



SHICK/SMP/MIPPA

Volunteer Initial BASIC Training

Presented By – Medicare Grants Regional Manager

AGENDA

9:00 **WELCOME** - Sign In, Agenda Review, Introductions
SHICK Basics, MIPPA Information, SMP Information
Privacy Practices and Confidentiality
Medicare - Part A, Part B,
Prescription Drug Coverage A & B
Medicare Prescription Drug Coverage – Part D

LUNCH! (1 hour please)

Medicare Advantage Plans Part C
Assistance programs
Medicare Supplements
Rights & Appeals
Coordination of Benefits
Medicare Training website – www.medicare.gov
STARS reporting website

Test

Closing – Resource Information, Next Steps, Questions?

Course Evaluation

5:00 **Thank you for your attention and time today!!**



SMP/SHICK/MIPPA Training Program Initial Training Course 4 Basic

Medicare Grants Regional Manager

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Welcome

- Introductions
- Agenda Review
- Required paperwork
- Please turn cell phones off, on silent, or vibrate only



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Training Record/Memorandum of Understanding

- Training Record – Maintaining contact information and required demographics for counselor
- Memorandum of Understanding – an agreement to abide by all program guidelines and regulations, signed annually.
- Confidentiality Agreement for Unique ID
- <https://kdads.ks.gov/shick-tr-mou-form>



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<https://kdads.ks.gov/shick-tr-mou-form>

State Health Insurance Assistance Program (SHIP)

- The State Health Insurance Assistance Program, or SHIP, is a national program that offers one-on-one counseling and assistance to people with Medicare and their families.
- They were created to provide personalized counseling and assistance to Medicare beneficiaries and their caregivers who need help navigating the increasingly complex health care system.
- SHIPs provide accurate, understandable, and objective information, counseling and assistance to Medicare beneficiaries on a wide range of health insurance issues including Medicare, Medicaid, long-term care, and prescription drugs

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Senior Health Insurance Counseling for Kansas – SHICK

- The SHIP in Kansas is called the Senior Health Insurance Counseling for Kansas program (SHICK)
 - part of the Kansas Department for Aging and Disability Services (KDADS).
- SHICK Mission Statement
 - SHICK educates the public and assists consumers on topics related to Medicare and health insurance so they can make informed decisions.
- SHICK’s mission is accomplished by
 - Information and Education
 - One-on-One Counseling

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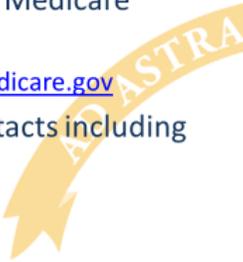
Medicare Improvements for Patients and Providers Act (MIPPA)

- MIPPA - Under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), states, territories, and the District of Columbia received funding to help Medicare beneficiaries apply for the Medicare Part D Extra Help/Low-Income Subsidy (LIS) and the Medicare Savings Programs (MSPs).
- MIPPA provides targeted funding for SHIPs, AAAs, and ADRCs to:
 - Conduct outreach and enrollment of low-income Medicare beneficiaries into Part D Low Income Subsidy (LIS/Extra Help) and the Medicare Savings Programs (MSPs).
 - Promote utilization of free preventive services offered under Medicare since the passage of the Affordable Care Act (ACA) in 2010.

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MIPPA Reminders

- More information: <http://www.ncoa.org/enhance-economic-security/center-for-benefits/mippa/>
- Make sure all beneficiaries seen by SHICK are screened for Extra Help and MSP.
- During a comprehensive counseling appointment be certain to hand out information about Medicare Preventive Services.
 - Talk to the beneficiary about www.mymedicare.gov
- Make sure you are recording your contacts including low-income Medicare beneficiaries



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The SMP mission is...

to empower and assist Medicare beneficiaries, their families, and caregivers

to protect, detect, and report health care fraud, errors, and abuse

through outreach, counseling, and education.



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Kansas Senior Medicare Patrol Contact Information

Visit us online:

<http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/kansas-senior-medicare-patrol>

For more information

Call Toll-free: 800-432-3535

- For training, speakers, and/or materials
- To volunteer with the SMP program
- Call OIG direct at 1-800-HHS-TIPS (1-800-447-8477)
 - To report suspected fraud/abuse



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Protecting Client Privacy and Confidentiality



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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.



Privacy Practices and Conflict of Interest

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What is "confidentiality?"

- "To confide" means to trust in someone
 - Especially when sharing secrets or private matters
- "Confidence" means firm belief, trust, reliance
 - Belief that another person will keep a secret, or "maintain strict confidence"
- "Confidential" means entrusted with private or secret matters
- It's about building and maintaining trust!



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Why is Confidentiality Important in SHIP and SMP Work?

It frees clients to share personal information that counselors need to do their work.

It shows respect for, and helps protect clients.

It builds the program's reputation as a trusted, reliable resource.

It helps prevent costly privacy and security breaches (e.g., legal fees and fines).

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What Rules Affect Confidentiality in SHIP & SMP Work?

Federal law

HIPAA (Health Insurance Portability and Accountability Act of 1996)

Privacy Rule: privacy rights and access to records

Security Rule: data protection duties and penalties

State law

Constitutional privacy rights in some states

Privacy (data breach) acts

Agency policies

Volunteer Risk & Program Management (VRPM) Policies

CMS Unique ID for SHIPs and SMPs

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HIPAA's Two Parts

The HIPAA Privacy Rule

- Defines "protected health information," or P.H.I.
- Establishes permitted uses & disclosures of P.H.I.
- Regulates authorized uses of P.H.I.
- Limits uses and disclosures to minimum necessary

The HIPAA Security Rule

- Addresses safeguards for "electronic protected health information," or e-P.H.I.
- Requires covered entities to:
 - Ensure confidentiality and integrity of all e-P.H.I.
 - Identify and protect against anticipated security threats
 - Protect against anticipated impermissible uses or disclosures
 - Ensure compliance by their workforce through training and oversight.

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Who does HIPAA Apply To?

“Covered Entities” and their business associates must comply with HIPAA’s Privacy and Security Rules

- Health plans
 - Includes Medicare, Medicare health plans, Medicaid, Medicare supplement insurers (Medigap), group health plans
- Health care providers
 - Hospitals, nursing facilities, physicians, etc.
- Health care clearinghouses
 - Billing services, health management information systems
- Business associates
 - A person or organization that contracts with a covered entity to perform some of its functions

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Does HIPAA Apply to SHIP & SMP?

The programs are not “covered entities” but...

Local cosponsors may be covered entities if they provide health care services or contact with those who do.

Most third parties with whom SHIPs & SMPs interact are covered entities (i.e., Medicare, Medicare Advantage plans, hospitals, doctor offices, 1-800-MEDICARE, etc.)

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What is the HIPAA Privacy Rule?

It’s a federal law that protects all “individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

This information is called “protected health information,” or P.H.I.

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Individually Identifiable Health Information

“Individually identifiable health information” is information, including demographic data, that relates to:

- an individual’s past, present or future physical or mental health or condition,
- providing health care to the individual, or the past, present, or future payment for providing health care to an individual, and,
- identifies the individual or gives a reasonable basis to use in identifying an individual.

Individually identifiable health information includes common identifiers like, name, address, birth date, Social Security Number.

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HIPAA Privacy Rule Protections

Purpose

The Privacy Rule defines and limits the circumstances when covered entities may use or disclose an individual’s P.H.I.

Basic Principle

Covered entities may not use or disclose P.H.I. except as:
**the Privacy Rule requires or permits, or
the individual/patient (or personal representative) authorizes in writing**

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Privacy Rule Protections

An individual has rights under the Privacy Rule to:

- Receive notice about a provider’s privacy practices
- Review and obtain a copy of their P.H.I. in a covered entity’s designated record set
- Have covered entities amend their protected health information in a designated record set when that information is inaccurate or incomplete
- An accounting of P.H.I. disclosed by a covered entity
- Request a covered entity to restrict P.H.I. disclosure
- Request alternate means or location for receiving communications of P.H.I., other than those typically used

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What is the HIPAA Security Rule?

It covers P.H.I. that is created, received, maintained or transmitted in an electronic form. This includes P.H.I.:

- Transmitted over the Internet (e.g., email)
- Stored on a computer, a CD, a disk, magnetic tape, or other related means.
- Stored on personal devices (e.g., cell phones and tablets)

The Security Rule does not cover P.H.I. that is transmitted or stored on paper or provided orally.

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Security Rule Safeguards

Covered entities must protect against reasonably anticipated threats to, and impermissible uses and disclosures of, P.H.I. by



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HIPAA: SHIP & SMP Operations

Covered entities, including health care providers, can't disclose an individual's P.H.I. without written consent or the individual's presence and oral consent

- Use consent forms to document authorization
- Make 3-way calls with provider and client on the line

Customer service representatives at 1-800-MEDICARE can't discuss a client's P.H.I. with third parties

- Must use the SHIP Unique ID to conduct SHIP work
- Privacy training required

Electronic transmissions containing P.H.I. must be secure

- Use email encryption

HIPAA Security Rule is model for Volunteer Risk & Program Management Information Technology (IT) policies

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What is Personal Protected Information (P.P.I.)?

“A beneficiary’s first name and last name or first initial and last name in combination with at least one of the following:

- Social Security number
- Driver’s license number or state-issued identification card number
- Financial account number or credit or debit card number, with or without any required security code, access code, personal identification number or password, that would permit access to a resident’s financial account

Protected personal information does not, however, include information that is lawfully obtained from publicly available information or from federal, state, or local government records lawfully made available to the general public.”

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P.P.I. = P.I.I. and P.H.I.

Personally Identifiable Information (P.I.I.)

Information which can be trace an individual’s identity, such as their name, social security number, biometric records, etc. alone or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as a data and place of birth, mother’s maiden name, etc.”¹

Protected Health Information (P.H.I.)

Individually identifiable health information that is explicitly linked to a particular individual, and health information which can allow individual identification.²
P.H.I. includes many common identifiers (e.g., name, address, birth date, Social Security Number) when they can be associated with the health information listed above.

1. See www.whitehouse.gov/sites/whitehouse.gov/files/omb/memoranda/2007/m07-16.pdf Safeguarding Against and Responding to the Breach of Personally Identifiable Information to more details.
2. Health Insurance Portability and Accountability Act of 1996. See website for more details at: <https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html#protected>

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What is a security breach?

Security breaches occur when unauthorized persons gain access to P.P.I./P.H.I. by:

- Stealing computers and/or computing files
- Overhearing conversations about clients
- Dumpster diving for medical and payment records
- Reading documents left on unattended desks or copy machines
- Extracting data from the hard drives of discarded copy machines
- Any other means

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VRPM Confidentiality Policy

What is the policy for protecting client confidentiality?

Policy 3.81: SHIP & SMP volunteers are responsible for maintaining the confidentiality of all proprietary or privileged information to which they are exposed while serving as a volunteer, whether this information involves a member of staff, a volunteer, a beneficiary or other person, or involves the overall business of the SHIP.

<https://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick/shick-coordinator-counselor-information/ship-volunteer-risk-and-program-management-policies>

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VRPM Confidentiality Policy, cont.

How does Policy 3.81 affect SHIP & SMP operations?

- Volunteers are to be trained on confidentiality before they get a CMS Unique ID
- Volunteers are to sign a written confidentiality agreement
- The agreement informs volunteers that a confidentiality breach is grounds for immediate dismissal
- Participation in SHIP & SMP is conditioned on full compliance with the agreement.

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Confidentiality Best Practices

Volunteers take steps needed to safeguard beneficiary related information and prevent unauthorized persons from accessing P.P.I./P.H.I.

Use private spaces in meetings with clients to ensure confidentiality

Use computer screen covers to block P.P.I./P.H.I. from unauthorized viewers

Store documents containing P.H.I. in locked offices or filing cabinets

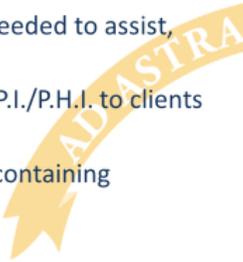
Shred written notes when no longer needed

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Confidentiality Best Practices, cont.

Volunteers use information obtained in the course of their work only to assist the client or otherwise meet their responsibilities. They do not disclose confidential information to others unless authorized.

- Discuss cases with other SHIP & SMP staff in private
- Limit information sharing to minimum needed to assist, train, or report
- Return original documents containing P.P.I./P.H.I. to clients and make copies only when necessary
- Follow protocols to destroy documents containing P.P.I./P.H.I.

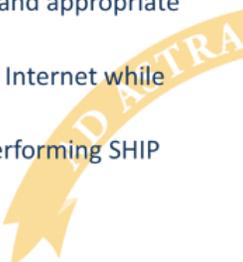


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VRPM IT Policies

Volunteers are to comply with Information Technology (IT) procedures or protocols for:

- Controlling access to and use of beneficiary information
- Safe operation of computers used to collect and store program and beneficiary information
- Using the Internet, including e-mail use and appropriate access to web sites.
- Using wireless devices to connect to the Internet while performing SHIP or work
- Using their personal computers while performing SHIP or SMP work.



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VRPM IT Policy Best Practices

Do's

- Store PPI in password-protected file on password-protected computer that only authorized users can access
- Encrypt or password-protect PPI before sending in email
- Report lost or stolen client information to supervisor
- Lock computer when you step away
- Clear web browser history
- Use strong passwords
- Lock up portable devices, laptops and cellphones

Don'ts

- Do not send work-related information to your personal email account
- Do not forward emails containing PPI unless properly encrypted
- Do not upload PPI to unauthorized websites
- Do not use unauthorized mobile devices to access PPI



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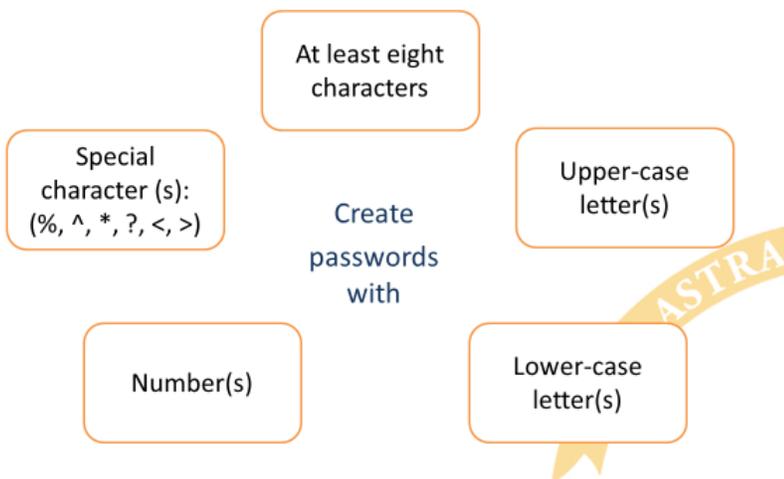
Best Practice: Strong Passwords

Strong passwords include a random combination of 8 or more numbers, symbols, capital and lower-case letters. Using different character types makes it harder for intruders to crack the password.

Pass phrase: Use an easily remembered phrase and substitute letters and numbers for words. Here's an example of a pass phrase: "I Like To Sing and Take Long Walks" = 1L2\$&Tlw.

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Password Do's



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Password Don'ts

- Create easy-to-remember passwords.
- Use obvious passwords related to common information such as child's or pet's name, or your favorite sports team.
- Use passwords that someone can guess, using your social media information.
- Write down your password in a place that is accessible to others.
- Share your passwords.

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Best Practice: Wi-Fi Networks

Wi-Fi Networks

Malicious actors could be lurking in the free Wi-Fi networks that you might use at your local coffee shop or while traveling.

Tips on the secure use of Wi-Fi

Use secured Wi-Fi networks such as your home Wi-Fi or Hotspot devices (mobile phone/tablet). Do not access or transmit P.P.I. when using an unsecured Wi-Fi connection.

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Conflict of Interest

- Attestation of SHIP Minimum Requirements:
 - Assuring that SHIP staff members (including volunteers) have no conflict of interest in providing health insurance information, counseling and assistance, and abiding by the Security Plan for safeguarding confidential beneficiary information.

Privacy Practices and Conflict of Interest

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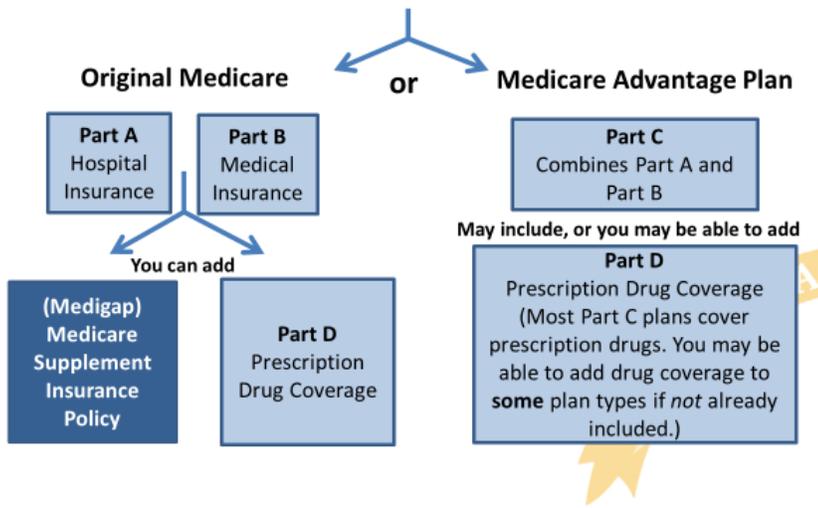
Conflict of Interest - Counselors

- 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.
- 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.

Privacy Practices and Conflict of Interest

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Medicare Coverage Choices



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Enrolling in Medicare

Automatic enrollment

- for those receiving
 - Social Security benefits
 - Railroad Retirement Board benefits
- Initial Enrollment Period Package
 - Mailed 3 months before
 - Includes your Medicare card

Not automatically enrolled

- You need to enroll with Social Security
- Visit socialsecurity.gov
- If retired from the Railroad, enroll with the Railroad Retirement Board (RRB)
- Call your local RRB office or 1-877-772-5772



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Original Medicare Enrollment Periods

- Medicare Initial Enrollment Period (IEP) –
 - Seven month period based around the initial eligibility month.
- Medicare General Enrollment Period (GEP) –
 - Annual three month period from January 1 through March 31
- Medicare Special Enrollment Period (SEP)
 - Eight month SEP to sign up for Part A and/or Part B that starts at one of these times (whichever happens first):
 - The month after the employment ends
 - The month after group health plan insurance based on current employment ends



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Medicare Card

- Keep it and accept Medicare Part A and Part B
- Return it to refuse Part B
 - Follow instructions on back of card



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Original Medicare – Part A

Part A–Hospital Insurance helps cover medically necessary

- Inpatient hospital care
- Inpatient skilled nursing facility (SNF) care
- Blood (inpatient)
- Certain inpatient non-religious, nonmedical health care in approved religious nonmedical institutions (RNHCIs)
- Home health care
- Hospice care

What's not covered?

- Private-duty nursing
- Private room (unless medically necessary)
- Television and phone in your room (if there's a separate charge for these items)
- Personal care items, like razors or slipper socks

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Medicare Part A Premium

- Most people get Part A premium free
 - If you or your spouse paid FICA taxes at least 10 years (40 credits)
 - FICA - Federal Insurance Contributions Act
 - Medicare Part A is financed by FICA taxes
- Premium Part A - If you paid FICA less than 10 years
 - pay a premium to get Part A
 - Under 30 credits - \$458
 - Between 30 and 39 credits - \$252
- Can have penalty if not bought when first eligible
 - Penalty for Medicare Part A is rare
 - 10% increase payable for twice the number of full 12 month periods the beneficiary could have been but was not enrolled in Medicare Part A.

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Part A—What You Pay in 2020

- Deductible—\$1,408 for inpatient hospital stays (days 1-60)
 - For inpatient hospital stays longer than 60 days
 - \$352 per day for days 61-90
 - \$704 per each day beyond 90
 - “lifetime reserve days” (up to 60 in your lifetime)
 - All costs after 150 days
- Out-of-pocket maximum—None in Original Medicare
- Skilled Nursing Facility Care
 - Days 1 – 20 - \$0
 - Days 21 – 100 - \$176 daily copay
 - After Day 100 – all costs

NOTE: Part B pays for most of your doctor services when you are an inpatient.

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Benefit Periods in Original Medicare

- Measures use of inpatient hospital and skilled nursing facility (SNF) services
 - Begins the day you first get inpatient care in hospital or SNF
 - Ends when not in hospital/SNF 60 days in a row
- Pay Part A deductible for each benefit period
- No limit to number of benefit periods you can have

Ends 60 days in a row here... ✓



Home

Not here... ✗



Hospital or SNF

Benefit periods can span across calendar years.

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Are You an Inpatient or an Outpatient?

- Your hospital status affects how much you pay out-of-pocket, what is covered by Part A and/or Part B, and whether Medicare will cover subsequent skilled nursing facility (SNF) care.
- Medicare Outpatient Observation Notice (MOON) – provided when in observation status longer than 24 hours, but before 36th hour

Inpatient – When you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.

Outpatient – When the doctor hasn't written an order to admit you, even if you spend the night.

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Part B Late Enrollment Penalty

- See how your insurance works with Medicare
 - Contact your employer/union benefits administrator
- Penalty for not signing up when first eligible
 - 10% more for each full 12-month period
 - May have a penalty as long as you have Part B
- Sign up during a Special Enrollment Period
- Usually no penalty if you sign up within 8 months of employer coverage ending

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Part B Special Enrollment Period Employer or Union Coverage

- May affect your Part B enrollment rights
 - You may want to delay enrolling in Part B if
 - You have employer or union coverage and
 - The employer has 20 or more employees if you are over 65, or 100 or more employees if you are disabled
 - You or your spouse, or family member if you are disabled, are still working
- See how your insurance works with Medicare
 - Contact your employer/union benefits administrator
 - Don't make assumptions

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When Employer or Union Coverage Ends

- When your employment ends
 - You may get a chance to elect COBRA
 - COBRA – not insurance based on active employment
 - You may get a Special Enrollment Period
 - Sign up for Part B without a penalty
- You MUST have an Enrollment Period to enroll in Medicare
 - Initial Enrollment Period
 - General Enrollment Period
 - Special Enrollment Period

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When You Must Have Part B

- If you want to buy a Medigap policy
- If you want to join a Medicare Advantage Plan
- You're eligible for TRICARE for Life (TFL) or CHAMPVA
- Your employer coverage requires you have it when you become eligible for Medicare (less than 20 employees)
 - Talk to your employer's or union benefits administrator
- Veterans Affairs (VA) benefits are separate from Medicare
 - You pay a penalty if you sign up late or if you don't sign up during your Medicare Initial Enrollment Period

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Medicare Advantage Plans

- Health plan options
 - Approved by Medicare
 - Run by private companies
- Part of the Medicare program
- Sometimes called Part C
- Available across the country
- Provide Medicare-covered benefits
 - May cover extra benefits
- Beginning in 2021, beneficiaries with ESRD can join a Medicare Advantage plan

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How Medicare Advantage Plans Work

- Receive services through the plan
 - All Part A and Part B covered services
 - Some plans may provide additional benefits
- Most plans include prescription drug coverage
- You may have to use network doctors/hospitals
- May differ from Original Medicare
 - Benefits
 - Cost-sharing
- You still pay the Part B premium

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Types of Medicare Advantage Plans

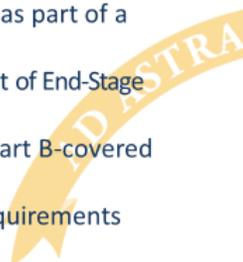
- Health Maintenance Organization (HMO)
- HMO Point-of-Service (HMO-POS)
- Preferred Provider Organization (PPO)
- Private Fee-for-Service (PFFS)
- Special Needs Plan (SNP)
- Programs of All-Inclusive Care for the Elderly (PACE) Plans
- Medicare Medical Savings Account



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Part A & Part B Prescription Drug Coverage

- Part A generally pays for all drugs during a covered inpatient stay received as part of treatment in a hospital or skilled nursing facility
 - Drugs used in hospice care for symptom control and pain relief only
- Part B covers limited outpatient drugs
 - Most injectable and infusible drugs given as part of a doctor’s service
 - Drugs and biologicals used for the treatment of End-Stage Renal Disease (ESRD)
 - Drugs used at home with some types of Part B-covered durable medical equipment (DME)
 - Some oral drugs with special coverage requirements



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Immunization Coverage

- Part B covers certain immunizations as part of Medicare-covered preventive services
 - Flu shot
 - Pneumococcal shot (to prevent pneumonia)
 - Hepatitis B shot
- Part D covers the shingles vaccine and all other vaccines unless it is needed after exposure to a disease or after an injury such as a Tetanus shot



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Self-Administered Drugs in Hospital Outpatient Settings

- Part B doesn't cover self-administered drugs in a hospital outpatient setting
 - Unless needed for hospital services
- If enrolled in Part D, drugs may be covered
 - If not admitted to hospital
 - May have to pay and submit for reimbursement



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Medicare Prescription Drug Plans

- Can be flexible in benefit design
- Must offer at least a standard level of coverage
- Vary in costs and drugs covered
 - Different tier and/or copayment levels
 - Deductible
 - Coverage for drugs not typically covered by Part D
- Benefits and costs may change each year



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What Is Part D (Medicare Prescription Drug Coverage)?

- Medicare drug plans
 - Approved by Medicare
 - Run by private companies
 - Available to everyone with Medicare
- You must join a plan to get coverage
- There are 2 ways to get coverage
 1. Medicare Prescription Drug Plans
 2. Medicare Health Plans with prescription drug coverage



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Part D Eligibility Requirements

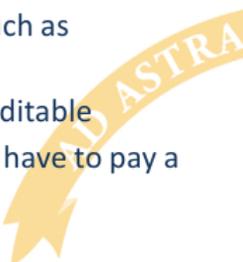
- You must have Medicare Part A and/or Part B to join a Medicare Prescription Drug Plan
- You must have Medicare Part A and Part B to join a Medicare Advantage Plan with drug coverage
- You must live in the plan’s service area
 - You can’t be incarcerated
 - You can’t be unlawfully present in the United States
 - You can’t live outside the United States
- You must join a plan to get drug coverage



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Creditable Drug Coverage

- Current or past prescription drug coverage
 - For example, employer group health plans, retiree plans, Veterans Affairs, TRICARE, the Indian Health Service, and the Federal Employee Health Benefits Program
- Creditable if it pays, on average, as much as Medicare’s standard drug coverage
- Plans inform yearly about whether creditable
- With creditable coverage you may not have to pay a late enrollment penalty



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When You Can Join or Switch Plans

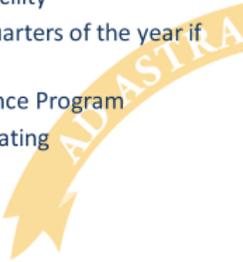
- During your Initial Enrollment Period when you first become eligible for Medicare or when you turn 65.
- During certain enrollment periods that happen each year.
 - Open Enrollment Period (OEP) October 15 – December 7 annually
 - Medicare Advantage Open Enrollment Period January 1 – March 31 annually
- Under certain circumstances that qualify you for a Special Enrollment Period (SEP)



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Special Enrollment Period (SEP)

- Life events that allow an SEP include
 - You permanently move out of your plan’s service area
 - You lose other creditable prescription coverage
 - You weren’t properly told that your other coverage wasn’t creditable, or your other coverage was reduced and is no longer creditable
 - You enter, live at, or leave a long-term care facility
 - You have a quarterly SEP for the first three quarters of the year if you qualify for Extra Help
 - You belong to a State Pharmaceutical Assistance Program
 - You join or switch to a plan that has a 5-star rating
 - Other exceptional circumstances



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Part D Late Enrollment Penalty

- Higher premium if you wait to enroll
 - Exceptions if you have
 - Creditable coverage
 - Extra Help
- Pay penalty for as long as you have coverage
 - 1% of base beneficiary premium (\$32.74 in 2020)
 - For each full month eligible and not enrolled
 - Amount changes every year



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Part D—Covered Drugs

- Prescription brand-name and generic drugs
 - Approved by the U.S. Food and Drug Administration
 - Used and sold in United States
 - Used for medically accepted indications
- Includes drugs, biological products, and insulin
 - And supplies associated with injection of insulin
- Plans must cover a range of drugs in each category
- Coverage and rules vary by plan



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Required Coverage

- All drugs in 6 protected categories
 1. Cancer medications
 2. HIV/AIDS treatments
 3. Antidepressants
 4. Antipsychotic medications
 5. Anticonvulsive treatments
 6. Immunosuppressants
- All commercially available vaccines
 - Except those covered under Part B (e.g., flu shot)



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Drugs Excluded by Law Under Part D

- Drugs for anorexia, weight loss, or weight gain
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products
- Non-prescription drugs



86

Formulary

- A list of prescription drugs covered by the plan
- Formulary will be different for each plan
- May have tiers that cost different amounts



87

Formulary Changes

- beginning of each plan year
 - May make maintenance changes during year
- Plans usually notify you 30 days before changes or when you request a refill and will provide you a month's refill
 - You may be able to continue to have your drug covered until the end of the calendar year
 - May ask for exception if other drugs don't work
- Plans may immediately (without notice and at any time)
 - Remove brand-name drugs and replace them with new generic drugs if they meet certain requirements
 - Remove drugs deemed unsafe by the FDA or withdrawn from the market by the manufacturer

88

NEW Formulary Changes

Plans can immediately remove or change the price for a brand-name drug if

- It adds a therapeutically equivalent generic drug to formulary on the same or lower cost tier and with the same or less restrictive criteria
- The generic drug became available on the market after the plan submitted its initial formulary
- It notifies all plan members and prospective enrollees of change
- It provides advance notice to CMS and other specified entities before making the substitution
- It directly notifies the affected enrollees

89

How Plans Manage Access to Drugs

Prior Authorization	<ul style="list-style-type: none">▪ Doctor must contact plan for prior approval and show medical necessity for drug before drug will be covered
Step Therapy	<ul style="list-style-type: none">▪ Must first try similar, less expensive drug▪ Doctor may request an exception if<ul style="list-style-type: none">• Similar, less expensive drug didn't work, or• Step therapy drug is medically necessary
Quantity Limits	<ul style="list-style-type: none">▪ Plan may limit drug quantities over a period of time for safety and/or cost▪ Doctor may request an exception if additional amount is medically necessary

90

Exception Requests

- Two types of exceptions
 1. Formulary exceptions
 - Drug not on plan's formulary, or
 - Access requirements (for example, step therapy)
 2. Tier exceptions
 - For example, getting a tier 4 drug at tier 3 cost
- Exception may be valid for rest of year



91

Annual Notice of Change (ANOC)

- All Medicare drug plans must send an ANOC to members by September 30
 - May be sent with Evidence of Coverage (EOC)
- Will include information for upcoming year
 - Summary of Benefits
 - Formulary
 - Changes to monthly premium and/or cost sharing
- Read ANOC carefully and compare your plan with other plan options



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NEW Changes to the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)

- Plans may send ANOC and EOC separately
- ANOC still due to enrollees by October 1
- EOC now due to enrollees by October 15
- Plans may now distribute EOC (and some other required documents, like directories) electronically
 - May post on a website but must send hard copy notice that documents are available



93

Compare Plans on Medicare Plan Finder

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on star ratings, benefits, costs, and more
- Visit <https://www.medicare.gov/plan-compare>



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What Is Extra Help?

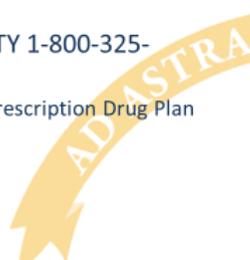
- Program administered through the SSA to help people pay for Medicare prescription drug costs (Part D)
 - Also called the low-income subsidy
- Assistance for cost of Medicare Part D, Prescription Drug Insurance for Medicare Beneficiaries including those over the age of 65 and those eligible for Medicare who receive SSA disability.
- There are two levels of income eligibility
- No coverage gap or late enrollment penalty if you qualify for Extra Help



95

Qualifying for Extra Help

- You automatically qualify for Extra Help if you get
 - Full Medicaid coverage
 - Supplemental Security Income (SSI)
 - Help from Medicaid paying your Medicare premiums (Medicare Savings Program)
- All others must apply
 - Online at [socialsecurity.gov](https://www.socialsecurity.gov)
 - Call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)
 - Ask for “Application for Help with Medicare Prescription Drug Plan Costs” (SSA-1020)
 - Contact a SHICK counselor



96

Medicare Savings Programs

- Three different Levels:
 - Qualified Medicare Beneficiary (QMB)
 - Part B Premium
 - Medicare deductibles, co-pays, and co-insurance
 - Low-Income Medicare Beneficiary (LMB or SLMB)
 - Part B Premium only
 - Expanded Low-Income Medicare Beneficiary (ELMB or QI-1)
 - Part B Premium only
- Income determines which level one will be at, the lower the income the more benefits covered.

100

Medicare Savings Programs in 2020

- Monthly Income Limits
 - QMB - \$1063/individual; \$1437/married couple
 - LMB - \$1276/individual; \$1724/married couple
 - ELMB - \$1436/individual; \$1940/married couple
- Resource limits - \$9,360/individual; \$14,800/couple
 - Resources include, bank accounts, stocks, bonds and life insurance.
 - Not counted: your home, personal belongings, vehicle, and burial plans

101

What Is Medicaid?

- Federal-state health insurance program
 - For people with limited income/resources
 - Covers most health care costs
 - If you have both Medicare and Medicaid
- Eligibility determined by state
- Application processes and benefits vary
- In Kansas, Medicaid is called KanCare, <http://www.kancare.ks.gov/>
 - Administered by the Kansas Department of Health & Environment (KDHE)
 - Application is through the KanCare Clearinghouse
- Children's Health Insurance Program (CHIP)
 - Covers uninsured children up to age 19 and may cover pregnant women when
 - Family income too high for Medicaid
 - In Kansas, this is also a part of KanCare

102

Delayed Medigap Open Enrollment Period

- If you delay enrolling in Medicare Part B
 - Because you or your spouse is still working, and
 - You have group health coverage
- Medigap OEP is delayed
 - Until you are enrolled in Part B
 - No late enrollment penalty
- Notify Social Security to delay Medicare Part B

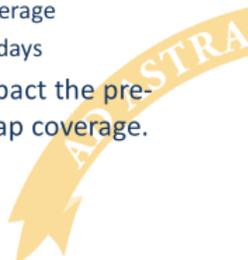


115

Pre-Existing Conditions and Medigap

- Health problem you had before the new insurance policy starts
 - Treated or diagnosed six months before coverage start date
- Pre-Existing Condition Waiting Period
 - Insurance companies can refuse to cover out-of-pocket costs for excluded condition for up to six months (“look back period”)
 - Without 6 months of prior creditable coverage
 - With no break in coverage more than 63 days

NOTE: The Affordable Care Act does not impact the pre-existing condition waiting period for Medigap coverage.



116

Medigap for People with a Disability or ESRD

- People with a disability or ESRD may not be able to buy a policy until they turn 65 in some states
- Kansas requires Medigap insurers to sell policies to people with a disability or ESRD
- Have same six-month OEP when Part B is effective
- An additional Medigap OEP at age 65



117

Finding a Medigap Plan In Your Area

- <https://insurance.kansas.gov/>



118

Switching Medigap Policies

- You might switch policies if
 - You're paying for benefits you don't need
 - You need more benefits now
 - You want to change your insurance company
 - You find a cheaper policy
- If not in your Medigap open enrollment period
 - You may pay more for the new policy
 - There might be medical underwriting
 - Could have delay in coverage for pre-existing condition
 - Might not sell you a policy



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When Can You Switch Medigap Policies?

- Right under Federal law to switch **only**
 - During your Medigap open enrollment period
 - If you have a guaranteed issue right
 - If your state has more generous requirements
 - If you move out of your Medigap SELECT service area
- A 30-day *free look* period – pay both premiums
- Any time insurance company will sell you one



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Guaranteed Issue Rights to Buy Medigap

- Federal protections in certain situations
 - You have the right to buy a Medigap policy
 - Companies must sell you a Medigap policy
 - All pre-existing conditions must be covered
 - Can't be charged more
 - Must apply within 63 days of date other coverage ends



121

Medicare Rights and Protections Guaranteed Rights

- No matter how you get your Medicare, you have certain rights and protections.
- These rights are guaranteed. They protect you when
 - You get healthcare
 - Make sure you get the medically necessary health care services that the law says you can get
 - Protect you against unethical practices
 - Protect your privacy



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Your Medicare Rights

- You have the right to
 - Be treated with dignity and respect
 - Be protected from discrimination due to
 - Race, color, national origin
 - Disability
 - Age
 - Religion
 - Sex
- If you think you have been treated unfairly call the Office of Civil Rights at 1-800-368-1019



123

Medicare and Your Information Rights

- All people with Medicare have a right to:
 - Have personal health information kept private
 - Get information in a way you understand from
 - Medicare
 - Health care providers
 - Medicare Contractors
 - Get information to help you make decisions
 - What is covered
 - What Medicare pays and how much you have to pay
 - What to do to file a complaint or an appeal



Your Coverage and Appeal Rights

- When a claim is filed, you get a notice from Medicare letting you know what will and won't be covered.
- The coverage may be different from what your doctor says.
- If you disagree with Medicare's decision on your claim, you have the right to appeal
- Appeal – if you disagree with a decision about your health care payment, coverage of services, and prescription drug coverage.
- Instructions on how to start the appeal process are included on the Medicare Summary Notice



Medicare Rights – Claims and Appeals

- Have a claim for payment filed with Medicare
- Get decisions about
 - Health care payment
 - Coverage of services
 - Prescription drug coverage
- Get an appeal (review) of the decisions above



Medicare Rights and Access to Care

- Have access to doctors, specialists, hospitals
- Learn about your treatment choices
 - In clear language
 - Participate in treatment decisions
- Health care services
 - In a language you understand
 - In a culturally-sensitive way
- Emergency care when and where you need it
 - If your health is in danger, and emergency help is needed, call 911



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Medicare Grievance Rights

- File complaints (also called grievances)
 - Including complaints about the quality of care
 - In Original Medicare, call the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
 - In Medicare Advantage or other Medicare plan, call your plan, the BFCC-QIO, or both
 - BFCC-QIO for Kansas
 - Livanta
 - Helpline: (888) 755 - 5580



Handbook Ch 8

128

Rights in Original Medicare

- Your rights when you are enrolled in Original Medicare include the following
 - The right to see any participating doctor or specialist
 - Including women's health specialists
 - To go to any Medicare-certified hospital
 - Get certain information such as notices, and appeal rights that help you resolve issues when Medicare isn't expected to pay or doesn't pay for health care



Handbook Ch 8

129

How to Appeal in Original Medicare

- “Medicare Summary Notice” (MSN) will tell you
 - Why Medicare didn’t pay
 - How to appeal
 - Where to file your appeal
 - How long you have to appeal
- Every three months
- Collect information that may help your case
- Keep a copy of everything you send to Medicare

130

Protection from Unexpected Bills

- Medicare Advance Beneficiary Notice of Non-Coverage or ABN
 - Given by a health care provider or supplier
 - Says Medicare probably won’t pay for an item or service
 - Used only in Original Medicare
 - Not required for items or services excluded under law
 - Will ask you to choose whether to get service
 - Will ask you to confirm you read/understood notice
- More than one kind of ABN

131

Coordination of Benefits When Does Medicare Pay?

- Medicare may be primary payer
 - In the absence of other primary insurance
- Medicare may be secondary payer
 - There may be other insurance that must pay first
- Medicare may not pay at all
 - For services and items other health insurance is responsible for paying
- Your Guide to Who Pays First – CMS publication
<http://www.medicare.gov/Pubs/pdf/02179.pdf>

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When Medicare is Primary Payer

- If Medicare is your only insurance
- Your other source of coverage is
 - A Medigap policy
 - Medicaid
 - Retiree benefits
 - The Indian Health Service
 - Veterans benefits
 - TRICARE
 - COBRA continuation coverage
 - Except 30-month coordination period for people with End-Stage Renal Disease (ESRD)



133

Medicare Secondary Payer (MSP)

- When Medicare isn't responsible for paying a claim first
- Legislation that protects the Medicare Trust Funds
- Helps ensure Medicare doesn't pay when another insurer should
- Saves \$8 billion annually
 - Claims processed by insurances primary to Medicare



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Benefits Coordination & Recovery Center (BCRC)

- Identifies health benefits available to people with Medicare
- Coordinates claims
 - To ensure claims are paid by correct payer
- Responsible for identifying
 - Medicare Secondary Payer (MSP) situations
 - Claims that should crossover to supplemental insurers
- Phone number: 855-798-2627



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Marketplace and People With Medicare

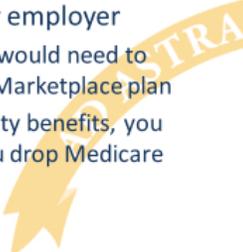
- Medicare isn't part of the Marketplace
- If you have Medicare you don't need to do anything related to the Marketplace
 - Your benefits don't change because of the Marketplace
 - No one can sell you a Marketplace plan
 - Even if you have only Medicare Part A and/or Part B
 - Except an employer through the Small Business Health Options Program (SHOP) if you're an active worker or dependent of an active worker
 - The SHOP employer coverage may pay first
 - No late enrollment penalty if you delay Medicare
 - Doesn't include COBRA coverage
- The Marketplace doesn't offer Medigap or Part D plans



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Marketplace/Medicare Enrollment Considerations

- If you don't enroll in Medicare when you're first eligible (Initial Enrollment Period)
 - A late enrollment penalty may apply (lifetime)
 - You generally can't enroll until the Medicare General Enrollment Period (January 1 to March 31) and coverage won't start until July 1
- If your Marketplace plan isn't through your employer
 - And you must pay a premium for Part A, you would need to drop Part A and Part B to be eligible to get a Marketplace plan
 - However, if you're also receiving Social Security benefits, you would have to drop your Social Security if you drop Medicare



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STARS

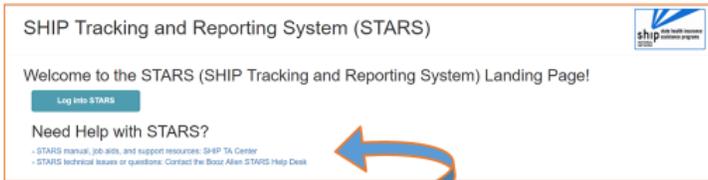
- The system that collects and compiles data about the activities of the SHIP programs.
 - Describes the activities of the SHIPs
 - Provides data that generates program measure reports
 - Data vital to the success of the SHIP/SHICK Program



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STARS Landing Page

- <https://stars.acl.gov>

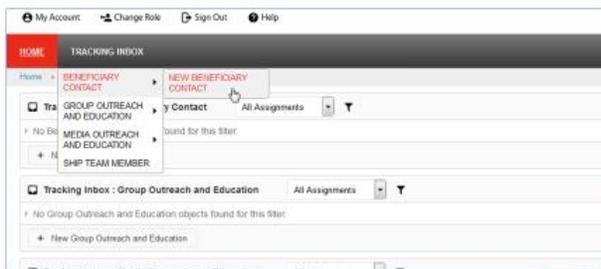


- Contains link to SHIP TA Center STARS training materials (and, when it becomes available, ACL's STARS manual)
- Contains link to Booz Allen STARS Help Desk

139

New Beneficiary Contact

Hover your mouse over the Tracking Inbox, the Menu drops down, then hover over Beneficiary Contact, Click on New Beneficiary Contact when it appears.



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When shouldn't a BCF be completed?

- Do not fill out BCF to document the following:
 - Unsuccessful attempts to reach a beneficiary (e.g., leaving messages on an answering machine)
 - Individuals reached at public events such as presentations or health fairs, or for questions asked during or after a presentation
 - Calls or other contact when the only purpose is to schedule an appointment
 - Calls or other contact when the sole purpose is referral to another agency or program
 - Unsolicited or mass mailings (email or postal) to SHIP contacts
- These are not considered individual contacts unless one-on-one counseling occurs.

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Multiple Contacts on the Same Day

- Multiple sessions with the same team member and the same beneficiary on the same day, are considered the same contact
 - Only one BCF should be entered to capture the contact with the beneficiary for that day with total minutes spent for that day with the beneficiary
 - To report additional contacts with a beneficiary on the same date when a BCF is entered in form (after the first session), edit the BCF in STARS

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MIPPA Reporting

MIPPA

Yes No **R**

- MIPPA is a required field
- You must select Yes or No
- Select “Yes” radio button when outreach includes MIPPA topics



MIPPA Topics Discussed include Extra Help/LIS, Medicaid, Medicare Savings Program, or Preventive Services

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“Send to SMP” Reporting

- SMP fields are not required
- SIRS eFile ID will auto-populate based on
 1. Team member log in (change ID if entering another’s form)
 2. SIRS eFile ID must be present on the STARS form for the data to transfer to SIRS
- SIRS Reference Number auto-populates after form is saved

Auto-populates when save form and sends to SMP/SIRS.

Send to SMP

Yes No

SIRS eFile ID

SIRS Reference Number

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Part D/MAPD Enrollment Data Collection

- Report this additional data whenever you assist with an enrollment in either Part D or MAPD plan
 - Includes reporting cost data for both old plan and new plan (using Medicare Plan Finder info)
 - Reporting is optional and voluntary
- Cost changes must be auditable
 - Supporting documentation should be attached whenever this data is reported
 - If you can't provide supporting documentation, please do not enter any information in the special use fields
 - The following file types are accepted in STARS: doc/docx; ppt/pptx; xls/xlsx; pdf; rtf.

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Part D/MAPD Enrollment Data Steps

1. Collect plan estimated cost information from Medicare Plan Finder (MPF)
2. Assist beneficiary with enrollment via MPF or via phone or paper application
 1. Enrollment confirmation information must be saved no matter which method of enrollment used.
3. Enter plan cost amounts in STARS SUFs on the Beneficiary Contact Form (BCF)
4. Attach MPF cost and enrollment verification to the BCF

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STARS Plan Cost SUF Fields

- **Original PDP/MA-PD Cost**
 - Enter the Estimated Drug Cost* of the plan the beneficiary's **current plan** listed in the Medicare Drug and Health Plan Finder
 - If beneficiary has no current Medicare PDP/MA-PD plan, do not enter data in these cost fields
 - Round to nearest whole dollar
- **New PDP/MA-PD Cost**
 - Enter the Estimated Drug Cost* of the **future plan** the SHIP team member assists the beneficiary current plan listed in the Medicare Drug and Health Plan Finder
 - Round to nearest whole dollar

* Enrollment timing will dictate whether the 'Estimated Drug Cost' appears as an 'annual' cost or 'rest of year' cost.

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Example

The beneficiary wants to enroll in the EnvisionRxPlus (PDP) with an estimated total drug + premium cost of \$222.60 at the pharmacy of their choice, highlighted with a red star ("New" cost).

Example continued

- Click the Plan Details blue box to locate the plan's negotiated drug price for use as the Original PDP/MA-PD Cost SUF 1. Scroll down to find the monthly total retail cost at the beneficiary's pharmacy (red arrow added for emphasis).

Estimated drug costs during coverage phases [Learn more about coverage phases.](#)

CVS PHARMACY #01366 - Drug costs during coverage phases
 ✓ Preferred in-network pharmacy

Selected drugs	Retail cost	Cost before deductible	Cost after deductible	Cost in coverage gap	Cost after coverage gap
Epinephrine 0.15mg/0.15ml solution auto injector	\$421.41	\$9.00	\$9.00	\$105.35	\$21.07
Lisinopril 20mg tablet	\$3.17	\$1.00	\$1.00	\$0.79	\$3.17
Monthly totals	\$424.58	\$10.00	\$10.00	\$106.14	\$24.24

Example continued

- Multiply this cost by the number of coverage months. During the Open Enrollment Period, the calculation would be \$424.58 X 12 months = \$5,094.96 estimated drug cost for SUF 1.



1.2 STARS SUF Entry:

Special Use Fields	5094.96
Original PDP/MA-PD Cost	
New PDP/MA-PD Cost	222.60



Plan Finder Cost Data

Comparing 2 Prescription Drug plans

Comparing 2 Prescription Drug plans

[Back to results](#)

Overview

Premium	Total	Total
	\$0.00	\$40.40
Deductible	Yearly drug deductible	Yearly drug deductible
	\$0.00	\$0.00

Drug coverage & costs

Drugs covered/Not covered	12 of 12	12 of 12
	Prescription drugs covered	Prescription drugs covered
	Restrictions may apply	Restrictions may apply
Estimated total drug + premium cost		
	AUBURN LTC WICHITA #181 ✓ Preferred in-network \$0.00 Mail order pharmacy ✓ Standard in-network \$0.00	AUBURN LTC WICHITA #181 ✓ Standard in-network \$484.90 Mail order pharmacy ✓ Standard in-network \$484.90

Page 1 of 1

Original Part D/MAPD:
WellCare Medicare Rx Value Plus (PDP)
Cost: \$485

New Part D/MAPD:
Silver Choice Rx Plan (PDP)
Cost: \$0

MPF Application Confirmation

Your enrollment application has been received

Your 2020 enrollment request was received and will be processed by:
(SilverScript Choice (PDP)) S5601-048-0

Your Confirmation number [REDACTED]

Name [REDACTED]

Please contact the plan directly with any additional questions.
 SilverScript Choice (PDP)
 P.O. Box 30016
 Pittsburgh, PA 15222

Example: Entering Cost Data in STARS

Original Part D/MAPD:
WellCare Medicare Rx Value Plus (PDP)
Cost: \$485

New Part D/MAPD: Silver Choice Rx Plan (PDP)
Cost: \$0

Special Use Fields

Original PDP/MA-PD Cost	485
New PDP/MA-PD Cost	0

Ongoing Quality Checks

- SHICK conducts regular quality checks to assure accurate reporting
- Any cost change data without verification will be deleted if supporting materials are not provided



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Individualized Technical Assistance

- For STARS username, password, and hierarchy support:
 - Contact the STARS help desk at Booz Allen Hamilton, boozallenstarshelpdesk@bah.com
- For STARS resources support:
 - Contact the SHIP TA Center, stars@shiptacenter.org or 877-839-2675.



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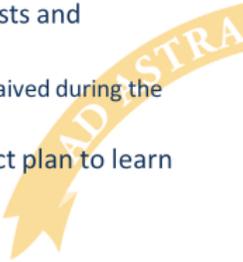
MEDICARE-COVERED SERVICES RELATED TO CORONAVIRUS



165

Medicare Coverage

- Medicare covers medically necessary items and services that beneficiary receives from provider who:
 - Accepts Original Medicare, or
 - Is in-network for the beneficiary's Medicare Advantage (MA) Plan
- MA Plans must cover everything that Original Medicare does, but they can do so with different costs and restrictions.
 - Note: Some of these restrictions must be waived during the Public Health Emergency (PHE)
- Beneficiaries with MA Plans should contact plan to learn about cost and coverage specifics



166

Corona Virus Testing

- Covered under Part B as clinical laboratory test
- As of April 1, 2020, doctor can bill for testing provided after February 4, 2020
- No cost-sharing (deductible, coinsurance, or copayment) for test and associated visits
- Applies to Original Medicare and MA Plans
- MA Plans cannot require prior authorization for testing provided after March 17, 2020



167

Coronavirus Vaccine

- No vaccine available yet
- If one becomes available, it will be covered under Part B and have no cost-sharing (deductible, coinsurance, or copayment)



168

Prescription Refills

- Drug plans must cover up to 90-day supply of prescription at beneficiary's request
 - Plan cannot impose quantity limit on drug that would prevent beneficiary from getting full 90-day supply, as long as they have prescription for that amount
 - Some safety checks are still in place to prevent unsafe doses of opioids
- Plans can relax restrictions on beneficiary filling prescription early
 - If beneficiary wants to refill prescription early, they should contact plan

169

Skilled Nursing Facility Waivers: Benefit Period

- Part A typically covers up to 100 days of SNF care each benefit period
 - Benefit period begins when beneficiary is admitted to a hospital as an inpatient, or to a SNF, and it ends when they have been out of a SNF or hospital for at least 60 days in a row
 - 100 days of covered SNF care renews with each benefit period
- Beneficiaries who are unable to start a new benefit period because of the public health emergency can get another 100 days of covered SNF care without having to begin a new benefit period

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Skilled Nursing Facility Waivers

- SNF waivers: apply nationally as blanket waivers
- If beneficiary has trouble accessing SNF care under these waivers, or if SNF is not aware of the waiver, file quality of care complaint with Beneficiary and Family Centered Care-Qualify Improvement Organization (BFCC-QIO) for Kansas
 - Livanta: <https://www.livantaqio.com/en>
- SNF can also contact its Medicare Administrative Contractor (MAC)

171

Home Health Care: Homebound Requirement

- Medicare has changed some home health care coverage requirements; homebound requirement still applies
- Homebound requirement can be met in additional ways
- Someone can be considered homebound if their physician certifies that they should not leave their home because:
 - They have a medical condition that makes them susceptible to contracting COVID-19
 - Or, if they have a suspected or confirmed case of COVID-19

172

Home Health Care: Prescribing Physician and Telehealth

- Normally, a physician must prescribe home health care
- During public health emergency other providers, including nurse practitioners and physician assistants, can prescribe
- Home health care agencies can provide more services via telehealth, as long as services are listed on the beneficiary's plan of care
 - Telehealth services cannot be used in place of in-person services listed on the plan of care
 - Face-to-face visit requirement can be met via telehealth

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Physicians' Services at Home

- Part B covers services a beneficiary receives from a physician (or other provider, such as registered nurse) who visits their home
- Part B also covers some services that are not provided face-to-face with a doctor, such as check-in phone calls and assessments using an online patient portal
- Virtual check-ins can be used to assess whether a beneficiary should go to their doctor's office for an in-person visit

174

Telehealth Services

- Telehealth services are provided during full visit with provider using telephone or video technology that allows for both audio and video communication
- Medicare generally only covers telehealth in limited situations for certain beneficiaries, but it has expanded coverage and access during the public health emergency
- During the PHE, telehealth services are covered under Part B for all beneficiaries throughout the country in health care settings and at home

175

Covered Telehealth Services

- Examples of covered visits include:
 - Hospital and doctors’ office visits
 - Behavioral health counseling
 - Preventive health screenings
 - Face-to-face visits required for Medicare coverage of hospice care

176

Telehealth Providers and Costs

- Health care providers who can offer telehealth services include:
 - Doctors, nurse practitioners
 - Clinical psychologists, licensed clinical social workers
 - Physical therapists, occupational therapists, speech language pathologists
- Standard cost-sharing may apply, but provider can choose not to charge the beneficiary for the cost-sharing charges
 - Providers usually cannot routinely waive cost-sharing but may during PHE
- Beneficiary with MA Plan should contact their plan to learn about its costs and coverage rules

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Technology Requirements

- Telehealth services must use audio and video
 - Limited telehealth services can be delivered using audio only, including counseling and therapy provided by an opioid treatment program and behavioral health care services
- Guidance from Department of Health and Human Services (HHS) allows providers to temporarily use any non-public facing remote technology (such as FaceTime or Skype) to communicate with their patients
- If a beneficiary has questions about technology requirements for telehealth services, they should ask their provider

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Online Medicare Enrollment

- Local Social Security offices are closed to appointments with the public
- There are two ways to apply for Medicare online:
 - **If individual is applying for Medicare Part A and Part B at the same time**, they can use online application found here: <https://www.ssa.gov/benefits/medicare/>
 - **If individual is applying for Medicare Part B using the Part B Special Enrollment Period (SEP)**, they can use online application found here: <https://secure.ssa.gov/mpboa/medicare-part-b-online-application>

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Part B SEP Online Enrollment

- Individual can use Part B SEP to enroll in Medicare if they, their spouse, or sometimes a family member recently lost the job that provided them with health insurance
- Online form asks individual to upload proof that they had coverage based on current work
 - Proof is usually form CMS L564, which employer fills out to confirm that individual had coverage based on current employment
 - Individual should ask employer if they can fill out the form, sign it, and send them digital copy
 - If employer cannot fill out the form, individual should fill it out on their behalf and upload other proof of job-based insurance
 - Example: Income tax returns that show health insurance premiums paid

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Problems with Online Enrollment

- Not everyone can enroll online or has access to a computer and internet connection
- If individual cannot enroll in Medicare online, they can enroll through local Social Security office



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Step 1: Contact Local Office

- Local offices are closed to the public, but still accepting mail
- Use field office locator to find local office's phone number:
<https://secure.ssa.gov/ICON/main.jsp>
- Call local office to learn best way to submit enrollment paperwork



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Step 2: Collect Paperwork

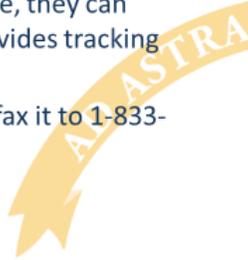
- **Form 40B:** Application for enrollment in Medicare
- **Form L564:** Request for Employer Information if individual is using Part B Special Enrollment Period (SEP)
 - Employer usually fills out Section B, but individual can fill it out on employer's behalf, however, the should not sign it
- **Proof of job-based insurance** if employer did not fill out Section B of Form L564, such as:
 - Income tax return that shows health premiums paid
 - W-2s reflecting pre-tax medical contribution
 - Pay stubs showing health insurance premiums deducted
 - Health insurance card showing policy start date
 - Explanations of Benefits paid by job-based insurance
 - Statements showing premium payments



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Step 3: Mail Paperwork

- Use certified mail
 - Certified mail provides receipt and confirmation that mail was received
 - Having proof that paperwork was submitted, and the date it was submitted, can be helpful if the individual has any issues with their enrollment in the future
- If an individual cannot get to the post office, they can access Priority Mail from home, which provides tracking information but no confirmation receipt
- If individual cannot mail their paperwork, fax it to 1-833-914-2016



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Troubleshooting

- Various strategies exist for addressing enrollment delays at Social Security office, such as contacting federal elected representative
- Speak with supervisor and others at your organization about possible troubleshooting strategies



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Equitable Relief

- Individual who missed their Initial Enrollment Period (IEP), General Enrollment Period (GEP), or Part B SEP could request equitable relief from Social Security for more time to enroll in Medicare
- Enrollment period must have happened between March 17, 2020 and June 17, 2020
- **This time period has now passed; advocates are working on getting it extended**



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Webinar Resources in the Libraries

SMPs

- Step 1: Login at www.smpresource.org (click the blue SMP Login  padlock).
- Step 2: Search for keyword "COVID".

SHIPs

- Step 1: Login at www.shiptacenter.org (click the orange SHIP Login  padlock).
- Step 2: Go to the Resource Library.
- Step 3: Search for keyword "COVID".

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Helpful Resources

- www.ksinsurance.org – 800-432-2484
- www.kdads.ks.gov – 800-432-3535
- KanCare Clearinghouse – 800-792-4884
- KanCare Ombudsman – kancare.ombudsman@ks.gov
<https://www.kancare.ks.gov/kancare-ombudsman-office/about-contact-us>
855-643-8180
- SHICK coordinator and counselor resource page - <http://www.kdads.ks.gov/shick-coordinator-counselor-information>

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Medicare Grants Staff

1. Nicki Houk, nicki.houk2@ks.gov, 785-296-8450, Medicare Grants Coordinator
2. Janet Boskill, janet.boskill@ks.gov, 785-296-6319, Medicare Grants Regional Manager
3. Chris Merriweather, chris.merriweather@ks.gov, 785-296-3325, Medicare Grants Regional Manager

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What's next?

- Complete the Course 4 test
- You are a certified SHICK Counselor
- Continue your mentoring sessions!
- Practice, Practice, Practice
- Questions? Issues? Concerns?
 - Contact Local Coordinator, Mentor, or Regional Manager
 - Use SHICK Handbook
 - Use www.medicare.gov



APPENDIX - Resources and Websites

Kansas Department for Aging and Disability Services

1-800-432-3535

kdads.ks.gov

Kansas Insurance Department

1-800-432-2484 (Kansas only)

www.ksinsurance.org

Centers for Medicare & Medicaid Services (CMS)

1-800-MEDICARE (1-800-633-4227).

TTY: 1-877-486-2048.

Medicare.gov

CMS.gov

Medicaid.gov/

Social Security

1-800-772-1213. TTY: 1-800-325-0778

SocialSecurity.gov/

SSA Red Book

ssa.gov/redbook

Railroad Retirement Board

1-877-772-5772. TTY: 1-312-751-4700

RRB.gov/

Affordable Care Act

HealthCare.gov

HHS.gov/healthcare/about-the-aca/index.html

State Health Insurance Assistance Programs and State Insurance Departments

shiptacenter.org/

Benefits Coordination & Recovery Center

Call 1-855-798-2627. TTY: 1-855-797-2627

U.S. Department of Health and Human Services, Office for Civil Rights

HHS.gov

HHS.gov/ocr/office/index.html

1-800-368-1019. TTY: 1-800-537-7697

Beneficiary Notice Initiative

CMS.gov/Medicare/Medicare-General-Information/BNi

Medicare.gov/claims-and-appeals

Medicare Beneficiary Ombudsman

Medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman

Medicare.gov/what-medicare-covers/part-a/rights-in-snf

Limited Income NET Program (Humana)

Call 1-877-783-1307 or 711 (TRS)

linetoutreach@humana.com

Prescription Drug Benefit Manual

CMS.gov/Medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html

PD Enrollment and Disenrollment Guidance

CMS.gov/Medicare/eligibility-and-enrollment/medicarepresdrugeligenrol/index.html

Medicare Premiums: Rules for Higher-Income Beneficiaries

<https://www.ssa.gov/benefits/medicare/medicare-premiums.html>

CMS Guide to Mailings From CMS, Social Security, and Plans

<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf>

MyMedicare.gov

MyMedicare.gov/

Medicare Marketing Guidelines

<https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines>

Medicare Managed Care Manual

CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html

<p>U.S. Department of Labor Call 1-866-4-USA-DOL (1-866-487-2365). TTY: 1-877-889-5627 dol.gov/dol/topic/health-plans/cobra.htm</p> <p>Office of Personnel Management (Federal Employees Health Benefit Program) opm.gov/healthcare-insurance/healthcare/</p> <p>Patient Assistance Program Center rxassist.org</p> <p>Medicare/TRICARE Benefit Overview tricare.mil/Plans/Eligibility?sc_database=web</p> <p>TRICARE TRICARE.mil/</p> <p>Department of Veterans Affairs Call 1-800-827-1000. TTY: 1-800-829-4833 va.gov/opa/publications/benefits_book.asp benefits.va.gov/benefits/</p> <p>Black Lung Program dol.gov/compliance/topics/benefits-comp-blacklung.htm Call 1-800-638-7072. TTY: 1-877-889-5627</p> <p>Senior Medicare Patrol Program smpresource.org Medicare.gov/fraud</p> <p>OIG Fraud Hotline Call 1-800-HHS-TIPS (1-800-447-8477) TTY: 1-800-337-4950 Fax 1-800-223-8162</p> <p>Prevention Toolkit CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html</p> <p>National Training Program – Partner Job Aids CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram</p>	
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Medicare Health Maintenance Organization (HMO) Plan

- You generally must get your care and services from doctors or hospitals in the plan's network (except emergency care, out of area urgent care, or out-of-area dialysis). In some plans, you may be able to go out of network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (HMO-POS) option.
- If you want drug coverage, you must join an HMO Plan that offers prescription drug coverage. **If you join an HMO which does not cover Part D prescription drugs, you cannot join a separate Part D plan.**
- In most cases, you need to choose a primary care doctor and will have to get a referral to see a specialist. Certain services don't require a referral.

Medicare Preferred Provider Organization (PPO) Plan

- In a PPO Plan you have PPO network providers; however, you can also use out-of-network providers for covered services, usually for a higher cost.
- If you want drug coverage, you must join a PPO Plan that offers prescription drug coverage. You cannot join a separate Part D plan if the PPO does not offer prescription drug coverage.
- You don't need to choose a primary care doctor and don't have to get a referral to see a specialist.

Medicare Private Fee-for-Service (PFFS) Plan

- You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you.
- If you join a PFFS Plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, but you may pay more.
- If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan (Part D) to get coverage.
- You don't need to choose a primary care doctor, and you don't have to get a referral to see a specialist.

Medicare Private Fee-for-Service (PFFS) Plan (Continued)

- The plan decides how much you must pay for services
- 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 that 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

Medicare Special Needs Plans (SNPs)

- Medicare Special Needs Plans (SNPs) are Medicare Advantage Plans designed to provide focused care management, special expertise of the plan's providers, and benefits tailored to enrollee conditions.
- You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).
- All SNPs must provide Medicare prescription drug coverage (Part D).
- You generally need to choose a primary care doctor, and in most cases, need a referral to see a specialist.

Medicare Special Needs Plans (SNPs) Continued

- A plan must limit plan membership to people in one of the following groups:
 - Those living in certain institutions (like a nursing home), or who require nursing care at home
 - Those eligible for both Medicare and Medicaid
 - Those with specific chronic or disabling conditions
 - Plan may further limit membership
- Plan should coordinate your needed services and providers
- Plan should make sure providers that you use accept Medicaid if you have Medicare and Medicaid
- Plan should make sure that plan's providers serve people where you live, if you live in an institution

Medicare PACE Plans

- PACE - Programs of All-Inclusive Care for the Elderly
- Combine services for frail elderly people
 - Medical, social, and long-term care services
 - Include prescription drug coverage
- Alternative to nursing home care
- Only in states that offer it under Medicaid - qualifications vary from state to state
- Three PACE programs available in Kansas
 - Via Christi HOPE, Midland Care Services, and Bluestem



Medicare and Medical Savings Account Plans

- Combine a high-deductible insurance plan with a medical savings account
- Medicare deposits money into account
 - Use money to pay for health care services
 - No cost-sharing once the deductible has been paid
- Must cover Part A and Part B services, and except costs like dental, vision, and long-term care not covered by Medicare
- For drug coverage, must join a Part D plan



Medicare Supplement Insurance (Medigap) Plans

Benefits	A	B	C	D	F*	G	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
Out-of-Pocket Limit in 2020**							\$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 & G are also offered as a high-deductible plan by some insurance companies in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of \$2,340 in 2020 before your policy pays anything.

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$198 in 2020), the Medigap plan pays 100% of covered services for the rest of the calendar year.

***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.

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
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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
PBM s	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
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V

VA (DVA)	Department of Veterans Affairs
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W

WCMSA	Workers' Compensation Medicare Set-Aide Arrangement
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WPS	Wisconsin Physician Services
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X

XIXED	Title 19 Entitlement Date
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Y

YOB	Year of Birth
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YTD	Year to Date
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YYYY	Year
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Z

ZPIC	Zone Program Integrity Contractor
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2020 Overview of Medicare A & B

Key: Shaded areas – Medicare Pays

White areas – You Pay

A	B
Premium:	Premium: \$144.60
<div style="background-color: white; padding: 2px;"> <i>40 work quarters = zero</i> <i>less than 30 quarters = \$458</i> <i>30 - 39 quarters = \$252</i> </div>	<div style="background-color: white; padding: 2px;"> unless individual income over \$85,000 or couple \$170,000. </div>
Each benefit period*	\$198 Deductible
In-patient Hospital	(per calendar year, January 1 to December 31)
First 60 days	\$1408 Deductible
Days 61-90	\$352 per day co-payment
Lifetime	
Reserve Days	
91-150	\$704 per day co-payment
Skilled Nursing Facility	
First 20 days	100% (No co-pay)
Days 21-100	\$176 per day co-pay
100% Services	Preventive Services
Home Health	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
Hospice	WITH CO-PAY OR DEDUCTIBLE: Abdominal Aortic Aneurysm Screening, Diabetes Supplies & Self-Management, Prostate Cancer Screening, Glaucoma Screening, CCS - Barium enema, HIV Screening
<div style="background-color: white; padding: 2px;">\$5 prescription drug co-pay</div>	
<div style="background-color: white; padding: 2px;">5% co-insurance inpatient respite care</div>	
* 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)

80%	20%
Physician's Charges (in or out of the hospital)	C
Durable Medical Equipment & Supplies	O
Ambulance	I
Outpatient Hospital	N
Blood	S
Lab Services	U
The first 3 pints	R
	A
	N
	C
	E

BENEFICIARY CONTACT FORM

*** Items marked with asterisk (*) indicate required fields**

MIPPA Contact *: Yes No

Send to SMP: Yes No **SIRS eFile ID:**
 (*required if sending record to SMP)

Counselor Information *

Session Conducted By * : _____ ZIP Code of Session Location * : _____ State of Session Location * : _____
 Partner Organization Affiliation * : _____ County of Session Location * : _____

Beneficiary & Representative Name and Contact Information

Beneficiary First Name: _____ Representative First Name: _____
 Beneficiary Last Name: _____ Representative Last Name: _____
 Beneficiary Phone: (_____) - _____ - _____ Representative Phone: (_____) - _____ - _____
 Beneficiary Email: _____ Representative Email: _____

Beneficiary Residence *

State of Bene Res. * : _____ Zip Code of Bene Res. * : _____ County of Bene Res. * : _____

Date of Contact *:

How Did Beneficiary Learn About SHIP * (select only one):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> CMS Outreach | <input type="checkbox"/> Previous Contact | <input type="checkbox"/> SHIP TA Center | <input type="checkbox"/> Other |
| <input type="checkbox"/> Congressional Office | <input type="checkbox"/> SHIP Mailings | <input type="checkbox"/> SSA | <input type="checkbox"/> Not Collected |
| <input type="checkbox"/> Friend or Relative | <input type="checkbox"/> SHIP Media | <input type="checkbox"/> State Medicaid Agency | |
| <input type="checkbox"/> Health/Drug Plan | <input type="checkbox"/> SHIP Presentation | <input type="checkbox"/> 1-800 Medicare | |
| <input type="checkbox"/> Partner Agency | <input type="checkbox"/> State SHIP Website | | |

Method of Contact * (select only one):

- | | | |
|---|--|--|
| <input type="checkbox"/> Phone Call | <input type="checkbox"/> Face to Face at | <input type="checkbox"/> Face to Face at |
| <input type="checkbox"/> Email | Session Location/ | Bene Home/ |
| <input type="checkbox"/> Web-based | Event Site | Facility |
| <input type="checkbox"/> Postal Mail or Fax | | |

Beneficiary Age Group * (select only one):

- | | |
|--|--|
| <input type="checkbox"/> 64 or Younger | <input type="checkbox"/> 85 or Older |
| <input type="checkbox"/> 65 – 74 | <input type="checkbox"/> Not Collected |
| <input type="checkbox"/> 75 – 84 | |

Beneficiary Gender * (select only one):

- | |
|--|
| <input type="checkbox"/> Female |
| <input type="checkbox"/> Male |
| <input type="checkbox"/> Other |
| <input type="checkbox"/> Not Collected |

Beneficiary Race * (multiple selections allowed):

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Not Collected |
| <input type="checkbox"/> Hispanic or Latino | |

Beneficiary Language *:

English is Beneficiary's Primary Language Yes No

Receiving or Applying for Social Security Disability or Medicare Disability * (select only one):

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

Beneficiary Monthly Income * (select only one):

- | | |
|---|--|
| <input type="checkbox"/> Below 150% FPL | <input type="checkbox"/> Not Collected |
| <input type="checkbox"/> At or Above 150% FPL | |

Beneficiary Assets * (select only one):

- | | |
|---|--|
| <input type="checkbox"/> Below LIS Asset Limits | <input type="checkbox"/> Not Collected |
| <input type="checkbox"/> Above LIS Asset Limits | |

Topics Discussed * (At least one Topic Discussed selection is required. Multiple selections allowed)

- | | |
|--|---|
| <p>Original Medicare (Parts A & B)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Appeals/Grievances <input type="checkbox"/> Benefit Explanation <input type="checkbox"/> Claims/Billing <input type="checkbox"/> Coordination of Benefits <input type="checkbox"/> Eligibility <input type="checkbox"/> Enrollment/Disenrollment <input type="checkbox"/> Fraud and Abuse <input type="checkbox"/> QIO/Quality of Care | <p>Medigap and Medicare Select</p> <ul style="list-style-type: none"> <input type="checkbox"/> Benefit Explanation <input type="checkbox"/> Claims/Billing <input type="checkbox"/> Eligibility/Screening <input type="checkbox"/> Fraud and Abuse <input type="checkbox"/> Marketing/Sales Complaints & Issues <input type="checkbox"/> Plan Non-Renewal <input type="checkbox"/> Plans Comparison |
|--|---|

Topics Discussed (multiple selections allowed) (continued from p.1)*

Medicare Advantage (MA and MA-PD)

- Appeals/Grievances
- Benefit Explanation
- Claims/Billing
- Disenrollment
- Eligibility/Screening
- Enrollment
- Fraud and Abuse
- Marketing/Sales Complaints & Issues
- Plan Non-Renewal
- Plans Comparison
- QIO/Quality of Care

Medicare Part D

- Appeals/Grievances
- Benefit Explanation
- Claims/Billing
- Disenrollment
- Eligibility/Screening
- Enrollment
- Fraud and Abuse
- Marketing/Sales Complaints & Issues
- Plan Non-Renewal
- Plans Comparison

Part D Low Income Subsidy (LIS/Extra Help)

- Appeals/Grievances
- Application Assistance
- Application Submission
- Benefit Explanation
- Claims/Billing
- Eligibility/Screening
- LI NET/BAE

Other Prescription Assistance

- Manufacturer Programs
- Military Drug Benefits
- State Pharmaceutical Assistance Programs
- Union/Employer Plan
- Other

Medicaid

- Application Submission
- Benefit Explanation
- Claims/Billing
- Eligibility/Screening
- Fraud and Abuse
- Medicaid Application Assistance
- Medicare Buy-in Coordination
- Medicaid Managed Care
- MSP Application Assistance
- Recertification
- Other

Other Insurance

- Active Employer Health Benefits
- COBRA
- Indian Health Services
- Long Term Care (LTC) Insurance
- LTC Partnership
- Other Health Insurance
- Retiree Employer Health Benefits
- Tricare For Life Health Benefits
- Tricare Health Benefits
- VA/Veterans Health Benefits
- Other

Additional Topic Details

- Ambulance
- Dental/Vision/Hearing
- DMEPOS
- Duals Demonstration
- Home Health Care
- Hospice
- Hospital
- New Medicare Card
- New to Medicare
- Preventive Benefits
- Skilled Nursing Facility

Total Time Spent on This Contact *

____ Hours _____ Minutes

Status *

- In Progress Completed

Special Use Fields

Original PDP/MA-PD Cost: _____

Field 3: _____

New PDP/MA-PD Cost: _____

Field 4: _____

Field 5: _____

Notes

GROUP OUTREACH & EDUCATION FORM

*** Items marked with asterisk (*) indicate required fields**

MIPPA Event *:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Send to SMP:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	SIRS eFile ID: (*required if sending record to SMP) _____

Event Details *	
Session Conducted By *: _____	Partner Organization Affiliation* : _____
Total Time Spent on Event *: _____ Hours _____ Minutes	Title of Interaction *: _____
Number of Attendees * : _____	Type of Event * (select only one): <input type="checkbox"/> Booth/Exhibit (Health Fair, Senior Fair or Community Event) <input type="checkbox"/> Enrollment Event <input type="checkbox"/> Interactive Presentation to Public (In-Person, Video Conference, Web-based Event, Teleconference)
Start Date of Activity * : _____	
End Date of Activity : _____	

Event Location *	
State of Event * : _____	Zip Code of Event * : _____
County of Event * : _____	

Event Contact Information	
Event Contact First Name: _____	Event Contact Phone: _____
Event Contact Last Name: _____	Event Contact Email: _____

Intended Audience * (multiple selections allowed):		
<input type="checkbox"/> Beneficiaries	<input type="checkbox"/> Limited-English Proficiency	<input type="checkbox"/> People with Disabilities
<input type="checkbox"/> Employer-Related Groups	<input type="checkbox"/> Medicare Pre-Enrollees	<input type="checkbox"/> Rural Beneficiaries
<input type="checkbox"/> Family Members/Caregivers	<input type="checkbox"/> Partner Organizations	<input type="checkbox"/> Other

Target Beneficiary Group * (multiple selections allowed):		
<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Rural
<input type="checkbox"/> Asian	<input type="checkbox"/> Languages Other Than English	<input type="checkbox"/> N/A
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Low Income	<input type="checkbox"/> Not Collected
<input type="checkbox"/> Disabled	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Other

Topics Discussed * (multiple selections allowed):		
<input type="checkbox"/> Duals Demonstration	<input type="checkbox"/> Medicare Fraud and Abuse	<input type="checkbox"/> Other Prescription Drug Coverage
<input type="checkbox"/> Extra Help/LIS	<input type="checkbox"/> Medicare Part D	<input type="checkbox"/> Partnership Recruitment
<input type="checkbox"/> General SHIP Program Information	<input type="checkbox"/> Medicare Savings Program	<input type="checkbox"/> Preventive Services
<input type="checkbox"/> Long-Term Care Insurance	<input type="checkbox"/> Medigap or Supplemental Insurance	<input type="checkbox"/> Volunteer Recruitment
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Original Medicare (Parts A and B)	<input type="checkbox"/> Other
<input type="checkbox"/> Medicare Advantage		

(Continued on p.2)

Special Use Fields

Field 1: _____

Field 2: _____

Field 3: _____

Field 4: _____

Field 5: _____

Notes

MEDIA OUTREACH & EDUCATION FORM

*** Items marked with asterisk (*) indicate required fields**

MIPPA Event *:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Send to SMP:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	SIRS eFile ID: (*required if sending record to SMP) _____

Event Details *

Session Conducted By *: _____	Partner Organization Affiliation* : _____
Total Time Spent on Event *: _____ Hours _____ Minutes	Title of Interaction *: _____
Type of Media * (select only one): <input type="checkbox"/> Billboard <input type="checkbox"/> Radio <input type="checkbox"/> Email <input type="checkbox"/> Social Media <input type="checkbox"/> Magazine <input type="checkbox"/> Television <input type="checkbox"/> Newsletter <input type="checkbox"/> Website <input type="checkbox"/> Newspaper <input type="checkbox"/> Other	Estimated Number of People Reached: _____ Geographic Coverage (select only one): <input type="checkbox"/> County or Counties <input type="checkbox"/> Regional <input type="checkbox"/> Multi-State <input type="checkbox"/> Statewide <input type="checkbox"/> National <input type="checkbox"/> Zip Code

Start Date of Activity * : _____ End Date of Activity: _____

Event Location *

State of Event * : _____ Zip Code of Event * : _____

County of Event * : _____

Media Contact Information

Media Contact First Name: _____	Media Contact Phone: _____
Media Contact Last Name: _____	Media Contact Email: _____

Intended Audience * (multiple selections allowed):

<input type="checkbox"/> Beneficiaries	<input type="checkbox"/> Limited-English Proficiency	<input type="checkbox"/> People with Disabilities
<input type="checkbox"/> Employer-Related Groups	<input type="checkbox"/> Medicare Pre-Enrollees	<input type="checkbox"/> Rural Beneficiaries
<input type="checkbox"/> Family Members/Caregivers	<input type="checkbox"/> Partner Organizations	<input type="checkbox"/> Other

Target Beneficiary Group * (multiple selections allowed):

<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Rural
<input type="checkbox"/> Asian	<input type="checkbox"/> Languages Other Than English	<input type="checkbox"/> N/A
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Low Income	<input type="checkbox"/> Not Collected
<input type="checkbox"/> Disabled	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Other

Topics Discussed * (multiple selections allowed):

<input type="checkbox"/> Duals Demonstration	<input type="checkbox"/> Medicare Fraud and Abuse	<input type="checkbox"/> Other Prescription Drug Coverage
<input type="checkbox"/> Extra Help/LIS	<input type="checkbox"/> Medicare Part D	<input type="checkbox"/> Partnership Recruitment
<input type="checkbox"/> General SHIP Program Information	<input type="checkbox"/> Medicare Savings Program	<input type="checkbox"/> Preventive Services
<input type="checkbox"/> Long-Term Care Insurance	<input type="checkbox"/> Medigap or Supplemental Insurance	<input type="checkbox"/> Volunteer Recruitment
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Original Medicare (Parts A and B)	<input type="checkbox"/> Other
<input type="checkbox"/> Medicare Advantage		

(Continued on p.2)

Special Use Fields

Field 1: _____

Field 2: _____

Field 3: _____

Field 4: _____

Field 5: _____

Notes