client meets eligibility criteria during those months.

Because the LMB program does not cover the Medicare Part A and Part B deductibles and coinsurance amounts, a Medicare supplement policy may still be needed.

Expanded LMB - (QI)

Expanded LMB (Qualified Individual - QI) - A QI beneficiary cannot work toward a spend down.

- **Income Limit for Expanded LMB** (QI) = 135% of federal poverty level + $20 (SSI income disregard)
- **Resource Limit for Expanded LMB** – Exempt resources are not counted.
  Lower Resource level
- **Benefit**
  Medicaid pays the Medicare Part B premium. The premium is no longer deducted from the Social Security check.
- **Effective Date**
  The effective date is the first of the month of application. Benefits can also be retroactive for three months if the client meets eligibility criteria during those months.

Because the LMB program does not cover the Medicare Part A and Part B deductibles and coinsurance amounts, a Medicare supplement policy may still be needed.

Qualified Working Disabled (QWDI):

This program is for persons who lose Medicare Part A due to work. If a person's income is below 200% of the Federal Poverty level, this program may pay the premium.

- **Income Limit for QDWI** (QDWI) = 200% of federal poverty level + $20 (SSI income disregard)
- **Resource Limit for QDWI** – Exempt resources are not counted.

Single:	$4,000.00
Couple:	$6,000.00

Home and Community Based Services

Kansas has a variety of programs promoting independent living in safe, healthy environments. Home and Community Based Services (HCBS) were created to provide medical and nonmedical services to children and adults in their home, assisted living, or residential care facility. Services are designed to provide individuals with the least intensive level of care, who may otherwise be placed in a nursing home, hospital, or intermediate care facility for the mentally retarded.

Persons must have a medical need for the special care. There must be an opening in the HCBS program and the individual must be determined eligible for Medicaid. The resource limit is $2000 for single persons and there are special resource provisions for those individuals who have a spouse. People on HCBS must also share in the cost of care. Persons with income more than $747.00 a month help pay for their care.

HCBS Waivers Available

- **Frail and Elderly** – Serves individuals age 65 and older who want community-based services as an alternative to nursing home care.
- **Physical Disabilities** – Serves individuals age 16-64 who are physically disabled and need assistance with activities of daily living.
- **Intellectual and Developmental Disabilities** – Serves individuals age 5 and up who meet the definition of mental retardation or developmental disability.
- **Severely Emotionally Disturbed** – Serves individuals age 4-18 at risk of being removed from their homes or hospitalized due to severe emotional and behavioral difficulties. (There are exemptions for children younger than 4 and extension of services up to the age of 22)
- **Autism** – Serves children from time of diagnosis through 5 years of age.
- **Technology Assisted** – Serves children under 21 who are dependent upon mechanical ventilators or intravenous administration of nutritional substances or drugs.
- **Traumatic Brain Injuries** – Serves individuals 16-65 who have sustained traumatic brain injury.

Senior Care Act Program

The Senior Care Act program provides homemaking, personal care, chore services, and respite care to enable senior adults to live independently at home; the service is available with a sliding fee scale according to income.

Spousal Impoverishment Law (also referred to as Division of Assets)

The Spousal Impoverishment Law, sometimes called Division of Assets, changes the Medicaid eligibility requirement for couples in situations in which only one spouse needs nursing home care. It allows the spouse remaining at home to protect a portion of income and resources. The spouse needing care can receive Medicaid sooner and without the spouse at home being reduced to poverty.

How Can I Get More Information?

More frequently asked questions are available the KDADS's website at http://www.kdads.ks.gov/commissions/commission-on-aging/spousal-impoverishment-law.

Where Can I Get Advice on This Subject?

For advice regarding Spousal impoverishment, contact: The *Kansas Elder Law Hotline (1-888-353-5337)* or the local Area Agency on Aging or a family attorney.

Transfer of Resources

Transfers of resources may be completed to remove them from being counted toward Medicaid eligibility limits. When a resource is transferred, the original owner gives up ownership, control, and benefit of the resource.

Transfer completed within certain look-back periods from the date of Medicaid application will be reviewed to see if the resident received compensation equal to fair market value. Any uncompensated value will be used in calculating a penalty period during which Medicaid will not pay for nursing facility or HCBS costs.

It is important for people to know the changes in the law as they are planning. For those who are considering plans which may include transfer activity of any type, it is necessary to have professional and competent legal and financial advice.

The Law (Effective August 10, 1993)

In the Omnibus Budget Reconciliation Act (OBRA) of 1993, Congress changed the law regarding transfers. Transfers done on or after that date are subject to the following guidelines:

> **Look-Back Period** - for transfers to determine eligibility for Medicaid. All transfers are subject to a 60-month look-back time limit. (5 years)
>
> **Penalty Period -** There is NO maximum on the number of months for a penalty period based on ineligible transfers. The penalty period is calculated by dividing the uncompensated value of an ineligible transfer by $3,000.

NOTE: Call an Attorney or the Elder Law Hotline 1-888-353-5337

Estate Recovery

The State of Kansas is authorized to recover medical assistance costs from the estate of a deceased Medicaid recipient. Estate recovery is limited to recipients who were receiving long-term institutional or HCBS care at the time of their death, or if they were not in long-term care at the time of death, were 55 years of age or older at the time of death.

Estate recovery is further limited to deceased recipients who have no surviving spouse, no surviving children under the age of 21, and no surviving children regardless of age, who are permanently and totally disabled or blind. If there is a surviving spouse, then the recovery is deferred until the death of the surviving spouse. If there is a surviving child who meets one of the criteria mentioned above, the recovery is waived.

KDHE contracts with Health Management Systems (HMS), Kansas Estate Recovery Contractor, ksestaterecovery@hms.com, phone: 800-817-8617. KDHE Estate Recovery can be contacted by phone at (785) 296-6707.

More specific information can be found at http://www.kancare.ks.gov/docs/default-source/Consumers/benefits-and-services/fact-sheets/estate-recovery-fact-sheet-2018-01.pdf

NOTE: Call an Attorney or the Elder Law Hotline 1-888-353-5337

Other Assistance Programs

Kansas Relay Center

The Kansas Relay Center allows specially trained operators to relay conversations between persons with speech and/or hearing impairments and those who can hear and speak. The service is offered seven days a week, 24-hours a day. CALL 1-800-766-3777 (Voice/TTY) or 1-866-305-1344 (Speech to Speech) or 1-866-305-1343 (Spanish) to use the Relay Center. See their website at http://www.da.ks.gov/phonebook/specialservices.htm.

Kansas TAP - Kansas Telecommunication Access Program

The Kansas Telecommunications Access Program (TAP) is an equipment distribution program. The purpose of the program is to provide specialized telephones and other telecommunications devices to Kansans with disabilities who can't use traditional home telephones. Based on a state law, the program receives funds through the Kansas Universal Service Fund (KUSF) and is regulated by the Kansas Corporation Commission (KCC).

Assistive Technology for Kansans (ATK) began to manage Kansas TAP in May 2014. The management office is located in Parsons and each of the regional AT Access Sites and the affiliate office assist with applications and provide demonstrations. Contact: Assistive Technology for Kansans – (800) 526-3648or E-mail: tkapps@ku.edu or write to2601 Gabriel, Parsons, KS 67357. See their website at http://atk.ku.edu/ks-tap.

Free or Low-Cost Dental Care

The purpose of the Donated Dental Service Program (DDS) is to provide free, comprehensive care for people who are permanently disabled, elderly, or medically compromised who are unable to afford dental care. It was designed to help disabled and elderly persons who are indigent by matching them with volunteer dentists. Dentists throughout Kansas have volunteered to participate. Applicants must be permanently disabled, chronically ill, or elderly; unable to afford dental care or not be able to get care through other programs; and need extensive treatment, beyond cleaning and a check-up.

Applications are reviewed and placed on a waiting list. Because of overwhelming need, each patient only receives DDS service one time.

To apply for services, patients can call 785-273-1900 or 888-870-2066 (toll free) or apply online at http://dentallifeline.org/kansas/.

Free Eye Exams

Eye Care America helps to ensure that all eligible seniors have access to medical eye care and promotes annual, dilated eye exams. The organization raises awareness about age-related eye disease, including cataracts, provides **free** eye care educational materials, and facilitates access to eye care.

People eligible for a referral through the program receive a comprehensive, medical eye exam and up to one year of care—at no out-of-pocket cost—for any disease diagnosed during the initial exam. Volunteer ophthalmologists accept Medicare and/or other insurance reimbursement as payment in full.

The program is designed for people who:

- Are US citizens or legal residents
- Are age 65 and older
- Have not seen an ophthalmologist in three or more years

- Do not belong to an HMO or the VA

To determine if you, a family member or friend qualify, call 800-222-EYES (3937) or visit http://www.aao.org/eyecare-america.

Free Facility Services - Hill-Burton Act

The Hill-Burton Act authorizes assistance to public and other nonprofit medical facilities such as acute care general hospitals, special hospitals, nursing homes, public health centers, and rehabilitation facilities.

The Community Service Assurance under Title VI of the Public Health Service Act requires recipients of Hill-Burton funds to make services provided by the facility available to persons residing in the facility's service area without discrimination on the basis of race, color, national origin, creed, or any other ground unrelated to the individual's need for the service or the availability of the needed service in the facility. These requirements also apply to persons employed in the service area of the facility if it was funded under Title XVI of the Public Health Service Act. Please note that the community service obligation is different from the uncompensated care provision. The community service obligation does *not* require the facility to make *non-emergency* services available to persons unable to pay for them. It does, however, require the facility to make *emergency* services available without regard to the person's ability to pay.

There are several basic requirements that every Hill-Burton hospital or other facility must comply with to fulfill the community service obligation:

- A person residing in the Hill-Burton facility's service area has the right to medical treatment at the facility without regard to race, color, national origin, or creed.
- Hill-Burton facilities must participate in the Medicare and Medicaid programs unless they are ineligible to participate.
- Hill-Burton facilities must make arrangements for reimbursement for services with principal State and local third-party payers that provide reimbursement that is not less than the actual cost of the services.
- A Hill-Burton facility must post notices informing the public of its community service obligations in English and Spanish. If ten percent or more of the households in the service area usually speak a language other than English or Spanish, the facility must translate the notice into that language and post it as well.
- A Hill-Burton facility may not deny emergency services to any person residing in the facility's service area on the grounds that the person is unable to pay for those services.
- A Hill-Burton facility may not adopt patient admissions policies that have the effect of excluding persons on grounds of race, color, national origin, creed, or any other ground unrelated to the patient's need for the service or the availability of the needed service.

Hill-Burton Facilities in Kansas

There is currently one health care facility under Hill-Burton obligation in the state of Kansas:

UMKC Center on Aging
3901 Rainbow Blvd.
Kansas City, Kansas 66160
913-588-5273
www.kumc.edu

Chapter 12
SHICK COUNSELOR PROTOCOLS

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COUNSELING TOOLS

SHICK is a free, unbiased and confidential program that uses trained, community volunteers to answer people's questions about Medicare and other insurance issues.

Our counselors do not work for any insurance company. Their goal is to educate and assist the public in making informed decisions about their health care options.

The ideal SHICK counselor has:

- the ability to work with others
- a caring, confident attitude
- the ability to understand health care information and options
- a willingness to stay up-to-date with changing regulations
- familiarity with computers and the internet
- good communication skills
- strong organizational skills
- time to commit to multiple ongoing projects

As a counselor, you will be called upon to provide accurate, unbiased health insurance information in a supportive, easy to understand manner that will enable the client to make well-informed decisions. The Counselor's job responsibilities emphasize the role that effective interpersonal and communication skills play in providing services. The training that Counselors receive provides opportunities for developing and applying communication skills and techniques to assure that clients feel comfortable in seeking assistance and that clients understand what their options are regarding Medicare and other insurances.

Training

SHICK volunteers receive training on Medicare, Medicare Prescription Drug Insurance, Medicare Supplement Insurance, Long-Term Care Insurance and other health insurance subjects that concern Kansans. Training is offered in local communities, and there are also online options.

Support

Volunteers are supported by staff at the state and local level. Regional SHICK Coordinators provide assistance, office space and equipment, supplies, and training support to volunteers in their areas.

Satisfaction

Health insurance options can be confusing. SHICK volunteers help Medicare beneficiaries, caregivers, and others to understand their choices, access the benefits available to them, and find programs to help pay for medications and other services.

SHICK Counselor Responsibilities and Obligations

SHICK counselors are expected to attend SHICK Update training each year, after completing their initial training. They are required to read and sign a Memorandum of Understanding each year agreeing to follow all program guidelines and regulations. They are also expected to track client contacts and group outreach and media outreach events if applicable. SHICK uses the SHIP Tracking and Reporting System (STARS) to report all contact data. This system is available through https://stars.acl.gov/, a secure website used to enter Beneficiary Contact forms (BC) and both Group outreach and Media outreach activity.

What is a Beneficiary Contact?

A beneficiary contact includes all contacts between a counselor or staff and a client, which may include Medicare or Medicaid beneficiaries, seniors, and their family members or others working on behalf of a client. Client contacts may be conducted over the telephone, in person (on site), in person (at home), or via postal mail, e-mail, or fax.

When should I fill out a Beneficiary Contact form?

A Beneficiary Contact form must be completed or updated for each contact between a counselor/staff and a beneficiary or his/her representative. The Beneficiary Contact form is used by registered State Health Insurance Assistance Program (SHIP) counselors only. These individuals must have received counselor training and signed a Memorandum of Understanding (MOU) with their local SHIP agency, SHICK. SHICK counselors may include volunteers, agency staff, toll-free Help Desk counselors, and local coordinators/sponsors.

Beneficiary Contact forms are considered confidential and must be treated by counselors as confidential information. The counselor must assure the client that all personal information collected is confidential.

The BC form and instructions for using the national STARS website to enter beneficiary contacts are on the SHICK website, https://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick/shick-coordinator-counselor-information/ship-tracking-and-reporting-system-STARS.

What are Group Outreach and Media Outreach activities?

A Group Outreach activity can include an in-person interactive presentation to the public conducted by SHICK; a booth/exhibit at a fair, conference, or other public event; and an enrollment event. These outreach activities will count towards SHIP Performance measures. A Media Outreach activity can include Billboard, Email, Magazine, Newsletter, Newspaper, Radio, Social Media, Television, Website, or Other. These activities do not count towards SHIP Performance measures.

Group Outreach activities and Media Outreach activities are reported on separate forms.

The Group Outreach and Media Outreach forms and instructions for using the national STARS website to enter these events are on the SHICK website, https://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick/shick-coordinator-counselor-information/ship-tracking-and-reporting-system-STARS.

Communication Techniques

During a counseling session please keep in mind these communication techniques to facilitate understanding between you and your clients:

- Provide assurances of confidentiality.
- Treat your client with respect from your initial contact through all phases of the service you provide.
- Listen patiently as the client describes his/her situation.
- Ask clarifying questions to focus the discussion.
- Ask “open-ended” questions to clarify information and check that you understand key points.
- Maintain a cordial but professional tone throughout your interactions with the client.

- Observe signs of anxiety or misunderstanding and provide appropriate assurances to ease your client's discomfort.
- Summarize often during conversations with your client to confirm that you understand the client's situation.
- Take care to define terms and explain concepts in ways that the client will understand.
- Provide precise explanations paced appropriately to avoid misunderstanding.
- Encourage the client to participate in pursuing ways to resolve his/her health insurance-related problems.
- Remain flexible about your ideas for resolving problems and be open to your client's ideas. Obtain the client's approval before taking action on his/her behalf.
- Provide information the client can take with them for a reminder of what was talked about.
- If follow-up is needed be specific about when you will be contacting the client or what the next step in the process may be.

Counseling Guidelines

Protecting Beneficiary Privacy

As a SHICK counselor, you will have access to beneficiaries' health information as well as personal identifying information like Medicare numbers and Social Security Numbers. You must handle this information carefully and keep it confidential to protect beneficiaries from fraud, identity theft, health-based discrimination, and other potential problems.

- Only collect the information you need to provide the help the beneficiary has asked for (for example, you don't need a list of medications to help someone enroll in a Medigap plan).
- Only share beneficiary information with people or agencies who are directly involved in providing the help the beneficiary has asked for (like a Part D plan, for example).
- Don't keep beneficiary information on a laptop or in a file that you take out of the office with you.
- Don't leave beneficiary information out on a desk or up on a computer screen where it can be seen by others.
- Conduct counseling sessions in private where personal information shared by the beneficiary won't be overheard by others.
- If you believe beneficiary information has been lost, stolen or misused, contact your SHICK Coordinator immediately.
- If you believe a beneficiary has been the victim of fraud or identity theft, contact your Kansas SMP Coordinator and/or SHICK Coordinator immediately.

Conflict of Interest

SHICK counselors are trusted resources for Medicare beneficiaries. To maintain that trust, counselors cannot be allowed to profit in any way from their contacts with beneficiaries. SHICK has adopted several rules to ensure that no volunteer has a conflict of interest that would prevent him or her from providing unbiased counseling.

- Anyone who is currently associated with the insurance industry is prohibited from being a SHICK volunteer counselor.

- Anyone who could use their position as a SHICK counselor to solicit business from beneficiaries is prohibited from being a SHICK volunteer.
- If a SHICK Coordinator is unclear about whether a conflict of interest exists, the Coordinator should request a ruling from the SHICK Director.
- Potential volunteers cannot take SHICK training until the Coordinator or Director has determined that no conflict of interest exists.
- People who work for organizations that serve Medicare beneficiaries may be SHICK volunteers as long as they do not use their position to solicit business of any kind.

Preparing to Conduct a Counseling Session

Depending on the type of appointment needed by the Medicare beneficiary, both the client and the counselor need to prepare for the counseling session. The Client should be advised to bring along:

- All of his/her health insurance policies and cards.
- Claim forms, medical bills, and copies of relevant correspondence pertaining to the claim and meeting.
- Medicare Card.
- List of current prescription drugs medications with dosage and quantity taken daily.

The client should be advised that a relative or trusted friend may also attend the session.

While preparing for the counseling session, you should take care to assemble the material and information necessary to conduct a productive meeting. You'll want to have reference data about the client readily available. Depending on the client's concern, other useful information to have with you includes:

- Existing files about client, if available,
- Policy comparison materials,
- Referral information,
- Client Contact Form

Beforehand, confirm that the meeting site is available as scheduled and that your clients will be able to meet you as planned. Get to the meeting site a few minutes ahead of time to see that things are in order and to be able to greet your client when he/she arrives.

Basic Counseling Techniques

The following outline provides guidance for conducting the interview and counseling the client. A critical point to remember is that we are to listen to the needs of the clients, educate them about the options available to them, and then allow *them* to make their own well-informed final decisions.

- **Open the session with a brief introduction summarizing your role as a Counselor.**
  - Introduce yourself and then brief the client about what you can and cannot do for them as a counselor.
  - Help the client feel comfortable. Beginning with introductions, it is important to establish rapport. Inform the client that everything he/she shares with you will be held in strict confidence.
- **Ask the client to describe the problem.**
  - Ask why they have come to see you and how they heard about the program. Listen carefully to what they are saying and how they are saying it.

  - Ask open-ended questions, not "yes/no" types of questions when you are in this stage of the interview. The goal is to have the client open up and tell you everything they know about the perceived problem. It may take some time, but you will have a clearer picture of their actual problem and of their understanding about Medicare and insurance.

- **Clarify your understanding of the problem.**
  - Restate back to the client what you heard the problem to be. This will assure the client that you are listening to them and will allow you to progress to the next step of setting goals for solving the problem.
  - For example: "What I heard you say is that you are confused about why the doctor has continued sending you bills when you believe Medicare has already paid him…" Remember to use "I" statements as much as possible so that you refer only to what you hear and not necessarily what the client actually said.
  - Ask if your understanding of the problem is correct.

- **Discuss the goals and problem-solving strategy with the client, and then decide on the next steps for action.**
  - After you have developed a strategy to address the issue, discuss with your client what needs to be done. Make certain your client approves all actions to be taken to resolve claims-related concerns.
  - Decide who will perform specific tasks for investigating and resolving the issue. Some clients will be able to do much, or most, of the work. Other clients will need a great deal more assistance from you. The counselor will need to assess the client's abilities and desires in determining how much the client can do.
  - Make a clear agenda about what both the client and the counselor have agreed to do, and the time frame involved. Let the client know when you will contact him/her for the next steps or to assure him/her that the issue is resolved. Be certain to fill out a Client Contact Form so you have a record of the session and the client's address and telephone number.

- **Develop the client's ability to avoid this problem in the future or to take care of it themselves the next time.**
  - Encourage your client's participation as you review his/her claims situation, as you review the Medicare Summary Notice and as you determine ways to assure maximum payment.
  - If the client's problem is fairly simple (organizing billings, Medicare Summary Notices or Supplemental Insurance statements) you should be able to give some assistance to help organize the bills in the future. Many people simply need a few good suggestions to get organized. Other issues may be too complicated and the client should not be expected to master the details of the Medicare regulations.

- **Close the case and record the service on your counseling Client Contact Forms.**
  - Assure the client that you believe the problem is resolved. Invite the person to contact you again if the need occurs. Also, encourage clients to inform others about this service.
  - Be certain to complete the counseling Client Contact Form. All of your forms should be entered in the SHIPNPR database before the end of the following month. The information is collected and compiled on the SHIPNPR website. By keeping accurate records and getting the information entered in a timely manner it will be possible to get a better picture of how well Medicare is working in your part of the state.

Getting Ready for Medicare

Counseling Steps for assisting a beneficiary who is new to Medicare due to turning 65 or qualifying for Medicare due to disability.

Remember to take the usual counseling steps:

- Ensure your site is free from distractions, protects clients' privacy, and accommodates clients' needs.
- Have publications, computers, and phones handy.
- Tell clients about SHICK, the role of staff/volunteers. Explain why we ask personal questions. Assure client that their information and privacy is protected.
- Ask clients how we can help them. Listen to the things they tell you that are most important to them. Check with clients to make sure you understand their issues and concerns.
- Ask any unanswered questions from the Client Contact Form.

Step 1: Identify if the client has Medicare and find out which parts of Medicare they have.

Step 2: Identify if the client has any other health care coverage.

Step 3: Identify if the client has low income and assets.

- General questions are best.
- Is your income above or below this amount?
- Are your assets above or below this amount?
- More specific income and asset information is not needed unless the beneficiary qualifies for Extra Help or the Medicare Savings Program.

Step 4: Identify if the client is eligible for Medicare, or will be soon.

Step 5: If needed, explain to the client the different parts of Medicare (A-D) and what each part covers.

Step 6: Tell client points to think about for each part of Medicare:

- Cost and programs to help with cost (Medicare Savings Programs, Part D Extra Help)
- Penalties and gaps
- Effective start dates, and impact on current or past bills or treatment needs
- Impact to other health care coverage for client and family (such as will other coverage continue or end, which insurance will be primary, etc.)

Step 7: Identify whether Social Security Administration (SSA) will automatically enroll client in any parts of Medicare, or if client will need to enroll self in to join.

- Options for enrolling in Medicare – www.ssa.gov, apply online or go to their local Social Security office.
- Let client know about any parts of Medicare client will need to enroll self in to join.
- If client must enroll to have Medicare, ensure client knows how and when he or she may enroll.

Step 8: Identify if client may defer enrolling in any parts of Medicare without a penalty.

Step 9: Ensure client understands Medicare billing process, including:

- Finding providers who take their coverage

- What happens if providers don't accept assignment under Original Medicare
- What to expect with Medicare billing

Step 10: Make sure client knows how to protect self against fraud (give SMP brochure).

Step 11: If client needs help with the costs or gaps of Medicare, give explanation of supplemental insurance. Refer to Medicare Supplement Shopper's Guide from the Kansas Insurance Department or refer to the Kansas Insurance Department website: www.ksinsurance.org .

Step 12: Provide appropriate referrals, publications, and Web references.

Other reminders

- Tell clients points to think about with each option.
- Help clients compare choices with resources provided in SHICK training, Kansas Insurance Department publications or information found on www.medicare.gov website

Provide related publications and referrals.

- Find out if clients have other questions.
- Warn clients about fraud. The SMP brochure and SMP Personal Healthcare Journal are good resources.
- Summarize next steps.
- Complete the Client Contact Form or data enter your contact on SHIPNPR.

Advocacy

There may be times when your client needs an advocate to act on his/her behalf in resolving a claims-related issue. As a result of your objective assessment of the situation during your discussion with your client, you will be in a position to determine if advocacy is required and to make recommendations for appropriate action. The Kansas Insurance Commissioner's Office is an example of one advocacy resources available to the consumer.

Remain flexible about your ideas for resolving your client's difficulties. Remember the client is not obligated to follow your suggested course of action.

You may find it useful to organize the documents you'll be reviewing in a uniform manner. The following procedure is recommended:

- Separate "Medicare Summary Notices" from bills
- Separate medical bills by provider
- Arrange bills from each provider in order of date of services rendered
- Arrange "Medicare Summary Notices" by carrier and then put into chronological order according to the date issued
- While studying the Medicare Summary Notices, check for Medicare or insurance company checks that may have been made payable to the client
- Record amount applied toward the deductibles for relevant insurance policies to determine if deductible requirements have been met

When applying for benefits, it is important to consider all relevant policies your client may have. Check with your client to determine that all policies have been considered in your review of plan provisions. Take care to file eligible claims under policies.

Questions and Problem Resolution

As a SHICK Counselor the difficulty and degree of beneficiary questions and problems will vary. The information in this section is presented to provide a uniform problem resolution strategy for SHICK Counselors.

Initial question or problem from the Medicare beneficiary.

Step 1: Research using www.medicare.gov website or your SHICK Handbook to see if you can find the answer to the question.

Step 2: If you cannot find the appropriate answer consider using your unique ID to contact Medicare to see if you can find the answer to the question.

Step 3: If you have still not found a satisfactory answer contact the SHICK Coordinator for your area.

Step 4: If the local SHICK Coordinator cannot answer your question please contact the State SHICK Office for help resolving the issue or answering the question.

1. As a certified Counselor, you may know more about Medicare, Medicare supplement insurance, and long-term care insurance than many insurance professionals in the United States.
2. You are offering seniors a free service that is available in every state. Use the knowledge and information that you know to be accurate. You will do a fine job for the client.
3. You have everything you need to handle most cases. Don't worry about the small details. Settle down and help the client.
4. It is not a crime if you do not know the answer to every question asked about Medicare, Medicare supplement coverage, or Long-Term Care plans. No one knows it all……even the experts.
5. If you are not sure…do not provide an answer!!! ("I don't know, but I'll get back to you" is an acceptable answer.)
    a. When in doubt: take the client's name, phone number, and questions or concerns and promise to follow up.
    b. Tell the client you will call in several days after you have explored the questions, or after you have contacted your Coordinator for guidance. Even experts have to check with other experts in specialized areas. The only "sin" and embarrassment is to give faulty information!!!

REMEMBER! Everything a client tells you is ***confidential.***

Chapter 13
GLOSSARY

A

Abuse – A range of the following improper behaviors or billing practices including, but not limited to: Billing for a non-covered service; Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or Inappropriately allocating costs on a cost report.

Activities of Daily Living (ADL) - Activities you usually do during a normal day such as getting in and out of bed, dressing, bathing, eating, and using the bathroom.

Administrative Law Judge (ALJ) - A hearings officer who presides over appeal conflicts between providers of services, or beneficiaries, and Medicare contractors.

Advance Beneficiary Notice of Noncoverage (ABN) - In Original Medicare, a notice that a doctor, supplier, or provider gives a Medicare beneficiary before furnishing an item or service if the doctor, supplier, or provider believes that Medicare may deny payment. In this situation, if you aren't given an ABN before you get the item or service, and Medicare denies payment, then you may not have to pay for it. If you are given an ABN, and you sign it, you will probably have to pay for the item or service if Medicare denies payment.

Advance Coverage Decision - A notice you get from a Medicare Advantage Plan letting you know in advance whether it will cover a particular service.

Advance Directive - A written document stating how you want medical decisions to be made if you lose the ability to make them for yourself. It may include a Living Will and a Durable Power of Attorney for health care.

Aging and Disability Resource Center (ADRC) – The ADRC is a trusted source of information where people of all ages, abilities and income levels - and their caregivers - can go to obtain assistance in planning for their future long-term service and support needs.

Allowed Charge (Medicare) – An individual charge determination made by a Medicare carrier on a covered Part B medical service or supply. In the absence of unusual medical circumstances, it is the lowest of: 1) the physician’s fee schedule amount in most cases; or 2) the actual charge made by the physician or supplier.

ALS - Amyotrophic lateral sclerosis, also known as Lou Gehrig's disease.

Ambulatory Services – Medical services provided to patients who are not hospitalized.

Ambulatory Surgical Center - A facility where simpler surgeries are performed for patients who aren't expected to need more than 24 hours of care.

Ancillary Services - Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.

Annual Coordinated Election Period (AEP) - The Annual Coordinated Election Period for Medicare beneficiaries begins in October 15 through December 7 each year. Also called the Open Enrollment Period.

Appeal - An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. Appeals involve money – Medicare paid too much, Medicare didn't pay enough, Medicare denied the claim.

Approved Amount - The fee Medicare sets as reasonable for a covered medical service.

Area Agency on Aging (AAA) - A nationwide network of State and local programs that help older people plan and care for their life-long needs. Services include information and referral for in-home services, counseling, legal services, adult day care, skilled nursing care/therapy, transportation, personal care, respite care, nutrition and meals.

Assignment (Medicare) – An agreement by your doctor or other supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

B

Beneficiary - A person who has health care insurance through the Medicare or Medicaid programs.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) - A type of QIO (an organization of doctors and other health care experts under contract with Medicare) that uses doctors and other health care experts to review complaints and quality of care for people with Medicare. The BFCC-QIO makes sure there is consistency in the case review process while taking into consideration local factors and local needs, including general quality of care and medical necessity.

Benefit Period - The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Benefits - The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.

Benefits Coordination & Recovery Center - The company that acts on behalf of Medicare to collect and manage information on other types of insurance or coverage that a person with Medicare may have, and determine whether the coverage pays before or after Medicare. This company also acts on behalf of Medicare to obtain repayment when Medicare makes a conditional payment, and the other payer is determined to be primary.

Biologicals - Usually a drug or vaccine made from a live product and used medically to diagnose, prevent, or treat a medical condition. For example, a flu or pneumonia shot.

C

Capped Rental Item - Durable medical equipment (like nebulizers or manual wheelchairs) that costs more than $150, and the supplier rents it to people with Medicare more than 25% of the time.

Centers for Medicare & Medicaid Services (CMS) - The Federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs.

CHAMPVA - A health care benefit for dependents of qualifying veterans.

Claim - A request for payment that you submit to Medicare or other health insurance when you get items and services that you think are covered.

Clinical breast exam - An exam by your doctor or other health care provider to check for breast cancer by feeling and looking at your breasts. This exam isn't the same as a mammogram and is usually done in the doctor's office during your Pap test and pelvic exam.

Cognitive Impairment - A breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.

Coinsurance – An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Complaint (of Fraud or Abuse) - A statement, oral or written, alleging that a provider or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which he or she is not entitled under current Medicare law, regulations, or policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services.

Conditional Payment - A payment made by Medicare for services for which another payer is responsible.

Consolidated Omnibus Budget Reconciliation Act (COBRA) - A law that lets some people keep their employer group health plan coverage for a period of time after: the death of your spouse, losing your job, having your working hours reduced, leaving your job voluntarily, or getting a divorce. You may have to pay both your share and the employer's share of the premium.

Coordinated Care Plan - A plan that includes a CMS-approved network of providers that are under contract or arrangement with the MA organization to deliver the benefit package approved by CMS. Coordinated care plans include plans offered by health maintenance organizations (HMOs), preferred provider organizations (PPOs), as well as other types of network plans (except network MSA plans).

Coordination of Benefits - A way to figure out who pays first when two or more health insurance plans are responsible for paying a medical claim.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Cost Sharing - An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. This amount can include copayments, coinsurance, and/or deductibles.

Coverage gap (Medicare prescription drug coverage) - A period of time in which you pay higher cost sharing for prescription drugs until you spend enough to qualify for catastrophic coverage. The coverage gap (also called the "donut hole") starts when you and your plan have paid a set dollar amount for prescription drugs during that year.

Creditable Coverage (Medigap) - Health coverage you have had in the past, such as group health plan (including COBRA continuation coverage), an HMO, an individual health insurance policy, Medicare or

Medicaid, and this prior coverage was not interrupted by a significant break in coverage (more than 63 days). The time period of this prior coverage must be applied toward any pre-existing condition exclusion imposed by a new health plan. Proof of your creditable coverage may be shown by a certificate of creditable coverage or by other documents showing an individual had health coverage, such as a health insurance ID card.

Creditable Prescription Drug Coverage - Prescription drug coverage (like from an employer or union), that pays out, on average, as much as or more than Medicare's standard prescription drug coverage.

Critical Access Hospital (CAH) - A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Custodial Care - Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

D

Deductible - The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or other insurance begins to pay.

Deemed Status – A provider or supplier earns this when they have been accredited by a national accreditation program (approved by the Centers for Medicare & Medicaid Services) that they demonstrate compliance with certain conditions.

Demonstrations - Special projects, sometimes called "pilot programs" or "research studies," that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time, for a specific group of people, and in specific areas.

Department of Health and Human Services (HHS) - A Federal agency that administers programs for protecting the health of all Americans, including the Medicare, Medicaid, and Children's Health Insurance Programs.

Disability – For Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for continuous period of not less than 12 months. Special rules apply for workers aged 55 or older whose disability is based on blindness. The law generally requires that a person be disabled continuously for 5 months before he or she can qualify for a disabled worker cash benefit. An additional 24 months is necessary to qualify under Medicare for most applicants.

DME Medicare Administrative Contractor (MAC) - A private company that contracts with Medicare to pay bills for durable medical equipment.

Drug List - A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. This list is also called a formulary.

Durable Medical Equipment (DME) – Certain medical equipment, such as a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

Durable Power of Attorney - A legal document that enables you to designate another person, called the attorney-in-fact, to act on your behalf, in the event you become disabled or incapacitated.

E

Emergency Care - Care given for a medical emergency when you believe that your health is in serious danger when every second counts.

Employer or Union Retiree Plans - Plans that give health and/or drug coverage to employees, former employees, and their families. These plans are offered to people through their (or a spouse's) current or former employer or employee organization.

End-Stage Renal Disease (ESRD) - Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Enrollment Period - A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Exception - A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its drug list or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that's on its non-preferred drug tier. You must request an exception, and your doctor or other prescriber must send a supporting statement explaining the medical reason for the exception.

Excess Charge – If you have Original Medicare, and the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount, the difference is called the excess charge.

Exclusions - Items or services that Medicare does not cover, such as most routine services like eye exams, hearing exams, annual physical, long-term care, and custodial care in a nursing or private home.

Extra Help - A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

F

Federally-Qualified Health Center - Federally-funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services even if you can't afford it. Services are provided on a sliding scale fee based on your ability to pay.

Fee-For-Service Payment – A method of paying for medical care in which each service performed by an individual provider can bear a related charge.

Formulary - A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

Fraud - The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

Fraud and Abuse - Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.

Free Look (Medigap Policy) - A period of time (30 days) when you can try out a Medigap policy. During this time, if you change your mind about keeping the policy, it can be cancelled. If you cancel, you will get your money back.

G

Gaps - The costs or services that are not covered under the Original Medicare Plan.

General Enrollment Period (GEP) - The General Enrollment Period is January 1 through March 31 of each year. If you enroll in Premium Part A or Part B during the General Enrollment Period, your coverage starts on July 1.

Generic Drug - A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

Grievance - A complaint about the way your Medicare health plan or Medicare drug plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person at the plan has behaved towards you. However, if you have a complaint about a plan's refusal to cover a service, supply, or prescription, you file an appeal.

Group health plan - In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Guaranteed Issue Rights (Also Called "Medigap Protections") - Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a Medigap policy, or place conditions on a Medigap policy, such as exclusions for pre-existing conditions, and can't charge you more for a Medigap policy because of a past or present health problem.

Guaranteed Renewable Policy - An insurance policy that can't be terminated by the insurance company unless you make untrue statements to the insurance company, commit fraud, or don't pay your premiums. All Medigap policies issued since 1992 are guaranteed renewable.

H

Health care provider - A person or organization that's licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.

Health coverage - Legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

Health Insurance Claim Number (HICN) – The ten (10) to eleven (11) digit number assigned by Medicare to each beneficiary. Also referred to as your Medicare Claim Number.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - The "Standard for Privacy of Individually Identifiable Health Information (also called the "Privacy Rule")" of HIPPA assures your health

information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being.

Health Maintenance Organization (HMO) (Medicare) – A type of Medicare Advantage Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency.

Home - Location, other than a hospital or other facility, where the patient receives care in a private residence.

Home and Community-Based Service Waiver Programs (HCBS) - The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly and disabled, intellectually disabled, developmentally disabled, and certain other disabled adults. These programs give quality and low-cost services.

Home Health Care - Health care services and supplies a doctor decides you may receive in your home under a plan of care established by your doctor. Medicare only covers home health care on a limited basis as ordered by your doctor.

Homebound - Normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious service. A need for adult day care doesn't keep you from getting home health care.

Hospice - A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver as well.

Hospital Care (Inpatient) - Treatment you get in an acute care hospital, critical access hospital, inpatient rehabilitation facility, long-term care hospital, inpatient care as part of a qualifying research study, and mental health care.

Hospital Outpatient Setting - A part of a hospital where you get outpatient services, like an emergency department, observation unit, surgery center, or pain clinic.

I

Independent Reviewer - An organization (sometimes called an Independent Review Entity or IRE) that has no connection to your Medicare health plan or Medicare Prescription Drug Plan. Medicare contracts with the IRE to review your case if you appeal your plan's payment or coverage decision or if your plan doesn't make a timely appeals decision.

Initial Coverage Limit - Under Part D, once you have met your yearly deductible, you will pay a copayment or coinsurance for each covered drug until you reach your plan's out-of-pocket maximum (or initial coverage limit). You will then enter your plan's coverage gap (sometimes called the "donut hole").

Initial Enrollment Period (IEP) - The Initial Enrollment Period is the first chance you have to enroll in Medicare Part B & buy a Medicare Part D Prescription Drug plan. Your Initial Enrollment Period starts three months before you first meet all the eligibility requirements for Medicare and lasts for seven months.

In-Network - Doctors, hospitals, pharmacies, and other health care providers that have agreed to provide members of a certain insurance plan with services and supplies at a discounted price. In some insurance plans, your care is only covered if you get it from in-network doctors, hospitals, pharmacies, and other health care providers.

Inpatient Care - Health care that you get when you're admitted to a health care facility, like a hospital or skilled nursing facility.

Inpatient Hospital Services - Services you get when you're admitted to a hospital, including bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

Inpatient Prospective Payment System (IPPS) - Hospitals that have contracted with Medicare to provide acute inpatient care and accept a predetermined rate as payment in full.

Inpatient Psychiatric Facility - A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Inpatient Rehabilitation Facility - A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

L

Large Group Health Plan (LGHP) - In general, a group health plan that covers employees of either an employer or employee organization that has 100 or more employees.

Liability Insurance - Liability insurance is insurance that protects against claims for negligence or inappropriate action or inaction, which results in injury to someone or damage to property.

Lifetime Reserve Days - In Original Medicare, these are additional days that Medicare will pay for when you are in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Limiting Charge - In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don’t accept assignment. The limiting charge is 15% over Medicare’s approved amount. The limiting charge only applies to certain services and doesn’t apply to supplies or equipment.

Living Wills - A legal document also known as a medical directive or advance directive. It states your wishes regarding life-support or other medical treatment in certain circumstances, usually when death is imminent.

Long-Term Care - Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living, like dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living, or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don’t pay for long-term care.

Long-Term Care Hospital - Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Long-Term Care Insurance - A private insurance policy to help pay for some long-term medical and non-medical care, like help with activities of daily living. Because Medicare generally does not pay for long-term care, this type of insurance policy may help provide coverage for long-term care that you may need in the future. Some long-term care insurance policies offer tax benefits; these are called "Tax-Qualified Policies."

Long-Term Care Ombudsman - An independent advocate (supporter) for nursing home and assisted living facility residents who works to solve problems between residents and nursing homes or assisted living facilities. They may be able to provide information about home health agencies in their area.

Low-Income Medicare Beneficiary (LMB) - A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.

M

Medicaid - A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary- Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare - The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Medicare Administrative Contractor (MAC) - A company that processes claims for Medicare.

Medicare Advantage Plan (Medicare Part C) (MA) - A type of Medicare health plan offered by a private company which contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Advantage Open Enrollment Period (MA-OEP) - January 1 through March 31 every year. Available only for beneficiaries who are enroll in a Medicare Advantage plan as of January 1. Beneficiaries have a one-time opportunity to switch MA plans or drop their MA plan and return to Original Medicare, Part A and Part B.

Medicare Advantage Prescription Drug (MA-PD) PLAN - A Medicare Advantage plan that offers Medicare prescription drug coverage (Part D), Part A, and Part B benefits in one plan.

Medicare Health Plan - A plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Outpatient Observation Notice (MOON) - The MOON is a standardized notice to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH).

Medicare Part A (Hospital Insurance) - Coverage for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance) - Coverage for certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Preferred Provider Organization (PPO) PLAN - A type of Medicare Advantage Plan (Part C) available in some areas of the country in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Prescription Drug Coverage (Part D) - Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Medicare Private Fee-for-Service Plan - A type of Medicare Advantage Plan (Part C) in which you can generally go to any doctor or hospital you could go to if you had Original Medicare, if the doctor or hospital agrees to treat you. The plan determines how much it will pay doctors and hospitals, and how much you must pay when you get care. A Private Fee-For-Service Plan is very different than Original Medicare, and you must follow the plan rules carefully when you go for health care services. When you're in a Private Fee-For-Service Plan, you may pay more or less for Medicare-covered benefits than in Original Medicare.

Medicare Savings Program (MSP) - A Medicaid program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance.

Medicare Select - A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medicare Summary Notice (MSN) - A notice you get after the doctor or provider files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Medicare Special Needs Plan (SNP) - A special type of Medicare Advantage Plan (Part C) that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.

Medicare Supplement Insurance - Medicare supplement insurance are health insurance policies that coordinate with Medicare as the primary payer. This could be a Medigap policy, an employer group plan, TRICARE for Life, and Medicaid, to name a few. Most are sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage.

Medicare-Approved Amount - In the Original Medicare Plan, this is the amount a doctor or supplier can be paid, including what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount charged by a doctor or supplier.

Medigap Insurance – Private standardized supplementary medical insurance covering out-of-pocket expenditures of Medicare beneficiaries such as deductibles and coinsurance.

Medigap Open Enrollment Period - A one-time-only six month period when you can buy any Medigap policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems. Kansas law has provisions for people under 65, on SSA disability.

Military Treatment Facility - A medical facility operated by one or more of the Uniformed Services. A Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Services (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

MIPPA - Medicare Improvements for Patients and Providers Act of 2008 - On July 15, 2008, Congress overrode President Bush's veto and enacted this law. It is perhaps best known for blocking scheduled cuts in Medicare's payments to doctors as well as changes in three key areas: 1) improvements to Medicare benefits, especially for low-income beneficiaries; 2) new policies to reduce racial and ethnic disparities among people with Medicare; and 3) reining in rapidly-growing and inefficient private Medicare Advantage plans.

Multi-Employer Plan - In general, a group health plan that's sponsored jointly by two or more employers.

N

Network - The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Network Pharmacies - Pharmacies that have agreed to provide members of certain Medicare plans with services and supplies at a discounted price. In some Medicare plans, your prescriptions are only covered if you get them filled at network pharmacies.

No-Fault Insurance - No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

Non-Covered Service - The service: does not meet the requirements of a Medicare benefit category, Is statutorily excluded from coverage on ground other than 1862(a)(1), or is not reasonable and necessary under 1862 (a)(1).

Non-Formulary Drugs – Drugs not on a plan-approved drug list.

Non-Participating Physician - A doctor or supplier who does not accept assignment on all Medicare claims.

Non-Preferred Pharmacy - A pharmacy that's part of a Medicare drug plan's network but isn't a Preferred Pharmacy. You may pay higher out-of-pocket costs if you get your prescription drugs from a Non-Preferred Pharmacy instead of a Preferred Pharmacy.

O

Occupational Therapy - Treatment that helps you return to your usual activities (like bathing, preparing meals, and housekeeping) after an illness.

Open Enrollment Period - See Annual Coordinated Enrollment Period

Original Medicare - Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

Out-of-network - A benefit that may be provided by your Medicare Advantage plan. Generally, this benefit gives you the choice to get plan services from outside of the plan's network of health care providers. In some cases, your out-of-pocket costs may be higher for an out-of-network benefit.

Out-of-pocket costs - Health or prescription drug costs that you must pay on your own because they aren't covered by Medicare or other insurance.

Outpatient Prospective Payment System - The way that Medicare pays for most outpatient services at hospitals or community mental health centers under Medicare Part B.

Outpatient Hospital CARE- Medical or surgical care you get from a hospital when your doctor hasn't written an order to admit you to the hospital as an inpatient. Outpatient hospital care may include emergency department services, observation services, outpatient surgery, lab tests, or X-rays. Your care may be considered outpatient hospital care even if you spend the night at the hospital.

P

Participating Physician or Supplier - A doctor or supplier who agrees to accept assignment on all Medicare claims. These doctors or suppliers may bill you only for Medicare deductible and/or coinsurance amounts. (See Assignment.)

Penalty - An amount added to your monthly premium for Medicare Part B, or for a Medicare Prescription Drug Plan, if you don't join when you're first able to. You pay this higher amount to Medicare as long as you have Medicare. There are some exceptions.

Personal Care - Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. The Medicare home health benefit does pay for personal care services.

Physical Therapy - Treatment of injury and disease by mechanical means, such as heat, light, exercise, and massage.

Point-of-Service Option - In a Health Maintenance Organization (HMO), this option lets you use doctors and hospitals outside the plan for an additional cost.

Power of Attorney - A medical power of attorney is a document that lets you appoint someone you trust to make decisions about your medical care. This type of advance directive also may be called a health care proxy, appointment of health care agent or a durable power of attorney for health care.

Pre-Existing Condition - A health problem you had before the date that a new insurance policy starts.

Preferred Providers – Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.

Premium - The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive Services - -Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Doctor - The doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider.

Prior Authorization - Approval from a Medicare drug plan that may be required before you fill your prescription for the prescription to be covered by your plan.

Primary Payer - An insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or other health insurance.

Programs of All-Inclusive Care for the Elderly (PACE) A special type of health plan that provides all the care and services covered by Medicare and Medicaid as well as additional medically-necessary care and services based on your needs as determined by an interdisciplinary team. PACE serves frail older adults who need nursing home services but are capable of living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.

Prospective Payment System - A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

Provider - Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare Part B. Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.

Q

Qualified Disabled and Working Individuals (QDWI) Program - A state program that helps pay Part A premiums for people who have Part A and limited income and resources.

Qualified Individual (QI) Program - A state program that helps pay Part B premiums for people who have Part A and limited income and resources.

Qualified Medicare Beneficiary (QMB) Program - A state program that helps pay Part A premiums, Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) for people who have Part A and limited income and resources.

R

Railroad Retirement - A federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

Referral - A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services - Services that help you regain abilities, such as speech or walking, that have been impaired by an illness or injury. These services are given by nurses, and physical, occupational and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed.

Respite Care – Temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient's caregiver can rest or take some time off.

S

Secondary Payer - The insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

Self-Insured – An individual or organization that assumes the financial risk of paying for health care.

Service Area - A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Care - Care such as intravenous injections that can only be given by a registered nurse or doctor.

Skilled Nursing Facility (SNF) - A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Special Enrollment Period - A set time when you can sign up for Medicare Part B if you didn't take Medicare Part B during the Initial Enrollment Period, because your or your spouse were working and had group health plan coverage through the employer or union. You can sign up at any time you are covered under the group plan based on current employment status. The last eight months of the Special Enrollment Period starts the month after the employment ends or the group health coverage ends, whichever comes first.

Specified Disease Insurance – This kind of insurance pays benefits for only a single disease, such as cancer, or for a group of disease. Specified Disease Insurance doesn't fill gaps in your Medicare coverage.

Specified Low-Income Medicare Beneficiary (SLMB) Program - A state program that helps pay Part B premiums for people who have Part A and limited income and resources.

Speech-Language Therapy - Treatment that helps you strengthen or regain speech, language, and swallowing skills.

State Health Insurance Assistance Program (SHIP) - A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. The SHIP in Kansas is SHICK (Senior Health Insurance Counseling for Kansas).

State Insurance Department - A state agency that regulates insurance and can provide information about Medigap policies and other private insurance.

Step Therapy - A coverage rule used by some Medicare Prescription Drug Plans that requires you to try one or more similar, lower cost drugs to treat your condition before the plan will cover the prescribed drug.

Supplemental Security Income (SSI) - A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits aren't the same as Social Security retirement or disability benefits.

Supplier - Generally, any company, person, or agency that gives you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.

Swing Bed – Bed approved for multiple patient use, i.e. hospital and Skilled Nursing Facility.

T

Telemedicine - Medical or other health services given to a patient using a communications system (like a computer, telephone, or television) by a practitioner in a location different than the patient's.

Tiers - Groups of drugs that have a different cost for each group. Generally, a drug in a lower tier will cost you less than a drug in a higher tier

TRICARE - A health care program for active duty and retired uniformed services members and their families. Previously known as Civilian Health And Medical Program (CHAMPUS).

TRICARE for Life (TFL) - Expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses.

TTY - A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe-speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don’t have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

U

Underwriting - The process that an insurance company uses to decide, based on your medical history, whether to take your application for insurance, whether to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Urgently Needed Care - Care that you get outside of your Medicare health plan's service area for a sudden illness or injury that needs medical care right away but isn’t life threatening. If it’s not safe to wait until you get home to get care from a plan doctor, the health plan must pay for the care.

W

Waiting Period - The period that must pass before an employee or dependent is eligible to enroll (becomes covered) under the terms of the group health plan. If the employee or dependent enrolls as a late enrollee or on a special enrollment date, any period before the late or special enrollment is not a waiting period. If a plan has a waiting period and a pre-existing condition exclusion, the pre-existing condition exclusion period begins when the waiting period begins. Days in a waiting period are not counted toward creditable coverage unless there is other creditable coverage during that time. Days in a waiting period are not counted when determining a significant break in coverage.

Workers Compensation - Insurance that employers are required to have to cover employees who get sick or injured on the job.

World Health Organization – An organization that maintains the International Classification of Diseases (ICS) medical code set.

Chapter 14
APPENDIX

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2020 Overview of Medicare A & B

Key: Shaded areas – Medicare Pays
White areas – You Pay

A		B	
Premium:	*40 work quarters = zero* *less than 30 quarters = $458* *30 - 39 quarters = $252*	Premium: $144.60 unless individual income over $85,000 or couple $170,000.	
Each benefit period* **In-patient Hospital**		$198 Deductible (per calendar year, January 1 to December 31)	
First 60 days	$1408 Deductible	**80%**	**20%**
Days 61-90	$352 per day co-payment	Physician's Charges (in or out of the hospital) Durable Medical Equipment & Supplies Ambulance Outpatient Hospital	**C O I N S U R A N C E**
Lifetime Reserve Days 91-150	$704 per day co-payment		
Skilled Nursing Facility		Blood	The first 3 pints
First 20 days	100% (No co-pay)	Lab Services	
Days 21-100	$176 per day co-pay		
100% Services Home Health Hospice		**Preventive Services** **PAID 100%:** Welcome to Medicare Physical Exam, Screening Mammograms, Annual Pap Tests, Diabetes Screening, Bone Mass Measurement, Flu Shots, some Colorectal Cancer Screening, Screening & Counseling for Obesity, Medical Nutrition Therapy, Tobacco Use Cessation, Yearly Wellness Visit	
	$5 prescription drug co-pay 5% co-insurance inpatient respite care	**WITH CO-PAY OR DEDUCTIBLE:** Abdominal Aortic Aneurysm Screening, Diabetes Supplies & Self-Management, Prostate Cancer Screening, Glaucoma Screening, CCS - Barium enema, HIV Screening	
* Benefit period ends when patient is out of the hospital or skilled nursing facility for 60 consecutive days.		**Excess Charges** (15% over Medicare Allowed Charge)	

Annual Medicare Premium and Cost-Sharing Amounts

2020

Part A – Hospital Insurance

Part A Standard Premium – No charge for most people (at least 40 work credits)
$458.00 per month for people with less than 30 work credits
$252.00 per month for people with 30 to 39 work credits

Part A – Hospital Insurance – Covered Services (Per Benefit Period)

Part A Deductible for Each Benefit Period	$1,408.00
Hospital Inpatient	$0 for days 1 - 60 $352.00 a day for days 61 to 90 $704.00 a day for days 91 – 150 (lifetime reserve days) All costs for days after 150
Skilled Nursing Facility	$0 for days 1 – 20 $176 a day for days 21 – 100 All costs for all days after 100
Home Health Care	$0 for home health care services 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	$0 for hospice care You may need to pay a copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control while you're at home. In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan to see if it's covered under Part D. You may need to pay 5% of the Medicare-approved amount for inpatient respite care. Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).
Blood	Blood Transfusion

Part A Late Enrollment Surcharges/Penalties:

If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up.

Part B -Medical Insurance

Part B deductible -$198 per year

Part B coinsurance -After your deductible is met, you typically pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy, and durable medical equipment.

Part B Standard Premium -$144.60 per month (or higher depending on your income)

You'll pay a higher premium amount in 2020 if your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount.

If you're in 1 of these 5 groups, your 2020 Part B monthly premium rates are listed below.

If Your Yearly Income in 2018 (for what you pay in 2020) was			**You pay (in 2020)***
File Individual Tax Return	**File Joint Tax Return**	**File married and separate tax return**	
$87,000 or less	$174,000 or less	$87,000 or less	$144.60
above $87,000 up to $109,000	above $174,000 up to $218,000	Not applicable	$202.40
above $109,000 up to $136,000	above $218,000 up to $272,000	Not applicable	$289.20
above $136,000 up to $163,000	above $272,000 up to $326,000	Not applicable	$376.00
above $163,000 and less than $500,000	above $326,000 and less than $750,000	above $87,000 and less than $413,000	$462.70
$500,000 or above	$750,000 and above	$413,000 and above	$491.60

*If beneficiary pays a late-enrollment penalty, this amount is higher.

Part B Late Enrollment Surcharges/Penalties:

If you don't sign up for Part B when you're first eligible, or if you drop Part B and then get it later, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period that you could've had Part B, but didn't sign up for it.

Part D – Medicare Prescription Drug Coverage

Part D Base Beneficiary Premium -$32.74 (Used to determine any late enrollment penalty amount).

Listed below are the 2020 Part D monthly income-related premium adjustment amounts to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

If Your Yearly Income in 2018 (for what you pay in 2020) was			**You pay (in 2020) Income-related monthly adjustment amount + your plan premium (YPP)**
File individual tax return	**File joint tax return**	**File married and separate tax return**	
$87,000 or less	$174,000 or less	$87,000 or less	your plan premium
above $87,000 up to $109,000	above $174,000 up to $218,000	not applicable	$12.20 + your plan premium
above $109,000 up to $136,000	above $218,000 up to $272,000	not applicable	$31.50 + your plan premium
above $136,000 up to $163,000	above $272,000 up to $326,000	not applicable	$50.70 + your plan premium
above $163,000 and less than $500,000	above $326,000 and less than $750,000	above $87,000 and less than $413,000	$70.00 + your plan premium
$500,000 or above	$750,000 and above	$413,000 and above	$76.40 + your plan premium

Part D deductibles, copayments, & coinsurance

The amount you pay for Part D deductibles, copayments, and/or coinsurance varies by plan. Look for specific Medicare drug plan costs, and then call the plans you're interested in to get more details.

Defined Standard Plan (Basic Benefit) in 2020

What you pay	100%	25%	25% brand names 25% generics	5%
What Medicare pays	0%	75%	75% brand names 75% generics	95%
Costs	$0 - $435	$435 - $4020	$4021-$6350	Drug costs > $6350 OOP Max $6350
Coverage Level	Deductible **1**	Initial Coverage Level **2**	Coverage Gap **3**	Catastrophic Coverage **4**

2020 Monthly Poverty Guidelines

Guidelines for the 48 contiguous states and the District of Columbia

Persons in family/ household	100%	120%	135%	140%	145%	150%
1	$1,063	$1,276	$1,436	$1,489	$1,542	$1,595
2	$1,437	$1,724	$1,940	$2,011	$2,083	$2,155
3	$1,810	$2,172	$2,444	$2,534	$2,625	$2,715
4	$2,183	$2,620	$2,948	$3,057	$3,166	$3,275
5	$2,557	$3,068	$3,452	$3,579	$3,707	$3,835
6	$2,930	$3,516	$3,956	$4,102	$4,249	$4,395
7	$3,303	$3,964	$4,460	$4,625	$4,790	$4,955
8	$3,677	$4,412	$4,964	$5,147	$5,331	$5,515

Federal poverty level guidelines at: https://aspe.hhs.gov/poverty-guidelines.

2020 Resource Standards for Individuals/Couples

	With Burial Exclusion	Without Burial Exclusion
Lower Resources Level	$9,360/$14,800	$7,860/$11,800
Higher Resources Level	$14,610/$29,160	$13,110/$26,160

Medicare Savings Programs (MSPs): Eligibility and Coverage (2020)

Type of MSP	Financial Eligibility	Benefits Covered by MSP
Qualified Medicare Beneficiary (QMB)	Monthly Income*: At or below 100% FPL Resources: Lower resource level	Part A hospital deductible ($1,408/per benefit period) Part A hospital copays: days 61-90 ($352 daily), days 91-150 ($704 daily) Part A SNF copays: days 21-100 ($176 daily) Part A premium if owed ($458 for most voluntary enrollees) Part B annual deductible ($198) Part B monthly premium ($144.60) Part B coinsurance (amount varies)
Specified Low-Income Medicare Beneficiary (SLMB)	Monthly Income*: Between 100-120% FPL Resources: Lower resource level	Part B monthly premium ($144.60)
Qualifying Individual (QI) or Expanded LMB (ELMB)	Monthly Income*: 121-135% FPL Resources: Lower resource level	Part B monthly premium ($144.60)
Qualified Disabled Working Individual (QDWI)	Monthly Income**: $4,045 if single $5,425 if married Resources: $4,000 if single, $6,000 if married	Medicare Part A premium (for people with Medicare who are under age 65, disabled, and no longer qualify for free Medicare Part A or Medicaid because they returned to work and their income exceeds the limit)

Medicare Drug Plan Costs if You Automatically Qualify for Extra Help

If you have Medicare and	Your monthly premium*	Your yearly deductible	Your cost per prescription at the pharmacy (until $6,350)	Your cost per prescription (after $6,350)
Full Medicaid coverage & for each full month you live in an institution, like a nursing home	$0	$0	$0	$0
Full Medicaid coverage & yearly income below 100% FPL	$0	$0	$1.30 for generic & certain preferred drugs; $3.90 for brand-name drugs	$0
Full Medicaid coverage & yearly income above 100 % FPL	$0	$0	no more than $3.60 for generic & certain preferred drugs; no more than $8.90 for brand-name drugs	$0
Medicare Savings Program – all levels	$0	$0		$0
Get Supplemental Security Income (SSI) but not Medicaid	$0	$0		$0

Medicare Drug Plan Costs if You Apply and Qualify for Extra Help

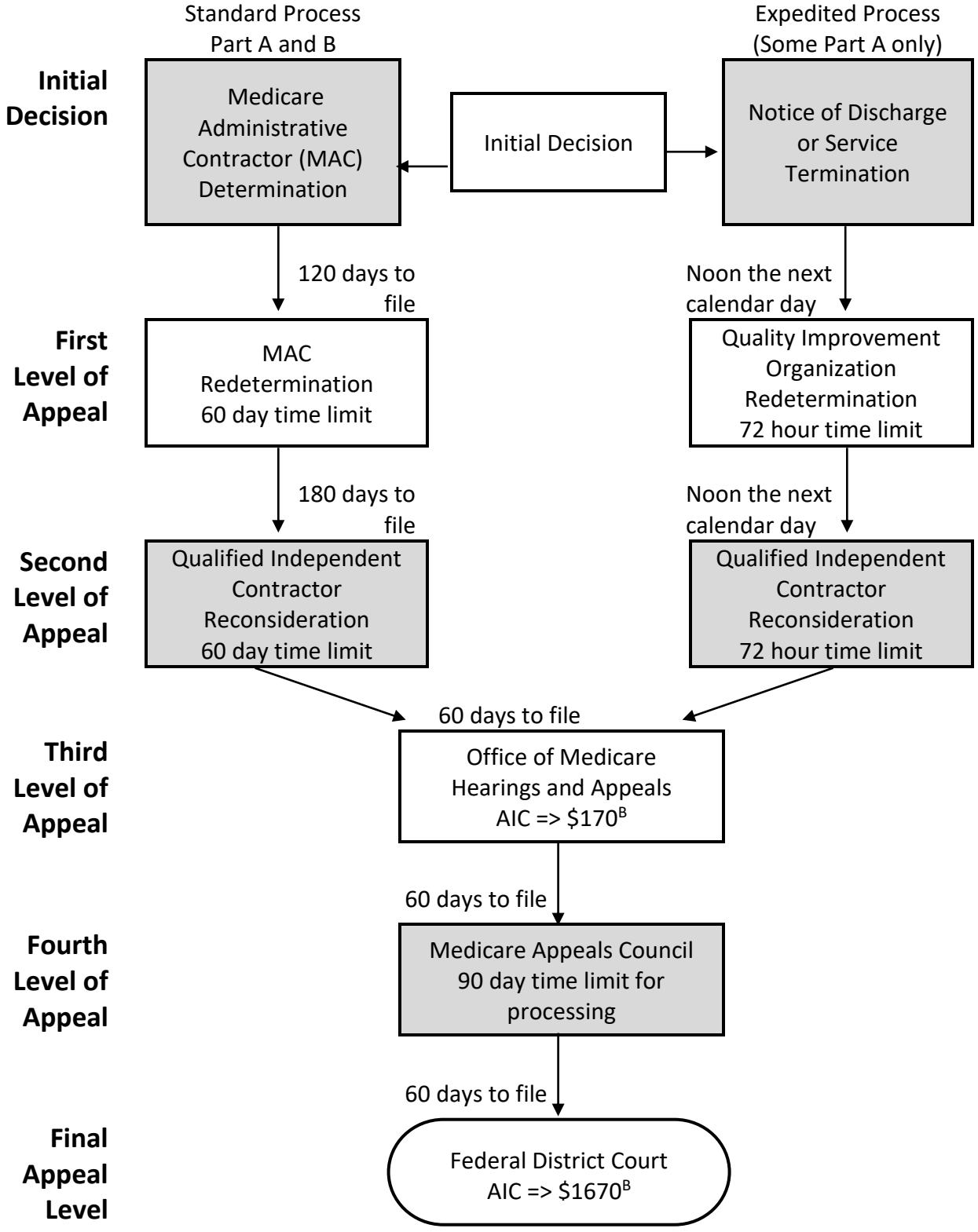
If you have Medicare and	Your monthly premium*	Your yearly deductible	Your cost per prescription at the pharmacy (until 6,350)	Your cost per prescription (after $6,350)
a yearly income at or below 135% FPL Lower resource level	$0	$0	$3.60 for generic & certain preferred drugs; $8.90 for brand-name drugs	$0
a yearly income below 135% FPL Higher resource level	$0	$89	up to 15% of the cost of each prescription	no more than $3.60 for generic & certain preferred drugs; no more than $8.90 for brand-name drugs
a yearly income between 135% and 140% FPL higher resource level	25%			
a yearly income between 140% and 145% FPL higher resource level	50%			
a yearly income between 145% and 150% FPL higher resource level	75%			

Notes:

*Income limit does not include $20 “unearned income disregard.” States may disregard other income as well.
**This includes additional earned income exclusions

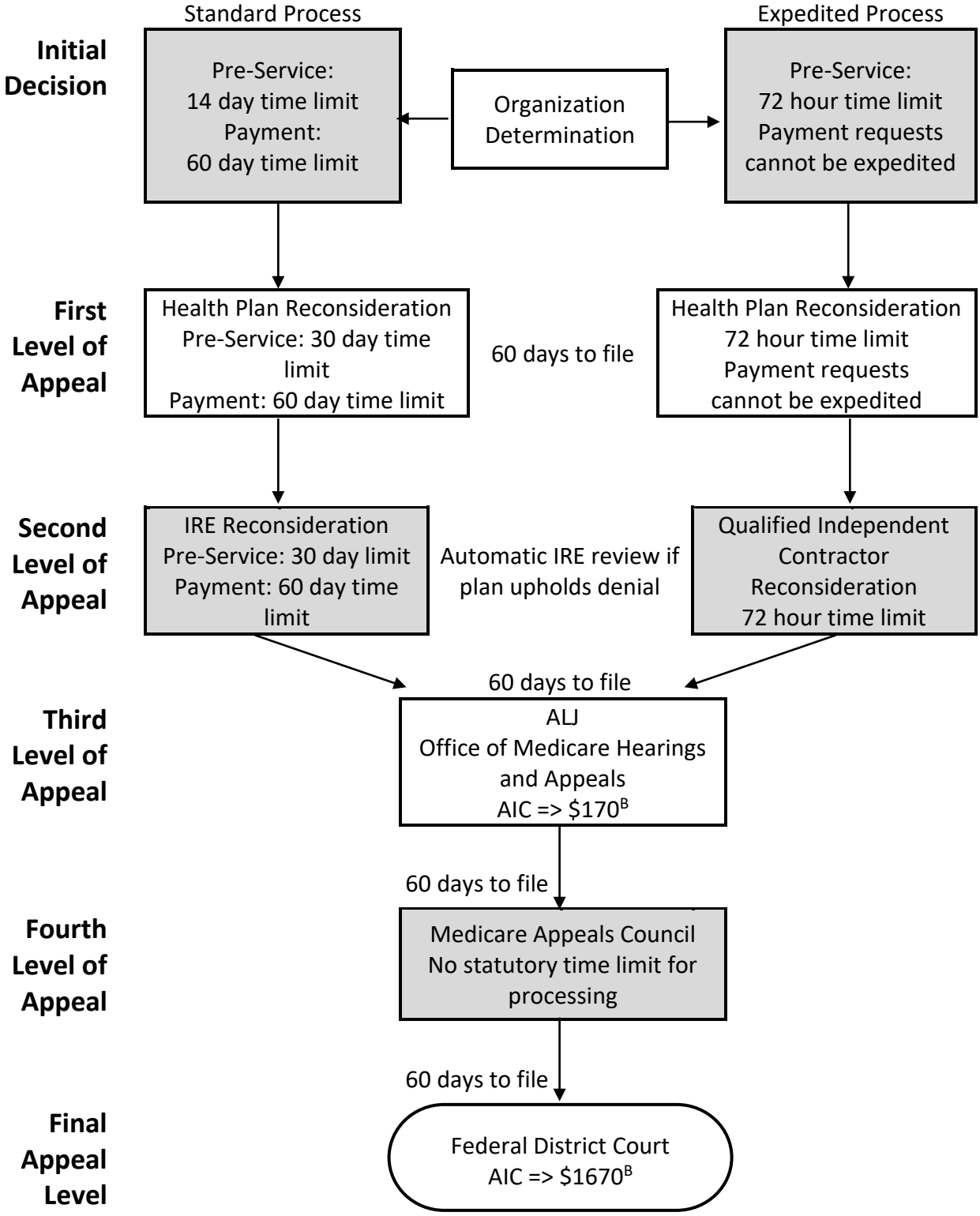
Note: There are plans with no monthly premium. There are other plans where the beneficiary will have to pay part of the premium even when qualifying for full extra help. The beneficiary should tell the plan that he/she qualifies for extra help and ask how much the monthly premium will be.

Parts A & B (Fee-for-Service) Appeals Flowchart



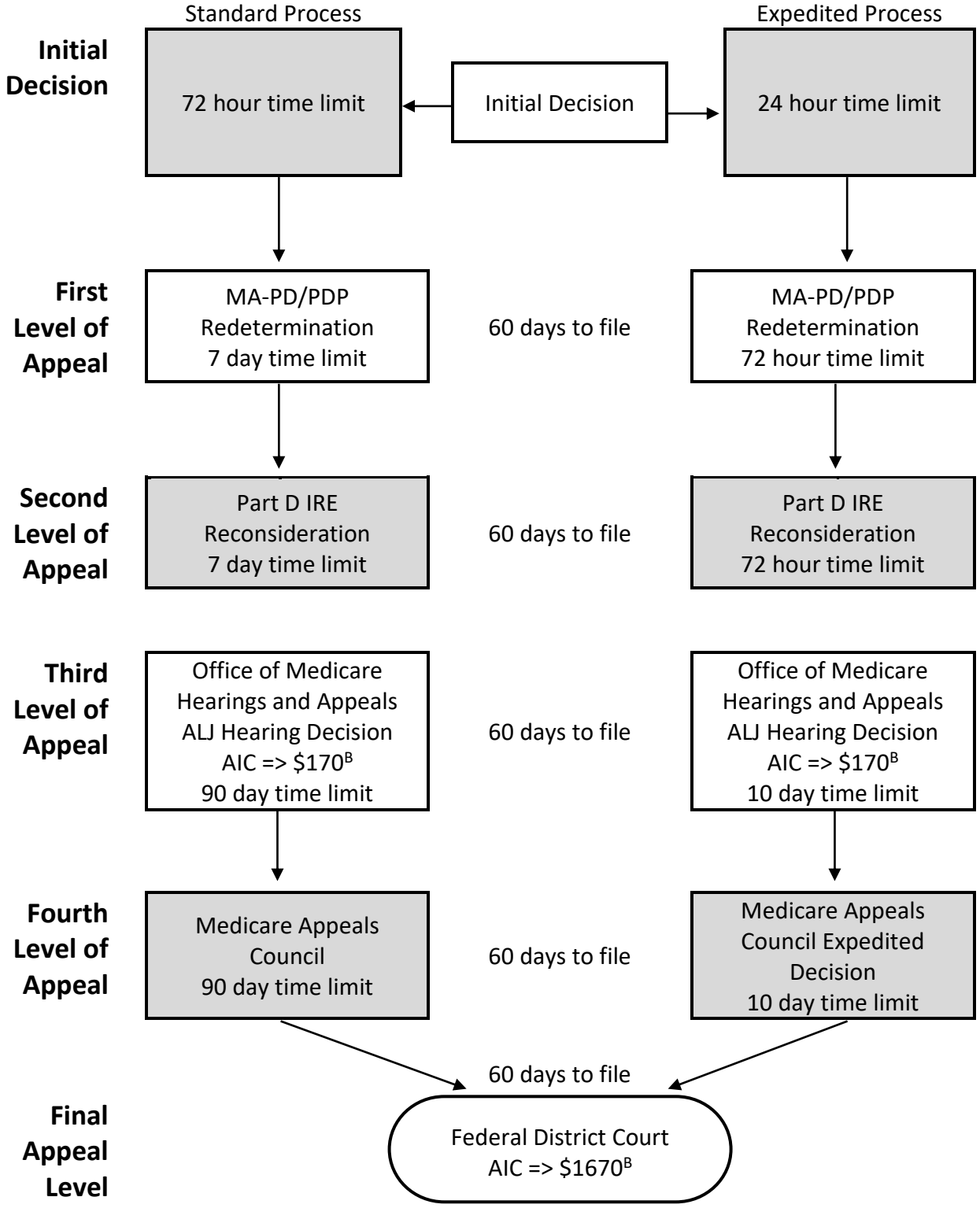
B = 2020 Amount

Part C (MA) Appeals Flowchart



B = 2020 Amount

Part D (Drug) Appeals Flowchart



B = 2020 Amount

Standard Medicare Supplement Policies at a Glance

	A	B	C	D	F*	G*	K	L	M	N
Part A Coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Blood	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A Hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess Charges					✓	✓				
Foreign Travel Emergency			✓	✓	✓	✓			✓	✓
							Out-of-Pocket Limit**			
							$5,880	$2,940		

Plans C & F are not available for individuals who are new to Medicare on or after 1/1/2020. People new to Medicare are those who turn 65 on or after January 1, 2020, and those who first become eligible for Medicare benefits due to age, disability or ESRD on or after January 1, 2020.

*Plans F and G also offers a high-deductible plan. If you choose this option, this means you must pay for Medicare-covered costs up to the deductible amount of $2,340 in 2020 before your Medicare supplement plan pays anything.

**After you meet your out-of-pocket yearly limit and your yearly Part B deductible ($198 in 2020), the Medicare supplement plan pays 100% of covered services for the rest of the calendar year. Out-Of-Pocket Annual Limit will increase each year for inflation. The Out-Of-Pocket Annual Limit DOES NOT include "excess charges." The beneficiary is responsible for these charges.

***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

Websites of Interest

SHICK Website – http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick

This website is the SHICK webpage on the Department on Aging website

SHICK Listserv Information Page – https://list.ink.org/mailman/listinfo/shick

Use this page to access subscription information for the SHICK listserv and the SHICK listserv Archives. A password is required to access the archives.

SHIP Tracking and Reporting System (STARS) – https://stars.acl.gov/

Use this database to enter Beneficiary Contacts and Group and Media Event contacts.

Kansas Department for Children and Families – http://www.dcf.ks.gov

Kansas Insurance Department – http://www.ksinsurance.org/

Kansas Department for Aging and Disability Services - http://www.kdads.ks.gov/

Beneficiary and Family Centered Care (BFCC)-QIOs – Livanta – https://www.livantaqio.com/en

BFCC-QIOs improve healthcare services and protect beneficiaries through expeditious statutory review functions, including complaints and quality of care reviews for people with Medicare.

Quality Innovation Network (QIN)-QIO – Great Plains Quality Innovation Network – http://greatplainsqin.org/

QIN-QIOs improve healthcare services through education, outreach, sharing practices that have worked in other areas, using data to measure improvement, working with patients and families and convening community partners for communication and collaboration.

Wisconsin Physicians Service Insurance Corporation (WPS) – http://www.wpsmedicare.com/

This organization is currently processing all Kansas Part A claims and all Kansas Part B claims except for Durable Medical Equipment.

Noridian Administrative Services – https://www.noridianmedicare.com/dme/

This organization is currently processing all Kansas Part B claims for Durable Medicare Equipment.

Palmetto GBA – https://www.palmettogba.com/rr

The Railroad Specialty Medicare Administrative Contractor (RRB SMAC) and processes Part B claims for Railroad Retirement beneficiaries nationwide

Medicare – http://www.medicare.gov

Centers for Medicare and Medicaid Services – http://www.cms.gov/

Social Security Administration – http://www.ssa.gov/

Official Medicare Website: Centers for Medicare & Medicaid Services – http://www.cms.gov/home/medicare.asp

Medicare Policy Manuals: CMS – http://www.cms.gov/manuals

BenefitsCheckUp and BenefitsCheckUp Rx – http://www.benefitscheckup.org

Center for Medicare Advocacy – http://www.medicareadvocacy.org

Center for Social Gerontology – http://www.tcsg.org

Kaiser Family Foundation Medicare Policy Project – http://www.kff.org/medicare

Medicare Rights Center – http://www.medicarerights.org

NOTE: Secure websites require the "https://" preface to enter the site. This preface is included for all secure websites on this page.

Understanding the Medicare Beneficiary Identifier (MBI) Format

How many characters will the MBI have?

The MBI has 11 characters, like the Health Insurance Claim Number (HICN), which can have up to 11.

Does the MBI's characters have any meaning?
Each MBI is randomly generated. This makes MBIs different than HICNs, which are based on the Social Security Numbers (SSNs) of people with Medicare. The MBI's characters are "non-intelligent" so they don't have any hidden or special meaning.

What kinds of characters are used in the MBI?
MBIs are numbers and upper-case letters. We'll use numbers 0-9 and all letters from A to Z, except for S, L, O, I, B, and Z. This will help the characters be easier to read.

How do the MBI look on the Medicare card?
The MBI will contain letters and numbers. Here's an example: 1EG4-TE5-MK73

- The MBI's 2nd, 5th, 8th, and 9th characters will always be a letter.
- Characters 1, 4, 7, 10, and 11 will always be a number.
- The 3rd and 6th characters will be a letter or a number.
- The dashes aren't used as part of the MBI. They won't be entered into computer systems or used in file formats.

MBI Format											
Pos.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Type	C	A	AN	N	A	AN	N	A	A	N	N

C – Numeric 1 thru 9 **N** – Numeric 0 thru 9
AN – Either A or N **A** – Alphabetic Character (A thru Z) excluding (S, L, O, I, B, Z)

Where will the MBI's characters go?
Position 1 – numeric values 1 thru 9
Position 2 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 3 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)
Position 4 – numeric values 0 thru 9
Position 5 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 6 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)
Position 7 – numeric values 0 thru 9
Position 8 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 9 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 10 – numeric values 0 thru 9
Position 11 – numeric values 0 thru 9

How will the MBI fit on forms?
MBIs will fit on forms the same way HICNs do. You don't need spaces or dashes.

Who will get a new MBI?
Each person with Medicare has their own randomly-generated MBI. Spouses or dependents who may have had similar HICNs will each have their own different MBI.

Common Acronyms for People with Medicare

A	
AAA	Area Agency on Aging
AAA	Abdominal Aortic Aneurysms
AARP	American Association of Retired Persons
A/B MAC	A/B Medicare Administrative Contractor
ABD	Aged, Blind & Disabled
ABN	Advanced Beneficiary Notice
ACA	Affordable Care Act
ACL	Administration for Community Living
ACO	Accountable Care Organization
ADC	Adult Day Care
ADL	Activities of Daily Living
ADRC	Aging and Disability Resource Center
AEP	Annual coordinated election period (10/15 – 12/7 each year)
AI/AN	American Indian/Alaska Native
AIC	Amount in controversy
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
ALS	Amyotrophic Lateral Sclerosis
ANOC	Plan Annual Notice of Change
AO	Accreditation Organization
AOA	Administration on Aging
APTC	Advanced Premium Tax Credits
ARRA	American Recovery and Reinvestment Act 2009
AVF	Arteriovenous Fistulas
B	
BAE	Best Available Evidence
BBA	Balanced Budget Act (of 1997)
BBRA	Balanced Budget Refinement Act (of 1999)
BC/BS	Blue Cross/Blue Shield
BCRC	Benefits Coordination & Recovery Center
BFCC	Beneficiary and Family Centered Care
BFCC-QIO	Beneficiary and Family-Centered Care Quality Improvement Organization
BHP	Basic Health Program
BMI	Body Mass Index
BP	Benefit Period
BPH	Benign Prostatic Hyperplasia
C	
CAH	Critical Access Hospital
CAL	Compassionate Allowance
CBO	Community-Based Organizations
CBO	Congressional Budget Office
CCN	Claim Control Number

CCRC	Continuing Care Retirement Community
CFC	Conditions for Coverage
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CHIP	Children's Health Insurance Program
CKD	Chronic Kidney Disease
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of benefit(s)
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act (of 1985)
CORF	Comprehensive Outpatient Rehab Facility
COVID-19	Coronavirus Disease 2019
CP	Claims Processing
CPAP	Continuous positive airway pressure
CPI	Center for Program Integrity
CSR	Customer Service Representative
CSR	Cost Sharing Reductions
CVD	Cardiovascular disease
CWF	Current Working File
CY	Calendar Year
D	
DCF	Kansas Department for Children and Families, formerly SRS
DE	Dual-Eligible
DENC	Detailed Explanation of Non-coverage
DES	Diethylstilbestrol
DFC	Dialysis Facility Compare
DHHS	Department of Health & Human Services
DI	Disability Insurance
DME	Durable medical equipment
DME-MAC	Durable Medical Equipment-Medicare Administrative Contractor
DMEPOS	Durable Medicare Equipment Prosthetics, Orthotics and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DOB	Date of Birth
DOD	Date of Death
DOE	Date of Entitlement
DoD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
DOS	Date of Service
E	
EGHP	Employer Group Health Plan
EOB	Explanation of Benefits
EOC	Evidence of Coverage
EOMB	Explanation of Medicare Benefits (replaced by MSN)
ERISA	Employee Retirement Income Security Act (of 1974)

ESRD	End-stage renal disease
F	
FAQ	Frequently Asked Questions
FBDE	Full Benefit Dual-Eligible
FDA	Food and Drug Administration
FEHBP	Federal Employee Health Benefits Program
FFS	fee-for-service
FI	Fiscal Intermediary
FICA	Federal Insurance Contributions Act
FMAP	Federal Medical Assistance Percentage
FPL	Federal poverty level
FPS	Fraud Prevention System
FR	Federal Register
FY	Fiscal year
G	
GAO	Government Accountability Office
GEP	General Enrollment Period (1/1 – 3/31 – each year)
GHP	Group Health Plan
H	
HBV	Hepatitis B Virus
HCBS	Home and Community Based Services
HCBWP	Home and Community Based Waiver Program
HCFA	Health Care Financing Administration (now CMS)
HCV	Hepatitis C Virus
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS (DHHS)	Department of Health and Human Services
HIC	Health insurance claim
HICN	Health insurance claim number (Medicare number)
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIV	Health Care Fraud Prevention and Enforcement Action Team
HMO	Health maintenance organization
HMO-POS	HMO Point-of-Service
HPV	Human Papillomavirus
HSA	Health Savings Accounts
I	
IADL	Instrumental Activities of Daily Living
ICFs/MR	Intermediate care facilities for the mentally retarded
IDE	Investigational Device Exemption
IEP	Initial enrollment period
IHS	Indian Health Service
IPPE	Initial Preventive Physical Examination
IRE	Independent review entity
IRMAA	Income-Related Monthly Adjustment Amount
IRS	Internal Revenue Service

I/T/U	Indian Tribes and Tribal organizations, and urban Indian organizations
IVR	Interactive Voice Response
K	
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
L	
LEP	Late Enrollment Penalty
LIS	Low-income subsidy
LMB	Low-income Medicare beneficiary (KS-same as SLMB at Fed level)
L-OEP	Limited Open Enrollment Period
LPI	Low Performance Icon
LRD	Lifetime Reserve Days
LTC	Long-term care
LTCF	Long-term care facility
LTR	Lifetime Reserve
LTSS	
M	
M&M	Medicare and Medicaid
MA	Medicare Advantage
MAGI	Modified Adjusted Gross Income
MA-PD	Medicare Advantage with prescription drug plan
MAC	Medicare Administrative Contractor
MAC	Medicare Appeals Council
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAO	Medicare Advantage organizations
MEDIC	Medicare Drug Integrity Contractor
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person
MI	Medical Insurance (Medicare Part B)
MICs	Medicaid Integrity Contractors
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement, and Modernization Act (of 2003)
MMG	Medicare Marketing Guidelines
MNT	Medical Nutrition Therapy
MOON	Medicare Outpatient Observation Notice
MRI	Magnetic Resonance Imaging
MSA	Medicare Medical Savings Accounts
MSN	Medicare Summary Notice
MSP	Medicare Savings Program
MSP	Medicare Secondary Payer
MSPRC	Medicare Secondary Payer Recovery Contractor
MTM	Medication Therapy Management
N	
NAIC	National Association of Insurance Commissioners
NBI	National Benefit Integrity

NCC	National Coordinating Center
NCD	National Coverage Decision
NET	Newly Eligible Transition
NF	Nursing Facility
NIA	National Institute on Aging
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NOMNC	Notice of Medicare Non-coverage
NPA	National PACE Association
NPI	National Provider Identifier
NTP	National Training Program
O	
O&E	Outreach and Education
OASIS	Outcome and Assessment Information Set
OBRA	Omnibus Budget Reconciliation Act
OCR	Office for Civil Rights
OEP	Open enrollment period
OEPI	Open enrollment period for institutionalized individuals
OIG	Office of the Inspector General
OOP	Out-of-Pocket
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OPT	Outpatient Physical Therapy
OT	Occupational Therapy
P	
PA	Prior Authorization
PACE	Program of All-Inclusive Care for the Elderly
PAP	Patient Assistance Program
PBA	Pharmacy benefit administrator
PBMs	Pharmacy benefit managers
PDP	Medicare stand-alone prescription drug plan
PFFS	Private fee-for-service plan
PHI	Protected health information
PhRMA	Pharmaceutical Manufacturers and Researchers of America
POC	Plan of Care
POS	Point-of-Sale
PPACA	Patient Protection and Affordable Care Act 2010
PPO	Preferred provider organization
PPS	Prospective Payment System
PRO	Peer Review Organization (renamed QIO)
PSA	Prostate-specific antigen
PSO	Provider-sponsored organization
PT	Physical Therapy
Q	

Q&A	Questions and Answers
QAPI	Quality Assessment & Performance Improvement
QDWI	Qualified disabled and working individual
QHP	Qualified Health Plans
QI	Qualified Individuals
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
QMB	Qualified Medicare beneficiaries
QWDI	Qualified Working Disabled Individual (aka QDWI)
R	
RAC	Recovery Audit Contractor
RDF	Renal Dialysis Facility
REACH	Regional Education About Choices in Health
RFI	Request for Information
RHC	Rural Health Center
RHHI	Regional Home Health Intermediary
RNHCI	Religious Non Medicare Health Care Institution
RO	Regional Office
RRB	Railroad Retirement Board
S	
SCE	Subsidy-Changing Event
SEP	Special Enrollment Period
SGS	SafeGuard Services, LLC
SHI	Supplemental Health Insurance
SHICK	Senior Health Insurance Counseling for Kansas
SHIP	State Health Insurance Assistance Programs (SHICK)
SHOP	Small Business Health Options Program
SLMB	Special Low-Income Medicare Beneficiaries (Federal, same as LMB in KS)
SME	Subject Matter Expert
SMI	Supplemental Medical Insurance (Medicare Part B)
SMP	Senior Medicare Patrol
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SOW	Scope of Work
SPAP	State Pharmaceutical Assistance Program (NOT available in KS)
SS	Social Security
SSA	Social Security Act
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
SSN	Social Security Number
STI	Sexually transmitted infections
T	
TBD	To Be Determined
TDD	Telecommunications Device for the Deaf

TEFT	Testing Experience and Functional Assessment Tools
TFL	TRICARE for Life
Title I	Grants to State for old age assistance & medical assistance for the aged
Title II	Federal old age, survivors & disability insurance benefits (OASDI)
Title IV	Grants to States for aid & services to needy families with children (TAF)
Title X	Grants to State for aid to the blind (AB)
Title XIV	Grants to States for aid to the permanently & totally disabled (DI)
Title XIX	Grants to States for medical assistance programs (Medicaid)
Title XVI	Grants to States for aid to the aged, blind & disabled (ABD) & Supplemental Security Income (SSI)
Title XVIII	Health Insurance (Medicare)
Title XX	State operated home health care entitlement program
Title XXI	State Child Health Programs
TrOOP	True Out-of-Pocket
TTY	Text Telephones
TWWIA	Ticket to Work & Work Incentives Act (of 1999)
U	
U&C	Usual & customary
V	
VA (DVA)	Department of Veterans Affairs
W	
WCMSA	Workers' Compensation Medicare Set-Aide Arrangement
WPS	Wisconsin Physician Services
X	
XIXED	Title 19 Entitlement Date
Y	
YOB	Year of Birth
YTD	Year to Date
YYYY	Year
Z	
ZPIC	Zone Program Integrity Contractor

Medicare Prescription Drug Coverage Worksheet

1. What is your name as it appears on your Medicare card? ①

   _____

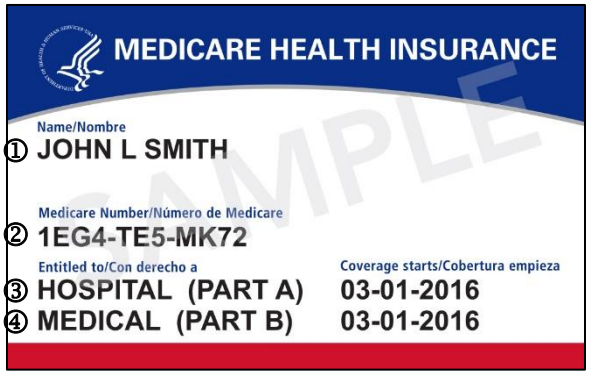
2. What is your Medicare Claim Number? ②

   _____

3. What is your date of birth?

   _____

   Month/Date/Year



4. What is the coverage start date for your Medicare?

   ③Part A _____ ④Part B _____

   Month/Date/Year *Month/Date/Year*

5. What is your Zip Code?_____ County? _____

   Address, City, State _____

   Phone # _____

*Questions 6 & 7 are optional. This information can help determine if you are eligible for Extra Help with Medicare Part D costs.

6. Check the **ONE** box that best describes your **INCOME**.*

Single, widowed, divorced or live apart from my spouse and:	Married and:
☐ My annual gross income is less than $19,140	☐ Our annual gross income is less than $25,860
☐ My annual gross income is greater than $19,140	☐ Our annual gross income is greater than $25,860

7. Check the **ONE** box that best describes your **LIQUID ASSETS**. Liquid assets are the total value of your savings, investments and real estate. Do not include your primary home, vehicles, burial plots or personal possessions.*

Single, widowed, divorced or live apart from my spouse and:	Married and:
☐ My assets are $14,800 or less	☐ Our assets are $29,160 or less
☐ My assets are greater than $14,800	☐ Our assets are greater than $29,160

8. List the pharmacy or pharmacies you use. (Required)

   _____

9. Which prescription drugs do you currently take? (Please also list the dosage, how often you take it per month and your monthly cost). **PLEASE PRINT CLEARLY. ATTACH AN EXTRA SHEET IF NEEDED.**

DRUG NAME	DOSAGE	30- DAY QUANTITY	MONTHLY COST

SHICK Disclaimer

SHICK Counselor Name:_____ Telephone: _____

I have reviewed a minimum of three Medicare Part D Prescription Drug Plans and have chosen the following plan: _____. I give the SHICK Counselor listed above my authorization to enroll me in the above plan using the information I have provided. I confirm that all information provided is truthful and accurate and I hereby release the SHICK Counselor, the SHICK organization and the State of Kansas from any liability whatsoever, known or unknown, related or pertaining my Medicare Part D enrollment herein. I also acknowledge that information discussed with the Counselor cannot be relied upon nor construed as legal advice. I understand that I may not change my drug plan until the next open enrollment period which will be October 15, 202( ) to December 7, 202( ).

I also understand the costs and covered medications quoted on the plan I've chosen may be subject to change.

Signature: _____Printed Name: _____

Date: _____

Chapter 15
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