



Medicare for Medicaid Advocates

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The Medicare Rights Center is a national, not-for-profit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives.

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at www.NSCLC.org.

Housekeeping

- ❖ All on mute. Use Chat function for questions and for technical concerns.
- ❖ Problems with getting on to the webinar? email trainings@nsclc.org
- ❖ You will be sent copies of the slides after the presentation. Slides and a recording will also be available at www.nsclc.org

What you will learn:

- ❖ Medicare Options
- ❖ Costs and Cost Protections
- ❖ Medicare Coverage Issues
- ❖ Medicare/Medicaid Issues
- ❖ The Medicare Appeals Process

MEDICARE OPTIONS

What is Medicare?

- ❖ Health insurance for people 65 or older and people with disabilities
- ❖ Covers most health care services and items
- ❖ Eligibility is not based on income
- ❖ Medicare is offered in two different ways:

Original Medicare **or** Medicare Advantage



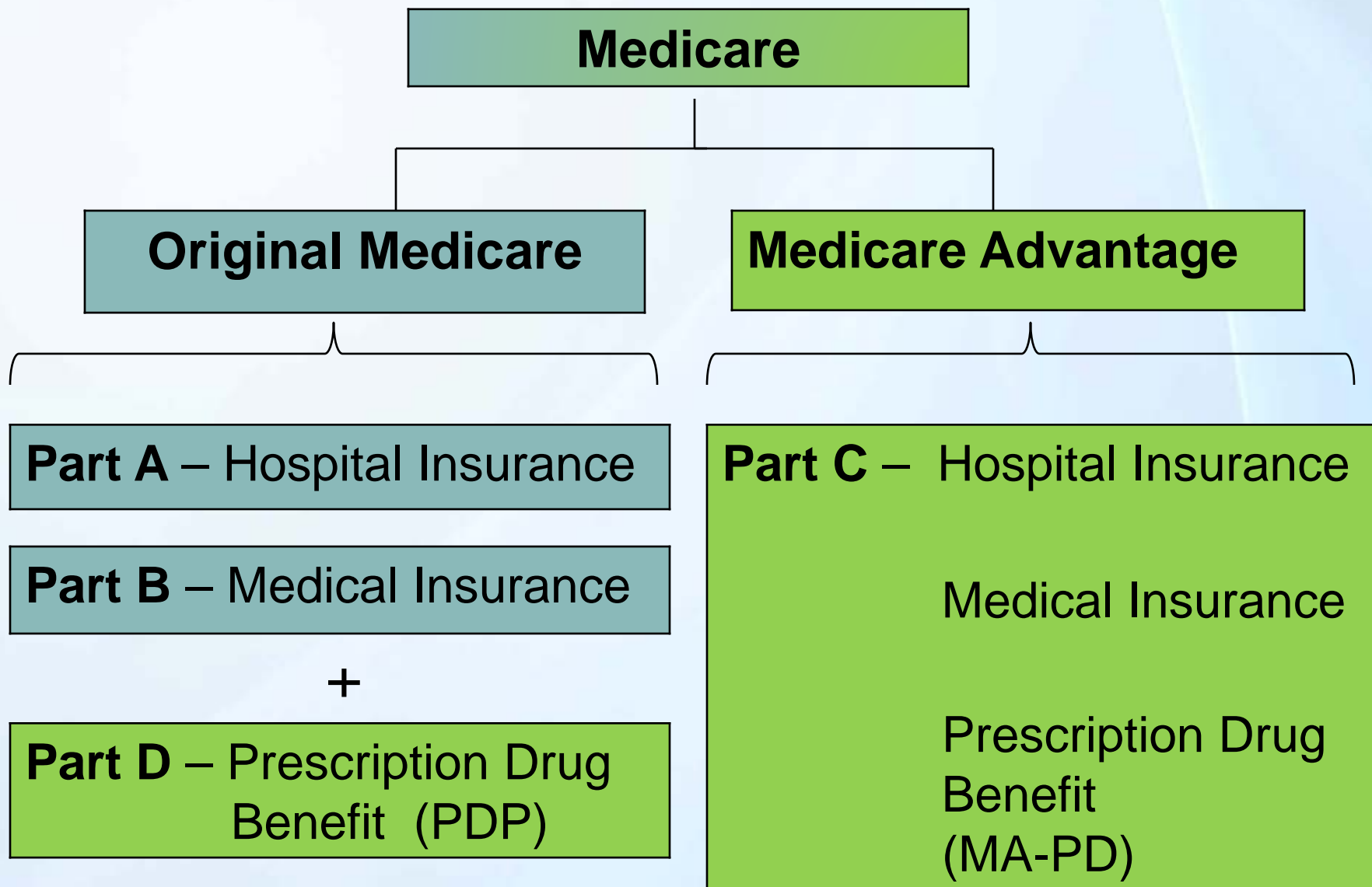
Original Medicare

Traditional Medicare program administered directly through the federal government

Medicare Advantage

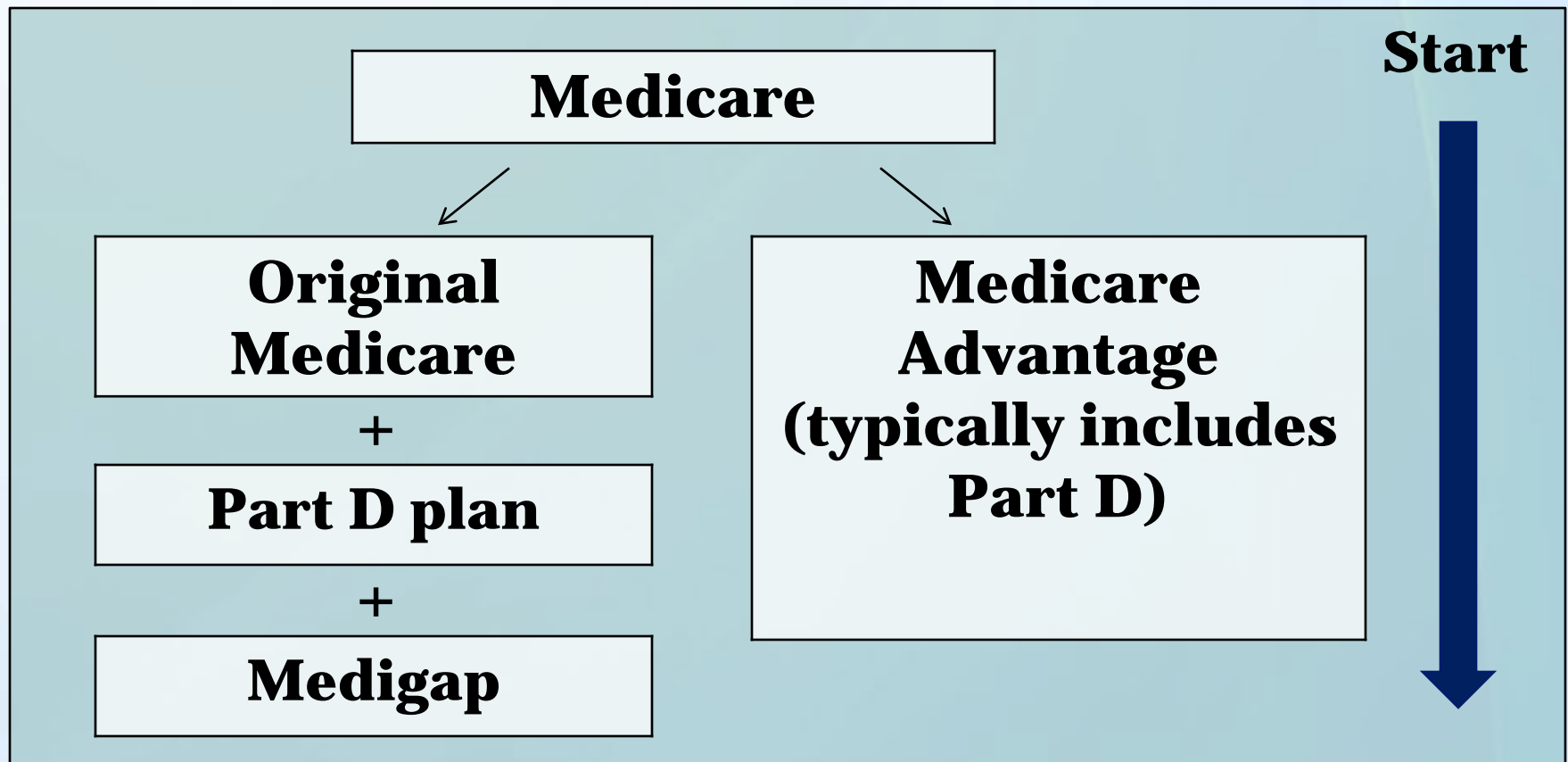
Medicare private health plan offered through private insurance companies

Parts of Medicare



Medicare Options

When first enrolling into Medicare, you can choose Original Medicare or Medicare Advantage.



Original Medicare vs. Medicare Advantage

Original Medicare	Medicare Advantage
• Parts A and B	• Parts A, B, and D
• Can see any provider in the U.S. as long as the provider accepts Medicare	• May be restricted to seeing in-network providers
• Don't need physician referral	• May need primary care referral
• 20% coinsurance for most services	• Costs and rules vary, depending on the plan
• Doesn't cover excluded services (e.g. vision, dental, hearing care)	• May cover excluded services (e.g. vision, dental, hearing care)
• Can have Medigap	• Cannot have Medigap

What are SNPs

Special Needs Plans - a subset of Medicare Advantage

- Limit enrollment to certain categories
- Must have a model of care to address the needs of the target population

D-SNPs for dual eligibles

C-SNPs for chronic conditions

I-SNPs for institutional level of care

Freedom of Choice in Medicare

- Many choices, often too many
- Plans can change coverage and costs significantly every year
- Aggressive marketing by agents and brokers
- Medicare rules re: home visits, cold calls, etc.

- Decision tool: Medicare Plan Finder
www.Medicare.gov
- One-on-one counseling: SHIPs – State Health Insurance Programs
<https://shipnpr.shiptalk.org/shipprofile.aspx>

Enrollment and Costs

Enrollment

- For most individuals, Part A is free if 40 quarters of work history
- Others can pay (or get QMB) if:
 - Age 65 and over
 - Resident of US
 - US Citizen or Lawfully-Admitted Permanent Resident (LAPR) for 5 continuous years
- Can purchase A and B, or B only (can't purchase A only)
- Applying is easy! Most get Medicare card before 65th birthday.

Premiums for 2013

- Part A
 - If 40 quarters: free
 - \$243/mo if 30-39 quarters
 - \$441/mo if fewer or no quarters
 - QMB can help low-income individuals
- Part B
 - \$104.90/mo (more for higher income)
 - MSP can help low-income individuals
- Penalties for late enrollment

Help with Medicare—Parts A and B

- Full Scope Medicaid
- Medicare Savings Programs (MSP)
 - Qualified Medicare Beneficiary-QMB (100% FPL): Pays Part A and B premiums, deductible, co-pays and protects against balance billing
 - Specified Low Income Medicare Beneficiary (120%FPL)-SLMB: Pays Part B premiums
 - Qualified Individual (135%FPL): Pays Part B premiums
 - MSP asset limit in most states: \$7,080/\$10,620
- Apply to state Medicaid program

Help with Medicare -Part D

- Low Income Subsidy (LIS), AKA “Extra Help”
- Covers premiums for “benchmark” plans, deductibles, co-pays, no donut hole
- Continuous enrollment period
- Automatic if Medicaid or MSP
- Others apply to SSA

<http://www.ssa.gov/prescriptionhelp/>

LIS Categories-Eligibility

- Group 1
 - Full Medi-Cal dual eligibles with countable incomes at or below 100% Federal poverty level (FPL) “**deemed** eligible”
- Group 2
 - Full-Medicaid dual eligibles above 100% of FPL; QMB, SLMB, QI, “**deemed** eligible”; and non-dual eligible beneficiaries with countable incomes below 135% FPL and limited countable resources (\$6,940 for an individual; \$10,410 for a couple *) “**determined** eligible”
- Group 3
 - Beneficiaries with countable incomes below 150% FPL and limited countable resources (\$13,300 individual and \$26,580 married couple*) “**determined** eligible”

* in addition, individuals may have \$1500 and couples \$3000 for burial fund

	Group 1	Group 2	Group 3
Cost #1: Premium	\$0 (up to benchmark amount)	\$0 (up to benchmark amount)	Sliding scale based on income
Cost #2: Deductible	\$0	\$0	\$65
Cost #3: Co-payments	\$1.15/\$3.50 (0 in nursing home or most HCBS)	\$2.65/\$6.60	15% coinsurance
Cost #4: Gap/"Donut Hole"	None (co-pays still \$1.15/\$3.50)	None (co-pays still \$2.65/\$6.60)	None (still 15% coinsurance)
Cost #5: Catastrophic Coverage	\$0	\$0	\$2.65/\$6.60

Limits to Covered Services

Understanding what is covered

- ❖ **Medicare & You Handbook** provides basic information on Medicare coverage, coverage limits, and payment obligations of the beneficiary.

www.medicare.gov/Pubs/pdf/10050.pdf

- ❖ **Evidence of Coverage** booklet of each Medicare Advantage plan and Prescription Drug Plan explains coverage and cost for that plan.

Available by calling plan, on plan website or through

www.Medicare.gov

Services Medicare does not cover

- ❖ Most dental care
- ❖ Most vision care
- ❖ Routine hearing care
- ❖ Most foot care
- ❖ **Most long-term care**
- ❖ Alternative medicine
- ❖ Most care received outside of the US
- ❖ **Most personal care or custodial care**
- ❖ Most non-emergency transportation

***Note:** Medicare Advantage plans (or Medicaid) may cover some of these services

Prior authorizations in Medicare

Original Medicare

- ❖ General rule is no prior authorization
- ❖ Medicare processes claims after service is delivered
- ❖ Advance Beneficiary Notification (ABN)
 - ❖ Says Medicare unlikely to pay
 - ❖ Requires beneficiary to agree to be responsible
 - ❖ If no ABN and Medicare denies, provider may not charge

Medicare Advantage

- ❖ Prior authorization frequently required

Medicare/Medicaid intersections

❖ Skilled nursing care

- ❖ Medicare limits 100 days, often less
- ❖ Must require skilled care, no custodial care
- ❖ Improvement standard does not apply
- ❖ Need 3 day Part A hospital stay for Medicare coverage of SNF
 - Observation status does not count as hospital stay

❖ Issues for duals

- ❖ Access to wider range of facilities if under Medicare
- ❖ Quality of rehab services if switch to Medicaid coverage
- ❖ Hospitalization of Medicaid SNF resident can restart Medicare.
Financial incentive for unnecessary hospitalization.

Medicare/Medicaid intersections

❖ Durable Medical Equipment (DME)

- ❖ Both Medicare and Medicaid cover
- ❖ Medicare limitation for use in the home (e.g., wheelchairs)

❖ Issues for duals

- ❖ Medicaid always payer of last resort
- ❖ Medicare usually does not use prior authorization. Only processes claim after delivery. Medicaid won't review claim until after a Medicare denial.
- ❖ Suppliers want to know they will be paid before they deliver DME. Dual left without DME.
- ❖ Some states have developed work-arounds

Medicare/Medicaid intersections

❖ Home Health

- ❖ Both Medicare and Medicaid cover
- ❖ Medicare “homebound” requirement
- ❖ Medicare-must require intermittent skilled nursing or PT, OT or speech-language pathology
- ❖ Improvement standard not applicable—true for OT and PT as well

❖ Issues for duals

- ❖ Like SNF, quality may be better if Medicare pays

Medicare/Medicaid intersections

❖ Prescription Drugs

- ❖ Almost all drug categories covered by Medicare, plans not required to cover every drug in a category
- ❖ Exceptions: OTC drugs, some uses of barbiturates, off-label uses not in compendiums and others

❖ Issues for duals

- ❖ If a drug is a “covered Part D drug”, Medicaid will not pay, even if the Part D plan has denied coverage
- ❖ If a drug is not a “covered Part D drug,” dual can seek Medicaid coverage (e.g., OTC)
- ❖ Duals and all LIS can change Part D plans at any time

**APPEALING AN
ADVERSE DECISION IN
MEDICARE**

Original Medicare Appeals

- ❖ Generally for payment of a service that someone already received
- ❖ Medicare Summary Notice (MSN)
 - A notice the beneficiary gets in the mail from Original Medicare that lists services they received over the previous three months from doctors, hospitals, or other health care providers
 - It tells the beneficiary what the provider billed Medicare, Medicare's approved amount for the service, the amount Medicare paid, and what they have to pay
 - The MSN is not a bill
- ❖ To appeal, someone must send a copy (keep the original) of the Medicare Summary Notice (MSN) to the address indicated on the MSN
- ❖ Circle the items they want to dispute and write “please review,” and sign the MSN at the bottom
- ❖ It’s critical that the person gets a letter from their healthcare provider stating why this service was medically necessary

Original Medicare Appeals Process

Medicare Determination (MSN)



Redetermination by Medicare Administrative Contractor



Reconsideration
by Qualified Independent Contractor (QIC)



Administrative Law Judge (ALJ) Hearing



Medicare Appeals Council (MAC) Review



Judicial Review (Federal District Court)

Private Health Plan Appeals

- ❖ Pre-service Denials
 - Plan is refusing to cover care the beneficiary needs
 - Standard and expedited appeals (different timelines)

- ❖ Post-service Denials
 - Plan denies payment for a service the beneficiary already received

- ❖ Explanation of Benefits (EOB)
 - The notice the beneficiary gets from their Medicare Advantage plan after receiving medical services from a doctor, hospital, or other health care provider
 - It tells them what the provider billed their plan, the plan's approved amount, the amount they paid, and what they have to pay
 - It is not a bill

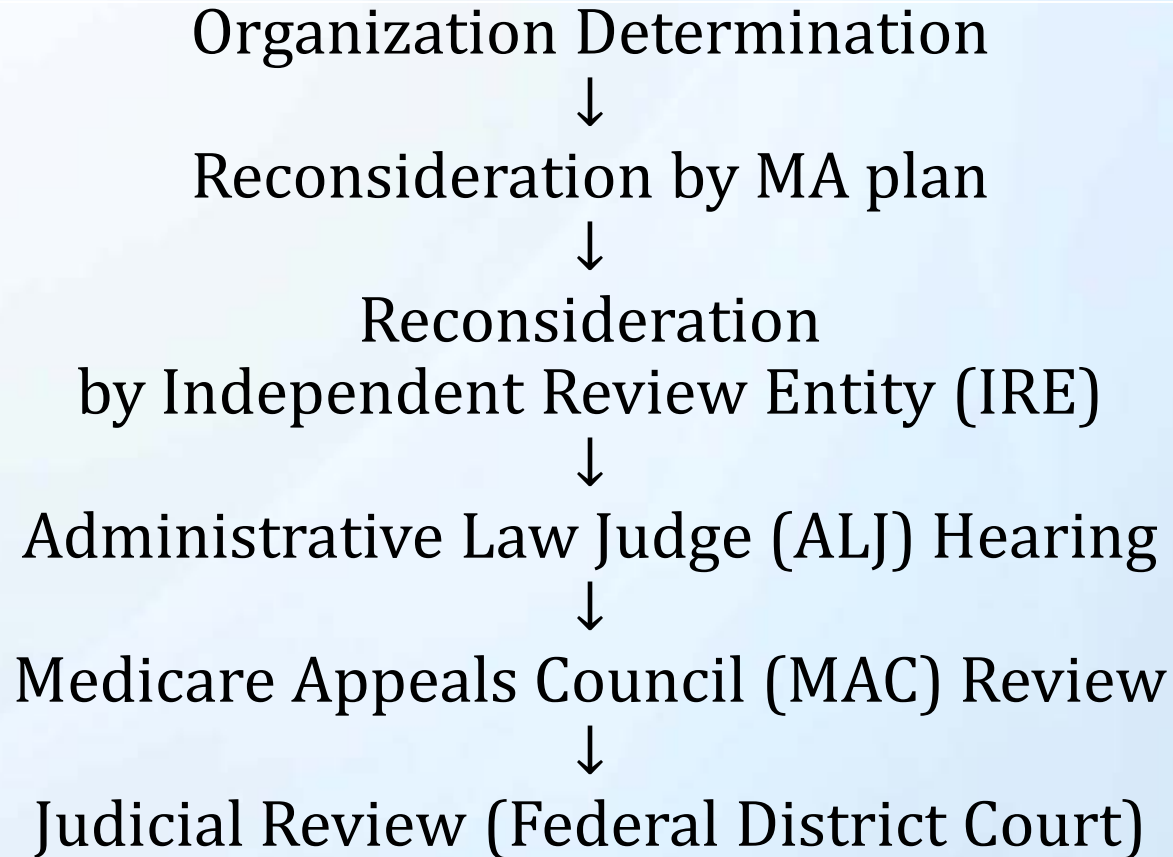
Private Health Plan Appeals –cont.

- ❖ After getting a denial notice, the beneficiary should request reconsideration from the plan
 - Send a letter explaining why they need the service
 - It's critical to include a supporting letter from their doctor or other provider

- ❖ Tell beneficiaries to keep copies of the letters, don't send originals

- ❖ Mail letters to the plan's appeals and grievances department

Private Plan Appeals Process



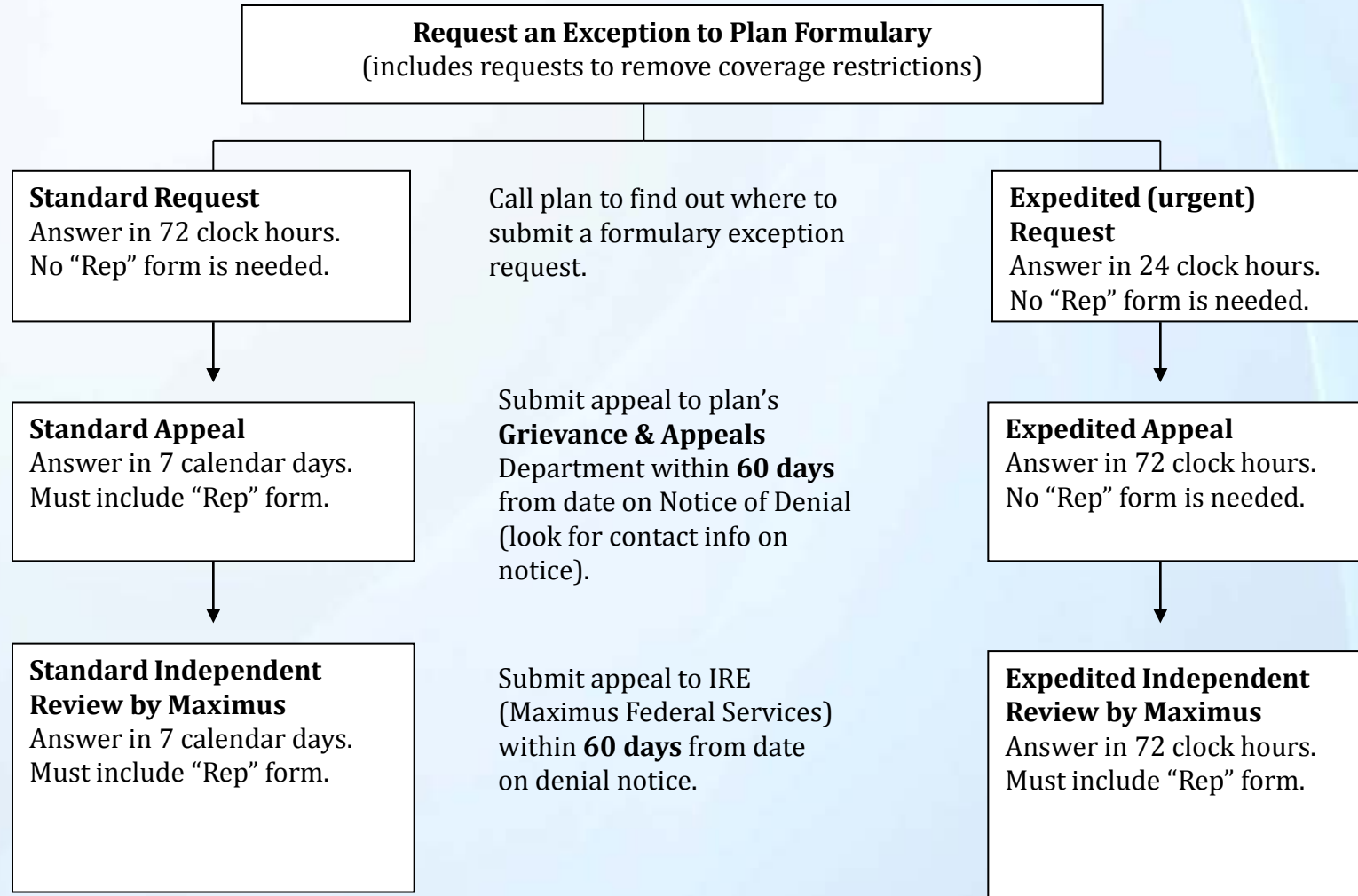
Part D Appeals

- ❖ A Part D appeal is a challenge to a Medicare private drug plan's decision to:
 - Not cover a prescribed medication
 - Limit the amount of a prescribed medication it will cover
 - Place a particular medication at a higher copay tier than other, similar medications
- ❖ Part D appeals procedures must follow federal rules and regulations
 - Rules are the same whether beneficiaries are in stand-alone Medicare private drug plans (PDP) or enrolled in Medicare Advantage plans with drug coverage (MA-PD)

Part D Levels of Appeal

1. Formulary Exception Request (Pre-appeal)
↓
2. Redetermination (Appeal)
↓
3. Reconsideration by the Independent Review Entity (IRE)
↓
4. Administrative Law Judge Hearing
↓
5. Medicare Appeals Council (MAC) Review
↓
6. Judicial Review (Federal District Court)

Part D Appeals Process



KEY CASE ISSUES AFFECTING CLIENTS WITH MEDICARE

Enrolling into Medicare at the right time

- Whether a person should enroll in Part B if they have current employer insurance depends on:
 - How many employees work at their or their spouse's (or other family members') company
 - If Medicare should be primary or secondary

Enrolling into Medicare at the right time

- ❖ Lets people enroll in Part B during these times:
 - Any time while in a group health plan based on their **current** employment or their spouse's (or other family member's in certain situations)
 - And during the 8 months after employment ends or the group health coverage ends, whichever comes first
- ❖ To qualify for an SEP, a person must meet specific criteria

Enrolling into Medicare at the right time

Two criteria to be eligible for the Part B Special Enrollment Period:

1. Must have insurance from a current job (an employer group health plan from their job, their spouse's job or sometimes a family member's job) or have had such insurance within the past 8 months
2. Must have been continuously covered since they became eligible for Medicare
 - Can have no more than 8 consecutive months of lapses in either Medicare or current employer coverage

Observation stays at the hospital

- ❖ Outpatient hospital services are covered under Medicare Part B
- ❖ Outpatient hospital care will not qualify someone for skilled nursing facility (SNF) coverage
 - Emergency room and observation services are considered outpatient care
- ❖ Observation care and inpatient admissions often look the same
- ❖ People should always ask the doctor or hospital what their official status is
 - The status affects costs and coverage both inside and outside of the hospital

Government web addresses

- ❖ Medicare consumer website www.Medicare.gov
- ❖ Medicare section of CMS website
<http://www.cms.gov/Medicare/Medicare.html>
- ❖ Medicare & You Handbook
www.medicare.gov/Pubs/pdf/10050.pdf
- ❖ Medicare Managed Care Manual www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
- ❖ Prescription Drug Benefit Manual
<http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html>

Additional references

❖ Medicare Interactive

- www.medicareinteractive.org
- Web based information system developed by Medicare Rights to be used as a counseling tool to help people with Medicare.

❖ NSCLC

- www.NSCLC.org
- www.dualsdemoadvocacy.org