SHICK Initial Counselor Training
Course 3 Introduction to Medicare Coordination, Protections, and More

Online Pre-Training
Rev. 2/2020

Pre-Training Objectives

- Course 3 provides basic training in Medicare Coordination of Benefits, Medicare Rights and Protections, Medicaid programs, Medicare and Medicaid Fraud Prevention, and Medicare and the Health Insurance Marketplace.
- You should thoroughly study the course including the notes. You will need to pass an exam after this course before attending Course 4 In-Person SHICK Initial Training.

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Coordination of Benefits Overview

- Each type of health insurance coverage is called a "payer"
- When there's more than one payer, coordination of benefits rules determine which pays first
- There may be primary and secondary payers, and in some cases, there may also be a third payer
  - Medicare may be primary payer or secondary payer
  - Medicare may make no payment in some cases

Coordination of Benefits

AD ASTRA

If you have Medicare and other health coverage and/or prescription drug coverage, each type of coverage is called a payer. When there's more than one payer, coordination of benefits rules determine which payer pays first. The primary payer pays what it owes on your bills first, up to the limits of its coverage, and then you or your provider submits the claim to the secondary payer if there are costs the primary payer didn't cover. In some rare cases, there may also be a third payer. Medicare doesn't automatically know if you have other coverage. However, insurers must report to Medicare when they're responsible to pay first on your medical claims.

Medicare may be the primary payer or the secondary payer—it depends on the circumstances.

Medicare may make no payment when circumstances warrant.

When Medicare Is the Primary Payer

- If Medicare is your only insurance, or
- Your other source of coverage is
  - A Medicare Supplement Insurance (Medigap) policy
  - Medicaid (dual eligible)
  - Retiree benefits
  - The Indian Health Service (IHS)
  - TRICARE for Life (TFL) and you're retired from active duty
  - Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage if based on a group health plan (GHP), like from an employer
    - Except during the 30-month coordination period for people with End-Stage Renal Disease (ESRD)

Coordination of Benefits

Medicare is the primary payer for most people with Medicare, which means Medicare pays first on health care claims.

Generally, Medicare pays first when

- Medicare is your only source of medical, hospital, or drug coverage.
- You have a Medicare Supplement Insurance (Medigap) policy or other privately purchased insurance policy that isn't related to current employment. A Medigap policy may cover amounts not fully covered by Medicare.
- You have both Medicaid and Medicare coverage—"dual eligible"—with no other coverage that may be primary to Medicare.
- You have retiree coverage, in most cases. To know how a plan works with Medicare, check the plan's benefits booklet, or plan description provided by the employer or union, or call the benefits administrator.
- You get health care services from the Indian Health Service (IHS).
- You have TRICARE for Life (TFL) and you're retired from active duty. **NOTE**: TRICARE is a health care plan for active-duty service members, military retirees, and their families. TFL provides expanded medical coverage to Medicare-eligible uniformed services retirees 65 or older, to their eligible family members and survivors, and to certain spouses.
- You're covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA), like from an employer. The exception is during the 30-month coordination period for people with End-Stage Renal Disease (ESRD).

Medicare Secondary Payer

- When Medicare isn't legally responsible for paying a claim first
- Legislation that protects the Medicare Trust Funds
- Helps ensure Medicare doesn't pay when another insurer should pay first
- Saves about $8.85 billion annually
  - Claims processed by insurances primary to Medicare

Coordination of Benefits

AD ASTRA

Medicare Secondary payer is when Medicare isn't legally responsible for paying a claim. When Medicare started providing coverage in 1966, it was the primary payer for all claims except for those covered by workers' compensation, Federal Black Lung benefits, and Veteran's Administration (VA) benefits.

In 1980, Congress passed legislation that made Medicare the secondary payer to certain primary plans in an effort to shift costs from Medicare to the other appropriate sources of payment.

The Medicare Secondary Payer provisions have protected Medicare's Trust Funds by making sure that Medicare doesn't pay for services and items that certain health coverage is primarily responsible for paying. The Medicare Secondary Payer provisions apply to situations when Medicare isn't the person's primary health insurance coverage, or in situations where another entity has been identified as the primary payer.

Medicare saves about $8.85 billion annually on claims where another insurer is the primary payer before Medicare.

For detailed examples of when Medicare is the secondary payer, view the "How Medicare works with other coverage" chart in the Medicare publication "Your Guide to Who Pays First" at Medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf (Publication no. 02179).

Benefits Coordination & Recovery Center

- Medicare crossover process
  - Assists in coordinating benefits with entities that pay after Medicare
  - The BCRC signs a Coordination of Benefits Agreement (COBA) with insurers
  - In the absence of an agreement, people with Medicare must coordinate secondary or supplemental payment of benefits with any other insurers
- Medicare Secondary Payer claims investigation
  - BCRC learns about other insurance
  - Identifies which is primary
- Reports pending liability, no-fault insurance, or workers' compensation cases
- Ensures Medicare gets repaid for any conditional payments

Coordination of Benefits

AD ASTRA

The Coordination of Benefits process determines the correct primary payer.

Medicare crossover process – To help Medicare coordinate benefits with private insurance companies and other entities that pay after Medicare, the Benefits Coordination & Recovery Center (BCRC) signs a Coordination of Benefits Agreement (COBA) with employer retiree plans, private insurance companies, and other entities, like Medicaid. Then these entities submit a bi-weekly or monthly eligibility file containing their covered members to the BCRC. The BCRC then makes this information available to Medicare's Common Working File (CWF) which causes the transfer of Medicare Part A and Part B Fee-for-Service claims to responsible payers. This process is commonly called the "Medicare crossover process," and it happens on a daily basis. In the absence of an agreement, the person with Medicare must coordinate secondary or supplemental payment of benefits with any other insurers he or she may have in addition to Medicare.

Medicare Secondary Payer claims investigation – The BCRC initiates an investigation when it learns that a person with Medicare has other insurance. The investigation figures out whether Medicare or the other insurance pays first for health care costs for a person with Medicare. Medicare Secondary Payer information-gathering activities identify Medicare Secondary Payer situations quickly, making sure responsible parties are making correct payments. When another insurer is primary to Medicare, the BCRC creates an Medicare Secondary Payer record on Medicare's CWF to make sure Medicare pays secondary when appropriate.

Medicare may make a conditional payment—a payment for services on behalf of a person with Medicare, when there's evidence on the claim that the primary plan isn't paying promptly—in certain circumstances, like when a person with Medicare is injured, involved in an accident, or incurs a work-related illness, injury, or disease. After a settlement, judgment, award, or other payment is secured in connection with a liability, no-fault, or workers' compensation case, Medicare then has the right to recover its conditional payment.

BCRC Customer Service Representatives are available to assist you Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

Medicare and Other Types of Health Coverage

- Medicare and the Marketplace
- Possible health claims payers and determining who pays first

AD ASTRA

Coordination of Benefits

"Medicare and Other Types of Health Coverage," explains

- Medicare and the Marketplace
- Possible health claims payers and determining who pays first

Medicare and the Marketplace

- Medicare isn't part of the Health Insurance Marketplace
- If you have Medicare Part A, you've met the minimum essential coverage (MEC) requirement
- If you have Marketplace and Medicare coverage, you need to end any Marketplace cost savings being paid on your behalf
- If you have Medicare, it's illegal for someone to knowingly sell you a Marketplace plan

NOTE: You may have Medicare and a Marketplace plan through your employer (sold through the Small Business Health Options Program (called (SHOP)) if you're an active worker or a dependent of an active worker and you signed up for the QHP before you had Medicare

AD ASTRA

Medicare isn't part of the Health Insurance Marketplace. If you have Medicare Part A, you don't need to do anything related to the Marketplace (you're considered covered under the minimum essential coverage (MEC) requirement). If you have coverage through the Marketplace and through Medicare, you need to contact the Marketplace plan and end any subsidies, like premium tax credits or cost-sharing reductions paid on your behalf, no matter how you get Medicare (whether Original Medicare or a Medicare Advantage (MA) Plan (like a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)).

Also, your Marketplace coverage might not be renewed at the end of the benefit year. In cases where you get Medicare Part A retroactively, you lose premium tax credits once you're notified of the retroactive entitlement. If you have Medicare, it's illegal for someone to knowingly sell you a Marketplace plan.

NOTE: You may have Medicare and a Marketplace plan through your employer (sold through the Small Business Health Options Program (called (SHOP)) if you're an active worker or a dependent of an active worker and you signed up for the QHP before you had Medicare.

Medicare and Marketplace Coordination

- Generally, there's no coordination of benefits between Marketplace QHPs and Medicare
  - Unless enrolled in an employer-sponsored Small Business Health Options Program (SHOP) plan
- QHPs aren't secondary insurance to Medicare
- You may pay a lifetime Part B late enrollment penalty if you don't enroll in Part B during your Medicare Initial Enrollment Period (IEP) unless you're enrolled in an employer-sponsored SHOP plan
  - Individual Marketplace coverage isn't employer-sponsored coverage
- If you have to pay for Medicare Part A, you should compare your Medicare benefits and premiums with your Marketplace plan to see which one best meets your needs and budget
  - You have the option to stop Medicare coverage and continue your Marketplace coverage with premium tax credits, if otherwise eligible

Coordination of Benefits

AD ASTRA

Generally, there's no coordination of benefits between Medicare and an individual Marketplace QHP that you buy through the Health Insurance Marketplace. You should consider several important factors when deciding whether or not to stay in a QHP after you enroll in Medicare Part A.

- The QHP isn't secondary insurance, and it isn't required to pay any costs toward your coverage if you have Medicare.
- Individual Marketplace coverage isn't employer-sponsored coverage and it isn't based on current employment. If you have individual Marketplace coverage and only enroll in Part A during your Medicare Initial Enrollment Period (IEP), you won't be able to enroll in Part B later using a Special Enrollment Period (SEP). You'll have to wait for the General Enrollment Period (GEP) (January 1–March 31 each year), and you'll have to pay a lifetime Part B late enrollment penalty if you went without Part B for more than 12 months.
- Once your Part A coverage starts, any premium tax credits and cost-sharing reductions you may have qualified for through the Marketplace will stop. That's because Part A is considered minimum essential coverage, not Part B.
- If you have to pay for Medicare Part A, you should compare your Medicare benefits and premiums with your Marketplace plan to see which one best meets your needs and budget.
  - You have the option to stop Medicare coverage and continue your Marketplace coverage with premium tax credits, if otherwise eligible.
  - You may have to pay back all or some of your premium tax credits paid on your behalf for the months you were also enrolled in Medicare Part A, when you file your federal income tax.

Only individuals enrolled in the Small Business Health Options Program (SHOP) in the Marketplace will have coordination of benefits because SHOP coverage is based on current employment. These individuals have GHP coverage and Medicare will pay secondary to the GHP coverage. In addition, if these individuals consider delaying enrollment in Part B, they won't get a late enrollment penalty because SHOP employer-sponsored coverage is based on current employment. Visit HealthCare.gov for more information about the Marketplace.

It's important to know whether your medical costs are payable by other insurance payers first. This information helps health care providers figure out who to bill and how to file claims with Medicare. There are many insurance benefits and you could have many combinations of insurance coverage. Your particular combination will affect who pays and when.

Here's a list of possible health claims payers other than Medicare:

- Medicaid
- Group Health Plan (GHP)
- Retiree Group Health Plan
- No-Fault Insurance
- Liability Insurance
- Workers' Compensation Insurance
- Federal Black Lung Benefits Program
- Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage
- Veterans' Coverage
- TRICARE for Life

Depending on the type of additional insurance coverage you may have, Medicare may be the primary payer or secondary payer for your claim.

Medicaid

- Joint federal and state program that helps to pay
  - Medical costs for individuals and families with limited income and resources, and meet other requirements
  - Medicare costs—premiums, deductibles, and/or coinsurance if you meet certain conditions
- Never pays first for services covered by Medicare
- Pays after other coverage has paid (in rare cases)

NOTE: Federal law prohibits Medicare and MA providers and suppliers from balance billing a person in the Qualified Medicare Beneficiary (QMB) program under any circumstances

Coordination of Benefits

Medicaid is a joint federal and state program that helps pay medical costs for people and families who have limited income and resources, and meet other requirements. If you meet certain conditions, Medicaid can also help you pay Medicare costs like Medicare premiums, deductibles, and/or coinsurance through the Medicare Savings Program.

Medicaid never pays first for services covered by Medicare. It only pays after Medicare has paid. In rare cases where there's other coverage, Medicaid pays after the other coverage has paid. The term often used is that "Medicaid is the payer of last resort."

NOTE: All Original Medicare and MA providers and suppliers–not only those that accept Medicaid–must not charge individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill State Medicaid programs for these costs, but States can limit Medicare costs-sharing payments under certain circumstances.

Group Health Plans (GHPs)

- Coverage offered by many employers and unions, to
  - Current employees, spouses, and family members
  - Retirees, spouses, and family members
    - Retiree coverage may be employer-based Medicare Advantage or Part D plans
  - Includes Federal Employee Health Benefits (FEHB) Program
  - May be fee-for-service plan or managed care plan
- Employees usually can choose to keep or reject
- Businesses with 50 or fewer employees can offer Small Business Health Options Program (SHOP) plans

Coordination of Benefits

AD ASTRA

Coordination of benefits depends on whether you, your spouse or a family member is currently working or retired, and on the number of employees employed under your current employer.

Many employers and unions offer group health plan (GHP) insurance to current employees and/or retirees. For example, the Federal Employee Health Benefits (FEHB) Program plan is a type of GHP. You may also get group health coverage through your spouse's or other family member's employer. If you have Medicare and are offered coverage under a GHP, usually you can choose to accept or reject the plan. Generally, when the employer has fewer than 20 employees during the current and previous calendar year, Medicare pays first, so your employer may require that you enroll in Medicare too. The GHP may be a fee-for-service plan or a managed care plan, like an HMO.

Employers/unions may also arrange for their Medicare-eligible retirees, spouses, and dependents to get Medicare Advantage (Part C) managed health care and/or Medicare Part D (prescription drug coverage) through employer group waiver plans.

Businesses with 50 or fewer employees can offer Small Business Health Options Program (SHOP) plans from the Health Insurance Marketplace.

Employer Group Health Plans (EGHP) Continued

If You Are	Medicare Pays First
65 or older and have **retiree** coverage	Yes (as long as you don't have excluding conditions such as black lung, or others specified on next page)
65 or older with **employer group health plans (EGHP)** coverage through **current** employment (yours or your spouse's)	If the employer has less than 20 employees
Under 65 with a **disability** and have **EGHP** coverage through **current** employment (yours or a family member's)	If the employer has less than 100 employees
Eligible for Medicare due to **End-Stage Renal Disease (ERSD)** and you have **EGHP** coverage	When the 30-month coordination period ends, or if you had Medicare primary before you had ESRD

Coordination of Benefits

Medicare pays first if you have Group Health Plan (GHP) coverage, and you're

- Sixty-five or older and have retiree coverage
- Sixty-five or older with GHP coverage through current active employment, either yours or your spouse's, and the employer has fewer than 20 employees
- Under 65, have a disability, and are covered by a GHP through current employment (either yours or a family member's), and your/their employer has fewer than 100 employees
- Eligible for Medicare due to End-Stage Renal Disease (ESRD) and has GHP coverage through current active employment, either yours or your spouse's, and the 30-month coordination period has ended.

NOTE: If Medicare was their primary payer before the 30-month coordination period, Medicare will continue to be their primary insurance throughout the coordination period.

Non-Group Health Plans

- Medicare doesn't usually pay for services when diagnosis indicates that other insurers may provide coverage, including
  - No-fault insurance
  - Liability insurance (including self-insurance)
  - Work-related injury or illness (workers' compensation)
  - Illness related to mining (Federal Black Lung Benefits Program)

Coordination of Benefits

AD ASTRA

Medicare doesn't usually pay for services when the diagnosis indicates that other insurers may provide coverage, including

- No-fault insurance
- Liability insurance (including self-insurance)
- Work-related injury or illness (workers' compensation)
- Illness related to mining (Federal Black Lung Benefits Program)

No-Fault Insurance

- Includes automobile insurance, homeowners' insurance, and commercial insurance plans
- Pays regardless of who's at fault
- Medicare is secondary payer
- Medicare may make conditional payment
  - If claim not paid within 120 days
  - You won't have to use your own money to pay bill
  - Must be repaid when claim is resolved by the primary payer

Coordination of Benefits

AD ASTRA

No-fault insurance is insurance that pays for health care services resulting from personal injury or damage to someone's property regardless of who's at fault for causing it. Types of no-fault insurance include:

- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

Medicare is the secondary payer when no-fault insurance is available. Medicare generally won't pay for medical expenses covered by no-fault insurance. However, Medicare may pay for medical expenses if the claim is denied for reasons other than not being a proper claim. Medicare will make payment only to the extent that the services are covered under Medicare. Also, if the no-fault insurance doesn't pay promptly (within 120 days), Medicare may make a conditional payment for which Medicare has the right to seek recovery.

The money that Medicare used for the conditional payment must be repaid to Medicare when the no-fault insurance settlement is reached. If Medicare makes a conditional payment and you later resolve the insurance claim, Medicare will seek to recover the conditional payment from you. You're responsible for making sure that Medicare gets repaid for the conditional payment.

The Medicare Modernization Act of 2003 (P.L. 108-173, Title III, Sec. 301) further clarifies language protecting Medicare's ability to seek recovery of conditional payments.

Part D plans will pay for covered prescriptions that aren't related to the accident or injury.

Liability Insurance

- Protects against certain claims
  - Negligence, inappropriate action, or inaction
- Medicare is secondary payer
  - Providers must attempt to collect before billing Medicare
- Medicare may make conditional payment
  - If the liability insurer won't pay promptly (within 120 days)
  - Must be repaid when claim is resolved by the primary payer

Coordination of Benefits

AD ASTRA

Liability insurance is coverage that protects you against claims based on negligence, inappropriate action, or inaction that results in injury to someone or damage to property. Liability insurance includes, but isn't limited to:

- Homeowners' liability insurance
- Automobile liability insurance
- Product liability insurance
- Malpractice liability insurance
- Uninsured motorist liability insurance
- Underinsured motorist liability insurance

Medicare is the secondary payer in cases where liability insurance is available. If health care professionals find that the services they gave a person can be paid by a liability insurer, they must attempt to collect from that insurer before billing Medicare. Providers are required to bill the liability insurer first, even though the liability insurer may not make a prompt payment. Sometimes this can take a long time. If the insurance company doesn't pay the claim promptly (usually within 120 days), your doctor or other provider may bill Medicare. Medicare may make a conditional payment for services for which another payer is responsible, so you won't have to use your own money to pay the bill. The payment is conditional because the person with Medicare is responsible for making sure Medicare is repaid when a settlement judgment, award, or other payment is made.

Workers' Compensation

- Medicare generally won't pay for health care related to workers' compensation claims
- If a workers' compensation claim is denied, a claim may be filed for Medicare payment
  - Medicare may pay a claim that relates to a service or item otherwise covered by Medicare
- Workers' compensation claims can be resolved by settlements, judgments, awards, or other payments

Coordination of Benefits

AD ASTRA

Medicare generally won't pay for an injury, illness or disease covered by workers' compensation. If workers' compensation denies all or part of a claim on the grounds that it's not covered by workers' compensation, you may file a claim with Medicare. Medicare may pay the denied claim as long as it is for a medical service or item otherwise payable by Medicare.

Workers' compensation claims can be resolved by settlements, judgments, awards, or other payments.

Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)

- Funds to be set aside to pay for future medical or prescription drug services
- Funds must be used for the injury, illness, or disease covered by workers' compensation
- Only used for Medicare-covered services
- Medicare pays for Medicare-covered services after WCMSA funds are used up

Coordination of Benefits

AD ASTRA

A Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) is a financial agreement that assigns a portion of a workers' compensation settlement to pay for future medical services related to the workers' compensation injury, illness, or disease.

- Money placed in your WCMSA is only for paying future medical and/or prescription drug expenses related to your work injury, illness, or disease, and only if the expense is for a treatment that Medicare would cover.
- You can't use the WCMSA to pay for any other work injury or any medical items or services that Medicare doesn't cover (for example, dental services).
- If you're not sure what type of services Medicare covers, call 1-800-MEDICARE before you use any of the money that was placed in your WCMSA. TTY: 1-877-486-2048.
- After you use all of your WCMSA money appropriately, Medicare can start paying for Medicare-covered services related to your work-related injury, illness, or disease.

You may learn more about WCMSAs at go.cms.gov/wcmsa.

For more information, see Section 1862(b)(2) of the Social Security Act of 1954 (42 USC 1395y(b)(2)).

Federal Black Lung Benefits Program

- Covers lung disease/conditions caused by coal mining
- Services under this program
  - Considered workers' compensation claims
  - Not covered by Medicare
- For more information, contact the U.S. Department of Labor (DOL)
  - Call 1-800-638-7072; TTY: 1-877-889-5627

Coordination of Benefits

AD ASTRA

Some people with Medicare can get medical benefits through the Federal Black Lung Benefits Program for services related to lung disease and other conditions caused by coal mining. Medicare doesn't pay for health services covered under this program. Black lung claims are considered workers' compensation claims. All claims for services that relate to a diagnosis of black lung disease are referred to the Division of Coal Mine workers' compensation in the U.S. Department of Labor (DOL).

However, if the services aren't related to black lung, Medicare will serve as the primary payer when all the following are true:

- You have no other insurance primary to Medicare
- You're eligible for and entitled to Medicare
- The services you receive are covered by Medicare

If you get Federal Black Lung Benefits, you're eligible for prescription drugs, inpatient and outpatient services, and doctors' visits. In addition, home oxygen and other medical equipment, home nursing services, and pulmonary rehabilitation may be covered with a doctor's prescription.

For more information, call the U.S. DOL at 1-800-638-7072; TTY: 1-877-889-5627.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

- Requires employers with 20 or more employees to let employees and dependents keep health coverage under certain conditions
- Allows certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates
- Coverage is only available when coverage is lost due to certain specific events
  - Generally for 18 months, but can be longer in special circumstances
- Person must pay the entire insurance premium

Coordination of Benefits

AD ASTRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers with 20 or more employees to let employees and their dependents keep their health coverage for a time after they leave their employer group health plan, under certain conditions. This is called COBRA "continuation coverage." The law applies to private sector plans and state and local government-sponsored plans. It doesn't apply to federal government-sponsored plans, the government of the District of Columbia, any territory or possession of the United States, or certain church-related organizations. The Federal Employee Health Benefits Program is subject to similar temporary continuation-of-coverage provisions under the Federal Employees Health Benefits Amendments Act of 1988.

COBRA coverage can begin due to certain events, like loss of employment or reduced working hours, divorce, death of an employee, or a child ceasing to be a dependent under the terms of the plan. For loss of employment or reduced working hours, COBRA coverage generally continues for 18 months. Certain disabled individuals and their non-disabled family members may qualify for an 11-month extension of coverage from 18 to 29 months. Other qualifying events call for continued coverage up to 36 months.

Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since the participant pays both his/her part and the part of the premium his/her employer paid while he/she still worked.

COBRA (continued)

If You	Medicare Pays First
Are 65 or older or have a disability and have **COBRA** continuation coverage	In most cases
Have **COBRA** continuation coverage and are eligible for Medicare due to End-Stage Renal Disease	When your 30-month coordination period ends

Coordination of Benefits

Medicare usually pays first before Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage for aged and disabled individuals. Medicare pays second to COBRA for individuals with End-Stage Renal Disease (ESRD) during the 30-month coordination period.

Before electing COBRA coverage, people may find it helpful to talk with a State Health Insurance Assistance Program (SHIP) counselor to understand their options better. For example, if a person who already has Medicare Part A (Hospital Insurance) chooses COBRA, but waits to sign up for Medicare Part B (Medical Insurance) until the last part of the 8-month Special Enrollment Period following end of employment, the employer can make the person pay for services that Medicare would have covered if he or she had signed up for Part B earlier. COBRA doesn't provide for a Medicare Special Enrollment Period.

In some states, SHIP counselors can also give information about time frames on COBRA and Medigap guaranteed issue rights in a given state. Time frames may differ depending on state law.

Medicare Part D plans generally pay first before COBRA coverage for people 65 and older and for those who have a disability.

If you have COBRA and have ESRD, Medicare Part D pays first once you're out of your 30-month coordination period.

Veterans Coverage

- If you have Medicare and VA benefits
  - Can get treatment under either program
- Medicare pays when you choose to get your benefits from Medicare
- To receive services under VA benefits
  - You must get your health care at a VA facility, or
  - Have the VA authorize, or agree to pay for, services in a non-VA facility

Coordination of Benefits

AD ASTRA

If you have both Medicare and Veterans' benefits, you can get health care treatment under either program. However, you must choose which benefit you'll use each time you see a doctor or get health care (for example, in a hospital). Medicare won't pay for the same service authorized by Veterans Affairs (VA); similarly, VA coverage won't pay for the same service covered by Medicare.

To receive VA services, you must get your health care at a VA facility or have the VA authorize services in a non-VA facility. Veterans could be subject to a penalty for enrolling late for Medicare Part B, even if they're enrolled in VA health care.

VA benefits are given to people who: a) served in the active military, naval, or air service and were honorably discharged or released or b) were/are a Reservist or National Guard member, were called to active duty by a federal order (for other than training purposes), and completed the full call-up period.

Veterans of the United States Armed Forces may be eligible for a broad range of programs and services provided by the VA. Eligibility for most VA benefits is based on the service member's discharge from active military service under other than dishonorable conditions. Active service means full-time service, other than active duty for training, as a member of the Army, Navy, Air Force, Marine Corps, Coast Guard or as a commissioned officer of the Public Health Service, Environmental Science Services Administration, or National Oceanic and Atmospheric Administration.

TRICARE for Life Coverage (TFL)

- Medical coverage for Medicare-eligible uniformed services retirees 65 or older, their eligible family members and survivors, and certain former spouses
  - Medicare pays first and TFL pays second
- For services covered by TFL but not Medicare
  - TFL pays first and Medicare pays nothing
- For services you get in a military hospital or other federal provider
  - TFL pays first and Medicare generally pays nothing

Coordination of Benefits

TRICARE for Life (TFL) is expanded medical coverage for Medicare-eligible uniformed services retirees 65 or older, their eligible family members and survivors, and certain former spouses. If you have Medicare and TFL, Medicare is your primary insurance. TFL acts as your secondary payer, minimizing your out-of-pocket expenses. TFL benefits include covering Medicare's coinsurance and deductibles.

If you use a Medicare provider, the provider will file your claims with Medicare. Medicare pays its portion and electronically forwards the claim to the TFL claims processor. TFL pays the provider directly for TFL-covered services.

For services covered by both Medicare and TFL, Medicare pays first and TFL pays the remaining coinsurance for TRICARE-covered services.

For services covered by TFL but not by Medicare, TFL pays first and Medicare pays nothing. You must pay the TFL fiscal year deductible and cost shares.

For services covered by Medicare, but not by TFL, Medicare pays first and TFL pays nothing. You must pay the Medicare deductible and coinsurance.

For services not covered by Medicare or TFL, Medicare and TFL pay nothing and you must pay the entire bill.

When you get services from a military hospital or any other federal provider, TFL will pay the bills. Medicare doesn't usually pay for services you get from a federal provider or from another federal agency.

NOTE: TFL is coverage for all TRICARE beneficiaries 65 or older who have both Medicare Part A and Part B. Active-duty personnel are covered by TRICARE insurance. Coordination of benefits situations concerning TRICARE should be handled like other group health plans. However, Medicare may pay secondary to TRICARE in situations where people who get Medicare are serving on active duty.

For services not covered by Medicare or TFL, Medicare and TFL pay nothing and you must pay the entire bill.

When you get services from a military hospital or any other federal provider, TFL will pay the bills. Medicare doesn't usually pay for services you get from a federal provider or from another federal agency.

NOTE: TFL is coverage for all TRICARE beneficiaries 65 or older who have both Medicare Part A and Part B. Active-duty personnel are covered by TRICARE insurance. Coordination of benefits situations concerning TRICARE should be handled like other employer group health plans.

Coordination of Prescription Drug Benefits

- Ensures proper payment by Medicare Part D plans
- Medicare Part D plan usually pays primary
- If Medicare is secondary payer
  - Part D plan denies primary claims
  - Part D plan may make conditional payment
    - To ease burden on enrollee
    - Medicare is reimbursed

Coordination of Benefits

AD ASTRA

Generally, Medicare Part D provides primary coverage for prescription drugs. Whenever Medicare is primary, the Medicare prescription drug coverage is billed and will pay first.

When Medicare is the secondary payer, Part D plans will generally deny primary claims.

When Medicare is the secondary payer to a non-group health plan, or when a plan doesn't know whether a covered drug is related to an injury, Part D plans will usually make a conditional primary payment to ease the burden on you, unless certain situations apply.

The Part D plan won't pay if it's aware that you have workers' compensation, Federal Black Lung Program benefits, or no-fault/liability coverage, and has previously established that a certain drug is being used exclusively to treat a related illness or injury. For example, when you refill a prescription previously paid for by workers' compensation, the Part D plan may deny primary payment and default to Medicare Secondary Payer. The payment is conditional because it must be repaid to Medicare once a settlement, judgment, or award is reached. You should report the proposed settlement or update to Medicare by calling the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627; TTY: 1-855-797-2627, or by mailing relevant documents to the BCRC at P.O. Box 138832 Oklahoma City, OK 73113.

Possible Drug Coverage Payers

Employer Group Health Plans	Federal
• Retiree • Active employment • COBRA continuation coverage	• Medicare Part A or Part B • Federal Black Lung Program • Indian Health Service • Veterans Affairs • TRICARE for Life • AIDS Drug Assistance Programs
State	**Other**
• Medicaid programs • State Pharmaceutical Assistance Programs • Workers' Compensation	• No-Fault/Liability • Patient Assistance Programs • Charities

Coordination of Benefits

AD ASTRA

Possible drug coverage payers include:

Employer Group Health Plans

- Retiree
- Active employment
- COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation coverage

State

- Medicaid programs
- State Pharmaceutical Assistance Programs
- Workers' compensation

Federal

- Medicare Part A or Part B (limited)
- Federal Black Lung Program
- Indian Health Service
- Veterans Affairs
- TRICARE for Life
- AIDS Drug Assistance Programs

Other

- No-Fault/Liability insurance
- Patient Assistance Programs
- Charities

Important Retiree Drug Coverage Considerations

- Most retiree plans offer generous coverage for the entire family
  - Employer/union must disclose how its plan works with Medicare drug coverage
  - Talk to your benefits administrator for more information
- If you lose your creditable prescription drug coverage
  - You will get a Special Enrollment Period (SEP); the SEP
    - Starts with notification of the loss of creditable coverage
    - Ends either two months after the notification, or two months after the end of the coverage – whichever is later
- People who drop retiree drug coverage may
  - Lose other health coverage
  - Not be able to get it back
  - Cause family members to lose their coverage

Coordination of Benefits

AD ASTRA

- As mentioned earlier, people with Medicare who have employer or union retirement plans that cover prescription drugs must carefully consider their options. Your needs may vary from year to year based on factors like health status and financial considerations. Options provided by employer or union retirement plans can also vary each year. Each plan is required by law to annually disclose to its members how it works with Medicare prescription drug coverage. If you lose creditable coverage, you have a Special Enrollment Period (SEP) to pick up Part D coverage. The SEP starts with notification of the loss of creditable coverage and ends either 2 months after the notification or 2 months after the end of the coverage, whichever is later. Creditable coverage is coverage that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Contact the Employer Group Health Plan's benefits administrator for information, including how it works with Medicare drug coverage. When making a decision on whether to keep or drop coverage through an employer or union retirement plan, consider these important points:
- Most employer/union retirement plans offer prescription coverage comparable to Medicare drug coverage and often offer generous hospitalization and medical insurance for the entire family, which is particularly important for those who are chronically ill or have frequent hospitalizations
- If you drop retiree group health coverage, you may not be able to get it back
- If you drop drug coverage, you may also lose doctor and hospital coverage
- Family members covered by the same policy may also be affected, so any decision about drug coverage should consider the entire family's health status and coverage needs.

Type of Plan	Situation	Does Part D Pay First for Medically-Necessary Part D-Covered Prescriptions?
Group Health Plan (GHP)	You're 65 or older and have retiree coverage	Yes
	You're 65 or older with GHP coverage through current active employment (yours or your spouse's)	If the employer has fewer than 20 employees
	You're under 65 with a disability and have GHP coverage through current employment (yours or a family member's)	If the employer has fewer than 100 employees
	You're eligible for Medicare due to End-Stage Renal Disease (ESRD) and you have GHP coverage	When the 30-month coordination period ends, or if you had Medicare before you had ESRD
COBRA	You're 65 or older and have a disability and have COBRA continuation coverage	In most cases
	You have COBRA continuation coverage and are eligible for Medicare due to ESRD	When your 30-month coordination period ends
	Coordination of Benefits	

Part D (Medicare prescription drug coverage) usually pays first if you're 65 or older and have retiree coverage.

If you have GHP coverage—Medicare Part D pays first if

- You're a working individual 65 or older (you or your covered spouse is still working) with Medicare **and have** GHP coverage from an employer with **fewer than 20** employees
- You're under 65 with a disability and have GHP coverage—if the employer has **fewer than 100** employees
- You're eligible for Medicare due to ESRD and have GHP coverage—**after** the 30-month coordination period ends, or if you had Medicare before you had End-Stage Renal Disease (ESRD)

If you have COBRA continuation coverage—Medicare Part D pays first

- Generally for people 65 and older as well as those under 65 who have a disability
- If you're eligible for Medicare due to ESRD—once your 30-month coordination period ends

NOTE: Federal Employees Health Benefits (FEHB) is a type of GHP. It covers participating current and retired federal employees. There's usually not much benefit to having both Part D and FEHB coverage, unless you qualify for Extra Help. If you have both, and are retired, Part D would pay first.

Type of Plan	Situation	Does Part D Pay First for Medically-Necessary Part D-Covered Prescriptions?
Federal Black Lung Program	If you get these benefits	Yes, for prescriptions not related to lung disease and other conditions caused by coal mining.
Indian Health Insurance Services (IHS)	You get benefits from the Indian Health Service	Yes, even if you get your drugs from IHS, Tribal, or Urban Indian clinics.
Veterans Affairs (VA)	You have coverage through the Department of Veterans Affairs	There's no coordination of benefits. A prescription must be covered solely by either the VA or Medicare.
TRICARE for Life (TFL)	You have TRICARE for Life benefits	You generally won't need to enroll in a Part D plan.
State Medicaid Programs	You're enrolled in your state's Medicaid program	Yes, for all Part D-covered drugs. States may provide Medicaid coverage of drugs excluded from Part D coverage.
State Pharmaceutical Assistance Programs (SPAPs)	You get assistance from a State Pharmaceutical Assistance Program	Yes. The state just helps pay your Part D costs.

The **Federal Black Lung Program** covers people with lung disease from coal mining. If you get Federal Black Lung Program benefits, Medicare prescription drug coverage won't cover prescriptions related to lung disease and other conditions caused by coal mining. It will pay first for all other covered prescriptions.

The **Indian Health Service** (IHS) is the primary provider for the American Indian/Alaska Native (AI/AN) Medicare population. AI/AN people with Medicare can't be charged any cost-sharing. IHS, Tribal, and Urban Indian (I/T/U) pharmacies—that is, a pharmacy operated by IHS, an Indian tribe or tribal organization, or an Urban Indian organization, all of which are defined in Section 4 of the Indian Health Care Improvement Act of 1976, 25 USC 1603—must waive any copayments or deductibles that would've been applied by a Medicare drug plan.

Many Indian health facilities participate in the Medicare prescription drug program. If you get prescription drugs through an Indian health facility, you pay nothing, and your coverage won't be interrupted. Coordination of benefits with IHS and Tribes is tied to pharmacy network contracting. Regulations require all Part D sponsors to offer network contracts to all I/T/U pharmacies operating in their service area. Plans also must prove to Medicare that they offer AI/AN enrollees convenient access to I/T/U pharmacies.

Veterans Affairs (VA) benefits, including prescription drug coverage, are separate and distinct from benefits provided under Part D. Legally, VA can't bill Medicare. Although a person with Medicare may be eligible to get VA prescription drug benefits and enroll in a Medicare drug plan, he or she can't use both benefits for a single prescription. VA prescriptions generally must be written by a VA physician and can only be filled in a VA facility or through VA's Consolidated Mail Outpatient Pharmacy operations. The VA doesn't fill prescriptions for Part D sponsors. Since VA and Part D benefits are separate and distinct, a veteran's payment of a VA medication copayment doesn't count toward his or her gross covered drug costs, or true out-of-pocket (TrOOP) costs,

under his or her Part D benefit. Since VA prescription drug coverage is creditable coverage, you won't face a penalty if you delay enrolling in a Medicare drug plan. However, if you receive less than full VA prescription drug benefits, you may benefit from enrollment in a Medicare drug plan—particularly if you're eligible for Extra Help.

TRICARE for Life (TFL) coverage includes prescription drug benefits. These benefits qualify as creditable coverage (meaning they're as good as or better than the Medicare Part D benefit). People with TFL don't need to enroll in a Medicare drug plan when they have the TFL pharmacy benefit. If they choose to enroll in a Medicare drug plan at a later date, they won't be charged a Part D late enrollment penalty.

Under the Medicare Modernization Act (MMA), people with both **Medicare and full Medicaid benefits** (called "full-benefit dual eligibles") get drug coverage from Medicare instead of Medicaid. States may choose to provide Medicaid coverage for drugs the MMA excludes from Part D coverage. Some Medicare Special Needs Plans (SNPs) coordinate Medicare-covered services, including prescription drug coverage, for people with both Medicare and Medicaid.

If you get help from a **State Pharmaceutical Assistance Program (SPAP)**, Medicare pays first. The state just helps pay your Part D costs.

Type of Plan	Situation	Does Part D Pay First for Medically-Necessary Part D-Covered Prescriptions?
Workers' Compensation	If you're covered under workers' compensation	Yes, for prescriptions other than those for the job-related illness or injury. Medicare may make a conditional payment.
Manufacturer-sponsored Patient Assistance Program (PAP)	If you get help from a Manufacturer-sponsored PAP	Yes
Charity	If you get help from a charitable program	Yes
No-fault/ Liability Insurance	If you're covered by No-Fault/Liability insurance, like for an automobile accident, injury in a public place, or malpractice	For prescriptions covered by Part D not related to the accident or injury.

Coordination of Benefits

If you're covered under **Workers' Compensation**, Medicare will pay first for covered prescriptions that aren't related to the job-related illness or injury. Medicare drug plans will always make a conditional primary payment to ease the burden on the policyholder, unless certain situations apply. The Medicare drug plan won't pay if it's aware that you have workers' compensation, Federal Black Lung Program benefits, or no-fault/liability coverage and has previously established that a certain drug is being used exclusively to treat a related illness or injury. For example, when you refill a prescription previously paid for by workers' compensation, the Medicare drug plan may deny primary payment and default to Medicare secondary payer. The payment is conditional because it must be repaid to Medicare once a settlement, judgment, or award is reached.

If you get help from a manufacturer-sponsored **Patient Assistance Program (PAP)**, that help won't count toward your TrOOP costs. Medicare encourages PAPs to exchange eligibility files with Medicare so that Medicare drug plans are aware of your eligibility for PAP assistance and can set their computer system's edits to show when you get the drugs for free under the PAP. PAPs may charge a small copayment when giving this in-kind assistance, and this amount may count toward TrOOP. You'll need to submit a paper claim to the drug plan, along with copayment documentation.

If you get help from a **charitable program**, you may present a retail ID card at the point of sale to get financial help. Charities that choose to participate in electronic data exchange can speed up the settlement of claims at the point of sale. Some charities require you to submit a paper claim and then send claims to the TrOOP contractor in a batch form so that the TrOOP costs can be calculated accurately.

Any financial help a charity gives on your behalf will count toward the TrOOP catastrophic threshold, unless it's a GHP, government-funded health program, or other third-party payment arrangement.

If you're covered by **no-fault/liability insurance**, like an automobile accident, injury in a public place, or malpractice, Medicare pays first for prescriptions covered by Part D that aren't related to the accident or injury.

Medicare Rights and Protections

- Patient rights
- Appeals process
  - Part A and Part B (Original Medicare)
    - Medigap Rights
  - Part C (Medicare Advantage)
  - Part D (Medicare Prescription Drug Coverage)

AD ASTRA

Medicare Rights and Protections

"Rights and the Appeals Process," provides an overview of your Medicare rights and the process for appealing certain decisions.

- Patient rights
- Appeals process

Part A and Part B (Original Medicare)

Medigap rights

Part C (Medicare Advantage)

Part D (Medicare Prescription Drug Coverage)

Your Medicare Rights

- Rights and protections are designed to
  - Protect you when you get health care
  - Protect you against unethical practices
  - Make sure you get the medically necessary health care services that the law says you can get
  - Protect your privacy

Medicare Rights and Protections

AD ASTRA

In general, your Medicare rights and protections are designed to

- Protect you when you get health care
- Protect you against unethical practices
- Make sure you get the medically necessary health care services that the law says you can get
- Protect your privacy

Medicare Rights for Everyone with Medicare

You have the right to be

- Treated with dignity and respect at all times.
- Protected from discrimination. The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age.

If you think you haven't been treated fairly

- Visit HHS.gov/ocr
- Call the Office for Civil Rights (OCR) at 1-800-368-1019; TTY: 1-800-537-7697
- Contact the Medicare Beneficiary Ombudsman at 1-800-MEDICARE

Medicare Rights and Protections

Everyone with Medicare has the right to be

- Treated with dignity and respect at all times.
- Protected from discrimination. The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

These protections are generally limited to complaints of discrimination filed against providers of health care and social services who get federal financial assistance.

NOTE: If you think you haven't been treated fairly for any of these reasons, call the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), at 1-800-368-1019; TTY: 1-800-537-7697. For more information, visit HHS.gov/ocr.

You can also call 1-800-MEDICARE (1-800-633-4227) with a question or complaint. TTY users can call 1-877-486-2048. If you've already called but still need help, ask the 1-800-MEDICARE representative to send your question or complaint to the Medicare Beneficiary Ombudsman. The Ombudsman staff helps make sure that your question or complaint is resolved.

For more information about Medicare's Accessibility & Nondiscrimination Notice, visit Medicare.gov/about-us/nondiscrimination/accessibility-nondiscrimination.html.

Medicare Rights for Everyone with Medicare—Information

You have the right to

- Have personal and health information kept private
- Get information in a way you understand from
  - Medicare
  - Health care providers
  - Medicare contractors
- Get clear and simple information about Medicare to help you make health care decisions, including
  - What's covered
  - What Medicare pays
  - How much you have to pay
  - What to do if you want to file a complaint or appeal

Medicare Rights and Protections

AD ASTRA

You have the right to

- Have your personal and health information kept private
  - Learn more about your privacy rights. If you have
    - ❑ Original Medicare, see the "Notice of Privacy Practices for Original Medicare" at Medicare.gov/forms-help-resources/notice-of-privacy-practices-for-original-medicare
    - ❑ Medicare Advantage (MA) (like a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO)), other Medicare health plan, or a Medicare Prescription Drug Plan (PDP), read your plan materials
- Get information in a way that you understand from
  - Medicare
  - Health care providers
  - Medicare contractors
- Get clear and simple information about Medicare to help you make health care decisions, including
  - What's covered
  - What Medicare pays
  - How much you have to pay
  - What to do if you want to file a complaint or appeal

For more information about getting health care services in languages other than English, visit Medicare.gov/about-us/information-in-other-languages, or call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048.

Medicare Rights for Everyone with Medicare—Access to Care

- You have the right to
  - Have access to doctors, specialists, and hospitals
  - Learn about your treatment choices in clear language, and participate in treatment decisions
  - Get health care services in a language you understand and in a culturally sensitive way
  - Get Medicare-covered services in an emergency, when and where you need it
    - If your health is in danger and emergency help is needed, call 911
    - MA Plans, other Medicare health plans, and Medicare PDPs will cover emergency services without prior authorization

Medicare Rights and Protections

AD ASTRA

If you have Medicare, you have the right to

- Have access to doctors, specialists, and hospitals.
- Learn about your treatment choices in clear language that you can understand, and participate in treatment decisions. If you can't fully participate in your treatment decisions, ask a family member, friend, or anyone you trust to help you make a decision about what treatment is right for you.
- Get Medicare-covered services in an emergency, when and where you need it.
  - If your health is in danger because you have a bad injury, sudden illness, or an illness quickly gets worse, call 911. You can get emergency care anywhere in the United States.

To learn about Medicare coverage of emergency care in Original Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. In a Medicare Advantage Plan or other Medicare health plan, review your plan materials.

Medicare Rights for Everyone with Medicare—Grievances

- You have the right to file complaints (also called grievances) about
  - Services you got
  - Other concerns or problems getting health care and the quality of care you got
- If you're concerned about the quality of care you're getting
  - In Original Medicare, call the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) in your region (see next slide)
  - In an MA Plan (like an HMO or PPO), or another type of Medicare health plan, or Medicare drug plan, call the BFCC-QIO, your plan, or both
  - If you have End-Stage Renal Disease (ESRD), call the ESRD network in your state

Medicare Rights and Protections

AD ASTRA

You have the right to file complaints (also called grievances) about

- Services you got
- Other concerns or problems you have in getting health care and the quality of the health care you got

If you're concerned about the quality of care you're getting

- In Original Medicare, call the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) in your region to file a complaint (see next slide). Visit Medicare.gov/Contacts to get your BFCC-QIO's phone number, or call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048. The BFCC-QIO is a type of QIO (an organization of doctors and other health care experts under contract with Medicare) that uses doctors and other health care experts to review complaints and quality of care for people with Medicare. The BFCC-QIO makes sure there is consistency in the case review process while taking into consideration local factors and local needs, including general quality of care and medical necessity.
- In an MA Plan (like an HMO or PPO) or other Medicare health plan, or Medicare drug plan, call the BFCC-QIO, your plan, or both. The next slide displays a table of the BFCC-QIOs by region.
- If you have End-Stage Renal Disease (ESRD) and have a complaint about your care, call the ESRD network in your state. To get the phone number, visit Medicare.gov/Contacts or call 1-800-MEDICARE.

Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIO) Service Areas

Region	QIO
1 (CT, ME, MA, NH, RI, VT)	KEPRO
2 (NJ, NY, PR, VI)	Livanta BFCC-QIO Program
3 (DE, DC, MD, PA, VA, WV)	Livanta BFCC-QIO Program
4 (AL, FL, GA, KY, MS, NC, SC, TN)	KEPRO
5 (IL, IN, MI, MN, OH, WI)	Livanta BFCC-QIO Program
6 (AR, LA, NM, OK, TX)	KEPRO
7 (IA, KS, MO, NE)	Livanta BFCC-QIO Program
8 (CO, MT, ND, SD, UT, WY)	KEPRO
9 (AZ, CA, HI, NV, Pacific Islands)	Livanta BFCC-QIO Program
10 (AK, ID, OR, WA)	KEPRO

Medicare Rights and Protections

There are 2 BFCC-QIOs that review quality-of-care concerns and beneficiary appeals—KEPRO and Livanta.

- There are 10 regions handled by KEPRO or Livanta. Kansas is in Livanta Area 7.
- **KEPRO Area 1** – Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Call 1-888-319-8452; TTY: 1-855-843-4776, or visit keprogio.com/providers/transition.
- **Livanta Area 2** – New Jersey, New York, Puerto Rico, and the Virgin Islands. Call 1-866-815-5440; TTY: 1-866-868-2289, or visit livantagio.com/en/provider/transition.
- **Livanta Area 3** – Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. Call 1-888-396-4646; TTY: 1-888-985-2660, or visit livantagio.com/en/provider/transition.
- **KEPRO Area 4** – Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. Call 1-888-317-0751; TTY: 1-855-843-4776, or visit keprogio.com/providers/transition.
- **Livanta Area 5** – Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. Call 1-888-524-9900; TTY: 1-888-985-8775, or visit livantagio.com/en/provider/transition.
- **KEPRO Area 6** – Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. Call 1-888-315-0636; TTY: 1-855-843-4776, or visit keprogio.com/providers/transition.
- **Livanta Area 7** – Iowa, Kansas, Missouri, and Nebraska. Call 1-888-755-5580; TTY: 1- 888-985-9295, or visit livantagio.com/en/provider/transition.
- **KEPRO Area 8** – Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming. Call 1-888-317-0891; TTY: 1-855-843-4776, or visit keprogio.com/providers/transition.
- **Livanta Area 9** – Arizona, California, Hawaii, Nevada, and the Pacific Islands. Call 1-877-588-1123; TTY: 1-855-887-6668, or visit livantagio.com/en/provider/transition.
- **KEPRO Area 10** – Alaska, Idaho, Oregon, and Washington State. Call 1-888-305-6759; TTY: 1-855-843-4776, or visit keprogio.com/providers/transition.

Your Rights in a Medicare Advantage (MA) Plan (Part C) or Other Medicare Health Plan

- You have the right to
  - Choose health care providers within the plan
  - Get a treatment plan from your doctor
  - Know how your doctors are paid
  - Get a coverage decision or coverage information from your plan before getting services
  - Request an appeal to resolve differences with your plan
  - File a grievance about concerns or problems

Medicare Rights and Protections

AD ASTRA

- If you're in an MA Plan (like an HMO or PPO) or other Medicare health plan, in addition to the rights and protections previously listed for everyone with Medicare, you also have the right to
- Choose health care providers within the plan, so you can get the health care you need.
- Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need. Women have the right to go directly to a women's health care specialist within the plan without a referral for routine and preventive health care services, like mammograms and cervical and vaginal cancer screenings.
- Know how your doctors are paid. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
- Get a coverage decision or coverage information from your plan before getting services. You can call your plan before you get an item, service, or supply to find out if it's covered. You can also call your plan with questions about home health care rights and protections.
- Request an appeal to resolve differences with your plan. You have the right to ask your plan to provide or pay for an item or service you think should be covered. If your plan denies your request, you have the right to appeal that decision.
- File a complaint (also called a "grievance") about other concerns or problems with your plan, like your plan's hours of operation or if there aren't enough specialists to meet your needs.
- **NOTE**: HMO and PPO Plans are both coordinated care plans. In most cases, you have to get a referral to see a specialist in HMO plans. However, MA Plans also include Private Fee-for-Service (PFFS) and Medicare Medical Savings Account (MSA) Plans. PFFS and MSA plans aren't coordinated care plans. If you enroll in these plan types, you won't necessarily have a network of providers or be required to have a provider coordinate your care. If you're in a Special Needs Plan (SNP), generally, you must get your care and services from doctors or hospitals in the SNP's network. Exceptions include emergency or urgent care, like care you get for a sudden illness or injury that needs medical care right away or if you have ESRD and need out-of-area dialysis.

Your Rights with Medicare Prescription Drug Coverage

- You have the right to
  - Request a coverage determination or appeal to resolve differences with your plan
  - File a complaint (called a "grievance") with the plan
  - Have the privacy of your health and prescription drug information protected

Medicare Rights and Protections

AD ASTRA

In addition to the rights all people with Medicare have, if you have a Medicare Prescription Drug Plan (Part D) (sometimes called "PDPs") or a Medicare Advantage Plan with prescription drug coverage (MA-PD), you have the right to

- Request a coverage determination or appeal to resolve differences with your plan
- File a complaint (also called a "grievance") with the plan
- Have the privacy of your health and prescription drug information protected

For detailed information about additional protections, view Chapter 5 of the Medicare Prescription Drug Benefit Manual: Benefits and Beneficiary Protections (CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_093011.pdf) and Chapter 6: Part D Drugs and Formulary Requirements (CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf).

Appeal Rights in Original Medicare

- Request an appeal of health coverage or payment decisions if
  - A service or item you got isn't covered and you think it should've been
  - Payment for a service or item is denied, and you think Medicare should've paid for it
  - You disagree with a Medicare coverage or payment decision (you can appeal the decision)

Medicare Rights and Protections

AD ASTRA

You have the right to request an appeal of health coverage or payment decisions. You have the right to a fair, timely, and efficient appeals process. You can file an appeal if

- A service or item you got isn't covered, and you think it should've been
- Payment for a service or item is denied, and you think Medicare should've paid for it
- You disagree with a Medicare coverage or payment decision (you can appeal the decision)

How to Appeal in Original Medicare

- The "Medicare Summary Notice" (MSN) tells you
  - What Medicare paid
  - What you owe the provider or supplier
  - If Medicare fully or partially denied of your medical claim
    - Why Medicare didn't pay
  - Your appeal rights, and who to contact if you need help filing an appeal
  - How and where to file your appeal
  - How much time you have to appeal
- If you disagree with a Medicare coverage or payment decision, you can appeal the decision
  - Collect information that may help your case
  - Keep a copy of everything you send to Medicare
- You may have the right to an expedited (fast) appeal in certain situations

Medicare Rights and Protections

AD ASTRA

In Original Medicare, you get a "Medicare Summary Notice" (MSN) in the mail every 3 months if you get Part A and Part B covered items and services. You can sign up on MyMedicare.gov to get electronic MSNs (eMSNs) every month. The MSN shows you details of all items and services that have been billed to Medicare, including

- What Medicare paid
- What you may owe the provider or supplier
- If Medicare has fully or partially denied your medical claim (this is the initial determination that's made by the Medicare Administrative Contractor (MAC), which processes Medicare claims)
  - Why Medicare didn't pay
- Your appeal rights, and who to contact if you need help filing an appeal
- How and where to file your appeal
- How much time you have to file an appeal

If you disagree with a Medicare coverage or payment decision, you can appeal the decision. If you decide to appeal the decision, ask your doctor, health care provider, or supplier for any information that may help your case. Be sure to keep a copy of everything you send to Medicare as part of your appeal.

You may have the right to an expedited (fast) appeal in certain situations.

Expedited (Fast) Appeals in Original Medicare

- You have the right to an expedited appeal if you think
  - You're being discharged too soon from your Medicare-covered inpatient hospital stay
  - Your Medicare-covered services from the following are ending too soon
    - Skilled nursing facility (SNF)
    - Home health agency (HHA)
    - Comprehensive outpatient rehabilitation facility (CORF)
    - Hospice
- Ask your provider for any information that may help your case
- Request an expedited appeal
  - Call the BFCC-QIO in your region
  - No later than the date listed on the notice
- If you miss the deadline, you still have appeal rights

Medicare Rights and Protections

AD ASTRA

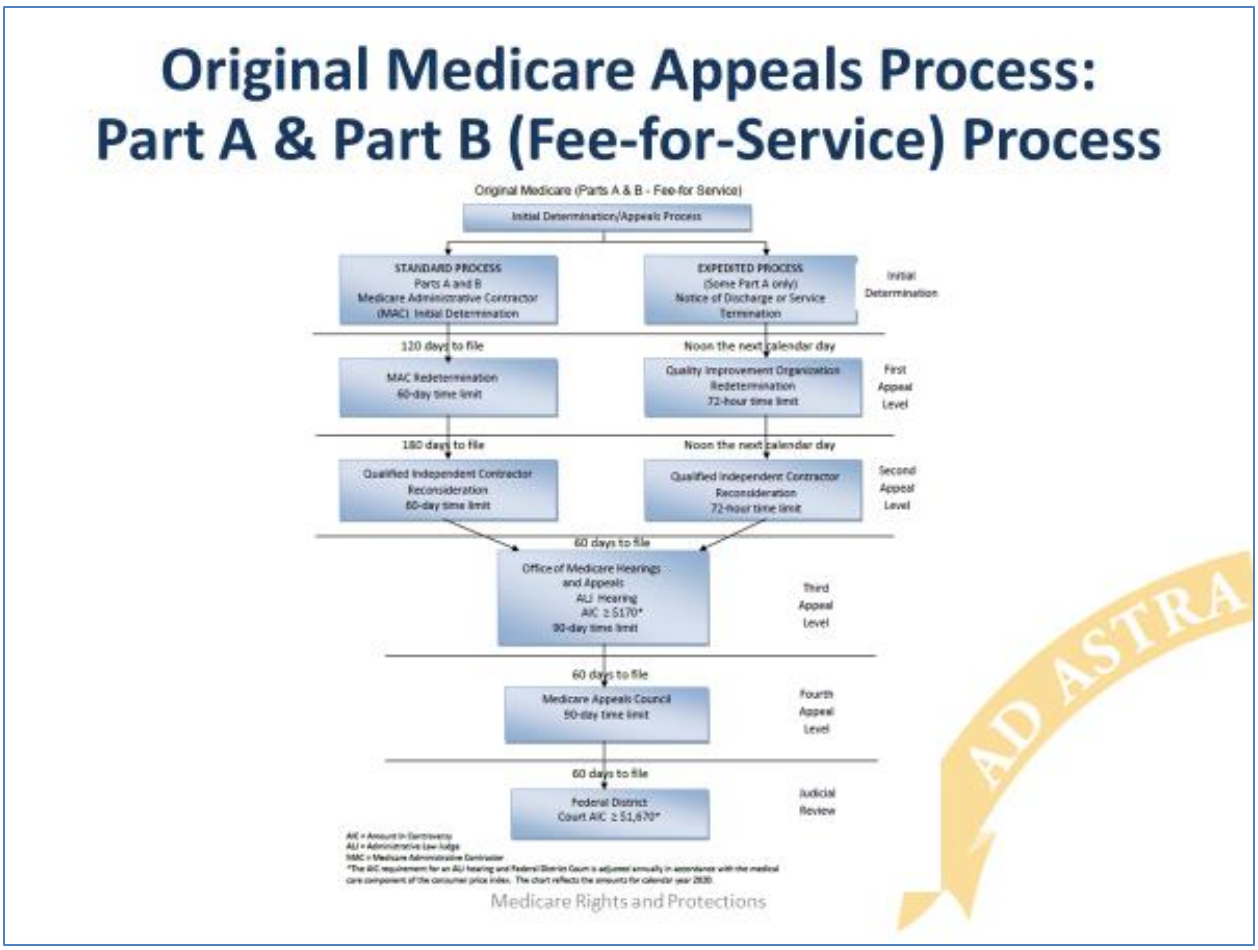
You have the right to an expedited (fast) appeal if you think you're being discharged too soon from your Medicare-covered inpatient hospital stay. Within 2 days of your hospital inpatient admission, you'll get a notice called "An Important Message from Medicare about Your Rights" (sometimes called the "Important Message from Medicare" or the "IM"). This notice gives you the BFCC-QIO's contact information and explains your rights.

You have the right to an expedited (fast) appeal if you think your Medicare-covered skilled nursing facility (SNF), home health agency (HHA), comprehensive rehabilitation outpatient facility (CORF), or hospice services are ending too soon. While you're getting SNF, HHA, CORF, or hospice services, you should get a notice called the "Notice of Medicare-Non Coverage" (NOMNC) at least 2 days before covered services end. This notice explains the date your covered services end, what you may have to pay for, your rights, and how to request an expedited (fast) appeal.

You may ask your doctor or health care provider for any information that may help your case if you decide to file an expedited (fast) appeal. You must call your regional BFCC-QIO to request an expedited (fast) appeal no later than the day you're scheduled to be discharged from a Medicare-covered inpatient hospital, and no later than noon of the day after you get the "Notice of Medicare Non-Coverage" (NOMNC) for a Medicare-covered SNF, HHA, CORF, or hospice.

To get the BFCC-QIO phone number, visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048.

If you miss the deadline, you can still ask the BFCC-QIO to review your case, but different rules and time frames apply.



There are 5 levels in the appeals process in Original Medicare (Part A and Part B) (fee-for-service).

Level 1: Redetermination by the MAC (by people at the MAC who weren't involved with the first decision). If you disagree with the redetermination decision made by the MAC in level 1, you have 180 days after you get the "Medicare Redetermination Notice" (MRN) to request a reconsideration by a Qualified Independent Contractor (QIC), which is level 2. Details are on the MRN.

Level 2: Reconsideration by a QIC (a contractor who didn't take part in the level 1 decision). If you disagree with the reconsideration decision in level 2, you have 60 days after you get the decision letter to request a hearing by an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals (OMHA), which is level 3.

Level 3: Decision by OMHA. The amount of your case must meet a minimum dollar amount, which is $170 for 2020. The ALJ will decide if your case meets the minimum dollar amount. You may be able to combine claims to meet the minimum dollar amount. Send the request to the OMHA office listed in the reconsideration decision letter. If you disagree with OMHA's decision in level 3, you have 60 days after you get the decision letter to request a review by the Medicare Appeals Council at the Department Appeals Board, which is level 4.

Level 4: Review by the Appeals Council. Follow the directions in the decision letter you got from OMHA in level 3 to file an appeal with the Appeals Council. There's no minimum dollar amount to request Medicare Appeals Council review. If you disagree with the Appeals Council's decision letter in level 4, you have 60 days after you get the Medicare Appeals Council's decision letter to request judicial review by a Federal District Court, which is level 5.

Level 5: Judicial Review by a Federal District Court. To get judicial review in Federal District Court, the amount of your case must meet a minimum dollar amount, which is $1,670 in 2020. You may be able to combine claims to meet this dollar amount. Follow the directions in the Appeals Council's decision letter you got in level 4.

NOTE: For a full-size copy of the appeals process flowchart, visit CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/Flowchart-FFS-Appeals-Process.pdf.

Original Medicare
Protection From Unexpected Bills

- "Advance Beneficiary Notice of Non-coverage (ABN)"
  - Given by health care provider or supplier
    - Says Medicare probably won't pay for a service or item
    - Isn't required for services or items excluded under law
    - Asks you to choose whether to get services or items
    - Asks you to confirm you read/understood notice

Medicare Rights and Protections

AD ASTRA

You're protected from unexpected bills. If your health care provider or supplier believes that Medicare won't pay for certain items or services, in many situations they'll give you a notice that says Medicare probably won't pay for an item or service under Original Medicare and explains why. This is called an "Advance Beneficiary Notice of Non-coverage (ABN)." The ABN, Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to people with Original Medicare (fee for service) in situations where Medicare payment is expected to be denied.

Doctors and suppliers aren't required to give you an ABN for services Medicare never covers (i.e., excluded under Medicare law), like routine eye exams, dental services, hearing aids, and routine foot care. However, they may voluntarily give you an ABN for items and services excluded by Medicare as a courtesy.

You'll be asked to choose an option on the ABN form and sign it to say that you've read and understand the notice. If you choose to get the items or services listed on the ABN, you'll have to pay if Medicare doesn't. In some cases, the provider may ask for payment at the time the item or service is received.

NOTE: See Appendix A for a copy of the ABN. It's also available at CMS.gov/Medicare/Medicare-General-Information/BNI/ABN.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Visit CMS.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

Medigap Rights in Original Medicare

- Buy a private Medicare Supplement Insurance (Medigap) policy
  - Guaranteed issue rights in your Medigap Open Enrollment Period ensure insurance companies
    - Can't deny you Medigap coverage
    - Can't place conditions on coverage
    - Must cover pre-existing conditions
  - Can't charge more because of past or present health problems
  - Some states give additional rights

Medicare Rights and Protections

AD ASTRA

A Medicare Supplement Insurance (Medigap) policy is a health insurance policy sold by private insurance companies to fill the gaps in Original Medicare coverage, like coinsurance amounts.

Your rights when you're enrolled in Original Medicare include the following:

- In some situations, you have the right to buy a Medigap policy. Medigap policies must follow federal and state laws that protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance." Medigap insurance companies in most states (except Massachusetts, Minnesota, and Wisconsin) can only sell you a standardized Medigap policy. These policies are identified by the letters A, B, C, D, F, G, K, L, M, and N. The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from.
- You have the right to buy a Medigap policy during your Medigap Open Enrollment Period, a 6-month period that automatically starts the month you're 65 and enrolled in Medicare Part B, and once it's over, you can't get it again.
- When you have guaranteed issue rights, the Medigap insurance company
  - Can't deny you Medigap coverage or place conditions on your policy
  - Must cover you for pre-existing conditions
  - Can't charge you more for a policy because of past or present health problems
- Some states offer additional rights to purchase Medigap policies.

Your Rights in Medicare Advantage and Other Medicare Health Plans

You have the right to

- Choose health care providers within the plan
- Get a treatment plan from your doctor
  - For complex or serious conditions
  - Allows you to directly see specialists as often as necessary

AD ASTRA

Medicare Rights and Protections

If you're in a Medicare health plan (such as a Medicare Advantage [MA] Plan), in addition to the rights and protections previously listed in the first section, you have the right to

- Choose health care providers within the plan, so you can get the health care you need.
- Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need. Women have the right to go directly to a women's health care specialist within the plan without a referral for routine and preventive health care services.

NOTE: Medicare Advantage Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) Plans are both coordinated care plans. In most cases you have to get a referral to see a specialist in HMO plans. However, Medicare Part C (MA Plans), also includes Private Fee-for-Service (PFFS) and Medicare Savings Account (MSA) Plans. PFFS and MSA plans aren't coordinated care plans. If you enroll in these plan types, you won't necessarily have a network of providers or be required to have a provider coordinate your care.

Coverage and Appeal Rights in Medicare Health Plans

You have the right to

- Know how your doctors are paid
- Get a coverage decision or coverage information from your plan before getting services
- A fair, efficient, and timely appeals process
  - Five levels of appeal
  - Decision letter sent explaining further appeal rights
  - Automatic review of Part C plan reconsideration
    - By Independent Review Entity (IRE)
- File a grievance about concerns or problems

Medicare Rights and Protections

AD ASTRA

If you're in a Medicare health plan, you have the right to

- Know how your doctors are paid. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
- Find out from your plan, before you get a service or supply, if it'll be covered. You can call your plan to get information about the plan's coverage rules.
- Resolve your appeal in a fair, efficient, and timely process to resolve differences with your plan. You have the right to ask your plan to provide or pay for an item or service you think should be covered, provided, or continued.

The appeals process consists of 5 levels

If coverage is denied at any appeal level, you'll get a letter explaining the decision and instructions on how to proceed to the next appeal level

If the plan continues to deny coverage at the reconsideration level, the appeal is automatically sent to the Part C (Medicare Advantage) Independent Review Entity

File a grievance about other concerns or problems with your plan, check your plan's membership materials or call your plan to find out how to file a grievance.

See "Medicare Rights & Protections" (CMS Product No. 11534) for more details at Medicare.gov/Pubs/pdf/11534.pdf.

Expedited (Fast) Appeals Process for a Medicare Advantage (MA) Plan or Other Medicare Health Plan

- You have the right to an expedited appeal if you think you're being discharged too soon from your Medicare-covered inpatient hospital stay
- Within 2 days of your inpatient hospital admission, you should get the "An Important Message from Medicare about Your Rights" notice which will include BFCC-QIO contact information and an explanation of your rights
- Contact your BFCC-QIO no later than the day you're scheduled to be discharged from the hospital to ask for an expedited appeal
  - You'll get a "Detailed Notice of Discharge" by noon the day after the BFCC-QIO tells the hospital with a decision
    - If the BFCC-QIO decides you're being discharged too soon, the plan will continue to cover your Medicare-covered hospital stay
    - If the BFCC-QIO decides you're ready to be discharged, you won't have to pay the hospital charges (except for applicable coinsurance or deductibles) until noon of the day after the BFCC-QIO decision

Medicare Rights and Protections

DASTRA

You have the right to an expedited (fast) appeal if you think you're being discharged too soon from your Medicare-covered inpatient hospital stay. Within 2 days of your inpatient hospital admission, you should get a notice called "An Important Message from Medicare about Your Rights" (sometimes called the "Important Message from Medicare" or the "IM") with BFCC-QIO contact information and an explanation of your rights.

Contact your BFCC-QIO no later than the day you're scheduled to be discharged from the hospital. When the BFCC-QIO gets your request, it will tell the plan and the hospital, and then the plan or your hospital will give you a "Detailed Notice of Discharge" by noon of the day after the BFCC-QIO tells the hospital. The notice will explain why your services are no longer covered, the applicable Medicare coverage rule or policy, and how the rule or policy applies to your specific situation.

If the BFCC-QIO decides that you're being discharged too soon, the plan will continue to cover your Medicare-covered hospital stay as long as medically necessary (except for applicable coinsurance or deductibles).

If the BFCC-QIO decides that you're ready to be discharged and you met the deadline for requesting a fast appeal, you won't be responsible for paying the hospital charges (except for applicable coinsurance or deductibles) until noon of the day after the BFCC-QIO gives you its decision. If you get any inpatient hospital services after noon of that day, you may have to pay for them.

If you miss the deadline for a fast appeal, you can still ask the BFCC-QIO to review your case, but different rules and timeframes apply and you may be responsible for paying for services after the original discharge date.

Expedited (Fast) Appeals Process for a Medicare Advantage (MA) Plan or Other Medicare Health Plan (continued)

- You have the right to an expedited appeal if you think your Medicare-covered services from a SNF, HHA, or a CORF are ending too soon
- Your plan must deliver the "Notice of Medicare Non-Coverage" (NOMNC) at least 2 days before covered services end
- Contact your BFCC-QIO no later than noon the day after you get the "NOMNC" to request an expedited appeal
- Provider will give you a "Detailed Explanation of Non-Coverage" by the end of the day that it gets the notice from the BFCC-QIO
  - If services are ending too soon, your plan will continue to cover the services (except for applicable coinsurance or deductibles)
  - If services should end, you won't be responsible for paying for the services provided before the termination date on the "NOMNC"

Medicare Rights and Protections

AD ASTRA

You have the right to a fast appeal if you think your services from a Medicare-covered SNF, HHA, or a CORF are ending too soon. Your provider or plan must deliver a "NOMNC" at least 2 days before covered services end. This notice explains the date your services end, what you have to pay for, your rights, and how to request an expedited (fast) appeal.

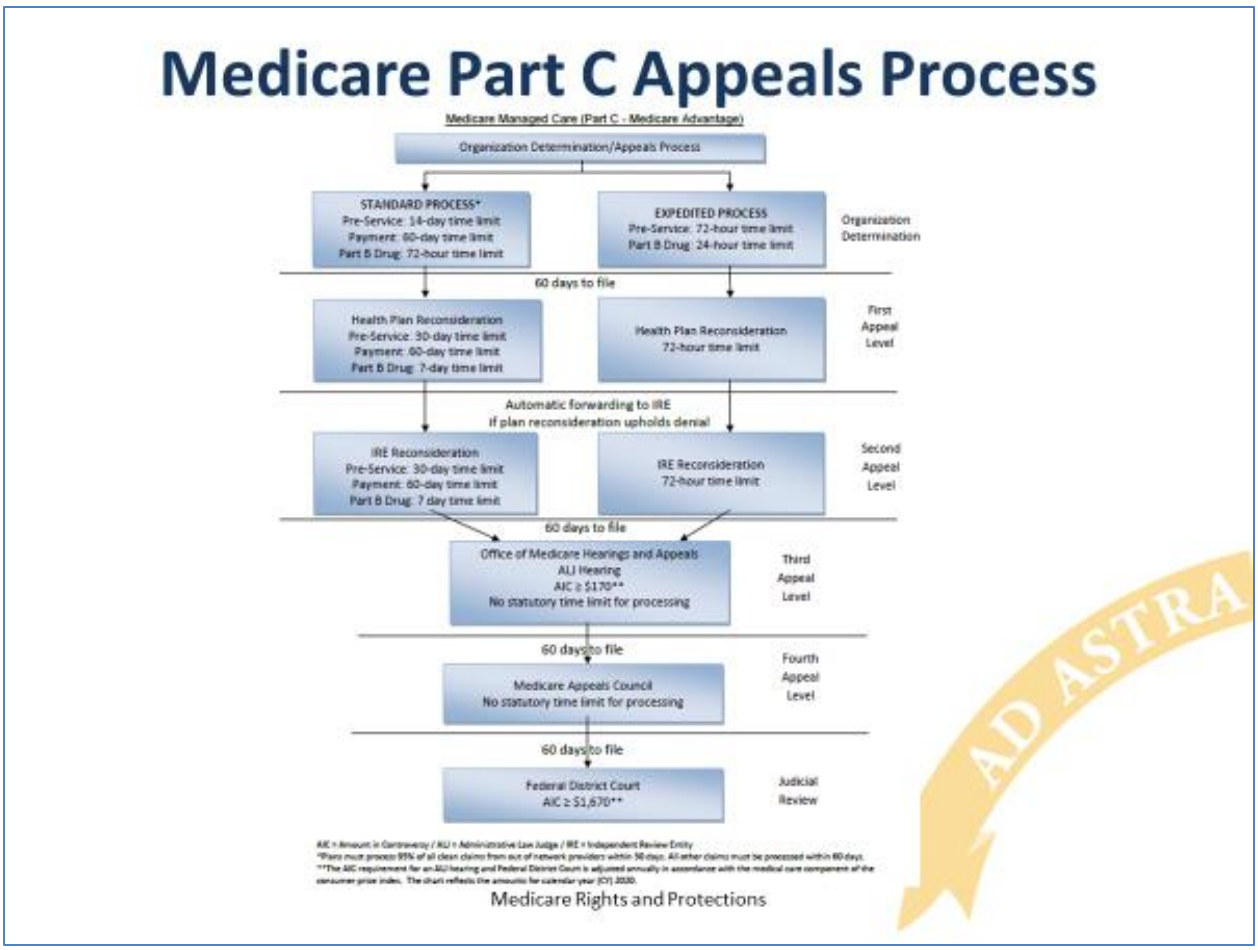
Contact the BFCC-QIO no later than noon of the day after you get the "NOMNC" to request an expedited (fast) appeal. See your notice for instructions on how to do this.

When the BFCC-QIO gets your request, it will tell the plan and the provider. The provider will give you a "Detailed Explanation of Non-Coverage" by the end of the day that it gets the notice from the BFCC-QIO. The notice will explain why your plan intends to stop covering your services, the Medicare coverage rule or policy that applies to your situation, and any plan policy, contract provision, or reason on which your discharge decision was based.

If the BFCC-QIO decides that your services are ending too soon, your plan will continue to cover your Medicare-covered SNF, HHA, or CORF services (except for applicable coinsurance or deductibles).

If the BFCC-QIO decides that your services should end, you won't be responsible for paying for any SNF, HHA care, or CORF services provided before the termination date on the "NOMNC." If you continue to get services after the coverage end date, you may have to pay for those services.

If you miss the deadline for requesting a fast appeal, you can still ask the BFCC-QIO to review your case, but different rules and timeframes apply.



This chart shows the appeals process for Medicare Advantage (MA) or other Medicare health plan enrollees. The time frames differ depending on whether you're requesting a standard appeal, or if you qualify for an expedited (fast) appeal. If you ask your plan to provide or pay for an item or service and your request is denied, you can appeal the plan's initial decision (the "organization determination"). You'll get a notice explaining why your plan denied your request and instructions on how to appeal your plan's decision.

There are 5 levels of appeal. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so.

First, your plan will make an Initial Determination. Pre-service time frames could possibly be extended 14 additional days. After each level, you'll get instructions on how to proceed to the next level of appeal. The 5 levels of appeal are

1. Reconsideration by the plan
2. Reconsideration by the Independent Review Entity (IRE)
3. Hearing with the Administrative Law Judge (ALJ)—the amount of your claim must meet a minimum dollar amount which is updated yearly. The amount for 2020 is $170
4. Review by the Medicare Appeals Council (MAC)
5. Review by a federal district court (to get a review by a federal court, the remaining amount in controversy of your case must meet a minimum dollar amount which is updated yearly. The amount in 2020 is $1,670

NOTE: For a full-size copy of the Part C (Medicare Advantage[MA]) appeals process flowchart, visit CMS.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart-.pdf.

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Medicare Prescription Drug Coverage (Part D) Rights—Access to Covered Drugs

- Must ensure enrollees can get the medically necessary drugs they need
- Must include more than one drug in each classification
- Must pay for brand-name as well as generic drugs
- Will have rules for managing access

Medicare Rights and Protections

AD ASTRA

Medicare drug plans provide people with Medicare high-quality, cost-effective prescription drug coverage. Medicare drug plans must ensure that their enrollees can get medically necessary drugs to treat their conditions.

Each plan has a list of covered drugs called a formulary. A plan's formulary may not include every drug you take. However, in most cases, a similar drug that is safe and effective will be available.

Plans must pay for both brand-name and generic drugs. Covered drugs include prescription drugs, biological products, and insulin. Medical supplies associated with the injection of insulin—like syringes, needles, alcohol swabs, and gauze—are also covered.

Some of the methods that plans use to manage access to certain drugs include prior authorization, step therapy, and quantity limits, which we'll discuss in this section.

Requesting Part D Appeals

- If your coverage determination or exception is denied, you can appeal the plan's decision
- In general, you must make your appeal requests in writing
  - Plans must accept verbal expedited (fast) requests
  - Limited time frame to file an appeal request (within 60 days or later with good cause)
- An appeal can be requested by
  - You or your appointed representative
  - Your doctor or other prescriber

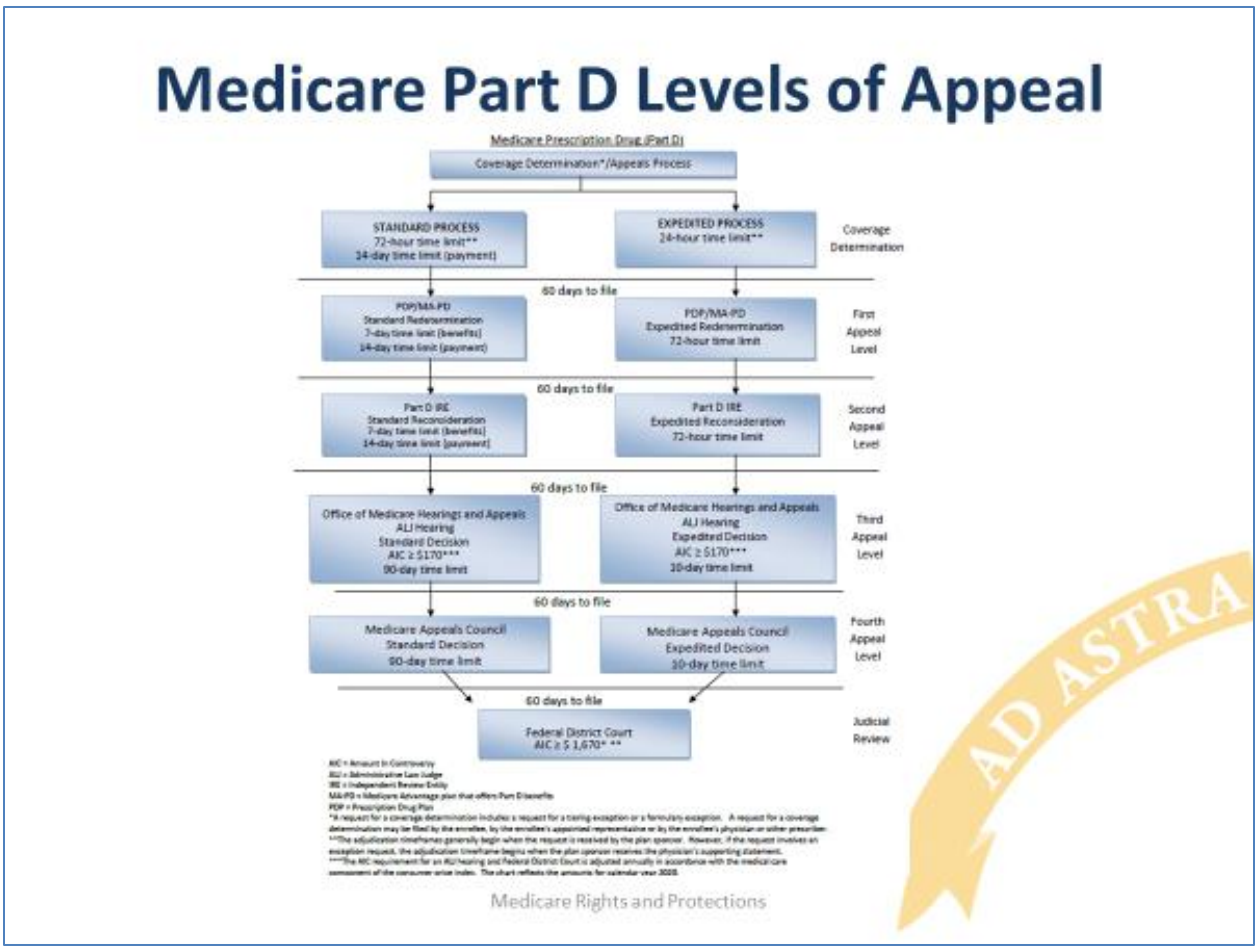
Medicare Rights and Protections

AD ASTRA

If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal the decision. Your plan's written decision will explain how you may file an appeal. Read this decision carefully and call your plan if you have questions. Most appeals must be requested within 60 days of the coverage determination or denial of an exception. However, this time frame may be extended for good cause (a circumstance that kept you from making the request on time or whether any actions by the plan may have misled you). For more information on good cause, visit CMS.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html.

In general, you must make your appeal requests in writing. However, plans must accept verbal expedited (fast) redetermination requests. In addition, plans may choose to accept verbal standard redetermination requests. Check your plan materials, or contact your plan to see if you can make verbal standard redetermination requests.

You or your appointed representative may ask for any level of appeal (CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/downloads/ModelCoverageDeterminationRequestForm.pdf). Your doctor or other prescriber can only ask for a redetermination or IRE reconsideration (level 1 or 2 appeal) on your behalf without being your appointed representative.



If you get an unfavorable initial decision, you have the right to appeal the decision.
There are 5 levels of appeal:

1. Redetermination from the Part D plan (sponsor)
2. Reconsideration by an Independent Review Entity
3. Hearing before an Administrative Law Judge—the amount of your claim must meet a minimum dollar amount which may change yearly. The amount for 2020 is $170. Review by the Medicare Appeals Council
4. Review by a federal district court—to get a review by a federal court, the remaining amount in controversy of your case must meet a minimum dollar amount which may change yearly. The amount for 2020 is $1,670.

Important: The Part D Late Enrollment Penalty (LEP) reconsideration process is unrelated to the appeals process flowchart—the appeals flowchart relates to benefit appeals. There's only one level of independent review for LEP disputes.

NOTE: For a full-size copy of the Part D (Drug) appeals process flowchart, visit CMS.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Downloads/Flowchart-Medicare-Part-D.pdf.

1: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days.2: The AIC requirement for all appeals at the Office of Medicare Hearings and Appeals (OMHA) and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2020 AIC amounts. 3: A request for a coverage determination includes a request for a tiering exception or a formulary exception. The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.4: Payment requests cannot be expedited.

Required Part D Notices

- "Medicare Prescription Drug Coverage and Your Rights" pharmacy notice
  - At the pharmacy counter
    - Whenever a prescription isn't filled as written
    - This isn't a coverage decision
  - For every coverage determination
  - For every appeal decision
  - Adverse (unfavorable) coverage decisions must
    - Include information on the next appeal level
    - Include specific filing instructions
    - Provide specific reason(s) for denial

Medicare Rights and Protections

AD ASTRA

Plan sponsors must ensure that their network pharmacies provide a written copy of the standardized CMS "Pharmacy Notice" to you whenever a prescription can't be filled by Part D and the issue isn't resolved at the pharmacy counter. This notice explains your right to contact your plan to ask for a coverage determination, including an exception.

Plans' sponsors are required to provide written notices for every coverage determination or appeal decision.

In addition, all other appeal entities are required to send written notice of decisions. If a decision is adverse (unfavorable), the notice will explain the reason for the decision, include information on the next appeal level, and provide specific instructions about how to file an appeal.

NOTE: An initial coverage decision about your Part D drugs is called a "coverage determination," or simply put, a "coverage decision." *A coverage decision is a decision the plan makes about your benefits and coverage*, or about the amount it will pay for your prescription drugs. The plan is making a coverage decision for you whenever it decides what's covered for you and how much it will pay.

Provider/Plan Disclosure of Personal Health Information (PHI)

- Plan may disclose relevant PHI to people you identify
  - Family members or other relatives
  - Close personal friends
  - Others (see examples on next page)
- Plan may disclose relevant PHI only if
  - You're present and agree or plan infers you don't object
  - You're not present or are incapacitated, the plan can exercise professional judgment

Medicare Rights and Protections

AD ASTRA

A health care provider or plan, like a Medicare drug plan, may disclose relevant protected Personal Health Information (PHI) to someone who assists you, specifically regarding your drug coverage. However, the guidance applies to all providers and plans, not just drug plans. It's important to note that health plans are permitted, but not required, to make these disclosures.

Your plan may disclose relevant PHI to those identified by you as being involved in your care or payment, including the following:

- Family members or other relatives
- Close personal friends
- Others (see examples on the next page)

Your plan may disclose relevant PHI to those identified by you only under the following conditions:

- When you're present and agree or the plan reasonably infers from the circumstances that you don't object. (For example, your representative is speaking to CMS on the phone and you've been included in the conversation. Although the CMS representative may not have explicitly asked for your permission to speak to the person who's assisting you, your direct involvement in the conversation may reasonably imply your consent.)
- When you're not present or are incapacitated, the plan may exercise its professional judgment to determine whether disclosure is in your best interest.

To Whom Plans May Disclose Personal Health Information (PHI)

- A plan may disclose PHI to
  - A person's adult child to resolve a claim or payment issue for a hospitalized parent when the parent gives permission
  - A human resources representative if the person is on the call or gives permission by phone
  - A congressional office that faxed your request for congressional assistance
  - CMS staff if information satisfies the plan that you requested CMS' help

Medicare Rights and Protections

AD ASTRA

A plan may disclose Personal Health Information (PHI) to

- A person's adult child who is resolving a claim or payment issue for a hospitalized parent when the parent gives permission
- A human resources representative if the person with Medicare is on the line or gives permission by phone
- A congressional office or staff person who has faxed the person's request for congressional assistance
- CMS staff if the available information satisfies the plan that the individual requested CMS' help

NOTE: PHI guidelines were published by the Office for Civil Rights, U.S. Department of Health and Human Services (HHS.gov/ocr/index.html).

Your Rights in Certain Settings

- A brief explanation of your rights
  - In the hospital
  - In a skilled nursing facility
  - When getting home health care
  - When getting hospice care
  - In a Comprehensive Outpatient Rehabilitation Facility

Medicare Rights and Protections

AD ASTRA

"Your Rights in Certain Settings," explains your guaranteed rights when you're admitted to a hospital or skilled nursing facility, or you're receiving care from a non-institutional provider, like home health care, hospice care, or from a Comprehensive Outpatient Rehabilitation Facility (CORF).

Many of these rights and protections are the same whether you're in Original Medicare, a Medicare Advantage (MA) Plan (like a Health Maintenance Organization [HMO] or Preferred Provider Organization [PPO]), or another Medicare health plan.

Right to Hospital Care

- Right to medically necessary Medicare-covered hospital care to
  - Diagnose an illness
  - Treat an illness or injury
  - Get follow-up care
- You'll get a notice within 2 days of hospital admission and not more than 2 days before the day of discharge
  - An "Important Message From Medicare About Your Rights"
- You'll get a notice if you receive observation services as an outpatient for more than 24 hours
  - A "Medicare Outpatient Observation Notice" (MOON)

Medicare Rights and Protections

AD ASTRA

All people with Medicare, including those in Medicare Advantage (MA) or other Medicare health plans, have the right to get all of the medically necessary Medicare-covered hospital care they need to diagnose and treat their illness or injury, including any follow-up care they need after leaving the hospital.

When admitted to the hospital as an inpatient, you'll get a notice within 2 days of hospital admission and not more than 2 days before the day of discharge. The notice is called an "Important Message From Medicare About Your Rights," and the hospital must provide you with a written copy of the notice so that you know your rights as a hospital inpatient.

You'll get a "Medicare Outpatient Observation Notice" (MOON) notice if you receive observation services as an outpatient for more than 24 hours.

Right to Hospital Care—Medicare Outpatient Observation Notice (MOON)

- Hospitals and critical access hospitals (CAHs) give you the MOON notice informing you of the reason(s) why you're an outpatient receiving observation services and what this means for you
  - Must give you the notice no later than 24 hours after observation services begin
  - An oral explanation will be given
  - You or someone representing you signs the notice

Medicare Rights and Protections

AD ASTRA

A MOON notice lets you know if you're an outpatient in a hospital or critical access hospital (CAH) getting observation services. You must get this notice if you're getting outpatient observation services for at least 24 hours.

The MOON will tell you why you're an outpatient getting observation services, instead of an inpatient. It will also let you know how outpatient observation services may affect what you pay while in the hospital, and for care you get after leaving the hospital.

- Must give you the notice no later than 24 hours after observation services begin
- An oral explanation will be given
- Notice signed by you or someone representing you

"Important Message From Medicare"

- When you're admitted to the hospital
  - Notice signed by you and copy provided
  - Notice explains your rights to
    - Get all medically necessary hospital services
    - Be involved in any decision(s)
    - Get services you need after you leave the hospital
    - Appeal discharge decision and steps for appealing decision
    - Circumstances in which your hospital services may be paid for during the appeal

Medicare Rights and Protections

AD ASTRA

The "Important Message From Medicare" is a notice you get after being admitted to the hospital. This notice is signed by you and a copy is provided to you explaining your rights to

- Get all medically necessary hospital services
- Be involved in any decision(s)
- Get services you need after you leave the hospital
- Appeal discharge decision and steps for appealing decision
- Circumstances in which your hospital services may be paid for during the appeal

Rights in a Skilled Nursing Facility (SNF)

- Freedom from discrimination
- Be treated with dignity and respect
- Freedom from abuse and neglect
- Freedom from restraints
- Get information on services and fees
- Manage your own money
- Get privacy, personal property, and spousal living arrangements
- Get medical care
- Spend private time with visitors at any reasonable hour
- Get medically-related social services
- Make a complaint
- Be protected against unfair transfer or discharge
- Have family members and legal guardians meet with the families of other residents and participate in resident/family groups

Medicare Rights and Protections

As a resident of a skilled nursing facility (SNF), you have certain rights and protections under federal and state law that help ensure you get the care and services you need. They can vary by state. The SNF must provide you with a written description of your legal rights. You have the right to

- Freedom from discrimination
- Be treated with dignity and respect
- Freedom from abuse and neglect
- Freedom from restraints
- Get information on services and fees
- Manage your own money
- Get privacy, personal property, and spousal living arrangements
- Get medical care
- Spend private time with visitors at any reasonable hour
- Get medically-related social services
- Make a complaint
- Be protected against unfair transfer or discharge
- Have family members and legal guardians meet with other families of other residents and participate in resident/family groups

Residents of SNFs who need assistance in resolving complaints or information about their rights may contact the Office of the State Long-Term Care Ombudsman. For contact information, visit Medicare.gov/Contacts.

More information is available at Medicare.gov/what-medicare-covers/part-a/rights-in-snf.html.

Rights in Home Health and Hospice Care

- Discharge appeal rights
- Home Health and Hospice providers must give you a written copy of your rights and obligations before care begins, to include your right to
  - Choose your agency
  - Have your property treated with respect
  - Participate in and receive a copy of your plan of care
  - Have your family or guardian act for you if you're unable
  - Receive a copy of the "Home Health Agency Outcome and Assessment Information Set (OASIS) Statement of Patient Privacy Rights" when getting in-home health care

Medicare Rights and Protections

AD ASTRA

All persons with Medicare have certain guaranteed rights and protections regardless of setting. In home health care and hospice care settings, you also have the following rights:

- Discharge appeal rights
- Home health care and hospice care providers must give you a written copy of your rights and obligations before care begins, to include your right to

Choose your agency (For members of managed care plans, choices will depend on which agencies your plan works with.)

Have your property treated with respect

Be given a copy of your plan of care, and participate in decisions about your care

Have your family or guardian act for you if you're unable

Reference—Home Health Agency Outcome and Assessment Information Set (OASIS) Statement of Patient Privacy Rights.

Rights in Other Settings—Comprehensive Outpatient Rehabilitation Facility (CORF)

- In a CORF setting, your provider must
  - Explain your treatment program
  - Add information to your therapy claims and your medical record if your therapy services reach $2,080 for 2020

Medicare Rights and Protections

AD ASTRA

A Comprehensive Outpatient Rehabilitation Facility (CORF) is a facility that provides a variety of services on an outpatient basis, including doctors' services, physical therapy, social or psychological services, and rehabilitation.

In a CORF setting, your provider must

- Explain your treatment program
- Add information to your therapy claims and your medical record if your therapy services reach $2,080 for 2020

For more information about therapy services, visit Medicare.gov/pubs/pdf/10116-Your-Medicare-Benefits.pdf, and visit Medicare.gov/pubs/pdf/10988-Medicare-Limits-Therapy-Services.pdf for information about coverage of therapy services.

"Notice of Privacy Practices"

- Tells you how Medicare
  - Must protect the privacy of your personal health information
  - Uses and discloses your personal medical information
- Describes your rights and how you can exercise them
- Published annually in the "Medicare & You" handbook and at Medicare.gov
- For more information
  - Visit Medicare.gov
  - Call 1-800-MEDICARE (1-800-633-4227)
  - TTY: 1-877-486-2048

Medicare Rights and Protections

AD ASTRA

Medicare is required to protect your personal medical information. The "Notice of Privacy Practices for Original Medicare" describes how Medicare uses and gives out your personal health information and tells you your individual rights. If you're enrolled in a Medicare Advantage (MA) or other Medicare health plan, or in a Medicare Prescription Drug Plan, your plan materials describe your privacy rights.

The "Notice of Privacy Practices" is published annually in the "Medicare & You" handbook at Medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf. This publication is mailed to all Medicare households every fall.

To learn more about the "Notice of Privacy Practices" for Original Medicare, visit Medicare.gov/forms-help-and-resources/privacy-practices/privacy.html.

For more information, go to Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Required Disclosures

- Medicare must disclose your medical information
  - To you
  - To someone with the legal right to act for you
  - To the Secretary of U.S. Department of Health and Human Services
  - When required by law

Medicare Rights and Protections

AD ASTRA

Medicare must disclose your personal medical information

- To you
- To someone who has the legal right to act for you (your personal representative)
- To the Secretary of U.S. Department of Health and Human Services, if necessary, to make sure your privacy is protected
- When required by law (federal, state, or local). For example: public health activities when required or authorized by law or in response to a lawsuit, court order, subpoena, warrant, summons, or similar process.

Permitted Disclosures

- Medicare may disclose medical information to
  - Pay for your health care
  - Operate the program
- Examples of when Medicare may disclose information to
  - Make sure you get quality health care
  - Give you customer service
  - Resolve your complaints
  - Contact you about research studies
  - Accountable Care Organizations (ACOs)

Medicare Rights and Protections

AD ASTRA

Medicare may use and give out your personal medical information to pay for your health care and to operate the Medicare Program. Medicare contractors use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), and to prepare your "Medicare Summary Notice."

Medicare may use your personal medical information to make sure that you and other people with Medicare get quality health care, to give you customer service, to resolve any complaints you have, or to contact you about research studies.

NOTE: An Accountable Care Organization (ACO) is a way for local health care providers and hospitals to volunteer to work together to provide you with coordinated care. If your doctor or health care provider chooses to participate in an ACO, you'll be notified. This notification might be a letter, written information provided to you when you see your doctor, a sign posted in a hospital, or it might be a conversation with your doctor the next time you go to see him or her.

Medicare will share certain information about your medical care with your doctor's ACO, including medical conditions, prescriptions, and visits to the doctor. This is important to help the ACO keep up with your medical needs and track how well the ACO's doing to keep you healthy and helping you get the right care. Your privacy is very important to us. You can remove the type of information Medicare shares with your doctor for care coordination by calling 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. Or, sign a form available in your doctor or other health care provider's office, which you may also get in the mail from your doctor.

If you get a letter from your doctor, unless you take one of the steps above, your medical information will be shared automatically for purposes of care coordination starting 30 days from the date you're notified. Medicare won't share information with an ACO about any treatment for alcohol or substance abuse without written permission. For more information, visit Medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations.html or Medicare.gov/Pubs/pdf/11588.pdf.

Permitted Disclosures (Continued)

- Medicare may disclose your medical information
  - To state and federal agencies
  - For public health activities
  - For government oversight
  - For judicial proceedings
  - For law enforcement purposes
  - To avoid a serious threat to health and safety
  - To contact you regarding a Medicare benefit
  - To create a non-traceable collection of information

Medicare Rights and Protections

AD ASTRA

Medicare also may use or give out your personal medical information for the purposes shown here, under limited circumstances:

- To state and other federal agencies that have the legal right to get Medicare data (like to make sure Medicare's making proper payments and to assist federal/state Medicaid Programs)
- For public health activities (like reporting disease outbreaks)
- For government health care oversight activities (like fraud and abuse investigations)
- For judicial and administrative proceedings (like in response to a court order)
- For law enforcement purposes (like giving limited information to locate a missing person)
- To avoid a serious threat to health or safety
- To contact you regarding a new or changed Medicare benefit
- To create a collection of information that can no longer be traced back to you

Personal Medical Information Authorization

- Written permission (authorization) is required
  - For Medicare to use or give out your personal medical information for any purpose not set out in the "Privacy Notice"
- You may revoke your permission at any time

Medicare Rights and Protections

AD ASTRA

By law, Medicare must have your written permission (an authorization) to use or give out your personal medical information for any purpose that isn't set out in the "Privacy Notice." You may take back (revoke) your written permission at any time. However, this won't affect information Medicare has already given out based on your earlier permission.

Visit Medicare.gov/MedicareOnlineForms/AuthorizationForm/OnlineFormStep.asp for an online version of the required "Authorization to Disclose Personal Health Information Form."

Personal Medical Information Privacy Rights

You have the right to

- See and copy your personal medical information
- Correct medical information you believe is wrong or incomplete
- Know who your medical information was sent to
- Ask Medicare to communicate in a different manner (like by mail or phone)
- Ask Medicare to limit use of your medical information
- Get a written privacy notice

Medicare Rights and Protections

AD ASTRA

You have the following privacy rights. You may

- See and copy your medical information held by Medicare.
- Correct any incorrect or incomplete medical information.
- Find out who received your medical information for purposes other than paying your claims, running the Medicare Program, or for law enforcement.
- Ask Medicare to communicate with you in a different manner (for example, by mail versus by phone) or at a different place (for example, by sending materials to a post office box instead of your home address).
- Ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare Program. Please note that Medicare may not be able to agree to your request.
- Ask for a separate paper copy of these privacy practices.

If you want information about the privacy rules, call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

If Privacy Rights Are Violated

- You may file a complaint in writing
  - Call 1-800-MEDICARE (1-800-633-4227) to get information on complaining to Medicare. TTY: 1-877-486-2048
  - Contact the U.S. Department of Health and Human Services Office for Civil Rights
    - Visit HHS.gov/ocr/office/file/
    - Call 1-800-368-1019
    - TTY: 1-800-537-7697
  - Electronically via the Office for Civil Rights complaint portal, or on paper by mail, fax, or email
  - Filing a complaint won't affect your Medicare benefits

Medicare Rights and Protections

AD ASTRA

Government programs that pay for health care—like Medicare, Medicaid, and the military and veterans' health care programs—are covered by Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules.

If you believe Medicare has violated your privacy rights, you may file a complaint.

You can file a complaint by mail, fax, email, or electronically via the complaint portal.

- Contact the U.S. Department of Health and Human Services, Office for Civil Rights at HHS.gov/ocr/privacy/hipaa/complaints/, or
- Call 1-800-368-1019. TTY: 1-800-537-7697.

Your complaint won't affect your benefits under Medicare.

Advance Directives

- A written document, like a durable power of attorney or a living will, stating how you want medical decisions to be made if you lose the ability to make them for yourself
  - Allows you to protect yourself
  - Lets people know your wishes now, and ensures they're followed should a time come when you can't speak for yourself
  - Makes sure your voice is heard
  - States which medical treatment(s) you'll accept

Medicare Rights and Protections

AD ASTRA

Advance directives are legal documents that allow you to put in writing what kind of health care you would want if you're too ill to speak for yourself. Advance directives most often include a health care proxy (durable power of attorney), a living will, and after-death wishes.

Talking with your family, friends, and health care providers about your wishes is important, but these legal documents ensure that your wishes are followed. It's better to think about these important decisions before you're ill or a crisis occurs.

A health care proxy (sometimes called a durable power of attorney for health care) is used to name the person you wish to make health care decisions for you if you aren't able to make them yourself. Having a health care proxy is important because if you suddenly aren't able to make your own health care decisions, someone you trust will be able to make these decisions for you.

A living will is another way to make sure your voice is heard. It states which medical treatment(s) you'll accept or refuse if your life is threatened. For example, dialysis for kidney failure, a breathing machine if you can't breathe on your own, cardiopulmonary resuscitation if your heart and breathing stop, or tube feeding if you can no longer eat.

Who's the Medicare Beneficiary Ombudsman?

- An ombudsman is a person who reviews complaints and helps resolve them
- The Medicare Beneficiary Ombudsman helps make sure information is available about
  - Medicare coverage
  - Making good health care decisions
  - Medicare rights and protections
  - Getting issues resolved
- The Ombudsman reviews the concerns raised by people with Medicare
- The Ombudsman reports yearly to Congress

Medicare Rights and Protections

AD ASTRA

An ombudsman is a person who reviews complaints and helps resolve them.

The Medicare Beneficiary Ombudsman helps make sure information is available about

- Medicare coverage
- Making good health care decisions
- Medicare rights and protections
- Getting issues resolved

The Ombudsman reviews the concerns raised by people with Medicare through 1-800-MEDICARE (1-800-633-4227), TTY: 1-877-486-2048, and through your State Health Insurance Assistance Program (SHIP).

Visit Medicare.gov for information on inquiries and complaints, activities of the Ombudsman, and what people with Medicare need to know.

The Ombudsman reports yearly to Congress.

Medicaid Overview

- Federal and state program
- Medical assistance for people with limited income and resources
- Covers about 72.6 million adults and children
  - Source: March 2019 Medicaid and CHIP enrollment report
- Supplements Medicare for more than 12 million people who are 65 or older, have a disability or have End-stage Renal Disease (ESRD)

Medicaid and the Children's Health Insurance Program

AD ASTRA

Medicaid is a federal and state program that helps with medical costs for certain individuals and families with limited income and resources. Medicaid isn't a cash support program; it pays medical providers directly for care.

Medicaid is the largest source of funding for medical and health-related services for those with limited income and resources. Medicaid provides health coverage to an estimated 72.6 million people, including children, pregnant women, parents, seniors, and individuals with disabilities.

Medicaid supplements Medicare for more than 12 million people who are 65 or older, have a disability or have End-stage Renal Disease (ESRD).

The program became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to help states provide medical assistance to eligible persons.

For more information, visit Medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html and Medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

*Entitlement program—a government program that guarantees certain benefits to a particular group or segment of the population.

Medicaid Administration

- Jointly financed entitlement program
- Federally established national guidelines
- States get federal matching funds
  - Known as the Federal Medical Assistance Percentage (FMAP)
  - Used to calculate amount of federal share of state costs
  - Varies from state-to-state
  - Based on state per capita income

Medicaid and the Children's Health Insurance Program

AD ASTRA

Medicaid is a joint federal and state partnership program with federally established national guidelines.

States get federal matching funds for covered services.

- The federal matching rate, also known as the Federal Medical Assistance Percentage (FMAP), is used to calculate the amount of the federal share of state costs for services
- The FMAP varies from state-to-state based on state per capita income
- FMAPs are updated every fiscal year (FY) and published in the Federal Register:
  - For FY 2020 amounts, view federalregister.gov/documents/2018/11/28/2018-25944/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for

State Medicaid Administration

- Within broad federal guidelines, each state
  - Develops its own programs
  - Develops and operates its own plan
  - Establishes its own eligibility standards
  - Determines the type, amount, duration, and scope of services
  - Sets the payment rate for services
  - Partners with the Centers for Medicare & Medicaid Services (CMS) to administer its program
- States may change eligibility, services, and reimbursement during the year subject to federal approval

Medicaid and the Children's Health Insurance Program

AD ASTRA

Within broad federal guidelines, each state

- Develops its own programs.
- Develops and operates a Medicaid State Plan outlining the nature and scope of services. The state plan is a contract between the Centers for Medicare & Medicaid Services (CMS) and the state, and any amendments must be approved by CMS.
- Establishes its own eligibility standards in accordance with federal guidelines. A person who's eligible for Medicaid in one state may not be eligible in another state.
- Determines the type, amount, duration, and scope of services covered within federal guidelines. Also, the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state.
- Sets the payment rate for services with CMS approval.
- Partners with CMS to administer its program.

States may change their Medicaid eligibility, services, and reimbursement during the year, subject to federal approval.

The Single State Medicaid Agency

- Administers the Medicaid State Plan
  - May delegate some administrative functions
- The State Medicaid Agency in Kansas is the Kansas Department of Health and Environment (KDHE)
  - In Kansas, Medicaid and CHIP are one program called "KanCare"

Medicaid and the Children's Health Insurance Program

AD ASTRA

The "single state agency" is strictly a legal concept that defines responsibility for administration of the Medicaid State Plan. The single state agency isn't required to administer the entire Medicaid Program. It may delegate some administrative functions to other local or state agencies, private contractors, or both. However, state or local agencies make all final eligibility determinations.

In Kansas, the Kansas Department of Health and Environment. Medicaid and CHIP are one program called "KanCare"

For more information about eligibility requirements and to apply for Medicaid, contact your state's Medicaid office at Medicaid.gov/about-us/contact-us/contact-state-page.html, or contact your local State Health Insurance Assistance Program (SHIP) at www.shiptacenter.org. For more information, visit Medicaid.gov/medicaid-chip-program-information/by-state/by-state.html.

Medicaid Eligibility

- States are required to cover certain population groups, like
  - Low income families
  - Qualified pregnant women and children
  - Individuals getting Supplemental Security Income (SSI)
- States have flexibility to cover other population groups, like
  - Individuals getting home and community based services
  - Children in foster care who aren't otherwise eligible
- Financial and non-financial requirements must be met to qualify for Medicaid

Medicaid and the Children's Health Insurance Program

AD ASTRA

To qualify for Medicaid, you must belong to one of the eligibility groups specified under the federal Medicaid law and chosen to be covered in the state in which you live. To be eligible for federal funds, states have to cover people in certain groups up to federally defined income requirements. However, many states have expanded Medicaid beyond these thresholds and have extended coverage to other optional groups.

There are financial and non-financial requirements that must be met to qualify for Medicaid. Non-financial requirements include residency, citizenship and immigration status requirements, and certain program requirements like spousal impoverishment, estate recovery, third party liability and coordination of benefits.

Visit Medicaid.gov/medicaid/eligibility/index.html for more information about Medicaid eligibility. Also, visit Medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/list-of-eligibility-groups.pdf to view the list of eligibility groups.

Medicaid Eligibility (continued)

- In all states:
  - You can qualify for Medicaid based on income, household size, disability, family status, and other factors
  - Eligibility rules differ between states
- In states that have expanded Medicaid coverage to the adult group
  - You can qualify based on your income and non-financial eligibility factors
  - If your household income is below 133% of the federal poverty level (FPL) (equal to 138% FPL with a general 5% disregard), you qualify

NOTE: A few states cover adults under a waiver with different income levels.

Medicaid and the Children's Health Insurance Program

AD ASTRA

In all states, you can qualify for Medicaid based on income, household size, disability, family status, and other factors. Eligibility rules differ between states.

States were given the option to extend eligibility to the adult group beginning in 2014. At the same time, mandatory eligibility for children was increased to at least 138% of the federal poverty level (FPL) in every state (most states cover children to higher income levels). The majority of states have chosen to expand coverage to the adult group, and those that haven't yet may choose to do so at any time.

Most states have expanded their Medicaid programs to cover non-disabled, non-pregnant adults age 19 through 64, with household incomes below a certain level. Whether you qualify for Medicaid coverage in this adult group depends partly on whether your state has expanded its program. In states that have expanded Medicaid to the adult group, you can qualify based on meeting the income standard as well as the non-financial eligibility factors. If your household income is below 133% FPL, you qualify. (Equal to 138% FPL with a general 5% disregard.)

For more Medicaid expansion information, visit Healthcare.gov/medicaid-chip/medicaid-expansion-and-you. CMS recently released program integrity expectations for states that have expanded to the adult group. See Medicaid.gov/federal-policy-guidance/downloads/cib062019.pdf.

States Not Expanding Medicaid

- If you live in a state that's NOT expanding Medicaid to adults, you may not qualify for either Medicaid or reduced costs on a private insurance plan in the Marketplace
  - Kansas has not expanded Medicaid
- Starting with the 2019 tax year (for which you'll file taxes by April 2020), there won't be a federal penalty if you don't have minimum essential coverage (MEC)
  - If you don't have coverage during 2019 or later, you don't need a hardship exemption to avoid a penalty
  - If you're 30 or older, you need a hardship exemption to enroll in a Catastrophic health plan

Medicaid and the Children's Health Insurance Program

AD ASTRA

Some states haven't expanded their Medicaid programs to the adult group. Kansas has not.

If you live in a state that hasn't expanded Medicaid to adults (who don't have blindness or a disability, or aren't 65 or older or with dependent children) with income below 138% of the FPL, you may not qualify for either Medicaid or reduced costs on a private insurance plan in the Marketplace; it depends on where your income falls.

- If your income is more than 100% of FPL—about $12,760 a year as a single person, or about $26,200 for a family of 4 (in 2020), you can buy a private health insurance plan in the Marketplace and may get lower costs based on your household size and income.
- If you make less than about $12,760 a year as a single person, or about $26,200 for a family of 4, you may not qualify for lower costs for Marketplace coverage based on your income. However, you may be eligible for Medicaid, even without the expansion, based on your state's existing rules for other eligibility groups.

Many adults with incomes below 100% FPL in non-expansion states, fall into a coverage gap. Their incomes may be too high to get Medicaid under their state's rules, but their incomes are too low to qualify for help buying coverage in the Marketplace. However, these individuals can apply for a hardship exemption so they can enroll in a Catastrophic plan for 2019. If you're under 30, you can enroll in a Catastrophic plan whether you have an exemption or not. Catastrophic plans have low monthly premiums and very high deductibles. They may be an affordable way to protect yourself from worst-case scenarios, like getting seriously sick or injured. But you pay most routine medical expenses yourself.

For more information on Medicaid expansion, visit HealthCare.gov/medicaid-chip/medicaid-expansion-and-you.

Coverage—Mandatory Medicaid State Plan Benefits

- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (assurance for children under 21)
- Nursing facility services (except for Medically Needy)
- Home health services (for individuals entitled to nursing facility care)
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Medicaid and the Children's Health Insurance Program

AD ASTRA

Mandatory Medicaid State Plan benefits include the following services:

- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (assurance for children under 21)
- Nursing facility services
- Home health services (for individuals entitled to nursing facility care)
- Physician services
- Rural Health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

For more information about mandatory and optional benefits, visit Medicaid.gov/medicaid/benefits/list-of-benefits/index.html.

Medicaid Waivers

- Allow states to test alternative delivery of care
  - Certain federal laws are "waived"
- Types of waivers
  - Section 1915(b) Managed Care Waiver
  - Section 1915(c) Home and Community-Based Services (HCBS) Waiver
  - Section 1115 Research and Demonstrations
  - Section 1332 State Innovation Waiver
- States can use these authorities concurrently

Medicaid and the Children's Health Insurance Program

Waivers are authorities states can use to test new or existing ways to deliver and pay for health care services in Medicaid and CHIP.

Types of waivers:

Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems for people which have more limited provider networks.

Section 1915(c) Home and Community-Based Services (HCBS) Waivers: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.

Section 1115 Research and Demonstration Projects: States can apply for program flexibility to test new or existing approaches to paying for and providing Medicaid and CHIP coverage.

Section 1332 State Innovation Waivers: Sometimes referred to as a State Relief and Empowerment Waiver, allows states to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance.

States can use any of these above authorities concurrently.

For more information, visit Medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers.html and CMS.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-.html.

KanCare (Medicaid) Application

- Application is through the KanCare Clearinghouse
  - 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
  - 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.

Medicaid and the Children's Health Insurance Program

Visit the KanCare website for more information http://www.kancare.ks.gov/home

How Are Medicare and Medicaid Different?

Medicare	Medicaid
National program that is the same across the country	Statewide programs that are different between states
Administered by the federal government	Administered by state governments within federal rules (federal/state partnership)
Health insurance for people 65 or over, with certain disabilities, or diagnosed with End-Stage Renal Disease (ESRD)	Health coverage for people who meet financial and non-financial requirements
Nation's primary payer of inpatient hospital services for the elderly and people with ESRD	Nation's primary public payer of mental health and long-term care services; covers 40% of all births/prenatal and postpartum

Medicaid and the Children's Health Insurance Program

Medicare and Medicaid are different in these ways:

- Medicare is a national program that is the same across the country; Medicaid consists of statewide programs that are different between states.
- Medicare is administered by the federal government; Medicaid is administered by state governments within federal rules (federal/state partnership).
- Medicare eligibility is based on age, disability, or End-Stage Renal Disease (ESRD); Medicaid eligibility is based on limited income and resources, and other non-financial requirements.
- Medicare is the nation's primary payer of inpatient hospital services for the elderly and people with ESRD; Medicaid is the nation's primary public payer of mental health and long-term care services (nursing home care) and finances 40% of all births (including prenatal care, labor, delivery and 60 days of postpartum and other pregnancy-related care).

Medicare-Medicaid Enrollees

- 12 people million nationally
  - Medicaid may provide full benefits (full dual) and/or partial assistance (partial dual) with Medicare costs
  - Medicare Savings Programs provide partial Medicaid benefits by paying Medicare premiums and sometimes cost-sharing
    - You can qualify for full Medicaid only, full Medicaid with a Medicare Savings Program, or just a Medicare Savings Program
    - Qualifying as a full or partial dual automatically qualifies you to get Extra Help with your Medicare drug costs (Part D)
  - For those with full Medicaid, Medicare pays first and Medicaid pays second for covered services

Medicaid and the Children's Health Insurance Program

IDASTKA

In total, 12 million people are "dually eligible" and enrolled in both Medicaid and Medicare. Dual-eligible beneficiaries include individuals who get full Medicaid benefits and those who only get help with Medicare premiums or cost-sharing.

Medicare Savings Programs are operated by State Medical Assistance (Medicaid) offices and provide coverage for Medicare premiums and cost-sharing for low-income individuals that get Medicare. Some Medicare enrollees are only eligible for this source of Medicaid assistance. Other people with Medicare may be eligible for full Medicaid coverage in addition to being eligible for Medicare Savings Programs, and others are eligible for full Medicaid coverage, but not Medicare Savings Programs. If you're getting Medicaid or assistance from a Medicare Savings Program, you can also get Extra Help, which is a program to help pay for your prescription drugs.

For people with Medicare who also have full Medicaid coverage, Medicare pays first and Medicaid pays second for care that Medicare and Medicaid both cover. Medicaid may cover additional services that Medicare may not or only partially covers—like long-term care services and supports.

NOTE: For more information, review the "People Dually Eligible for Medicare and Medicaid" factsheet (March 2019) at CMS.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf, page 41 of the Coordination of Benefits and Third Party Liability In Medicaid Handbook at Medicaid.gov/medicaid/eligibility/downloads/tpl-cob/training-and-handbook.pdf, and visit Medicare.gov/your-medicare-costs/get-help-paying-costs/Medicaid.

Medicare Savings Programs (MSPs)

- MSPs are categorized into groups:
  - Qualified Medicare Beneficiary* (QMB)
  - Specified Low-Income Medicare Beneficiary* (SLMB) (LMB or Low-Income Medicare Beneficiary in Kansas)
  - Qualified Individuals* (QI) (ELMB or Expanded Low-Income Medicare Beneficiary in Kansas)
  - Qualified Disabled and Working Individuals (QDWI)

*Automatically qualify for Extra Help for Part D

NOTE: Federal law bars Medicare and Medicare Advantage providers from balance billing a QMB beneficiary under any circumstances.

Medicaid and the Children's Health Insurance Program

You can get help from your state Medicaid program to pay your Medicare premiums. In some cases, Medicare Savings Programs may also pay Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) deductibles, coinsurance, and copayments if you meet certain conditions. There are 4 kinds of Medicare Savings Programs.

1. Qualified Medicare Beneficiaries (QMB) get some help from Medicaid to pay their Medicare premiums up to an amount set by their state. **NOTE**: Federal law bars Medicare and Medicare Advantage (MA) providers from balance billing a QMB beneficiary under any circumstance. Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by federal law, states can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.
2. Specified Low-Income Medicare Beneficiaries (SLMB)
3. Qualified Individuals (QI)
4. Qualified Disabled and Working Individuals (QDWI) get some help from Medicaid to pay Medicare premiums only.

If you qualify for QMB, SLMB, or QI you automatically get Extra Help paying for Medicare prescription drug coverage.

Minimum Federal Eligibility Requirements for MSP

Medicare Savings Program	Individual Monthly Income Limit* (2020)	Married Couple Monthly Income Limit* (2020)	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	$1,063	$1,437	Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments)
Specified Low-Income Medicare Beneficiary (SLMB)	$1,276	$1,724	Part B premiums only
Qualifying Individual (QI)	$1,436	$1,940	Part B premiums only
Qualified Disabled & Working Individuals (QDWI)	$4,338	$5,832**	Part A premiums only

*Does not includes $20 income disregard.

Medicaid and the Children's Health Insurance Program

These amounts are federal minimum eligibility requirements and states may have higher amounts.

If you qualify for the Qualified Medicare Beneficiary (QMB) Program you get help paying your Part A and Part B premiums, deductibles, coinsurance, and copayments. To qualify, you must be eligible for Medicare Part A and have an income not more than 100% of the federal poverty level (FPL). This will be effective the first month after the month QMB eligibility is approved (can't be retroactive).

If you qualify for the Specified Low-income Medicare Beneficiary (SLMB) program you get help paying for your Part B premium. To qualify, you must be eligible for Medicare Part A and have an income that's at least 100%, but isn't more than 120% of the FPL.

If you qualify for the Qualified Individual (QI) program, and there are still funds available in your state, you get help paying your Part B premium. It is fully federally funded. Congress only gave a limited amount of funds to each state. To qualify, you must be eligible for Medicare Part A because your income was too high and you lost your disability Part A and have an income not exceeding 135% of the FPL.

In 2020, the asset limits for the QMB, SLMB, and QI programs are $7,860 for a single person and $11,800 for a married person living with a spouse and no other dependents. These resource limits are adjusted on January 1 of each year, based on the change in the annual consumer price index since September of the previous year (official in April of each year).

If you qualify for the Qualified Disabled and Working Individual (QDWI) you get help paying your Part A premium. To qualify, you must be entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding substantial gainful activity (SGA), have an income not higher than 200% of the FPL and resources not exceeding twice maximum for Supplemental Security Income ($4,000 for an individual and $6,000 for married couple in 2020), and not be otherwise eligible for Medicaid. If your income is between 150% and 200% of the FPL, the state can ask you to pay a part of the Medicare Part A premium. The resource limits are $4,000 (individual) and $6,000 (married couple).

Medicare Savings Program Application Process

- Application is through Medicaid, in Kansas, KanCare
- Applications are available for download at: http://www.kancare.ks.gov/consumers/apply-for-kancare
- Fill out the paper application and mail to:
  KanCare Clearinghouse
  P. O. Box 3599
  Topeka KS 66601
  1-800-792-4884
  1-844-264-6285 Fax
- 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.

AD ASTRA

There is no online application available. Applicants must complete the paper application and submit to the KanCare Clearinghouse

What is the Children's Health Insurance Program (CHIP)?

- Health coverage for uninsured children in families who earn too much for Medicaid, but too little for private insurance
- Jointly funded by federal and state governments
- Administered by states
- Approximately 9.6 million children enrolled in fiscal year (FY) 2018

Medicaid and the Children's Health Insurance Program

AD ASTRA

Like Medicaid, Children's Health Insurance Program (CHIP) is a partnership between the states and the federal government that provides health coverage to eligible children, through both Medicaid and separate CHIP. States administer CHIP within broad guidelines established by CMS, and the federal government provides matching funds to states to provide the coverage.

The federal matching rate for CHIP was typically about 15 percentage points higher than the Medicaid Federal Medical Assistance Percentage (FMAP) rate for that state. For example, a state with a 50% FMAP would typically have an "enhanced" CHIP matching rate of 65%. For 2016-2019, states get a 23 percentage point increase to the CHIP FMAP, so CHIP matching rates range from 88% to 100%. In 2020, states will get an 11.5 percentage point increase to the CHIP FMAP. Beginning in 2021, states will go back to getting the regular enhanced CHIP matching rate. Unlike Medicaid, the money states get every year depends on the statute.

There were approximately 9.6 million children ever enrolled in CHIP in Fiscal Year (FY) 2018.

SOURCE: Medicaid.gov/chip/downloads/fy-2018-childrens-enrollment-report.pdf

State Options for the Children's Health Insurance Program (CHIP)

- All 50 states, the District of Columbia, and U.S. territories have CHIP Programs
- States can design their CHIP Program in one of 3 ways
  1. Medicaid expansion (8 states, the District of Columbia, and 5 territories)
  2. Separate Child Health Insurance Program (2 states)
  3. Combination of the 2 approaches (40 states)

Medicaid and the Children's Health Insurance Program

AD ASTRA

All 50 states, the District of Columbia, and U.S. territories have Children's Health Insurance Program (CHIP) Programs.

States can design their CHIP in 1 of 3 ways:

1. Medicaid expansion—Alaska, Hawaii, Maryland, New Hampshire, New Mexico, Ohio, South Carolina, Vermont, DC, American Samoa, Commonwealth of Northern Mariana Islands, Guam, Puerto Rico, U.S. Virgin Islands.
2. Separate Child Health Insurance Program—Connecticut and Washington.
3. Combination of the 2 approaches—Arkansas, California, Colorado, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Rhode Island, South Dakota, Tennessee, Virginia, and Wisconsin.

Of the 40 combination states, 11 states (Alabama, Arizona, Georgia, Kansas, Mississippi, Oregon, Pennsylvania, Texas, Utah, West Virginia, and Wyoming) had historically separate programs but are technically combination programs due to transitioning children ages 6-18 in families earning 133% of the FPL.

If a state adds CHIP into its Medicaid Program, the services given to CHIP-eligible children must be the same as those provided to Medicaid-eligible children, and the eligibility and enrollment processes must be the same. If a state has a separate CHIP, the state can have different standards and processes within the federal guidelines. Like Medicaid, CHIP has income and resource standards, and eligibility varies by state.

To see CHIP information by state, visit Medicaid.gov/chip/state-program-information/chip-state-program-information.html.

Children's Health Insurance Program (CHIP) Eligibility

- Targets low-income children
  - Under 19
  - Uninsured and not eligible for Medicaid
  - Generally, up to 200% of the federal poverty level (FPL) or 50 percentage points higher than Medicaid level (many states go higher)
  - No access to public employee coverage (except at state option) and not an inmate of a public institution
  - State-defined standards

Medicaid and the Children's Health Insurance Program

AD ASTRA

There are 2 minimum-income eligibility requirements for the Children's Health Insurance Program (CHIP), depending on the state where you live. States may cover children with incomes up to 200% of the federal poverty level (FPL), or 50% higher than Medicaid for the age of the child. Many states have higher income limits. There are 46 states and the District of Columbia covering children up to and above 200% of the FPL. Of these, 24 states cover children at 250% FPL or higher. Some states go as high as 400% of the FPL. In addition to the federal requirements, states can add eligibility requirements like residency requirements or income levels.

NOTE: A state can add its own eligibility criteria to CHIP, but must follow with federal eligibility standards, including that the state can't cover children in higher-income families over lower-income families.

Medicare and Medicaid Fraud, Waste, and Abuse Prevention Overview

- Definition of health care fraud, waste, and abuse
- Protecting the Medicare Trust Funds and other public resources
- Examples of Medicare and Medicaid fraud
- Who commits fraud?
- Causes of improper payments
- Quality of care concerns

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

This lesson provides an overview of fraud, waste, and abuse, including the following:

- Definition of health care fraud, waste, and abuse
- Protecting the Medicare Trust Funds and other public resources
- Examples of Medicare and Medicaid fraud
- Who commits fraud?
- Causes of improper payments
- Quality of care concerns

Definitions of Fraud, Waste, and Abuse

Fraud

When someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program.

Waste

The overutilization of services, or other practices that directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse

When health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program.

The primary difference between fraud, waste, and abuse is intention.

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

Medicare and Medicaid fraud, waste, and abuse affects every American by draining critical resources from our health care system, and contributing to the rising cost of health care. Taxpayer dollars lost to fraud, waste, and abuse harm multiple parties, particularly some of our most vulnerable citizens.

Fraud occurs when someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program. Ultimately, fraud is determined by our judicial system.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program (e.g., medically unnecessary services or DME or prescription drugs, or more disposable DME or drugs than necessary [more syringes, diabetic test strips, disposable diapers or underpads than are really needed over a period of time]). Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse occurs when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program.

The primary difference between fraud, waste, and abuse is intention.

Protecting Taxpayer Dollars

The Centers for Medicare & Medicaid Services must:

- Protect Medicare Trust Funds
  - Medicare Hospital Insurance (Part A) Trust Fund
  - Supplementary Medical Insurance (Part B) Trust Fund
- Protect the public resources that fund the Medicaid programs
- Manage the careful balance between paying claims quickly and limiting burden on the provider community with conducting reviews that prevent and detect fraud

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

The Centers for Medicare & Medicaid Services' (CMS') mission is to be an effective steward of public funds. CMS must protect the Medicare Hospital Insurance (Part A) Trust Fund and the Supplementary Medical Insurance (Part B) Trust Fund.

The Medicare Hospital Insurance Trust Fund pays for Medicare Part A benefits such as inpatient hospital care, skilled nursing facility care, home health care, and hospice care. It's funded by payroll taxes, income taxes paid on Social Security benefits, interest earned on trust fund investments, and Part A premiums from people who aren't eligible for premium-free Part A.

The Supplementary Medical Insurance Trust Fund pays for Medicare Part B benefits including doctor services, outpatient hospital care, home health care not covered under Part A, durable medical equipment, certain preventive services, lab tests, Medicare Part D prescription drug benefits, and Medicare program administrative costs. Its funding is authorized by Congress from Part B premiums, Part D (Medicare prescription drug coverage) premiums, and interest earned on trust fund investments.

The federal government contributes to the annual Medicaid expenditure, and CMS must protect the public resources that fund the 50 state-run Medicaid programs operated by the states, the District of Columbia, and U.S. Territories.

CMS has to manage the careful balance between paying claims quickly and limiting provider burden, versus conducting reviews that prevent and detect fraud.

Examples of Fraud

- Medicare or Medicaid is billed for
  - Services you never got
  - Equipment you never got or that was returned
- Documents are altered to gain a higher payment
- Misrepresentation of dates, descriptions of furnished services, or your identity
- Someone uses your Medicare or Medicaid card with or without your permission
- A company uses false information to mislead you into joining a Medicare Plan

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

Examples of possible fraud include the following:

- Medicare or Medicaid is billed for services you never got, equipment you never got or that was returned
- Documents that are altered to gain a higher payment
- Misrepresentation of dates, descriptions of furnished services, or your identity
- Someone else uses your Medicare/Medicaid card with or without your permission
- A company uses false information to mislead you into joining a Medicare Plan

Who Commits Fraud?

- Most individuals and organizations that work with Medicare and Medicaid are honest
- However, anyone can commit fraud
  - Doctors and health care providers
  - Suppliers of durable medical equipment
  - Employees of doctors or suppliers
  - Employees of companies that manage Medicare billing
  - People with Medicare and/or Medicaid

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

Most individuals and organizations that work with Medicare and Medicaid are honest, but there are some bad actors. The Centers for Medicare & Medicaid Services is continually taking the steps necessary to identify and prosecute these bad actors.

Any of the following may be involved in Medicare and Medicaid fraud, waste, and abuse:

- Doctors and health care providers
- Suppliers of durable medical equipment
- Employees of doctors or suppliers
- Employees of companies that manage Medicare and/or Medicaid billing
- People with Medicare and/or Medicaid

Medicare fraud is prevalent, so it's important for you to be aware of the various entities that have been implicated in fraud schemes. Those who commit fraud could be individuals who are in, or pretend to be in, any of the above-mentioned groups.

Preventing Fraud in Medicare Part C and Part D

- Plan agents and brokers must follow CMS's Marketing Guidelines. Examples of what plans can't do include
  - Sending you unwanted emails
  - Coming to your home uninvited to get you to join
  - Calling you unless you're already a member
  - Offering you cash to join their plan
  - Giving you free meals while trying to sell you a plan
  - Talking to you about their plan in areas where you get health care
- If you think an agent or broker broke Medicare Plan rules
  - Call 1-800-MEDICARE (1-800-633-4227)
  - TTY: 1-877-486-2048

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

Providers aren't the only focus in preventing Medicare fraud. Medicare health plans and Medicare Prescription Drug Plans that contract with Medicare have responsibilities beyond billing. Plans are responsible for ensuring that they market to people with Medicare in responsible ways that protect them and the Medicare program from marketing practices that could result in fraud. This includes the plan's agents or brokers who represent them.

Some examples of activities Medicare Plans and people who represent them aren't allowed to do:

- Sending you unwanted emails or coming to your home uninvited to sell a Medicare Plan.
- Calling you unless you're already a member of the plan. If you're a member, the agent who helped you join can call you.
- Offering you cash to join their plan.
- Giving you free meals while trying to sell you a plan.
- Talking to you about their plan in areas where you get health care, like an exam room, hospital patient room, or at a pharmacy counter.

NOTE: Although the Medicare Drug Integrity Contractor fights fraud, waste, and abuse in Medicare Advantage Plans (Part C) and Medicare prescription drug coverage (Part D), they don't handle Part C and Part D marketing fraud. Call 1-800-MEDICARE (1-800-633-4227) to report plans that ask for your personal information over the telephone or that call unsolicited to enroll you in a plan. TTY: 1-877-486-2048.

Quality of Care Concerns

- Patient quality of care concerns aren't necessarily fraud
  - Medication errors
  - Change in condition not treated
  - Discharged from the hospital too soon
  - Incomplete discharge instructions and/or arrangements
- Contact your Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO)
  - KEPRO (Area 4)
    1-855-408-8557
    TTY: 1-855-843-4776.
  - For more information, visit keproqio.com/bene/helpline.aspx.

Medicare and Medicaid Fraud, Waste, and AbusePrevention

AD ASTRA

There's a specific Quality Improvement Organization (QIO) just to address the concerns of people with Medicare and their families called a Beneficiary and Family-Centered Care (BFCC) QIO.

Patient quality of care concerns aren't necessarily fraud. Examples of quality of care concerns that your BFCC-QIO can address include the following:

- Medication errors like being given the wrong medication; being given medication at the wrong time; being given a medication to which you're allergic; or being given medications that interact in a negative way. They can evaluate if it merits Medicare Drug Integrity Contractor intervention.
- Change in condition not treated, like not receiving treatment after abnormal test results or when you developed a complication.
- Discharged from the hospital too soon.
- Incomplete discharge instructions and/or arrangements.

To get the address and phone number of the BFCC-QIO for your state or territory, visit Medicare.gov/contacts and search for information on the topic of "Complaints about my care or services." Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

CMS Fraud and Abuse Strategies

- The Center for Program Integrity
- CMS Program Integrity Contractors
- CMS Administrative Actions
- Law Enforcement Actions
- The Health Care Fraud Prevention Partnership
- Health Care Fraud Prevention and Enforcement Action (HEAT) Team
- The Fraud Prevention Toolkit at CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html
- Provider and Beneficiary Education

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

Centers for Medicare & Medicaid Services (CMS) fraud and abuse strategies:

- The Center for Program Integrity
- The CMS Program Integrity Contractors
- CMS Administrative Actions
- Law Enforcement Actions
- The Health Care Fraud Prevention Partnership
- Health Care Fraud Prevention and Enforcement Action (HEAT) Team
- The Fraud Prevention Toolkit at CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html
- Provider and Beneficiary Education

Outreach & Education Contractors

- To communicate efforts undertaken by the Center for Program Integrity to detect and reduce fraud, waste, and abuse
- Examples:
  - Outreach and education materials
  - Professional education
  - Regulation and guidance
  - Fraud-fighting resources
  - General news

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

To communicate efforts undertaken by the Center for Program Integrity to detect and reduce fraud, waste, and abuse

Examples:

- Outreach and education materials
- Professional education
- Regulation and guidance
- Fraud-fighting resources
- General news

Health Care Fraud Prevention Partnership

- Voluntary, public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and associations to identify and reduce fraud, waste, and abuse across the healthcare sector.
- Prevents fraud, waste, and abuse by:
  - Sharing information and best practices
  - Improving detection of fraud, waste, and abuse
  - Preventing improper and fraudulent payments across public and private payers
  - Enabling the exchange of data and information among the partners

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

The Health Care Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and associations to identify and reduce fraud, waste, and abuse across the health care sector.

The HFPP prevents fraud, waste, and abuse by:

- Sharing information and best practices.
- Improving detection of fraud, waste, and abuse.
- Preventing improper and fraudulent payments across public and private payers.
- Enabling the exchange of data and information among partners. The long-range goal of the partnership is to use sophisticated technology and analytics on industry-wide health care data to predict and detect health care fraud schemes (using techniques similar to credit card fraud analysis).

Provider and Beneficiary Education

- Provider education helps correct vulnerabilities
  - Maintain proper documentation
  - Reduce inappropriate claims submission
  - Protect patient and provider identity information
  - Establish a broader culture of compliance
- Beneficiary education helps identify and report suspected fraud

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

CMS is working to shift the focus to the prevention of improper payments and fraud while continuing to be vigilant in detecting and pursuing problems when they occur.

- Provider education helps correct vulnerabilities so that they
  - Maintain proper documentation
  - Reduce inappropriate claims submissions by educating providers on common billing mistakes
  - Protect patient and provider identity information
  - Establish a broader culture of compliance
    - Beneficiary education helps them join in the fight against fraud by learning to identify and report suspected fraud. For a copy of the "Program Integrity: Beneficiary Card Sharing Toolkit," visit CMS.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/beneficiary-education-toolkits/beneficiary-toolkit.html.
      - "Protecting Yourself & Medicare from Fraud" is a free publication to help people with Medicare get information on how to detect and protect against fraud and identity theft. To read or download this pub, visit Medicare.gov/Publications/PubID_10111.

"4Rs" for Fighting Medicare Fraud

- Here are some ways you can protect yourself from fraud
  - Record appointments and services
  - Review services provided
    - Compare services actually obtained with services on your Medicare Summary Notice
  - Report suspected fraud
  - Remember to protect personal information, such as your Medicare card and bank account numbers

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

- **Record** the dates of doctor's appointments on a calendar. Note the tests and services you get, and save the receipts and statements from your providers. If you need help, ask a friend or family member. Contact your local Senior Medicare Patrol (SMP) program to get a free "Personal Health Care Journal." To locate the SMP program in your area, use the SMP locator at smpresource.org, or call 1-877-808-2468.
- **Review** for signs of fraud, including claims you don't recognize on your Medicare Summary Notices (MSNs), and advertisements or phone calls from companies offering free items or services to people with Medicare. Compare the dates and services on your calendar with your MSNs to make sure you got each service listed and that all the details are correct. If you find items listed in your claims that you don't have a record of, it's possible that you or Medicare may have been billed for services or items you didn't get. Visit MyMedicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to review your Medicare claims. TTY: 1-877-486-2048. If you're in a Medicare Advantage Plan (like a Health Maintenance Organization or Preferred Provider Organization) or Medicare Prescription Drug Plan, call your plan for more information about a claim. You can get help from your local SMP program with checking your MSNs for errors or suspected fraud.
- **Report** suspected Medicare fraud by calling 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. When using the automated phone system, have your Medicare card with you and clearly speak or enter your Medicare number and letter(s). If you identify errors or suspect fraud, the SMP can also help you make a report to Medicare.
- **Remember** to protect your Medicare number. Don't give it out, except to your doctor or other health care provider. Never give your Medicare number in exchange for a special offer. Medicare will never contact you and ask for personal information, like your Medicare or bank account numbers. Never let someone use your Medicare card, and never use another person's card.

The "4Rs for Fighting Fraud," (CMS Product No. 11610), is available at Medicare.gov/Pubs/pdf/11610.pdf.

Medicare.gov/fraud

- Tips to prevent fraud
- Learn how to spot fraud
- Learn how to report fraud

- Find out what you need to know if you're in, or thinking about joining, a Medicare health or drug plan

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

You're the first line of defense against Medicare fraud. Medicare.gov/fraud is a good place for you to learn about resources available to protect yourself, your loved ones, and Medicare. You'll learn

- Tips to prevent fraud
- How to spot fraud
- How to report fraud
- What you need to know if you're in, or thinking about joining, a Medicare health or drug plan

Medicare Summary Notice (MSN)

- CMS redesigned the MSN for Part A and Part B to make it easier to read and spot fraud
- Shows all your services or supplies
  - Billed to Medicare in a 3-month period
  - What Medicare paid
  - What you owe
- Read it carefully

Jennifer Washington THIS IS NOT A BILL | Page 2 of 4

Making the Most of Your Medicare

How to Check This Notice

Do you recognize the name of each facility? Check the dates.

Did you get the claims listed? Do they match those listed on your receipts and bills?

If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement (Medigap) plan or other insurer. Your plan may pay your share.

How to Report Fraud

If you think a facility or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633-4227).

Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

You can make a difference! Last year, Medicare saved tax payers $4.2 billion—the largest sum ever recovered in a single year—thanks to people who reported suspicious activity to Medicare.

How to Get Help with Your Questions

1-800-MEDICARE (1-800-633-4227)
Ask for "hospital services." Your customer service code is 05536.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call 1-555-555-5555.

Your Benefit Periods

Your hospital and skilled nursing facility (SNF) stays are measured in **benefit days** and **benefit periods**. Every day that you spend in a hospital or SNF counts toward the benefit days in that benefit period. A benefit period begins the day you first receive inpatient hospital services or, in certain circumstances, SNF services, and ends when you haven't received any inpatient care in a hospital or inpatient skilled care in a SNF for 60 days in a row.

Inpatient Hospital: You have **56 out of 90 covered benefit days** remaining for the benefit period that began May 27, 2013.

Skilled Nursing Facility: You have **63 out of 100 covered benefit days** remaining for the benefit period that began May 27, 2013.

See your "Medicare & You" handbook for more information on benefit periods.

Your Messages from Medicare

Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment.

To report a change of address, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

Want to see your claims right away? Access your Original Medicare claims at www.MyMedicare.gov, usually within 24 hours after Medicare processes the claim. You can use the "Blue Button" feature to help keep track of your personal health records.

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

There's a Part A, a Part B, and a durable medical equipment (DME) Medicare Summary Notice (MSN). The MSN shows all services and supplies that were billed to Medicare, what Medicare paid, and what you owe each provider. You should review your MSN carefully to ensure that you got the services and supplies for which Medicare was billed.

CMS redesigned the MSN to make it simpler for people with Medicare to understand, spot, and report fraud.

For more information or to view samples of the Part A, Part B, and/or DME MSNs, visit Medicare.gov/forms-help-and-resources/mail-about-medicare/medicare-summary-notice-msn.html.

Visit Medicare.gov/pubs/pdf/summarynoticea.pdf to see how to read your Part A MSN.

Visit Medicare.gov/pubs/pdf/summarynoticeb.pdf to see how to read your Part B MSN.

Visit Medicare.gov/pubs/pdf/SummaryNoticeDME.pdf to see how to read your DME MSN.

NOTE: Medicare Advantage Plans provide an Explanation of Benefits (EOB) that provides similar information. The Medicare Part C EOB is an ad hoc enrollee communication that provides MA enrollees with clear and timely information about their medical claims to support informed decisions about their health care options. Medicare Advantage organizations are required to issue EOBs that include the information reflected in the CMS-developed templates. For additional information, please see the final templates and instructions at: CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html Medicare Part D sponsors must ensure that enrollees who utilize their prescription drug benefits get their EOBs by the end of the month following the month in which they utilized their prescription drug benefits.

MyMedicare.gov

- Secure site to manage personal information
- You register to
  - Review eligibility, entitlement, and plan information
  - Track preventive services
  - Keep a prescription drug list
- Review claims for Medicare Part A and Part B
  - Available almost immediately after they are processed

Select the "Blue Button" to download your data to a text file

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

MyMedicare.gov is Medicare's free, secure online website for accessing personalized information regarding Medicare benefits and services. MyMedicare.gov provides you with access to your personalized information at any time.

- View eligibility, entitlement, and preventive service information.
- Check personal Medicare information, including Medicare claims, as soon as they're processed.
- Check your health and prescription drug enrollment information as well as any applicable Part B deductible information.
- Manage your prescription drug list and personal health information.
- Review claims for Medicare Part A and Part B and identify fraudulent claims. You don't have to wait to get your Medicare Summary Notice (MSN) in the mail to view your Medicare claims. Visit MyMedicare.gov to track your Medicare claims or view electronic MSNs. Your claims will generally be available within 24 hours after processing.

If there's a discrepancy, you should call your doctor or supplier. Call 1-800-MEDICARE if you suspect fraud. TTY: 1-877-486-2048.

NOTE: To use this service you must register on the site. Newly eligible beneficiaries are automatically registered and sent a personal identification number.

1-800-MEDICARE (TTY: 1-877-486-2048)

- Incoming fraud complaints
  - Help target certain providers/suppliers for review
  - Show where fraud scams are heating up
- Using the Interactive Voice Response System
  - Access up to 15 months of claims
  - Check for proper dates, services, and supplies obtained
    - If not checking claims on MyMedicare.gov

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

People with Medicare can call 1-800-MEDICARE (1-800-633-4227) to make a complaint and report fraud. TTY: 1-877-486-2048.

The Call Center has an Interactive Voice Response (IVR) system available for people who haven't registered or don't use MyMedicare.gov. The IVR can access 15 months of Original Medicare claims processed on their behalf, if they're available.

The data gathered helps CMS to

- Target providers or suppliers with multiple consumer complaints for further review.
- Track fraud complaints to show when fraud scams are heating up in new areas. Using existing data in this innovative way enables CMS to target providers and suppliers with multiple consumer complaints for further investigation.

Before you report errors, fraud, or abuse, carefully review the facts and have the following information ready:

- The provider's name and any identifying number you may have
- Information on the service or item you're questioning
- The date the service or item was supposedly given or delivered
- The payment amount approved and paid by Medicare
- The date on your Medicare Summary Notice
- Your name and Medicare number (as listed on your Medicare card)

Fighting Fraud Can Pay

- You may get a reward if you meet all of these conditions:
  - You call either 1-800-HHS-TIPS (1-800-447-8477), or 1-800-MEDICARE (1-800-633-4227) to report suspected fraud. TTY: 1-877-486-2048.
  - The suspected Medicare fraud you report must be investigated and validated by Medicare contractors.
  - The reported fraud must be formally referred to the Office of Inspector General for further investigation.
  - You aren't an excluded individual.
  - The person or organization you're reporting isn't already under investigation by law enforcement.
  - Your report leads directly to the recovery of at least $100 of Medicare money.

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

You may get a reward of up to $1,000 if you meet all of these conditions:

- You call either 1-800-HHS-TIPS (1-800-447-8477), or 1-800-MEDICARE (1-800-633-4227) to report suspected fraud. TTY: 1-877-486-2048.
- The suspected Medicare fraud you report must be proven as potential fraud by the Zone Program Integrity Contractor (the Medicare contractors responsible for investigating potential fraud and abuse), and formally referred as part of a case by one of the contractors to the Office of Inspector General for further investigation.
- You aren't an "excluded individual." For example, you didn't participate in the fraud offense being reported. Or, there isn't another reward that you qualify for under another government program.
- The person or organization you're reporting isn't already under investigation by law enforcement.
- Your report leads directly to the recovery of at least $100 of Medicare money.

For more information, call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

To read the press release, visit HHS.gov/news/press/2013pres/04/20130424a.html and the Code of Federal Regulations at CFR 420.405" Rewards for information relating to Medicare fraud and abuse."

The Senior Medicare Patrol (SMP)

- Education and prevention program aimed at educating people with Medicare on preventing, identifying, and reporting health care fraud
- Active programs in all states, the District of Columbia, Puerto Rico, Guam, and U.S. Virgin Islands
- Seeks volunteers to represent their communities
- Toll-free number in Kansas: 1-800-432-3535
- For more information visit http://www.kdads.ks.gov/kansas-senior-medicare-patrol

SMP Empowering Seniors To Prevent Healthcare Fraud

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

The Senior Medicare Patrols (SMPs) empower and assist people with Medicare, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. SMPs are grant-funded projects of the U.S. Department of Health & Human Services U.S. Administration for Community Living. Their work is in 3 main areas:

1. Conduct Outreach and Education. SMPs give presentations to groups, exhibit at events, and work one-on-one with people with Medicare. Since 1997, more than 30 million people have been reached during community education events, more than 6.5 million people with Medicare have been educated and served, and more than 46,000 volunteers have been active.
2. Engage Volunteers. Protecting older persons' health, finances, and medical identity while saving precious Medicare dollars is a cause that attracts civic-minded Americans. The SMP program engages over 5,200 volunteers nationally who collectively contribute more than 155,000 hours each year.
3. Get Complaints from People with Medicare. When people with Medicare, caregivers, and family members bring their complaints to the SMP, the SMP makes a determination about whether or not fraud, errors, or abuse is suspected. When fraud or abuse is suspected, they make referrals to the appropriate state and federal agencies for further investigation.

There are SMP programs in each state, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. SMPs seek volunteers to represent the program in their communities.

NOTE: Kansas SMP toll-free number is 1-800-432-3535, the KDADS toll-free phone number

Protecting Personal Information

- Only share with people you trust
  - Doctors, other health care providers, and plans approved by Medicare
  - Insurers who pay benefits on your behalf
  - Trusted people in the community who work with Medicare, like your State Health Insurance Assistance Program (SHIP) or Social Security
- Call 1-800-MEDICARE (1-800-633-4227) if you aren't sure if a provider is approved by Medicare
- TTY: 1-877-486-2048

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

Keep your personal information safe, such as your Medicare, Social Security, and credit card numbers. Only share this information with people you trust, such as

- Your doctors, other health care providers, and plans approved by Medicare
- Insurers who pay benefits on your behalf
- Trusted people in the community who work with Medicare, like your State Health Insurance Assistance Program (SHIP) or Social Security

Call 1-800-MEDICARE (1-800-633-4227) if you aren't sure if a provider is approved by Medicare. TTY: 1-877-486-2048.

Identity Theft

- Identity theft is a serious crime
  - Someone else uses your personal information, like your Social Security or Medicare number
- If you think someone is using your information
  - Call your local police department
  - Call the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338
  - TTY: 1-866-653-4261
- If your Medicare card is lost or stolen, report it right away
  - Call Social Security at 1-800-772-1213
  - TTY: 1-800-325-0778

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

Identity theft is when someone else uses your personal information, like your Social Security or Medicare number. It's a serious crime. Currently, CMS is aware of 5,000 compromised Medicare provider numbers (Parts A/B/D) and 284,000 compromised beneficiary numbers.

If you think someone is using your information, you have options:

- Call your local police department.
- Call the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338.
  TTY: call 1-866-653-4261.

If your Medicare card is lost or stolen, report it right away:

- Call Social Security at 1-800-772-1213. TTY: 1-800-325-0778.

For more information about identity theft or to file a complaint online, visit ftc.gov/idtheft.

You can also visit stopmedicarefraud.gov/toolkit/documents/fightback_brochure_rev.pdf to view "Medical Identity Theft & Medicare Fraud."

Key Points to Remember

- ✓ The key difference between fraud, waste, and abuse is intention
- ✓ Improper payments are often mistakes
- ✓ CMS fights fraud, waste, and abuse with support from Program Integrity Contractors
- ✓ You can fight fraud, waste, and abuse with the 4Rs: Record, Review, Report, Remember
- ✓ There are many sources of additional information

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

AD ASTRA

Key points to remember include the following:

- The difference between fraud, waste, and abuse is intention
- While there are many causes of improper payments, many are honest mistakes
- The Centers for Medicare & Medicaid Services (CMS) fights fraud, waste, and abuse with support from Program Integrity Contractors and partnerships with organizations such as Senor Medicare Patrols and the private industry
- You can fight fraud, waste, and abuse with the 4Rs: record, review, report, and remember
- There are many sources of additional information

Medicare and the Health Insurance Marketplace

- Marketplace and People with Medicare
- Marketplace and Becoming Eligible for Medicare
- Enrollment Considerations

Medicare and the Health Insurance Marketplace

AD ASTRA

"Medicare and the Health Insurance Marketplace," provides information for people aging into Medicare or who qualify for Medicare based on a disability.

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

Medicare and the Health Insurance Marketplace

AD ASTRA

Medicare isn't a part of the Health Insurance Marketplace. Medicare Part A provides minimum essential coverage. If you have Medicare, you don't have to do anything related to the Marketplace. The Marketplace doesn't change your Medicare plan choices or your benefits. Medicare plans and Medicare Supplement Insurance (Medigap) Policies aren't available in the Marketplace. It's against the law for someone who knows that you have Medicare to sell or issue you a Marketplace policy. This is true even if you have only Medicare Part A or only Part B. The exception is coverage from your employer through the Small Business Health Options Program. If you receive your coverage this way

- The Small Business Health Options Program (SHOP) employer coverage may pay first
- You could delay Medicare enrollment without a penalty
  - This doesn't include COBRA coverage

Marketplace and Becoming Eligible for Medicare

- You can keep a Marketplace plan after your Medicare coverage begins
  - You may cancel the plan when Medicare coverage starts
    - Once your Part A coverage starts you won't be able to get lower costs for your Marketplace plan
- Sign up for Medicare during your Initial Enrollment Period
  - Or, if you enroll later, you may have to pay a late enrollment penalty for as long as you have Medicare

Medicare and the Health Insurance Marketplace

AD ASTRA

If you have coverage through an individual Health Insurance Marketplace plan (not through an employer), you may want to terminate your Marketplace coverage and enroll in Medicare during your Initial Enrollment Period to avoid the risk of a delay in future Medicare coverage and the possibility of a Medicare late enrollment penalty. Once you're considered eligible for Part A, you won't qualify for help paying your Marketplace plan premiums or other medical costs. If you continue to get help paying your Marketplace plan premium after you have Medicare, you might have to pay back the help you got when you file your taxes. Visit HealthCare.gov to connect to the Marketplace in your state and learn more. You can also find out how to terminate your Marketplace plan before your Medicare enrollment begins.

Once you're eligible for Medicare, you'll have an Initial Enrollment Period (IEP) to sign up. For most people, their 7-month Medicare IEP starts 3 months before their 65th birthday and ends 3 months after their 65th birthday. If you enroll in Medicare after your IEP, you may have to pay a late enrollment penalty for as long as you have Medicare.

If you have individual Marketplace coverage and only enroll in Part A during your IEP, you won't be able to enroll in Part B later using the Special Enrollment Period.

NOTE: You may have Medicare and Marketplace coverage concurrently, only if you had your Marketplace coverage before you had Medicare. It's against the law for someone who knows you have Medicare to sell you a Marketplace plan. There is no coordination of benefits between a Qualified Health Plan (QHP) and Medicare. You need to be aware of this if you decide to remain in a QHP after enrolling into Part A. It isn't a secondary insurance. Also, drug coverage in QHP may not be creditable and a penalty may result if you sign up for Part D later.

If You Have a Marketplace Plan First and Then Get Medicare Coverage

- You lose eligibility for any premium tax credits and/or reduced cost sharing for your Marketplace plan
- If you drop your Marketplace plan, you must contact the plan at least 14 days before you want to end that coverage. Time it to avoid a gap in coverage.
  - Depending on your income and resources, you may be eligible for help paying your Medicare Part B and Part D premiums and for some reduced cost sharing for Medicare Part D coinsurance/copayments
  - You may also be able to buy a Medicare Supplement Insurance (Medigap) Policy or join a Medicare Advantage Plan (like a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO))

Medicare and the Health Insurance Marketplace

ADASTRA

You can get a Marketplace plan to cover you before your Medicare begins. If you choose to drop your Marketplace plan, you must contact the plan at least 14 days before you want that coverage to end. However, it's important that you time the end of your Marketplace plan so that you don't have a gap in coverage.

Once you're eligible for Medicare, you'll have an Initial Enrollment Period to sign up. In most cases it's to your advantage to sign up when you're first eligible because once you're getting Medicare, you won't be able to get lower costs for a Marketplace plan based on your income like premium tax credits and reduced cost-sharing (except if you only have Part B).

If you have limited income and resources, you may be eligible for help paying your Medicare Part B and Part D premiums and for some reduced cost sharing for Medicare Part D coinsurance/copayments.

Choosing Marketplace Instead of Medicare

- The Individual Marketplace isn't employer-sponsored coverage
- You can't choose Marketplace coverage instead of Medicare unless
  - You pay or you'd have to pay a Part A premium
    - You can drop Part A and Part B and may be eligible to get a Marketplace plan
  - You have a medical condition that qualifies you for Medicare (like ESRD) but haven't applied for Medicare
  - You're not yet collecting Social Security retirement or disability benefits and not yet eligible for Medicare based on age (or you're in the waiting period)
    - Medicare enrollment will be automatic once eligible and getting a Social Security Cash benefit

Medicare and the Health Insurance Marketplace

AD ASTRA

It's against the law for someone who knows you have Medicare to sell you a Marketplace plan policy. You can choose Marketplace coverage instead of Medicare if you:

- Would have to pay a premium for Part A, you can drop your Part A and Part B coverage and get a Marketplace plan instead
- Only have Part B and would have to pay a premium for Part A, you can drop Part B and get a Marketplace plan instead
- Have a medical condition that qualifies you for Medicare, like End-Stage Renal Disease (ESRD), but haven't applied for Medicare coverage
- You're not yet collecting Social Security retirement or disability benefits and not yet eligible for Medicare based on age (or you're in the waiting period)
  - Medicare enrollment will be automatic once eligible and getting a Social Security Cash benefit

Before choosing a Marketplace plan over Medicare, there are 2 important points to consider:

1. If you enroll in Medicare after your Initial Enrollment Period (IEP) ends, you may have to pay a late enrollment penalty (LEP) for as long as you have Medicare.
2. Generally you can enroll in Medicare only during the Medicare General Enrollment Period (from January 1 to March 31). Your coverage won't begin until July of that year.

If you don't have or dropped Medicare Part A because you have to pay a premium, and instead enroll in a Marketplace plan, you'd be eligible for the premium tax credit and cost-sharing reductions, assuming that you meet the eligibility requirements for those programs.

REMEMBER: If you choose to enroll in Medicare later and keep your Qualified Health Plan (QHP) coverage, generally there's no coordination of benefits between a Marketplace plan and Medicare. You need to be aware of this, if you decide to remain in a QHP after enrolling into Medicare. Marketplace plans aren't secondary insurance. In fact, the QHP isn't required to pay any costs toward your coverage if you have Medicare.

Medicare for People With Disabilities and the Marketplace

- You may qualify for Medicare based on a disability
  - You must be entitled to Social Security Disability Insurance (SSDI) benefits for 24 months
    - On the 25th month, you're automatically enrolled in Medicare Part A and Part B
- If you're getting SSDI, you can get a Marketplace plan to cover you during your 24-month waiting period
  - You may qualify for premium tax credits and reduced cost-sharing until your Medicare coverage starts

Medicare and the Health Insurance Marketplace

AD ASTRA

If you're entitled to Social Security Disability Insurance (SSDI), you may qualify for Medicare. However, there is a 24-month waiting period before Medicare coverage can start. During this waiting period, you can apply for coverage in the Marketplace. You can find out if you'll qualify for Medicaid or for premium tax credits that lower your monthly Marketplace plan premium, and cost-sharing reductions that lower your out-of-pocket costs.

If you apply for lower costs in the Marketplace, you'll need to estimate your income for 2018. If you're getting Social Security disability benefits and want to find out if you qualify for lower costs on Marketplace coverage, you'll need to provide information about your Social Security payments, including disability payments.

Your Medicare coverage is effective on the 25th month of receiving SSDI. Your Medicare card will be mailed to you about 3 months before your twenty fifth month of disability benefits. If you don't want Part B, follow the instructions that are included with the card. However, once you're eligible for Medicare, you won't be able to get lower costs for a Marketplace plan based on your income.

Once your Part A coverage starts, any premium tax credits and reduced cost-sharing you may've qualified for through the Marketplace will stop. That's because Part A is considered minimum essential coverage, not Part B.

Also, remember, the QHP isn't required to pay any costs towards your coverage once you have Medicare.

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 penalty for as long as your have Part B)
  - 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 getting Social Security benefits, you would have to drop your Social Security if you drop Medicare

Medicare and the Health Insurance Marketplace

AD ASTRA

There are a few situations where you can choose a Marketplace private health plan instead of Medicare.

1. If you're paying a premium for Part A. In this case you can drop your Part A and Part B coverage and get a Marketplace plan instead. In the rare instance that you only have Part B, you also could drop it and get coverage in the Marketplace. If you're eligible for Medicare but haven't enrolled in it, this could be because you'd have to pay a premium; you have a medical condition that qualifies you for Medicare, like End-Stage Renal Disease (ESRD), but haven't applied for Medicare coverage; or you're not collecting Social Security retirement or disability benefits before you're eligible for Medicare.
2. If you're getting Social Security retirement or disability benefits before you're eligible for Medicare, you'll automatically be enrolled in Medicare once you're eligible. Before choosing a Marketplace plan over Medicare, there are two important points to consider:

If you enroll in Medicare after your Initial Enrollment Period ends, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up (Note: If you're already receiving Social Security benefits prior to becoming eligible then you'll be automatically enrolled in Part A; no penalty would be applicable here). If you don't enroll in Part B when first eligible, you may have to pay a late enrollment penalty for as long as you have Medicare. You may owe a Part D late enrollment penalty if, at any time after your Initial Enrollment Period (IEP) is over, there's a period of 63 or more days in a row when you don't have Part D or other creditable prescription drug coverage. Marketplace plans aren't required to provide creditable drug coverage. You may have to pay this penalty as long as you have Part D coverage.

Generally, if you miss your IEP, you can enroll in Medicare only during the Medicare General Enrollment Period (from January 1 to March 31 each year). Your coverage won't start until July. This may cause a gap in your coverage.

Employer coverage offered through the Small Business Health Options Program (SHOP) is treated like any other employer coverage. Medicare Secondary Payer rules apply. For more information, view the publication CMS Product No. 11694 at Medicare.gov/Pubs/pdf/11694-Medicare-and-Marketplace.pdf.

Course Completion

- Thank you for completing this pre-training course!
- You have reviewed the following:
  - Coordination of Benefits
  - Medicare Rights and Protections
  - Medicaid Overview
  - Medicare and Medicaid Fraud Prevention
  - Medicare and the Health Insurance
- You should now follow the instructions on the next page to complete the course exam.

AD ASTRA

Course Examination

- Please log into the SHIP Technical Assistance Center, https://www.shiptacenter.org/
- Use the Online Counselor Certification Tool, https://shipta.medicareinteractive.org/ship-certification-tool, to complete the SHICK Initial Pre-Training Course 3 Exam.
- After successful completion of the Course 3 Exam, you are eligible to attend ***Initial Training Course 4***: Initial Training – Medicare Basics.
  - Please register for this course through the SHICK Annual Training Calendar, http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick/shick-coordinator-counselor-information/shick-annual-training-calendar.

- Please log into the SHIP Technical Assistance Center, https://www.shiptacenter.org/
- Use the Online Counselor Certification Tool, https://shipta.medicareinteractive.org/ship-certification-tool, to complete the SHICK Initial Pre-Training Course 3 Exam.
- After successful completion of the Course 3 Exam, you are eligible to attend ***Initial Training Course 4***: Initial Training – Medicare Basics.
  - Please register for this course through the SHICK Annual Training Calendar, http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick/shick-coordinator-counselor-information/shick-annual-training-calendar.