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 Coordinator

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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.

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What is "confidentiality?"

- Confide: to trust in someone when sharing private matters
- Confidentiality: those entrusted with private or secret matters will keep information to themselves

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Importance of Confidentiality

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

It demonstrates respect

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

It helps prevent costly privacy and security breaches.

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Rules Affecting Confidentiality

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Two Parts of HIPAA: The Privacy Rule

- Privacy rule defines protected health information (PHI)
  - Individually identifiable information held or transmitted by covered entity or business associate, in any form or media (electronic, paper, or oral)
    - Relates to health condition and providing health care
    - Identifies individual or give reasonable basis to use in identifying individual
  - Medical bill is PHI because it contains individual name and their health data
- Privacy rule defines covered entities
  - Organizations and individuals subject to the rule, including health insurance plans, health care providers, health care clearinghouses and business associates
- Privacy rule establishes health care provider may disclose personal health information for a good use without getting authorization from the patient (known as permitted uses)

Two Parts of HIPAA: The Security Rule

- Security rule addresses safeguards for electronic PHI or (e-PHI)
  - Protected health information that is produced, saved, transferred, or received in electronic form
- Security rule places requirements on covered entities to ensure confidentiality and integrity of all e-PHI
- Covered entities expected to identify and protect against anticipated security threats
- US Department of Health and Human Services (HHS) Office of Civil Rights (OCR) oversees and enforces HIPAA compliance
- Report suspected violations to OCR at www.hhs.gov/OCR

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HIPAA's Privacy Rule

- Protects all individually identifiable health information held or transmitted by a covered entity
- Most SHIPs are not covered entities, but privacy rule provides guidance for best practices
- Privacy rule applies to:
  - Conversations that a person might have about a patient or client
  - Things that could be overheard
  - Paper left on a desk or copy machine that includes PHI
- Goal of privacy rule is to assure that individuals and health information are properly protected while allowing the flow of health information needed to provide and promote high quality health

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Required Disclosures

- Covered entities may not use or disclose PHI except:
  - as the privacy rule permits
  - Or, as the individual or the representative authorizes in writing
- Privacy rule requires covered entities to disclose PHI in two situations:
  - To individuals (or their personal representatives) when they request access to their PHI
  - To HHS when it undertakes compliance or enforcement action

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Permitted Disclosures

- Covered entities can disclose information:
  - To the individual when necessary
  - For purpose of treatment, payment, and health care operations
  - When individual would have had the opportunity to agree or object to the disclosure if not incapacitated
  - When it is incident to otherwise permitted use or disclosure or to law enforcement
  - For public interest and benefit activities, such during public health emergency
  - For research in public health and operations using limited data set

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Privacy Rule Protections

An individual has rights under the Privacy Rule to:

- Receive notice about provider's privacy practices
- Review and obtain copy of PHI in a covered entity's designated record set
- Ask covered entity to amend their PHI when it is incomplete or inaccurate
- Request covered entity restrict personal health information disclosure
- Request list of times when covered entity has shared their PHI
- Request alternate means or location for receiving communications of PHI

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HIPAA's Security Rule

Goal of security rule: Protect privacy of individual's health information and allow covered entities to adopt new technologies to improve quality and efficiency of patient care.

Security rule applies to electronic information that is:

- Transmitted over the Internet (e.g., email)
- Stored on computer, CD, USB drive, magnetic tape, or other related means.
- Stored on personal devices like cell phones

The Security Rule does not apply to PHI that is transmitted or stored on paper or provided orally

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Security Rule Safeguards

Covered entities must take steps to protect PHI against anticipated threats and impermissible disclosures

- Conduct risk analysis to identify and address system weaknesses
- Implement administrative safeguards such as hiring or consulting with security professionals
- Build physical safeguards such as requiring staff to turn off computers at the end of the day
- Install technical safeguards that encrypt information
- Document policies and procedures

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HIPAA: SHIP & SMP Operations

- SHIPs and SMPs are not covered entities, but people who sponsor them could be
  - Example: Area agency on aging may be covered entity if it provides health care services and maintains patient records or contracts with organizations that provide those kinds of services
- HIPAA may affect SHIP and SMP access to information, as covered entities can't disclose individual's PHI without written or oral consent
  - SHIPs and SMPS may address this by using consent forms or doing 3-way calls with client and provider
- Customer service representatives at 1-800-MEDICARE cannot disclose client's PHI with third parties, so using the CMS Unique ID is necessary

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State Law

- State laws related to privacy protection laws:
  - Apply to individuals and organizations, including nonprofit organizations
  - Define personal protected information (PPI)
  - Create process for notifying people affected by security or data breach
  - Some establish statutory duty to protect personal information
  - Some set fines for breaches

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Personal Protected Information (PPI)

- PPI has a different definition from PHI that is subject to HIPAA rules
- PPI = Beneficiary's first name and last name (or first initial and last name) plus any of the following:
  - Social Security number
  - Driver's license number or state-issued identification number
  - Financial account number, credit card or debit card number with or without any required access or password that would permit access to a resident's financial account

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PPI = PII + PHI

Personally Identifiable Information (PII)	Protected Health Information (PHI)
• Information which can be used to trace an individual's identity when combined with other personal information • Examples: Person's name, social security number, or biometric records + personal information like date or place of birth, mother's maiden name	• Information that is already explicitly linked to particular individual and includes health information which can allow individual identification. • Examples: name, address, Social Security Number when associated with health information

Check with your supervisor to learn about your organization's protocols for entering personal information into your electronic systems.

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Security breach

Security breaches occur when unauthorized persons gain access to PPI/PHI by:

- Stealing computers and/or computer 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, such as hacking

- Unlike HIPAA, security breach under state law does not need to involve electronic records

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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.

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VRPM Policies and SHIP/SMP operations

How does VRPM 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

- Use private spaces in meetings with clients
- Use computer screen covers to block information from unauthorized viewers
- Store documents and locked offices or filing cabinets
- Shred documents when they were no longer needed
- Discuss cases in private
- Collect the minimum amount of information from the client
- Share minimum information related to a case as needed to assist train or report
- Return original documents and only make copies when needed

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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 SMP work
- Using 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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Strong Passwords

- Include a random combination of 8 or more numbers, symbols, capital and lower-case letters
  - Secure password generators and reputable password managers can help you keep track of strong passwords
  - Passphrases are also an option.
  - For example the phrase I like to sing and take long walks could be 1L2$&tLW

DO NOT:

- create passwords that are easy to remember
- use obvious passwords, like name of your favorite sports team
- Make passwords that someone can guess using information on social media
- Write down password where someone can easily find it, like a sticky note on monitor

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Wi-Fi Networks

- Always use secured networks and look for HTTPS in URL's
- Someone can access information more easily when you use unsecured Wi-Fi at places like coffee shops or airports
- Do not transmit or access PPI when using unsecured Wi-Fi network

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Privacy & Confidentiality Resources

-HHS Health Information Privacy Website
- www.hhs.gov/hipaa/index.html

-SHIP Resource Library: STARS Security Slick Sheet

-SHIP and SMP resource libraries:
- VRPM Policies and Procedures
- VRPM Information Technology Resources
- Unique ID resources (job aids, confidentiality agreements, etc.)

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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.

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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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What Is Medicare?

- Health insurance for people
  - 65 and older
  - Under 65 with certain disabilities
    - Including Amyotrophic Lateral Sclerosis (ALS) without a 24-month waiting period
  - Any age with End-Stage Renal Disease
- Enrollment, Premiums, and Replacement Medicare Cards handled by:
  - Social Security Administration (SSA) enrolls most people in Medicare
  - Railroad Retirement Board (RRB) enrolls railroad retirees in Medicare
  - Federal retirees' premiums are handled by the Office of Personnel Management (OPM)
- Administered by
  - Centers for Medicare & Medicaid Services

NOTE: To get Part A and/or Part B, you must be a U.S. citizen or lawfully present in the United States.

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The Four Parts of Medicare

Original Medicare		Medicare Advantage Part C	Medicare Prescription Drug Coverage
Part A Hospital Insurance	**Part B** Medical Insurance	Part A + Part B + **Part D** (Usually)	**Part D** Medicare prescription drug coverage
Inpatient hospital stays, skilled nursing facility care, home health care, and hospice care	Medically necessary services like doctor's visits and outpatient care. Also covers many preventive services, diagnostic tests, some therapies, and durable medical equipment	Private insurance companies approved by Medicare cover medically necessary services. Can charge different copayments, coinsurance, or deductibles for these services.	Outpatient prescription drugs.

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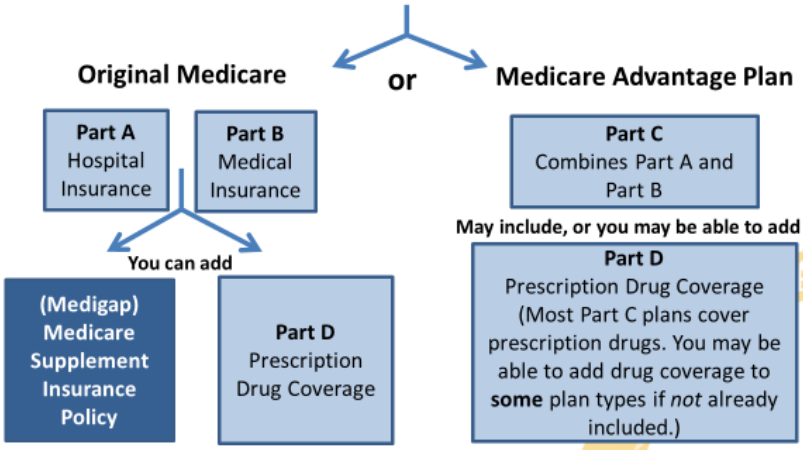
Medicare Coverage Choices



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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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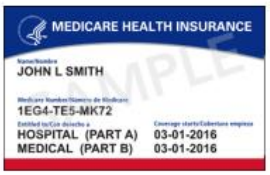
Medicare Card

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

New



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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 - 2021

- 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 - $471
    - Between 30 and 39 credits - $259
- 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 2021

- Deductible—$1,484 for inpatient hospital stays (days 1-60)
  - For inpatient hospital stays longer than 60 days
    - $371 per day for days 61-90
    - $742 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 - $185.50 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

Benefit periods can span across calendar years.

Ends 60 days in a row here...

Home

Not here...

Hospital or SNF

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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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Medicare Part B—Medical Insurance Coverage

- Part B—Medical Insurance helps cover
  - Doctors' services
  - Outpatient medical and surgical services, supplies
  - Clinical lab tests
  - Durable medical equipment
  - Diabetic testing supplies
  - Preventive services
  - Home health care

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Medicare Part B–Covered Preventive Services

- "Welcome to Medicare" preventive visit
- Yearly "Wellness" visit
- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (CVD) Risk Reduction Visit
- Cardiovascular disease screenings
- Cervical and vaginal cancer screening
  - Human Papillomavirus (HPV) Testing
- Colorectal cancer screenings
  - Screening fecal occult blood test
  - Screening flexible sigmoidoscop
  - Screening colonoscopy
  - Screening barium enema
  - Multi-target stool DNA test
- Depression screening

- Diabetes screenings
- Diabetes self-management training
- Flu shots (Vaccine)
- Glaucoma tests
- Hepatitis B shots (Vaccine)
- Hepatitis C screening test
- HIV screening
- Lung Cancer Screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Pneumococcal shots
- Prostate cancer screening
- Sexually-transmitted infections screening and counseling
- Tobacco use cessation counseling

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Medicare Part B Costs for Most People

Yearly Deductible	$203.00
Coinsurance for Part B Services	▪ 20% coinsurance for most covered services, like doctor's services and some preventive services, if provider accepts assignment ▪ $0 for some preventive services ▪ 20% coinsurance for outpatient mental health services, and copayments for hospital outpatient services

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What You Pay—Part B Premiums

- 2021 Premiums
  - Standard premium—$148.50 (or higher depending on your income)
  - The Medicare hold harmless provision prohibits Medicare Part B premiums from reducing the amount of an individual's Social Security benefits year over year.
  - Roughly 3.5% of beneficiaries who were subject to the "hold harmless" provision will pay less, as the increase in their Social Security benefits will not be large enough to cover the increased Part B premium.

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Monthly Part B Standard Premium—Income-Related Monthly Adjustment Amount for 2021

Chart is based on your yearly income *in 2019* (for what you pay in 2021)

File Individual Tax Return	File Joint Tax Return	File Married & Separate Tax Return	In 2021 You Pay
$88,000 or less	$176,000 or less	$88,000 or less	$148.50
above $88,000 up to $111,000	above $176,000 up to $222,000	Not applicable	$207.90
above $111,000 up to $138,000	above $222,000 up to $276,000	Not applicable	$297.00
above $138,000 up to $165,000	above $276,000 up to $330,000	Not applicable	$386.10
above $165,000 and less than $500,000	above $330,000 and less than $750,000	above $88,000 and less than $412,000	$475.20
$500,000 or above	$750,000 and above	$412,000 and above	$504.90

NOTE: You may pay more if you have a Part B late enrollment penalty.

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Paying the Part B Premium

- Deducted monthly from
  - Social Security benefit payments
  - Railroad retirement benefit payments
  - Federal retirement benefit payments
- If not deducted
  - Billed every 3 months
  - Medicare Easy Pay to deduct from bank account
- Contact Social Security, the Railroad Retirement Board, or the Office of Personnel Management about premiums

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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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How Medicare Advantage (MA) Plans Work (Continued)

- You're still in the Medicare program
  - Medicare pays the plan every month for your care
- Eligibility requirements
  - Enrolled in both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance)
  - Live in the plan's service area
- You still have Medicare rights and protections
- If the plan leaves Medicare you can
  - Join another MA Plan, or
  - Return to Original Medicare

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When You Can Join or Switch Medicare Advantage Plans

Initial Enrollment Period	▪ 7-month period begins 3 months before the month you turn 65 ▪ Includes the month you turn 65 ▪ Ends 3 months after the month you turn 65
Medicare Open Enrollment Period "Open Enrollment"	▪ October 15–December 7 ▪ Coverage begins January 1
Medicare due to a Disability	▪ 7-month period begins 3 months before the 25th month of disability. ▪ Ends 3 months after the 25th month of disability.
Special Enrollment Periods (SEP)	▪ You can make changes to your Medicare Advantage and Medicare prescription drug coverage when certain events happen in your life, like if you move or you lose other insurance coverage. Rules are different for each SEP.
Medicare Advantage Open Enrollment Period (MA-OEP)	▪ January 1 – March 31 - Medicare Advantage Plan members (See next slide)

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Medicare Advantage Open Enrollment Period (MA-OEP)

- January 1st through March 31st annually.
- This is in addition to the Fall Open Enrollment Period
- The Medicare Advantage OEP is somewhat more limited than the Fall Open Enrollment Period.
- Allows individuals ***enrolled in an MA plan to make a one-time election*** during this three month period to go to another MA plan or Original Medicare.
- If you enrolled in a Medicare Advantage Plan during your Initial Enrollment Period, you can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months you have Medicare.
- Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage.

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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

Medicare Part B will also cover the COVID-19 vaccination at no cost.

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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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Medicare Prescription Drug Plan Costs

- Costs vary by plan
- In 2021, most people will pay
  - A monthly premium
  - A yearly deductible (if applicable)
  - Copayments or coinsurance
  - 25% for covered drugs in the coverage gap
  - Very little after spending $6,550 out of pocket

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Medicare Part D – 2020-2021 Comparison

Part D Benefit Parameters	2021	2020
Standard Benefit		
Deductible	$445	$435
Initial Coverage Limit	$4,130	$4,020
Out-of-Pocket Threshold	$6,550	$6,350
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries	$9,313.75	$9,038.75
Estimated Total Covered Part D Spending for Applicable Beneficiaries	$10,048.39	$9,719.38
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$3.70	$3.60
Other	$9.20	$8.95

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Part D Standard Benefit

Ms. Smith joins a Medicare Prescription Drug Plan. Her coverage begins on January 1. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She pays a monthly premium throughout the year.

1. Yearly deductible	2. Copayment or coinsurance (what you pay at the pharmacy)	3. Coverage gap	4. Catastrophic coverage
Ms. Smith pays the first $445 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches $4,130 (Initial Coverage Limit).	Once Ms. Smith and her plan have spent $4,130 for covered drugs, she's in the coverage gap. In 2021, she gets a 70% discount from the drug manufacturer on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap. For 2021, she gets an additional 5% coverage from her plan on covered brand-name drugs and 75% coverage on covered generic drugs while in the coverage gap.	Once Ms. Smith has spent $6,550 out of pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.

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What is the Coverage Gap (Donut Hole)?

- Most Medicare Prescription Drug Plans have a coverage gap (also called the "donut hole").
- This means there's a temporary limit on what the drug plan will cover for drugs.
- The coverage gap begins after you and your drug plan have spent a certain amount for covered drugs.
  - In 2021, once you and your plan have spent $4,130 on covered drugs, you're in the coverage gap.
- People with Medicare who get Extra Help paying Part D costs do not have a coverage gap.

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Improved Coverage in the Coverage Gap

Year	What You Pay for Covered Brand-Name Drugs in the Coverage Gap	What You Pay for Covered Generic Drugs in the Coverage Gap
2020	25%	25%

H.R.1892 - Bipartisan Budget Act of 2018 – enacted 2/9/2018 - institutes key changes to Medicare Part D's "donut hole" (Coverage Gap) for applicable beneficiaries, effective January 1, 2019:

1. Closes the coverage gap one year early for applicable drugs, reducing standard beneficiary cost sharing in that phase from 30% to 25%
2. Increases pharmaceutical manufacturers' discount in the Coverage Gap Discount Program (CGDP) from 50% to 70% of the negotiated price of applicable drugs, resulting in lower costs to Part D plan sponsors

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Income-Related Monthly Adjustment Amount (Part D-IRMAA)

Your Yearly Income in 2019			In 2021 You Pay
Filing an Individual Tax Return	Filing a Joint Tax Return	File married & separate tax return	
$88,000 or less	$176,000 or less	$88,000 or less	$0.00 + YPP
above $88,000 up to $111,000	above $176,000 up to $222,000	Not applicable	$12.30* + YPP
above $111,000 up to $138,000	above $222,000 up to $276,000	Not applicable	$31.80* + YPP
above $138,000 up to $165,000	above $276,000 up to $330,000	Not applicable	$51.20* + YPP
above $165,000 and less than $500,000	above $330,000 and less than $750,000	above $88,000 and less than $412,000	$70.70* + YPP
$500,000 or above	$750,000 and above	$412,000 and above	$77.10* + YPP

***IRMAA is adjusted each year, as it's calculated from the annual beneficiary base premium.**

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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 ($33.06 in 2021)
    - 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

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Formulary

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

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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

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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

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How Plans Manage Access to Drugs

Prior Authorization	▪ Doctor must contact plan for prior approval and show medical necessity for drug before drug will be covered
Step Therapy	▪ Must first try similar, less expensive drug ▪ Doctor may request an exception if • Similar, less expensive drug didn't work, or • Step therapy drug is medically necessary
Quantity Limits	▪ 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

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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

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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

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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

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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
  - 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

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Extra Help – Income & Resource Limits

- Full extra help - income limited to
  - $17,388/year or $1,449/month individual
  - $23,517/year or $1,960/month couple
  - Resources*: $9,470/individual; $14,960/couple
- Partial extra help - income limited to:
  - $19,320/year or $1,610/month for an individual
  - $26,130/year or $2,178/month for a married couple
  - Resources*: $14,790/individual; $29,520/couple
  - Resources include bank accounts, stocks and bonds but not your home, life insurance, vehicle or personal belongings, and burial plans.

*includes a $1,500 burial exclusion

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Extra Help

- How to apply
  - Go to https://www.ssa.gov/extrahelp
  - Call Social Security at 1-800-772-1213
  - Apply at the nearest Social Security office
  - Call a SHICK counselor and apply over the phone or schedule an appointment with a local counselor
    - SHICK hotline phone number

1-800-860-5260

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What are Medicare Savings Programs

- Programs administered through KDHE (KanCare)
- Assistance with the cost of Medicare Part B for Medicare Beneficiaries including those over the age of 65 and those eligible for Medicare who receive SSA disability.
  - Savings may amount to up to $2,500 a year for an individual depending on which MSP they qualify for.
  - Medicare Savings Program are not subject to Estate Recovery.
    - This means that the home and assets will not be recouped by the state when one only receives funding through MSP, unlike Medicaid.

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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.

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Medicare Savings Programs in 2021

- Monthly Income Limits
  - QMB - $1073/individual; $1452/married couple
  - LMB - $1288/individual; $1742/married couple
  - ELMB - $1449/individual; $1960/married couple
- Resource limits - $9,470/individual; $14,960/couple
  - Resources include, bank accounts, stocks, bonds and life insurance.
  - Not counted: your home, personal belongings, vehicle, and burial plans

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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

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How to Apply

How to Apply for Medicaid or MSP:

- Apply on-line at: http://www.kancare.ks.gov/consumers/apply-for-kancare.
  - Call KanCare Clearinghouse – Family Medical 1-800-792-4884 for more information
- The MSP only application is available for download at the link above.
- Fill out the paper application and mail to:
  KanCare Clearinghouse
  P. O. Box 3599
  Topeka KS 66601
- Or you can fax your application to 1-844-264-6285.
- When applying for Extra Help, SSA will automatically send application information to the state to automatically apply for a Medicare Savings Program unless you opt out.

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Medicare Part D – 2020-2021 Comparison FBDE Part D Benefit Parameters

Full Subsidy – Full Benefit Dual Eligible (FBDE) Individuals (category code 3)	**2020**	**2021**
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries	$0.00	$0.00
Copayments for Beneficiaries Receiving Home and Community-Based Services	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL (category code 2)		
Generic/Preferred Multi-Source Drug/Biosimilar	$1.30	$1.30
Other	$3.90	$4.00
Above Out-of-Pocket Threshold	$0.00	$0.00
Over 100% FPL (category code 1)		
Generic/Preferred Multi-Source Drug/Biosimilar	$3.60	$3.70
Other	$8.95	$9.20
Above Out-of-Pocket Threshold	$0.00	$0.00

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Medicare Part D – 2020-2021 Comparison Non-FBDE & Partial Subsidy

Part D Benefit Parameters	**2020**	**2021**
Full Subsidy-Non-FBDE Individuals		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 135% FPL and resources ≤ $9,360 (individuals, 2020) or ≤ $14,800 (couples, 2020) [category code 1]		
Deductible	$0.00	$0.00
Generic/Preferred Multi-Source Drug/Biosimilar	$3.60	$3.70
Other	$8.95	$9.20
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Partial Subsidy		
Applied and income below 150% FPL and resources below $14,610 (individual, 2020) or $29,160 (couples, 2020) [category code 4]		
Deductible	$89.00	$92
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Generic/Preferred Multi-Source Drug/Biosimilar	$3.60	$3.70
Other	$8.95	$9.20

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Medicare's Limited Income Newly Eligible Transition (NET) Program

- LI-NET is a point-of-sale program which provides drug coverage for low-income individuals who are new to Medicare or newly eligible for Extra Help and don't have a Part D prescription plan already
- Gives temporary drug coverage until a beneficiary has enrolled in a Medicare prescription drug plan
- Administered by Humana, https://www.humana.com/pharmacy/pharmacists/linet

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Medicare Supplement Insurance (Medigap) Policies

- Medigap is private health insurance that supplements Original Medicare
  - You must have Part A and Part B
  - Helps pay some health care costs that Original Medicare doesn't cover
  - Medicare will pay its share of the Medicare-approved amounts for covered health care costs
    - Then your Medigap policy pays its share
  - **A Medigap policy covers one person**
- You pay a monthly premium for the Medigap policy
- You pay your Medicare Part B premium

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Medigap Plans

- Standardized plans identified by a letter (except in MA, MN, WI (waiver states))
- Plans with the same letter must offer all the same benefits
- Companies don't have to sell all plans
- Plans C & F are not available for individuals who are new to Medicare on or after 1/1/2020.

Plans Currently Sold	Plans that Exist, But Are No Longer Sold
A, B, C, D, F, G, K, L, M, and N	E, H, I, and J

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Medigap Plan Types

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**							$6,220	$3,110		

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 $2,370 in 2021 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 ($203 in 2021), 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.

See page 74 of the handout for full-size chart

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Original Medicare & Medigap Rights

- When you have Original Medicare this includes the right to buy a Medigap or Medicare Supplemental Insurance policy
  - Medigap policies must follow federal and state laws that protect the consumer
  - Medigap policy must be clearly identified as "Medicare Supplement Insurance"
  - Standardized policies in Kansas identified by letters A, B, C, D, F, G, K, L, M, N
  - The beneficiary has a right to buy a Medigap policy during your Medigap open enrollment period
  - The right to buy a policy for six months but the company may be able to make you wait for coverage for a pre-existing condition

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Gaps in Original Medicare Coverage

- Original Medicare doesn't cover everything
  - Original Medicare pays a share
  - You pay a share
    - Deductibles
    - Coinsurance/Copayments
    - Monthly Premiums
- Medigap insurance policies
  - Pay all or part of your share
  - Coverage depends on the supplement plan you buy

Buying a Medigap Policy

- You must have both Medicare Parts A and B
- You pay a monthly premium for Medigap
- You still pay the Medicare Part B premium
- Medigap policies cover one person
- Benefits are standardized
- Costs vary by plan and by company
- Do not cover prescription drugs if issued after January 1, 2006.

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Medigap Pricing Based on Age

Type of Rating	Description
No-age-rated (community-rated)	▪ Everyone pays same regardless of age if 65 or older ▪ Generally least expensive over lifetime
Issue-age-rated	▪ Based on age when purchased ▪ Doesn't go up automatically as you get older
Attained-age-rated	▪ Premium based on current age ▪ Costs less when you're 65 ▪ Cost goes up each year as you get older
Premiums may go up due to inflation and other factors. Not all states allow all 3 types of ratings.	

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The Best Time to Buy a Medigap Policy

- Your one 6-month Open Enrollment Period (OEP) begins when you're 65 or older and enrolled in Part B (some states have more generous rules)
- May buy a Medigap policy any time an insurance company will sell you one

Medigap Medicare Supplement Insurance

During Your Medigap OEP	NOT During Your Medigap OEP
Best time buy	May have pre-existing condition waiting period
Guaranteed Issue Period	May cost more
Companies must sell you any policy they sell for the same price even if you have a pre-existing condition	Companies can deny coverage

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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

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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.

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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

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Finding a Medigap Plan In Your Area

- https://insurance.kansas.gov/

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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

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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

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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

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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

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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

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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

AD ASTRA

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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

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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

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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

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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)

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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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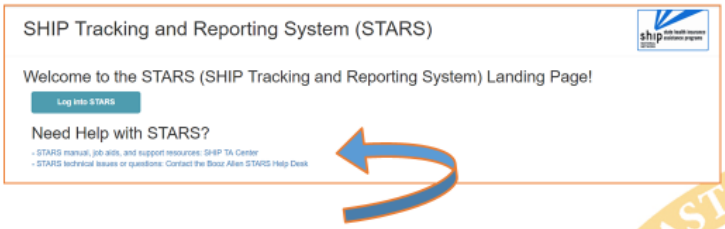
STARS Landing Page

- 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

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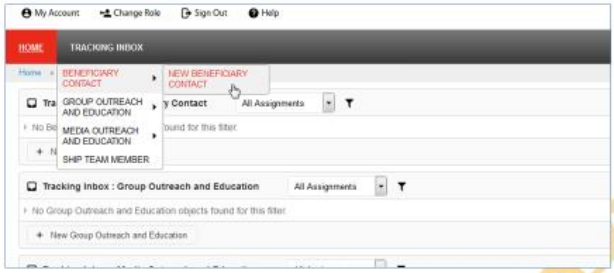
New Beneficiary Contact

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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SHIP Team Member Tracking Inbox

Date of Birth	01/01/1999
Gender	Male
Primary Language	English
Secondary Language	
SHIP eFile ID	26291
Program	SHIP
SIRS eFile ID	
Number of 1-800-Medicare Unique ID	

Your SIRS efile ID

Your Unique ID

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Group Outreach & Education (GOE)

- Report
  1. Interactive presentations
  2. Booth/Exhibits
  3. Enrollment Events
- GOE data count towards SHIP Performance Measure #2 – Number of Attendees
- Select date range for multiday events

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Outreach & Education Media (MOE)

- Remaining four options on NPR PAM (first three on GOE)
- Report all other media outreach and education

Billboards	Print	Radio
Email Blasts	Ads/Articles	Television
		Other

- Wide range of Geographic Coverage selections

Zip Code	Statewide	Regional
County/Counties	Multi-state	National

- Select date range for multiday events and campaigns

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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/xlx; 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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STARS Plan Cost SUF Fields

- **Original PDP/MA-PD Cost (Field 1)**
  - Enter the Estimated Drug Cost* of the plan the beneficiary's **current plan** listed in the Medicare Plan Finder
  - Round to nearest whole dollar
  - See the next page on how to calculate Original Medicare cost if beneficiary has no current Medicare PDP/MA-PD plan.
- **New PDP/MA-PD Cost (Field 2)**
  - 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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New to Medicare PDP/MA-PD

- If the beneficiary is new to PDP/MA-PD, select the New to Medicare topic in the "Additional Topic Details" group.
  - Select this even if the beneficiary has been enrolled in other parts of Medicare previously. This will allow ACL to track cost changes based on the plan's negotiated price vs. switching from one PDP-MA-PD to another.

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See the STARS Manual Chapter 4: Beneficiary Contacts Pg. 23 - 24 for more details

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New to Medicare PDP/MA-PD (cont.)

- Use the Plan Details page to locate the plan's negotiated drug price for use as the Original PDP/MA-PD Cost SUF 1.
- Multiply the monthly total retail cost at the beneficiary's pharmacy by the number of coverage months. This amount will be the estimated drug cost for SUF 1.
- Include a copy of the Plan Detail page as supporting documentation

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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).

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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

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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	
	Original PDP/MA-PD Cost	5094.96
	New PDP/MA-PD Cost	222.60

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Attach Part D Cost Verification

- Attach the following verification near the bottom of the Beneficiary Contact Form:
  1. Application confirmation (ex. previous slide)
  2. Cost change verification
     a. Comparison page displaying costs for the original plan and new plan OR
     b. Individual plan pages for both the original plan and the new plan

Attach File [ ] Browse

Attach File [ ] Browse

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Documentation - Confirmation

Your enrollment application has been received Page 1 of 2

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

Phone: 1-866-235-5660
Website: www.SilverScript.com

Print Your Application

It will take at least 10 days before you'll see your enrollment in your account.

If you don't see it after 10 days or you haven't heard from your plan, call your plan to

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Acceptable Documentation – Comparison

Round the amounts to the closest dollar, $0.00 = 0, $484.80 = 485
No decimal points, no commas, no dollar signs

Comparing 2 Prescription Drug plans Page 1 of 1

Comparing 2 Prescription Drug plans

Back to results

	SilverScript Choice (PDP)	WellCare Medicare Rx Value Plus (PDP)
Star rating	★★★★☆	★★★★☆
Monthly premium	$0.00	$40.40
Yearly drug deductible	$0.00	$0.00
	Plan Details	Plan Details

Overview

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

Drug coverage & costs

Drugs covered/Not covered	12 of 12 Prescription drugs covered Restrictions may apply	12 of 12 Prescription drugs covered Restrictions may apply
Estimated total drug + premium cost	AUBURN LTC WICHITA #181 ✓ Preferred in-network $0.00	AUBURN LTC WICHITA #181 ✓ Standard in-network $484.80
	Mail order pharmacy ✓ Standard in-network $0.00	Mail order pharmacy ✓ Standard in-network $484.80

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Plan Finder Cost Data

Comparing 2 Prescription Drug plans

Page 1 of 1

Comparing 2 Prescription Drug plans

Back to results

	SilverScript Choice (PDP)	WellCare Medicare Rx Value Plus (PDP)
Star rating: ★★★★☆		Star rating: ★★★★☆
Monthly premium	$0.00	$40.40
Yearly drug deductible	$0.00	$0.00
	Plan Details	Plan Details

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

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

Overview		
Premium	Total $0.00	Total $40.40
Deductible	Yearly drug deductible $0.00	Yearly drug deductible $0.00
Drug coverage & costs		
Drugs covered/Not covered	12 of 12 Prescription drugs covered Restrictions may apply	12 of 12 Prescription drugs covered Restrictions may apply
Estimated total drug + premium cost	AUBURN LTC WICHITA #181 ✓ Preferred in-network $0.00	AUBURN LTC WICHITA #181 ✓ Standard in-network $484.80
	Mail order pharmacy ✓ Standard in-network $0.00	Mail order pharmacy ✓ Standard in-network $484.80
	SilverScript Choice (PDP)	WellCare Medicare Rx Value Plus (PDP)

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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

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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

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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

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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

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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)

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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

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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)

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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

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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

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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

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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

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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 pad
  - 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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SHIP TA Center COVID-19 Resources

www.shiptacenter.org > SHIP Login

- COVID-19 in Toolbox > For Counselors
- COVID-19 Events
- COVID-19 News (from ACL, CMS, etc.)
- Resource Library:
  - COVID-19 Fact Sheets and Facebook images
  - COVID-19 resources from other SHIPs
- **Tip**: Use "Type for Search" – keyword "Covid"

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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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NCOA/MIPPA Center COVID-19 Resources (publicly available)

Key Resources about COVID-19:
www.ncoa.org/covid-19/covid-19-resources-for-professionals-1/key-government-resources-for-professionals/

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SMP Resource Center COVID-19 Resources

Publicly available

- COVID-19 Fraud page (includes a Spanish-language fraud alert): https://www.smpresource.org/Content/Medicare-Fraud/Fraud-Schemes/COVID-19-Fraud.aspx

Password-protected resources for SMPs: www.smpresource.org > SMP Login

- COVID-19 web events
- SMP Consumer Fraud Alert: COVID-19 Fraud Resources (includes several Spanish-language resources)
- SMP Resource Center Infographics – COVID-19
- **Tip:** Search for keyword "COVID".

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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. Janet Boskill, janet.boskill@ks.gov, 785-296-6319, Medicare Grants Coordinator
2. Chris Merriweather, chris.merriweather@ks.gov, 785-296-2991, Medicare Grants Coordinator

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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

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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

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 **Office of Personnel Management (Federal Employees Health Benefit Program)** opm.gov/healthcare-insurance/healthcare/ **Patient Assistance Program Center** rxassist.org **Medicare/TRICARE Benefit Overview** tricare.mil/Plans/Eligibility?sc_database=web **TRICARE** TRICARE.mil/ **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/ **Black Lung Program** dol.gov/compliance/topics/benefits-comp-blacklung.htm Call 1-800-638-7072. TTY: 1-877-889-5627 **Senior Medicare Patrol Program** smpresource.org Medicare.gov/fraud **OIG Fraud Hotline** Call 1-800-HHS-TIPS (1-800-447-8477) TTY: 1-800-337-4950 Fax 1-800-223-8162 **Prevention Toolkit** CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html **National Training Program – Partner Job Aids** CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram	

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.

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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.

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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.

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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

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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.

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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

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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

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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

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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 $2,370 in 2021 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 ($203 in 2021), 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

FBDE	Full Benefit Dual-Eligible
FDA	Food and Drug Administration
FEHBP	Federal Employee Health Benefits Program
FFS	fee-for-service
FI	Fiscal Intermediary
FICA	Federal Insurance Contributions Act
FMAP	Federal Medical Assistance Percentage
FPL	Federal poverty level
FPS	Fraud Prevention System
FR	Federal Register
FY	Fiscal year
G	
GAO	Government Accountability Office
GEP	General Enrollment Period (1/1 – 3/31 – each year)
GHP	Group Health Plan
H	
HBV	Hepatitis B Virus
HCBS	Home and Community Based Services
HCBWP	Home and Community Based Waiver Program
HCFA	Health Care Financing Administration (now CMS)
HCV	Hepatitis C Virus
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS (DHHS)	Department of Health and Human Services
HIC	Health insurance claim
HICN	Health insurance claim number (Medicare number)
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIV	Health Care Fraud Prevention and Enforcement Action Team
HMO	Health maintenance organization
HMO-POS	HMO Point-of-Service
HPV	Human Papillomavirus
HSA	Health Savings Accounts
I	
IADL	Instrumental Activities of Daily Living
ICFs/MR	Intermediate care facilities for the mentally retarded
IDE	Investigational Device Exemption
IEP	Initial enrollment period
IHS	Indian Health Service
IPPE	Initial Preventive Physical Examination
IRE	Independent review entity
IRMAA	Income-Related Monthly Adjustment Amount
IRS	Internal Revenue Service
I/T/U	Indian Tribes and Tribal organizations, and urban Indian organizations
IVR	Interactive Voice Response
K	
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment

L	
LEP	Late Enrollment Penalty
LIS	Low-income subsidy
LMB	Low-income Medicare beneficiary (KS-same as SLMB at Fed level)
L-OEP	Limited Open Enrollment Period
LPI	Low Performance Icon
LRD	Lifetime Reserve Days
LTC	Long-term care
LTCF	Long-term care facility
LTR	Lifetime Reserve
LTSS	
M	
M&M	Medicare and Medicaid
MA	Medicare Advantage
MAGI	Modified Adjusted Gross Income
MA-PD	Medicare Advantage with prescription drug plan
MAC	Medicare Administrative Contractor
MAC	Medicare Appeals Council
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAO	Medicare Advantage organizations
MEDIC	Medicare Drug Integrity Contractor
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person
MI	Medical Insurance (Medicare Part B)
MICs	Medicaid Integrity Contractors
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement, and Modernization Act (of 2003)
MMG	Medicare Marketing Guidelines
MNT	Medical Nutrition Therapy
MOON	Medicare Outpatient Observation Notice
MRI	Magnetic Resonance Imaging
MSA	Medicare Medical Savings Accounts
MSN	Medicare Summary Notice
MSP	Medicare Savings Program
MSP	Medicare Secondary Payer
MSPRC	Medicare Secondary Payer Recovery Contractor
MTM	Medication Therapy Management
N	
NAIC	National Association of Insurance Commissioners
NBI	National Benefit Integrity
NCC	National Coordinating Center
NCD	National Coverage Decision
NET	Newly Eligible Transition
NF	Nursing Facility
NIA	National Institute on Aging
NIH	National Institutes of Health

NIMH	National Institute of Mental Health
NOMNC	Notice of Medicare Non-coverage
NPA	National PACE Association
NPI	National Provider Identifier
NTP	National Training Program
O	
O&E	Outreach and Education
OASIS	Outcome and Assessment Information Set
OBRA	Omnibus Budget Reconciliation Act
OCR	Office for Civil Rights
OEP	Open enrollment period
OEPI	Open enrollment period for institutionalized individuals
OIG	Office of the Inspector General
OOP	Out-of-Pocket
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OPT	Outpatient Physical Therapy
OT	Occupational Therapy
P	
PA	Prior Authorization
PACE	Program of All-Inclusive Care for the Elderly
PAP	Patient Assistance Program
PBA	Pharmacy benefit administrator
PBMs	Pharmacy benefit managers
PDP	Medicare stand-alone prescription drug plan
PFFS	Private fee-for-service plan
PHI	Protected health information
PhRMA	Pharmaceutical Manufacturers and Researchers of America
POC	Plan of Care
POS	Point-of-Sale
PPACA	Patient Protection and Affordable Care Act 2010
PPO	Preferred provider organization
PPS	Prospective Payment System
PRO	Peer Review Organization (renamed QIO)
PSA	Prostate-specific antigen
PSO	Provider-sponsored organization
PT	Physical Therapy
Q	
Q&A	Questions and Answers
QAPI	Quality Assessment & Performance Improvement
QDWI	Qualified disabled and working individual
QHP	Qualified Health Plans
QI	Qualified Individuals
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
QMB	Qualified Medicare beneficiaries

QWDI	Qualified Working Disabled Individual (aka QDWI)
R	
RAC	Recovery Audit Contractor
RDF	Renal Dialysis Facility
REACH	Regional Education About Choices in Health
RFI	Request for Information
RHC	Rural Health Center
RHHI	Regional Home Health Intermediary
RNHCI	Religious Non Medicare Health Care Institution
RO	Regional Office
RRB	Railroad Retirement Board
S	
SCE	Subsidy-Changing Event
SEP	Special Enrollment Period
SGS	SafeGuard Services, LLC
SHI	Supplemental Health Insurance
SHICK	Senior Health Insurance Counseling for Kansas
SHIP	State Health Insurance Assistance Programs (SHICK)
SHOP	Small Business Health Options Program
SLMB	Special Low-Income Medicare Beneficiaries (Federal, same as LMB in KS)
SME	Subject Matter Expert
SMI	Supplemental Medical Insurance (Medicare Part B)
SMP	Senior Medicare Patrol
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SOW	Scope of Work
SPAP	State Pharmaceutical Assistance Program (NOT available in KS)
SS	Social Security
SSA	Social Security Act
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
SSN	Social Security Number
STI	Sexually transmitted infections
T	
TBD	To Be Determined
TDD	Telecommunications Device for the Deaf
TEFT	Testing Experience and Functional Assessment Tools
TFL	TRICARE for Life
Title I	Grants to State for old age assistance & medical assistance for the aged
Title II	Federal old age, survivors & disability insurance benefits (OASDI)
Title IV	Grants to States for aid & services to needy families with children (TAF)
Title X	Grants to State for aid to the blind (AB)
Title XIV	Grants to States for aid to the permanently & totally disabled (DI)
Title XIX	Grants to States for medical assistance programs (Medicaid)

Title XVI	Grants to States for aid to the aged, blind & disabled (ABD) & Supplemental Security Income (SSI)
Title XVIII	Health Insurance (Medicare)
Title XX	State operated home health care entitlement program
Title XXI	State Child Health Programs
TrOOP	True Out-of-Pocket
TTY	Text Telephones
TWWIA	Ticket to Work & Work Incentives Act (of 1999)
U	
U&C	Usual & customary
V	
VA (DVA)	Department of Veterans Affairs
W	
WCMSA	Workers' Compensation Medicare Set-Aide Arrangement
WPS	Wisconsin Physician Services
X	
XIXED	Title 19 Entitlement Date
Y	
YOB	Year of Birth
YTD	Year to Date
YYYY	Year
Z	
ZPIC	Zone Program Integrity Contractor

2020 Overview of Medicare A & B

Key: Shaded areas – Medicare Pays
White areas – You Pay

A		B	
Premium:	*40 work quarters = zero* *less than 30 quarters = $458* *30 - 39 quarters = $252*	Premium: $144.60 unless individual income over $85,000 or couple $170,000.	
Each benefit period* **In-patient Hospital**		$198 Deductible (per calendar year, January 1 to December 31)	
First 60 days	$1408 Deductible	**80%**	**20%**
Days 61-90	$352 per day co-payment		**C O I N S U R A N C E**
Lifetime Reserve Days 91-150	$704 per day co-payment	Physician's Charges (in or out of the hospital) Durable Medical Equipment & Supplies Ambulance Outpatient Hospital	
Skilled Nursing Facility First 20 days	100% (No co-pay)	Blood Lab Services	The first 3 pints
Days 21-100	$176 per day co-pay		
100% Services Home Health Hospice		**Preventive Services** **PAID 100%:** Welcome to Medicare Physical Exam, Screening Mammograms, Annual Pap Tests, Diabetes Screening, Bone Mass Measurement, Flu Shots, some Colorectal Cancer Screening, Screening & Counseling for Obesity, Medical Nutrition Therapy, Tobacco Use Cessation, Yearly Wellness Visit	
	$5 prescription drug co-pay 5% co-insurance inpatient respite care	**WITH CO-PAY OR DEDUCTIBLE:** Abdominal Aortic Aneurysm Screening, Diabetes Supplies & Self-Management, Prostate Cancer Screening, Glaucoma Screening, CCS - Barium enema, HIV Screening	
* Benefit period ends when patient is out of the hospital or skilled nursing facility for 60 consecutive days.		**Excess Charges** (15% over Medicare Allowed Charge)	

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* : _____

Partner Organization Affiliation* : _____

ZIP Code of Session Location * : _____

State of Session Location * : _____

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):

- ❑ CMS Outreach
- ❑ Congressional Office
- ❑ Friend or Relative
- ❑ Health/Drug Plan
- ❑ Partner Agency
- ❑ Previous Contact
- ❑ SHIP Mailings
- ❑ SHIP Media
- ❑ SHIP Presentation
- ❑ State SHIP Website
- ❑ SHIP TA Center
- ❑ SSA
- ❑ State Medicaid Agency
- ❑ 1-800 Medicare
- ❑ Other
- ❑ Not Collected

Method of Contact * (select only one):

- ❑ Phone Call
- ❑ Email
- ❑ Web-based
- ❑ Postal Mail or Fax
- ❑ Face to Face at Session Location/ Event Site
- ❑ Face to Face at Bene Home/ Facility

Beneficiary Age Group * (select only one):

- ❑ 64 or Younger
- ❑ 65 – 74
- ❑ 75 – 84
- ❑ 85 or Older
- ❑ Not Collected

Beneficiary Gender * (select only one):

- ❑ Female
- ❑ Male
- ❑ Other
- ❑ Not Collected

Beneficiary Race * (multiple selections allowed):

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Not Collected

Beneficiary Language *:

English is Beneficiary's Primary Language ❑ Yes ❑ No

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

❑ Yes ❑ No

Beneficiary Monthly Income * (select only one):

- ❑ Below 150% FPL
- ❑ At or Above 150% FPL
- ❑ Not Collected

Beneficiary Assets * (select only one):

- ❑ Below LIS Asset Limits
- ❑ Above LIS Asset Limits
- ❑ Not Collected

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

Original Medicare (Parts A & B)

- ❑ Appeals/Grievances
- ❑ Benefit Explanation
- ❑ Claims/Billing
- ❑ Coordination of Benefits
- ❑ Eligibility
- ❑ Enrollment/Disenrollment
- ❑ Fraud and Abuse
- ❑ QIO/Quality of Care

Medigap and Medicare Select

- ❑ Benefit Explanation
- ❑ Claims/Billing
- ❑ Eligibility/Screening
- ❑ Fraud and Abuse
- ❑ Marketing/Sales Complaints & Issues
- ❑ Plan Non-Renewal
- ❑ 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 *	**Status** *
____ Hours _____ Minutes	❑ In Progress ❑ Completed

Special Use Fields

Original PDP/MA-PD Cost: _____

New PDP/MA-PD Cost: _____

Field 3: _____

Field 4: _____

Field 5: _____

Notes

GROUP OUTREACH & EDUCATION FORM

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

MIPPA Event *:	❑ Yes ❑ No		
Send to SMP:	❑ Yes ❑ 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 *: _____

Start Date of Activity *: _____

End Date of Activity: _____

Type of Event * (select only one):

❑ Booth/Exhibit (Health Fair, Senior Fair or Community Event)

❑ Enrollment Event

❑ Interactive Presentation to Public (In-Person, Video Conference, Web-based Event, Teleconference)

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):

- ❑ Beneficiaries
- ❑ Employer-Related Groups
- ❑ Family Members/Caregivers
- ❑ Limited-English Proficiency
- ❑ Medicare Pre-Enrollees
- ❑ Partner Organizations
- ❑ People with Disabilities
- ❑ Rural Beneficiaries
- ❑ Other

Target Beneficiary Group * (multiple selections allowed):

- ❑ American Indian or Alaskan Native
- ❑ Asian
- ❑ Black or African American
- ❑ Disabled
- ❑ Hispanic/Latino
- ❑ Languages Other Than English
- ❑ Low Income
- ❑ Native Hawaiian or other Pacific Islander
- ❑ Rural
- ❑ N/A
- ❑ Not Collected
- ❑ Other

Topics Discussed * (multiple selections allowed):

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

(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 *:	❑ Yes ❑ No		
Send to SMP:	❑ Yes ❑ 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):

- ❑ Billboard
- ❑ Email
- ❑ Magazine
- ❑ Newsletter
- ❑ Newspaper
- ❑ Radio
- ❑ Social Media
- ❑ Television
- ❑ Website
- ❑ Other

Estimated Number of People Reached: _____

Geographic Coverage (select only one):

- ❑ County or Counties
- ❑ Multi-State
- ❑ National
- ❑ Regional
- ❑ Statewide
- ❑ 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):

- ❑ Beneficiaries
- ❑ Employer-Related Groups
- ❑ Family Members/Caregivers
- ❑ Limited-English Proficiency
- ❑ Medicare Pre-Enrollees
- ❑ Partner Organizations
- ❑ People with Disabilities
- ❑ Rural Beneficiaries
- ❑ Other

Target Beneficiary Group * (multiple selections allowed):

- ❑ American Indian or Alaskan Native
- ❑ Asian
- ❑ Black or African American
- ❑ Disabled
- ❑ Hispanic/Latino
- ❑ Languages Other Than English
- ❑ Low Income
- ❑ Native Hawaiian or other Pacific Islander
- ❑ Rural
- ❑ N/A
- ❑ Not Collected
- ❑ Other

Topics Discussed * (multiple selections allowed):

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

(Continued on p.2)

Special Use Fields
Field 1: _____ Field 2: _____ Field 3: _____ Field 4: _____ Field 5: _____
Notes