State Health Insurance Assistance Program

LOCAL HELP FOR PEOPLE WITH MEDICARE

NA TIONAL NETWORK

CLAIM
State Health Insurance Assistance Program

Manual

Department of Insurance, Financial Institutions & Professional Registrations
If you have a CLAIM manual, you are one of more than 1,500 unique volunteers since 1993 who have been trained to be a State Health Insurance Assistance Program (SHIP) volunteer. This information is compiled by CLAIM trainers using CMS materials and other reliable resources. This manual:

1) Is a guide to basic Medicare benefits
2) Gives you direction on providing assistance
3) Provides resources to find those smaller points that are not used every day
4) Verifies what you think you know
5) Outlines the rules for many situations

Keep this manual at your partner site or with you when you are counseling. Make it your own; personalize with notes, tips and resources. The more you use your manual, the easier counseling will be for you. Remember, you can always call your trainer or the central office staff when you need to talk it out.

This manual belongs to:__________________________________________
Counselor ID number:__________________________________________
Completed initial training:________________________________________

Help line: 800-390-3330
Local: 573-817-8320
Fax: 573-817-8341

www.missouriclaim.org
www.shiptacenter.org
https://shipnpr.acl.gov
Advance Beneficiary Notice of Noncoverage (ABN)............... s4p3-4 & 23
Ambulance Services......................... s4p8-9
Benefit Period ............................... s3p2
Cardiac Rehabilitation ....................... s4p13
Cardiovascular Screenings ................. s4p13
Catastrophic Coverage ....................... s7p2
Chiropractic Services ....................... s4p4
COBRA................................ s5p2, s9p17
Colonoscopy .................................. s4p14
Coordination of Benefits ........ s2p8, s7p12-14
Coverage Gap................................ s7p2-3
Diabetes screening ............................. s7p2-3
Dialysis (kidney dialysis).................... s4p15
Durable Medical Equipment................. s4p10-11
EKG/ECG ........................................ s4p15
Employer Group Health Plan (EGHP) Coverage .............................. s5p1
End-Stage Renal Disease (ESRD). Section 9
Enroll:
  Part A........................................ s2p12
  Part B........................................ s2p12
  Part C........................................ s6p1, s7p4-6 & 12
  Part D........................................ s7p4-6 & 12
Extra Help see Low-Income Subsidy
Flu Shot....................................... s4p16
Formulary..................................... s7p11
Guarantee Issue ................................ s5p6
General Enrollment Period ........ s2p4-5, s9p5-6
Health Insurance Marketplace .......... s2p10
Health Maintenance Organization (HMO)
......................................................... s6p5
Help with Costs.............................. s7p9-11 & s8
Home Health Care........................... s3p6-7, s4p7-8
Hospice Care.................................. s3p7-8
Hospital Care (inpatient coverage) ...... s3p2
Inpatient ...................................... s3p2
Late Enrollment Penalty
  Part A & B.................................. s2p5
  Part D........................................ s7p6
Lifetime Reserve Days...................... s3p3
LI Net (Limited Income Newly Eligible Transition Program)........... s7p10, s8p9
Low-Income Subsidy (LIS)................... s7p9-10, s8p8-9
Mammogram.................................... s4p16
Medicaid see MO HealthNet
Medical Savings Account (MSA)........ s2p9
Medicare:
  Part A................................ Section 3
  Part B................................ Section 4
  Part C................................ Section 6
  Part D................................ Section 7
Medicare Prescription Drug Coverage. Sec7
Medicare Savings Programs (MSP)....... s8p6
Medicare Suffixes............................ s1p3
Medicare Summary Notice (MSN)......... s3p10
Medicare Supplement Insurance (Medigap)
.................................................. s5p4-7
Medigap see above
MO Rx see State Pharmacy Assistance Program
MO HealthNet (Medicaid)................. s8-2
  Spend-down................................ s8p2-4
Obesity Screening & Counseling........ s4p17
Open Enrollment............................. s7p4
Original Medicare ........................ s1p1
Outpatient Hospital Services............. s4p5-6
Oxygen....................................... s4p10-11
INDEX

Penalty (Late Enrollment):
  Part A ................................................ s2p5
  Part B ................................................ s2p5
  Part D ................................................ s7p6
Private Fee-for-Service (PFFS) Plans ... Sec6
Physical Therapy .......................... s4p6
Preferred Provider Organization (PPO) s6p6
Prescription Drug Coverage: Appeals .... s7
Medicare Advantage Plans (MA).....s6 & s7
Private Contract .......................... s4p3
Railroad Retirement Board .......... s2p2
Respite Care ................................. s3p7-8
Shots (vaccinations)....................... s4p16
Skilled Nursing Facility (SNF)........ s3p4-5
Smoking Cessation ................. s4p19
Social Security .............................. s1p2, s2p1
Special Enrollment Period .............. s2p6, s7p5-6
Special Needs Plans (SNPs) .......... s6p6-7
State Health Insurance Assistance Program (SHIP) ...................................... s1p1
State Pharmacy Assistance Program (SPAP) a.k.a. MO Rx....................... s7p10-11, s8p9
Step Therapy ............................... s7p12
Supplemental Policy see Medicare Supplement Insurance (Medigap)
  Transition Fills ......................... s7p7-9
TRICARE ........................................ s5p2, s7p13
TROOP ........................................ s7p2-3
Veterans’ Benefits ....................... s2p5, s5p3
Vaccinations see Shots

Key:
S = Section Number
P = Page Number(s)
Tab Divider named “Section 1 Program Overview”
Section 1
Program Overview

I. Community Leaders Assisting the Insured of Missouri (CLAIM) Background ............... 1
   A. Medicare and Medicaid Assistance Program (MMAP) ............................................. 1
   B. State Health Insurance Assistance Program (SHIP) ................................................ 1
   C. Missouri .................................................................................................................. 1
   D. CLAIM Program ...................................................................................................... 1
   E. Primaris Foundation ............................................................................................... 2

II. Medicare Background .................................................................................................. 2
    A. Medicare-Eligible Persons ..................................................................................... 2
    B. Four Parts of Medicare ......................................................................................... 2
    C. Medicare Card ........................................................................................................ 2
    D. Medicare Claim Number Suffixes ........................................................................... 3
    E. Medicare Funding ................................................................................................... 3
    F. Medicare Administration ......................................................................................... 4

III. Major Milestones in Medicare History ........................................................................ 4
I. Community Leaders Assisting the Insured of Missouri (CLAIM) Background

A. Medicare and Medicaid Assistance Program (MMAP)

1. AARP had a national Medicare and Medicaid Assistance Program (MMAP) where volunteer counselors provided assistance for people on Medicare.
2. Missouri had many MMAP programs throughout the state.

B. State Health Insurance Assistance Program (SHIP)

1. Congress made money available to the Centers for Medicare and Medicaid Services (CMS) to provide a grant to each state to expand services that MMAP provided.
2. Missouri worked in partnership with AARP to transfer the local MMAP and develop the Missouri SHIP program.
3. SHIP grants are given to a state agency responsible for administering insurance or senior services.
4. In 2014, CMS transferred the funding from CMS to the Administration for Community Living (ACL) Office of Healthcare Information and Counseling.

C. Missouri

1. The SHIP grant has been awarded to the Missouri Department of Insurance, Financial Institutions & Professional Registration since 1993. The Department of Insurance, Financial Institutions & Professional Registration subcontracted the grant.
2. Primaris Foundation, a 501(c)(3) non-profit, has received the award for the subcontract since 1993.

D. CLAIM Program

1. CLAIM receives funding from the Missouri Department of Insurance, Financial Institutions, & Professional Registration (DIFP), through ACL.
2. CLAIM is the State Health Insurance Assistance Program (SHIP) for Missouri. Other states’ SHIPs may use a different name or acronym.
3. CLAIM provides free, non-biased information to help Medicare beneficiaries make informed decisions about health coverage options including but not limited to:
   a. personalized free counseling assistance regarding benefits and/or health plan options available to all beneficiaries,
   b. access to enrollment assistance from a trained counselor,
   c. community outreach.
4. CLAIM is able to provide these services through a statewide system of local community partners and volunteer counselors.
5. CLAIM’s central office is located in Columbia, MO. See staff directory for complete list of staff and positions.
E. Primaris Foundation

Knowledge Management Associates (KMA) dba Primaris Foundation is a 501(c)(3) non-profit organization. Primaris Foundation is affiliated with Primaris Holdings, Inc. Primaris Holdings Inc. is a healthcare consulting firm that works with hospitals, physicians and nursing homes to drive better health outcomes, improved patient experiences and reduced costs.

II. Medicare Background

A. Medicare-Eligible Persons

1. Those 65 and older
2. Some individuals under 65 with a permanent disability as determined by the Social Security Administration
3. Those under 65 with End-Stage Renal Disease (ESRD) or Atrophic Lateral Sclerosis (ALS)
4. U.S. citizens or legal residents for 5 years

B. Four Parts of Medicare

1. Part A – also known as Hospital Insurance
2. Part B – also known as Medical Insurance
3. Part C – also known as Medicare Advantage Plans - a different benefit delivery option
4. Part D – also known as Medicare Prescription Drug Coverage

C. Medicare Card

1. All persons enrolled in Medicare receive a red, white, and blue Medicare card.
2. This card contains the following information:
   a. Source of eligibility (Social Security or Railroad Retirement)
   b. Beneficiary’s name and gender
   c. Medicare claim number
   d. Types of coverage (Part A and/or Part B) and effective dates of coverage
D. Medicare Claim Number Suffixes

The Medicare claim number is usually a beneficiary’s social security number followed by a one- or two-digit alphanumeric suffix that helps further identify their claimant status. Below is a listing of the most common Medicare claim number suffixes and their meanings.

This is not a complete list; if you counsel a beneficiary with a suffix not included on the list, ask the beneficiary to contact a local Social Security office for explanation.

<table>
<thead>
<tr>
<th>Suffix</th>
<th>Meaning of Symbol</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Age 65 or over wage earner</td>
</tr>
<tr>
<td>B</td>
<td>Aged wife, age 62 or over</td>
</tr>
<tr>
<td>B1</td>
<td>Aged husband, age 62 or over</td>
</tr>
<tr>
<td>C</td>
<td>Child – Includes minor, student or disabled child</td>
</tr>
<tr>
<td>D</td>
<td>Aged Widow, age 60 or over</td>
</tr>
<tr>
<td>D1</td>
<td>Aged Widower, age 60 or over</td>
</tr>
<tr>
<td>D6</td>
<td>Surviving Divorced Wife, age 60 or over</td>
</tr>
<tr>
<td>M</td>
<td>Not entitled to premium-free Part A</td>
</tr>
<tr>
<td>M1</td>
<td>Entitled to premium-free Part A, but elected to file for Part B only</td>
</tr>
<tr>
<td>T</td>
<td>Uninsured – Entitled to HIB (Part A) under deemed renal provisions; or Enrolled in Medicare but temporarily delayed SS Retirement Benefits</td>
</tr>
<tr>
<td>TA</td>
<td>Medicare Qualified Government Employment (MQGE)</td>
</tr>
<tr>
<td>W</td>
<td>Disabled Widow</td>
</tr>
<tr>
<td>W1</td>
<td>Disabled Widower</td>
</tr>
<tr>
<td>W6</td>
<td>Disabled Surviving Divorced Wife</td>
</tr>
</tbody>
</table>

E. Medicare Funding

1. Part A is funded mostly through payroll and earnings taxes. A small portion of the funding comes from Part A premiums.
2. Part B is funded by paid premiums and general revenue taxes.
F. Medicare Administration

1. The Centers for Medicare & Medicaid Services (CMS) is the federal government agency within the Department of Health and Human Services that administers Medicare and Medicaid. CMS contracts with other organizations to provide specific services to Medicare beneficiaries, such as processing claims, Medicare Advantage Plans, Prescription Drug Plans and 1-800-MEDICARE.

2. Social Security Administration (SSA) is the federal government agency that administers Social Security benefits. SSA also handles Medicare eligibility and enrollment and issues Medicare cards.

3. State Health Insurance Assistance Program (SHIP) is the state program that provides free counseling and assistance to Medicare beneficiaries. SHIPs receive funding through a grant from ACL. CLAIM is the SHIP for Missouri.

4. A Medicare Administrative Contractor (MAC) is a private insurance company that contracts with CMS to process all hospital, skilled nursing facility, hospice, and home health care claims and Part B claims.

5. Beneficiary and Family Centered Care (BFCC) - Quality Improvement Organization (QIO) is an organization that manages all beneficiary quality of care complaints and discharges.

6. Quality Improvement Networks (QIN) QIOs are responsible for working with providers and communities on data-driven quality initiatives to improve patient safety, reduce harm and improve clinical care and transparency at local, regional and national levels. Primarís Holdings Inc. is part of the Texas QIN.

III. Major Milestones in Medicare History

<table>
<thead>
<tr>
<th>Year</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1965</td>
<td>Older Americans Act passed (establishing Medicare program)</td>
</tr>
<tr>
<td>1966</td>
<td>President Johnson signs Medicare into law. Harry S. Truman becomes first Medicare beneficiary.</td>
</tr>
<tr>
<td>1972</td>
<td>Disability and End-Stage Renal Disease eligibility added to Medicare</td>
</tr>
<tr>
<td>1983</td>
<td>Prospective Payment System introduced</td>
</tr>
<tr>
<td>1984</td>
<td>Peer Review Organization contracts created (later become QIOs)</td>
</tr>
<tr>
<td>1990</td>
<td>Physician Payment Reform Act</td>
</tr>
<tr>
<td>1993</td>
<td>SHIP grants created</td>
</tr>
<tr>
<td>1997</td>
<td>Balanced Budget Act (BBA)</td>
</tr>
<tr>
<td>1999</td>
<td>Balanced Budget Refinement Act (BBRA)</td>
</tr>
<tr>
<td>2000</td>
<td>Benefit Improvements and Protections Act (BIPA)</td>
</tr>
<tr>
<td>2003</td>
<td>Medicare Prescription Drug and Modernization Act (MMA) passed</td>
</tr>
<tr>
<td>2008</td>
<td>Medicare Improvements for Patients and Providers Act (MIPPA) passed</td>
</tr>
<tr>
<td>2010</td>
<td>Patient Protection and Affordable Care Act passed</td>
</tr>
<tr>
<td>2010</td>
<td>Health Care and Education Reconciliation Act passed</td>
</tr>
<tr>
<td>2012</td>
<td>Strengthening Medicare &amp; Repaying Taxpayers Act (SMART Act) passed</td>
</tr>
</tbody>
</table>
Tab Divider named “Section 2 Eligibility & Enrollment”
Section 2
Eligibility and Enrollment

I. Social Security and Railroad Retirement Board .................................................. 1
   A. Role of Social Security Administration (SSA) ................................................. 1
   B. Role of Railroad Retirement Board (RRB) ..................................................... 1
II. Types of Eligibility .................................................................................................. 1
   A. Automatic Eligible (no Part A Premium) ....................................................... 1
   B. Voluntary (with Part A Premium) ................................................................. 3
III. Enrollment Periods and Coverage Dates ................................................................ 4
   A. Automatic Enrollees ...................................................................................... 4
   B. Manual Enrollees ......................................................................................... 4
   C. Initial Enrollment Period ............................................................................. 4
   D. General Enrollment Period ......................................................................... 5
IV. Optional Enrollment .............................................................................................. 5
   A. Part A ............................................................................................................. 5
   B. Part B ........................................................................................................... 5
   C. Medicare as Secondary Payer ...................................................................... 6
   D. Special Considerations (HSA and Marketplace) ......................................... 7
V. Section 2 Review .................................................................................................... 12
I. Social Security and Railroad Retirement Board

A. Role of Social Security Administration (SSA)

1. Determines Social Security (SS) cash benefits
2. Determines eligibility for Medicare
3. Eligibility is based on amount of Medicare taxes paid while working (65 and older)
   a. 40 tax credits or more = automatic enrollment
   b. less than 40 tax credits = voluntary enrollment
   c. A maximum of 4 tax credits can be earned a year
4. Determine eligibility based on disability or end-stage renal disease (under 65)
5. Enroll individuals in Medicare
6. Issue Medicare cards
7. Process applications for Extra Help
8. Contact www.socialsecurity.gov or 1-800-772-1213

B. Role of Railroad Retirement Board (RRB)

1. Determines cash benefits
2. Eligibility and enrollment for Medicare including disability or end-stage renal disease (under 65)
3. Issue Railroad Retiree Medicare cards
4. Contact www.rrb.gov or 1-800-808-0772

II. Types of Eligibility

A. Automatic Eligible (no Part A Premium)

1. Card automatically issued by Social Security Administration or Railroad Retirement Board
   a. 65+ (or spouse) with 40 Medicare tax credits and already receiving Social Security cash benefits
   b. Disabled, on Social Security disability cash benefits for 24 months and meet work credit requirements (see Work Credit Chart)
2. Manually enroll – Must contact local SSA office or RRB to determine eligibility and enroll
   a. 65+ (or spouse) with 40 Medicare tax credits but not yet receiving Social Security cash benefits
   b. ESRD (on dialysis for 3 months or self-dialysis for 1 month)
   c. Amyotrophic Lateral Sclerosis (ALS) immediately allowed (no 24-month waiting period)
   d. Disabled workers (under 65): eligibility is determined by the work credit requirements from the Work Credit Chart. If a disabled individual does not meet eligibility requirements, he/she will be considered a manual enrollee and may pay a premium for Part A benefits
### Work Credit Chart

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Work Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 24</td>
<td>Six credits in the last three years before disability</td>
</tr>
<tr>
<td>24 – 31</td>
<td>Worked half the time from age 21 until disabled</td>
</tr>
<tr>
<td>31 – 42</td>
<td>20 credits in the last 10 years before being disabled</td>
</tr>
<tr>
<td>44 – 60</td>
<td>20 credits in the last 10 years, plus two credits for every two years over 44</td>
</tr>
<tr>
<td>62 &amp; older</td>
<td>40 credits</td>
</tr>
</tbody>
</table>

3. The person is the spouse or surviving spouse of a person who is receiving benefits or the spouse has worked the required amount of credits to be eligible.

4. The person who is an ex-spouse or surviving ex-spouse of a person who is receiving benefits or has worked the required amount of credits is eligible if:
   a. The person was married at least 10 years, and
   b. The person has not remarried

5. The person who is a dependent child of a person who is receiving benefits or has met the work requirements is eligible when:
   a. One parent has earned at least six credits within the last three years under Social Security, the Railroad Board or as a federal government employee. Important: Both parents cannot combine credits to meet the requirements.
   b. Who is considered a dependent child?
      i. Usually a dependent child is an unmarried person under the age of 22 who is the beneficiary’s child, legally adopted child or stepchild for at least one year prior to enrollment.
      ii. Someone age 22 or older is considered dependent if he/she has a disability that began before he/she turned 22.
      iii. Someone over age 22, but not yet 26, can be considered dependent if he/she received at least one-half of his/her support from a parent from the time he/she turned 22.
   c. Grandparent’s work record may be used for eligibility in these circumstances. A child can have Medicare based on his/her grandparent’s or step-grandparent’s work record if the grandchild meets both a relationship and a dependency requirement.
      1. **Relationship**
         a. The grandchild has been legally adopted by the grandparent or step-grandparent. This is true even if the adoption took place after the grandparent started drawing Social Security benefits OR
         b. If the grandchild is not adopted, he/she can still qualify for benefits by meeting all three of the following requirements:
            i. Both parents of the child must be deceased or disabled before the grandparent starts receiving Social Security benefits or, in the case of survivor benefits, before the grandparent dies
            ii. The grandchild must have been living with the grandparent before age 18
            iii. The grandchild must have lived with the grandparent for an entire year before the grandparent became entitled to Social Security benefits, became permanently disabled, or died
         c. The child lived with the grandparent in the United States OR
d. Received at least one-half of his/her financial support from the grandparent AND

2. Dependency
   a. The grandchild is under age 22 OR
   b. The grandchild is over age 22, but was disabled before age 22 OR
   c. The grandchild is over age 22, not yet 26, and has been receiving at least one-half of his/her financial support from the grandparent since age 22.

B. Voluntary (with Part A Premium)

1. A person 65 or older or the spouse of someone 65 or older, or legal residents with less than 40 credits of Medicare taxes paid. The premium is based on Medicare taxes paid while working.
   a. Less than 30 Medicare tax credits = full monthly premium
   b. 30 – 39 Medicare tax credits = a portion of monthly premium

2. If a beneficiary does not wish to pay the Part A premium, he or she is still eligible to enroll in Part B and Part D benefits and pay the required premiums. The beneficiary may continue to work to meet the tax credit requirement.

Counseling Note: If a person has not met their credits and has limited income and assets, enrollment into the Qualified Medicare Beneficiary (QMB) Program may be an option. QMB helps to pay for Part A and B premiums. See Public Benefits Section for more information and Money Tip Sheet for current income and resource limits.

<table>
<thead>
<tr>
<th>Enrollment Chart – Part A</th>
<th>Automatically Enrolled w/NO Part A Premium</th>
<th>Manually Enrolled w/NO Part A Premium</th>
<th>Manually Enrolled w/Part A Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a person is:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 or older and 40 credits paid (or spouse)</td>
<td>Receiving Social Security cash benefits</td>
<td>Not receiving Social Security cash benefits</td>
<td></td>
</tr>
<tr>
<td>65 or older with &lt;40 credits paid (or spouse or legal resident)</td>
<td></td>
<td></td>
<td>Part A premiums 0-29 = full premium 30-39 = partial premium</td>
</tr>
<tr>
<td>Under 65 and permanently disabled</td>
<td>After receiving Social Security cash benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed with End Stage Renal Disease (under 65)</td>
<td>After 3 months of dialysis or 1 month of self-dialysis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Example**: Mr. Williams is turning 65 on July 14. He will become eligible for Medicare on July 1, but is not yet receiving Social Security cash benefits due to his continued employment. Mr. Williams has accrued 40 Medicare tax credits, so he will not have to pay a Part A premium. He will, however, have to manually enroll, since he is not receiving SS cash benefits.

### III. Enrollment Periods and Coverage Dates

#### A. Automatic Enrollees

1. Do not have to go to Social Security to enroll
2. Should receive Medicare card up to 3 months before first day of coverage
3. Coverage begins:
   a. First day of the month of the 65th birthday (if birthday is after first day of the month)
   b. First day of the month before the 65th birthday month (if birthday falls on the first day of the month)
   c. First day of 25th month of Social Security disability payments

#### B. Manual Enrollees

1. Must go to Social Security to enroll and verify eligibility
2. Can enroll during the initial or general enrollment period

#### C. Initial Enrollment Period

1. Seven (7) month window surrounding 65th birthday
2. Enrollment period begins 3 months prior to 65th birthday, the month of the 65th birthday, and three months following 65th birthday
   a. If enrolled during the 3 months prior to birth month, then coverage begins on the 1st day of the month in which they turn 65.
   b. If enrolled the month of their 65th birthday, then coverage begins the first day of the month following the birth month.
   c. If enrolled in the month following their 65th birthday month, coverage begins 2 months following enrollment.
   d. If enrolled second or third month following birth month, then coverage begins 3 months following enrollment.
**Example:** Mr. Johnson turns 65 on May 21\textsuperscript{st} and must manually enroll in Medicare. Below is a table of his initial enrollment period for the year of his 65\textsuperscript{th} birthday.

<table>
<thead>
<tr>
<th>Enrollment Month</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>May 1\textsuperscript{st}</td>
</tr>
<tr>
<td>March</td>
<td>May 1\textsuperscript{st}</td>
</tr>
<tr>
<td>April</td>
<td>May 1\textsuperscript{st}</td>
</tr>
<tr>
<td>May</td>
<td>June 1\textsuperscript{st}</td>
</tr>
<tr>
<td>June</td>
<td>August 1\textsuperscript{st}</td>
</tr>
<tr>
<td>July</td>
<td>October 1\textsuperscript{st}</td>
</tr>
<tr>
<td>August</td>
<td>November 1\textsuperscript{st}</td>
</tr>
</tbody>
</table>

**D. General Enrollment Period**

1. If a beneficiary who must manually enroll fails to enroll during their initial enrollment period, then they may enroll during the general enrollment period.
2. General enrollment is January, February, and March of each following year. Coverage begins July 1. Penalties for delaying enrollment are calculated and assessed by Social Security Administration.

   **Part A**
   - 10% for every full 12 month period, only if the beneficiary is paying a premium. The penalty is capped at 10%.
   - The penalty will be paid for double the amount of time enrollment was delayed (example: delay 3 years pay penalty for 6 years).

   **Part B**
   - 10% for every full 12 month period, with a total penalty cap of 300%. The penalty never ends.
   - If penalty is assessed on a disabled person under the age of 65, at age 65 the penalty will end due to the change in eligibility status (due to age).

**IV. Optional Enrollment**

**A. Part A**

1. Automatically eligible enrollees may not decline Part A benefits.
2. Voluntary enrollees, however, may choose to do so.

**B. Part B**

1. Part B is optional for all enrollees.
2. When a beneficiary receives their Medicare card, they are automatically enrolled in Part B. If they do not want Part B, then they must return their card to Social Security Administration and be issued a new card for Part A coverage only.
3. Beneficiaries may decline Part B insurance and avoid a penalty only in certain situations (where another health plan is primary to Medicare):
   a. If over 65 and
      • Beneficiary or spouse is actively employed,
      • Beneficiary is covered by active employer’s group health plan, and
      • Employer has 20 or more employees.
   b. If under 65, disabled and
      • Beneficiary or family member is actively employed,
      • Beneficiary is covered by active employer’s group health plan, and
      • Employer has 100 or more employees.
   c. If ESRD and
      • Beneficiary is covered under their own or their spouse’s health insurance.
      • DO NOT have to be employed.
      • Plan may be either current employer’s plan or retirement plan for beneficiary or spouse.

4. **Special Enrollment Period (SEP)** is available for those individuals that turn down Part B benefits during the initial enrollment period due to current employment or spouse’s current employment. A person can sign up for Part B benefits:
   a. Anytime you are still covered by the employer group health plan.
   b. Within **8 months of the end of employment or end of Employer Group Health Plan coverage**, whichever is first.
   c. If this SEP is missed beneficiaries must wait until annual open enrollment to sign up and may pay a penalty.

**C. Medicare as Secondary Payer**

1. Medicare is secondary payer to an employer’s group health plan (EGHP). These specific groups include:
   a. Working Aged - Those individuals 65+ (or spouse) who are working with 20+ employees at their employer and have an EGHP through their current employer.
   b. Disabled People - Those individuals under 65 who have Medicare due to a disability and either them or a family member are currently employed. The beneficiary must be covered under that plan and there must be 100+ employees at employer.
   c. End Stage Renal Disease - Those individuals under 65 with ESRD with any health plan. The health plan will be primary for the first 30 months.

2. For some Medicare beneficiaries, Medicare may be secondary to other insurance coverage:
   a. Automobile, No-Fault, or any Liability Insurance - if another payer is responsible as primary payer because of a liability, Medicare will pay as secondary. For
example, if there were a car accident involving a beneficiary, the automobile liability insurance would pay first.

b. Worker’s Compensation—when payment is made or can reasonably expected to be made under a workers’ compensation law or plan, and then Medicare will pay as secondary.

c. Federal Black Lung Program—the U.S. Department of Labor is primary when a patient is entitled to reimbursement under the Federal Black Lung Program. These payments are considered workers’ compensation benefits.

d. Veteran’s Administration—When a VA refers a patient to a non-VA facility and authorizes care, Medicare is secondary payer.

3. To change Medicare to the primary payer, the beneficiary needs to contact the Medicare Coordination of Benefits Contractor at 1-855-798-2627 with their change of information.

<table>
<thead>
<tr>
<th>Medicare as Secondary Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conditions for Medicare to be Secondary</strong></td>
</tr>
<tr>
<td>• Age 65+</td>
</tr>
<tr>
<td>• Beneficiary or spouse employed</td>
</tr>
<tr>
<td>• 20+ employees at employer</td>
</tr>
<tr>
<td>• End Stage Renal Disease</td>
</tr>
<tr>
<td>• Employment not required</td>
</tr>
<tr>
<td>• Any health plan is applicable</td>
</tr>
<tr>
<td>• Under 65 and disabled</td>
</tr>
<tr>
<td>• Beneficiary or family member employed</td>
</tr>
<tr>
<td>• 100+ employees at employer</td>
</tr>
</tbody>
</table>

D. Special Considerations (HSA and Marketplace)

In recent times we have seen some changes in Health Insurance options and products that are available to potential Medicare beneficiaries that may have significant ramifications if not taken into account when thinking about enrolling into Medicare coverage. Specifically, we want to share a few points about Health Savings Accounts (HSA) with High Deductible Insurance policies and Market Place Insurance coverage.

**Health Savings Accounts**

HSA’s were created to work with high deductible insurance policies that allow a person to set money into an interest baring account at a financial institution before taxes and would be tax exempt if used on IRS approved medical expenses such as the person’s insurance deductible costs or other medical expenses. The IRS allows a person to set aside a set amount of money per person insured every year. Often a business will
contribute some funds for their employees that have these policies. The money does not have to be spent by the end of the year and can continue to grow as long as a person meets eligibility.

**IRS Definition** (from IRS publication 969): Health Savings Account is a tax–exempt trust or custodial account you set up with a qualified HSA trustee (bank or insurance company) to pay or reimburse certain medical expenses you incur. You must be an eligible individual to qualify.

To be an eligible individual and qualify for an HSA, you must meet all the following requirements:

- Must be covered under a high deductible health plan (HDHP), described later, on the first day of the month,
- Have no other health coverage except what is permitted under “other” health coverage (see below),
- **Are not enrolled in Medicare, and**
- Cannot be claimed as a dependent on someone else's tax return.

You can have additional insurance that provides benefits only for the following items:

1) Liabilities incurred under workers’ compensation laws, tort liabilities, or liabilities related to ownership or use of property.
2) A specific disease or illness.
3) A fixed amount per day (or other period) of hospitalization.
4) You can also have coverage (whether provided through insurance or otherwise) for the following items.
   a) Accidents
   b) Disability
   c) Dental care
   d) Vision care
   e) Long-term care

When a person enrolls into Medicare they become a non-eligible individual. The amount of contributions to the HSA is limited for that year. Example: Beginning with the first month you are enrolled in Medicare, your contribution limit is zero. You turned age 65 in July 2014 and enrolled in Medicare. You had an HDHP with self-only coverage and are eligible for an additional contribution of $1,000. Your contribution limit is $2,150 ($4,300 × 6 ÷ 12).

**From Medicare Interactive.org:**

If you enroll in Medicare Part A and/or B you can no longer contribute to your HSA. The month you enroll in Medicare (typically the month of your 65th birthday), the account overseer switches the contributing balance to your HSA to zero dollars per month. By law, people with Medicare are not allowed to put money into an HSA. This is because you generally cannot have any health coverage other than an HDHP if you are putting money into an HSA. However, you may withdraw money from your HSA after you enroll in Medicare to help pay for medical expenses (deductibles, premiums, copays...
or coinsurances). If you use the account for qualified medical expenses, it will continue to be tax-free.

**Delaying Medicare Enrollment**

Whether you should delay enrollment in Medicare so you can continue contributing to your HSA depends on your circumstances. If you work for a small employer (fewer than 20 employees), you typically need to take Medicare when you first qualify even though you will lose the tax advantages of your HSA. Health care coverage from small employers pays secondary to Medicare. This means that if you fail to enroll in Medicare when you are first eligible, you may have little or no health coverage. Current employers who have health care coverage for (20 or more employees) pays primary before Medicare so you may not need to have Medicare in order to pay your health expenses. This means that if you are currently working for a large employer and you wish to decline Medicare Part B, you can do so and enroll in Part B later when you lose your current employer coverage. However, you cannot decline Medicare Part A. An exception to this is, if you’re not accepting Social Security benefits. As long as you are not accepting Social Security benefits, you can choose to decline Part A also, which preserves your HSA tax benefit. As soon as you want to stop contributing to the HSA (and are if you are still currently working) you can enroll in Part A and get 6 months of retroactive coverage.

If you qualify for Medicare because you are 65 or older, an employer is small if it has fewer than 20 employees. If you qualify for Medicare because of a disability, an employer is small if it has fewer than 100 employees. **Remember** that if you delay enrollment in Medicare when you are first eligible, you must enroll when you lose your current employer coverage.

If you are collecting Social Security retirement benefits when you become eligible for Medicare, you will be automatically enrolled in Medicare Part A and Part B. If you are not collecting Social Security retirement benefits when you become eligible for Medicare, you must actively enroll yourself during your initial enrollment period. You can actively enroll by calling your local Social Security office. Whether you are enrolled in Part A and Part B automatically or you enroll yourself, you cannot continue to contribute to an HSA once you have Medicare.

**Important:** If you do not take Medicare when you first qualify, you must take special precautions if and when you do decide to collect Social Security benefits (either while working or when you retire). You need to be sure to stop all contributions to your HSA up to six months before you collect Social Security. This is because when you apply for Social Security, Medicare Part A will be retroactive for up to six months (as long as you were eligible for Medicare during those six months). If you do not stop contributing the six months before you apply for Social Security, you may have a tax penalty. The penalty is because you were not supposed to put money into your HSA while you had Medicare.
Marketplace Coverage and Medicare
The Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act created what we now call Marketplace Coverage. These acts now make Health Insurance available to most people without applying preexisting condition exclusions. This has opened up coverage to most people who did not have coverage due to a disability or those that retired early. As part of this coverage, those with limited incomes can get assistance in paying premiums and cost sharing reductions. This in some cases can make the Marketplace coverage more affordable then Medicare.

Medicare eligibility rules in most cases limit how long this may be cost effective. If a person does not enroll during their initial enrollment period and does not have coverage through active employment insurance they are subject to late enrollment penalties and limitations on when they can enroll.

Individuals who enroll in Medicare after their initial enrollment period ends can enroll in Medicare only during the Medicare general enrollment period (from January 1 to March 31) and coverage does not begin until July of that year. The 10% late enrollment penalty will be assessed for each 12 full months after the close of their initial enrollment period. The penalty for someone over age 65 may continue for as long as they are enrolled in Medicare.

An individual who does not have Medicare (either Part A or Part B) can enroll in a Qualified Marketplace Health plan. Note that individuals who get free Part A cannot drop it without dropping their retiree benefits (social security or railroad retirement, including disability payments) and paying back all retirement benefits received and costs incurred by the Medicare program as well.

<table>
<thead>
<tr>
<th>If you are:</th>
<th>Can you keep your Individual Marketplace QHP after enrolling in Medicare?</th>
<th>Are you eligible to continue receiving tax credits and reduced cost-sharing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently enrolled in a QHP and become entitled to free Part A</td>
<td>Yes</td>
<td>No. Any tax credits the individual is receiving in the QHP will be discontinued once Part A coverage begins.</td>
</tr>
<tr>
<td>Currently enrolled in a QHP and become eligible to buy Premium Part A and Part B</td>
<td>Yes</td>
<td>Yes, if you only enroll in Part B, because Part B does not constitute Minimum Essential Coverage. No, if you enroll in Premium Part A.</td>
</tr>
</tbody>
</table>

Can Medicare beneficiaries with coverage under SHOP plans delay enrollment in Medicare Part B without penalty?
Yes. A Medicare beneficiary who is enrolled in employer purchased SHOP coverage is treated the same as any other person with employer group health plan coverage. Individuals can delay enrollment if they are covered under a group health plan based on their or their spouse’s current employment. These individuals have a special enrollment period to sign up for Part B without penalty:
1. Any time they are still covered by the group health plan.
2. During the 8-month period that begins the month after the employment ends or the coverage ends, whichever happens first.
If the individual does not sign up during this special enrollment period, late enrollment penalties may apply, and enrollment will only be possible during the General Enrollment Period which occurs annually from January through March with coverage beginning July 1.

**What if I have a Marketplace plan but will be eligible for Medicare soon?**
If you have a Marketplace plan, you can keep it until your Medicare coverage starts. Then you can cancel it without penalty. If you like, you can keep your Marketplace plan too. But if you’ve been getting tax credits or lower out-of-pocket costs on a plan you bought through the Marketplace, these savings will end once your Medicare Part A coverage starts. You’d have to pay full price for the Marketplace plan.

**I recently turned 65 and I am eligible for Medicare Part A without having to pay a premium. But I have not yet signed up for Medicare Part A or Part B. Can I purchase a Marketplace plan?**
Yes, if you are not covered by Medicare, an insurer can sell you a Marketplace plan. But because you are eligible for premium-free Medicare Part A, you are not eligible to receive the premium tax credit to help reduce the cost of a Marketplace policy, even if you would qualify based on your income.

Also keep in mind that if you sign up for a Marketplace plan, rather than enroll in Medicare Part B when you are first eligible to do so, and then later you decide to sign up for Medicare, you may be required to pay a penalty for delaying enrollment in Medicare Part B. Your monthly Part B premium may go up 10% for each year that you could have had Part B, but didn't. You may also owe a late enrollment penalty for Part D drug coverage, which is equal to 1% of the national average premium amount for every month you didn't have coverage as good as the standard Part D benefit.

For more information, see “Medicare and the Marketplace FAQ’s” available in the Forms & Guides section of the CLAIM website (www.missouriclaim.org), www.healthcare.gov, or Kaiser Family Foundation website (www.kff.org).
V. Section 2 Review

Enrollment Periods

1. Edward Elder turns 65 on November 6. He has not worked enough under Social Security to be entitled to Medicare automatically but is willing to pay the premium. When is his initial enrollment period and when is the earliest his coverage would be effective?

2. It is March 3. Mr. Smith is a voluntary enrollee. Inadvertently, he did not enroll for Part A during his initial enrollment period which would have been February 1 to August 31, 2010. He now wants to enroll in Medicare. When may he do so and when is the earliest his coverage would be effective? Will he pay penalties, and if so how much?

3. Mrs. Older is a voluntary enrollee. She was not married and only worked 36 quarters in her lifetime. She turned 65 in July 2015. What will be Mrs. Older’s Part A premium if she does not sign up for hospital insurance coverage until January? What will her Part B premium be?
Tab Divider named “Section 3 Medicare Part A”
Section 3
Medicare Part A

I. General Coverage ............................................................................................................. 1
   A. Coverage for Part A (Hospital Insurance) ................................................................. 1
   B. Medicare Administrative Contractors (MAC) ......................................................... 1
II. Care Provided Outside the U.S. ....................................................................................... 1
   A. Explanation .............................................................................................................. 1
   B. Foreign Travel Insurance ....................................................................................... 1
III. Inpatient Hospital ........................................................................................................... 2
    A. Conditions for Coverage .................................................................................... 2
    B. Covered Days ....................................................................................................... 2
    C. Inpatient Psychiatric Care ................................................................................ 3
    D. Coverage ............................................................................................................... 4
    E. Services Not Covered ............................................................................................ 4
IV. Skilled Nursing Facility (SNF) ....................................................................................... 4
    A. Explanation ............................................................................................................ 4
    B. Skilled Care .......................................................................................................... 5
    C. Conditions for Coverage .................................................................................... 5
    D. Covered Days ....................................................................................................... 5
    E. Coverage ............................................................................................................... 6
    F. Services Not Covered ............................................................................................ 6
V. Home Health Care ........................................................................................................... 6
    A. Explanation ............................................................................................................ 6
    B. Conditions for Coverage .................................................................................... 6
    C. Covered Days ....................................................................................................... 7
    D. Beneficiary Costs ................................................................................................ 7
    E. Coverage ............................................................................................................... 7
    F. Services Not Covered ............................................................................................ 7
VI. Hospice ............................................................................................................................ 8
    A. Explanation ............................................................................................................ 8
    B. Conditions ............................................................................................................ 8
    C. Covered Days ....................................................................................................... 8
    D. Costs ...................................................................................................................... 8
    E. Coverage ............................................................................................................... 8
    F. Other Considerations ......................................................................................... 9
VII. Blood .............................................................................................................................. 9
A. Coverage.................................................................................................................. 9
B. Beneficiary Cost........................................................................................................ 9

VIII. Claim-Filing Procedures....................................................................................... 10
A. Participating vs. Non-participating Hospitals ....................................................... 10
B. Medicare Summary Notice (MSN) ......................................................................... 10

IX. Prospective Payment System .................................................................................. 10
A. Overview .................................................................................................................. 10
B. Inpatient Hospital .................................................................................................... 10
C. Outpatient Hospital (Covered by Part B) ............................................................... 11
D. Skilled Nursing Facilities ........................................................................................ 11
E. Home Health Care ................................................................................................... 11

X. Admissions and/or Continued Stays Overview ...................................................... 11
A. Appeals (Fee-for-Service and Medicare Advantage) .............................................. 11
B. Hospitals .................................................................................................................. 12
C. Skilled Nursing Facilities (SNFs) ......................................................................... 13
D. Hospice .................................................................................................................... 13
E. Comprehensive Outpatient Rehabilitation Facilities (CORFs)............................ 14
F. Home Health Agencies (HHAs) .............................................................................. 15

XI. Appeal of Claims ................................................................................................... 15
A. Explanation .............................................................................................................. 15
B. Contractor Redetermination – First Level ............................................................ 16
C. Qualified Independent Contractor (QIC) – Second Level ................................... 16
D. Medicare Appeals Council – Third Level .............................................................. 16
E. Judicial Review by the Federal Court – Fourth Level ........................................... 16

XII. Explanation of Terms ............................................................................................ 17

XIII. Section 3 Review .................................................................................................. 18
I. General Coverage

A. Coverage for Part A (Hospital Insurance)

1. Inpatient hospital
2. Skilled nursing facility (SNF)
3. Home health care
4. Hospice
5. Blood

B. Medicare Administrative Contractors (MAC)

1. A Medicare Administrative Contractor (MAC) is a private company that Medicare contracts with to process Part A and Part B claims under Original Medicare for a geographical region.
2. More information regarding the MAC can be found in the Resource section of this manual.

II. Care Provided Outside the U.S.

A. Explanation

Generally, only care provided within the United States will be considered for reimbursement by Medicare. There are three exceptions to this rule:
1. If a person is in the United States at the time of an emergency, and a Canadian or Mexican hospital is closer than a U.S. hospital, Medicare may pay for the needed emergency service.
2. If a person lives inside the United States and a Canadian or Mexican hospital is closer to his/her home than a U.S. hospital, Medicare may pay for services (not limited to emergency services).
3. If a person is in Canada traveling by the most direct route to/from Alaska to another state, Medicare may pay for emergency care received in a Canadian hospital. Emergencies occurring while on vacation in Canada are not covered.

B. Foreign Travel Insurance

1. Can be independently purchased or through a travel agent
2. Offered in Medigap policies C, D, F, G, M & N
3. Can be purchased through credit card companies (Visa, MasterCard, etc.)
III. Inpatient Hospital

A. Conditions for Coverage

1. A physician must prescribe inpatient hospital care for the treatment of an illness or injury.
2. The beneficiary requires and receives the kind of services that can be provided only as an inpatient in a hospital.
3. The hospital is a participating Medicare health service provider.
4. The Utilization Review Committee or the Beneficiary and Family Centered Care - Quality Improvement Organization (BFCC-QIO) does not disapprove of the stay.

B. Covered Days

**Benefit Period**—the period of time that Medicare uses to determine cost-sharing for Part A services. It begins the day a beneficiary is admitted as an inpatient to a hospital and ends when the person has been out of the hospital or skilled nursing facility (SNF) for 60 consecutive days.

- If a person returns to the hospital (or SNF, in some cases) within the 60-day time period, he or she is considered to be in the same benefit period.
- If a person returns to the hospital after the 60-day time period, he or she is considered to be in a new benefit period. There is no limit to the number of benefit periods a person may have.

**Example #1:** Mrs. George went into the hospital as an inpatient on Sept. 6 and was discharged five days later to her home. Two weeks later, she was readmitted as an inpatient and remained for 20 days. Since Mrs. George was only out of the hospital for 14 consecutive days, she was still within the same benefit period during her second admission. Therefore, she only has to pay one deductible.

**Example #2:** Mr. Gumball went into the hospital as an inpatient on January 20 and was discharged 25 days later to a SNF. He remained in the SNF for 7 days and was then discharged to home. Mr. Gumball was at home for 74 days when he had to be readmitted as an inpatient into the hospital. Since Mr. Gumball was out of the hospital and SNF for over 60 consecutive days, he started a new benefit period with his second hospital admission. Therefore, he has to pay two deductibles (one for each hospitalization).
1. **Days 1 - 60** – The beneficiary is responsible for the Part A deductible. These days are renewable for each benefit period.

2. **Days 61- 90** – The beneficiary is responsible for a coinsurance for each day. These days are also renewable for each benefit period.

3. **Days 91-150 (Lifetime Reserve Days)** – The beneficiary is responsible for a coinsurance for each day. Lifetime reserve days are nonrenewable. Once used, they are never available again. Use of the lifetime reserve days is optional. The beneficiary may choose to use all, a portion, or none of the lifetime reserve days. The beneficiary must notify the hospital in writing before the days are used, if he/she does not wish to use the lifetime reserve days.

4. **Beyond 150 Days** – If a beneficiary is in the hospital beyond 150 days, he/she (or their supplemental insurance) will be responsible for the full cost of the stay.

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**Example #3:** Ms. Bronstein was admitted to the hospital as an inpatient on October 18 and was discharged 133 days later. The first 90 days of Ms. Bronstein’s stay were renewable. Days 91 through 133, however, were lifetime reserve days. Since she used 43 out of 60 of her lifetime reserve days, the next benefit period she will only have 107 covered days (90 renewable and 17 nonrenewable).

---

**C. Inpatient Psychiatric Care**

1. Free standing psychiatric hospital
   a. a. Lifetime benefit of 190 days of inpatient care.
   b. b. A maximum of 150 days can be used in a benefit period.
   c. c. Regular inpatient deductibles and coinsurances apply.
   d. d. Lifetime reserve days can be used for psychiatric care, bringing the total available days to 250. However, it is important to remember that once lifetime reserve days are exhausted, they are no longer available in any setting.
   e. e. If a person becomes eligible for Medicare while he/she is a patient in a psychiatric hospital, the number of available days in the benefit period will be reduced by the number of days the individual has already been in the facility.

2. Psychiatric wing of an acute care hospital - regular inpatient benefit periods and limits apply.
D. Coverage

1. A semi-private room (Private rooms are covered only when medically necessary)
2. All meals, including special diets
3. Regular nursing services
4. Costs of special care units such as intensive care units and coronary care units
5. Drugs furnished by the hospital during the stay
6. Lab tests included in the hospital bill
7. X-rays and other radiology services, including radiation therapy, billed by the hospital
8. Medical supplies such as casts, surgical dressings, and splints
9. Use of medical appliances during hospitalization
10. Rehabilitation services such as physical therapy, occupational therapy, and speech pathology services
11. Blood transfusions furnished by the hospital during the stay (after the beneficiary pays for the first three pints of blood)
12. Customary medical social services, including discharge planning
13. Emergency care is included in hospital costs, if the beneficiary is admitted to the hospital from the emergency room for emergency treatment

E. Services Not Covered

1. Physician services (covered under Part B)
2. Patients admitted for observation are covered under Part B
3. Personal convenience items such as televisions, telephones, or radios if there is a separate charge
4. Private duty nurses
5. Extra charges for a private room, unless it is medically necessary
6. First three pints of blood each calendar year
7. Care received outside of the United States, except in certain situations (see II)

IV. Skilled Nursing Facility (SNF)

A. Explanation

1. A skilled nursing facility provides services under the general direction of a physician and performed by licensed professionals (RN, LPN, licensed therapist).
2. Services must be complex such that they may only be safely and effectively performed by a licensed professional.
3. Generally, skilled nursing care immediately follows a hospital stay.
B. Skilled Care

1. Skilled care consists of
   f. a. Nursing care provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN); or
   g. b. Skilled rehabilitation services including professional therapist services.

2. Skilled care does NOT consist of custodial care (also known as activities of daily living or ADLs)
   a. Assistance with bathing
   b. Dressing
   c. Walking
   d. Eating

C. Conditions for Coverage

1. Physician has certified the stay with a written order
2. Services needed may only be provided by SNF (and not in other settings)
3. Care is needed on a full-time basis
   a. Daily skilled care, or
   b. Therapy 5 days per week
4. The Utilization Review Committee does not disagree with the stay
5. Facility and bed are Medicare-certified
6. Beneficiary must have been an inpatient in a hospital for at least three days (not including day of discharge) prior to admittance to SNF
7. Must be admitted to SNF for the same condition that required hospitalization
8. Must be admitted to SNF within 30 days of being discharged from the hospital
9. Patient shows significant rehabilitation potential and/or steady improvement

D. Covered Days

1. Medicare provides coverage for up to 100 days per benefit period in a skilled nursing facility.
2. Days 1-20 are 100% covered by Medicare. There is no cost to the beneficiary.
3. For days 21-100, the beneficiary is responsible for a daily coinsurance.
4. If a beneficiary is in a skilled nursing facility beyond 100 days, he/she will be responsible for the full cost of the stay after the 100th day.
E. Coverage

1. A semi-private room (private rooms are only covered by Medicare if it is medically necessary)
2. All meals, including special diets
3. Regular nursing services
4. Drugs furnished by the SNF during the stay
5. Medical supplies such as casts, surgical dressings, and splints
6. Use of medical appliances during the stay
7. Rehabilitation services such as physical therapy, occupational therapy, and speech pathology services
8. Blood transfusions furnished by the SNF during the stay (after the beneficiary pays for the first three pints of blood)

F. Services Not Covered

1. Physician services (covered under Part B)
2. Personal convenience items such as televisions, telephones, or radios, if there is a separate charge
3. Private duty nurses
4. Extra charges for a private room, unless it is medically necessary
5. First three pints of blood each calendar year
6. Custodial care
7. Extra medications sent home at discharge

V. Home Health Care

A. Explanation

Home health care is part-time or intermittent skilled nursing care and/or therapy provided in the home.

B. Conditions for Coverage

1. A doctor must certify that a person needs care in the home and develop a plan of care.
2. Beneficiary must need skilled nursing care, physical therapy, or speech therapy. Occupational therapy can qualify a beneficiary for continued home health care if they were originally certified for physical or speech therapy.
3. A person must require part-time or intermittent care.
   a. Part-time care is less than 8 hours per day AND less than 28 hours per week.
   b. Intermittent care is less than 7 days per week OR less than 8 hours per day over a 21-day period.
4. A person must be homebound. Homebound means that a person can only leave the home with considerable effort.
   a. Only infrequent or short trips are allowed.
   b. Allowable activities outside the home include attendance at religious services, adult day care services and/or doctor appointments.
5. The home health agency must be Medicare-certified.

C. Covered Days

1. There is no limit to the number of days covered under the home health benefit. Medicare tracks the days in 60-day episodes of care. Medicare pays the provider a set amount of money for each episode of care and the services you need.
2. As long as a physician certifies medical necessity and homebound status, Medicare will pay for home health services.

D. Beneficiary Costs

1. There is no cost for home health services.
2. There is a 20% coinsurance for durable medical equipment.

E. Coverage

1. Part-time skilled nursing care
2. Physical therapy
3. Speech therapy
4. Occupational therapy, if initially certified due to physical or speech therapy
5. Part-time services of home health aides
6. Medical social services
7. Medical supplies and equipment supplied by the agency
8. Injectable drugs for the treatment of osteoporosis

F. Services Not Covered

1. Full-time care at home
2. Prescription drugs
3. Meals delivered to the home
4. Homemaker services such as cleaning, washing dishes/clothes, and shopping
5. Custodial care (such as bathing), unless these services are performed along with medically necessary services
VI. Hospice

A. Explanation

1. Hospice is a program of care and support that provides for the physical and emotional needs of a terminally ill patient.
2. Care is usually provided in the home.

B. Conditions

1. A physician and the hospice director certify that a person is terminally ill (probably have less than six months to live).
2. The hospice is Medicare-certified.
3. The beneficiary chooses to receive care from a hospice instead of standard Medicare benefits for their terminal illness.

C. Covered Days

1. There is no limitation to the number of days for hospice care.
2. Hospice care is given in periods of care. A beneficiary gets two, 90-day periods followed by an unlimited number of 60-day periods. At the start of each period the hospice medical director or other hospice doctor must certify the terminal illness. A beneficiary can change their hospice provider only once during each period of care.

D. Costs

1. 5% co-payment (maximum $5) for outpatient prescriptions for pain management
2. 5% of the Medicare approved charge for inpatient respite care (maximum of 5 days per stay)
3. Coinsurance and co-payments may be covered by other insurance or charitable donation

E. Coverage

1. Nursing services
2. Medical social services
3. Counseling, including bereavement counseling for the family
4. Physician services
5. Home health aide services
6. Medical supplies, including pain medications, needed to manage the patient’s illness
7. Physical, speech, and/or occupational therapy
8. Short-term inpatient respite care (maximum of 5 days per stay)
9. Medical Equipment (wheelchair or walkers)
10. Dietary Counseling
11. Short-term in-patient care (for pain and symptom management)
F. Other Considerations

1. Hospice programs require that a patient cease treatments to cure the illness, and instead focus on pain management and symptom relief.
2. Some programs require a “do not resuscitate” order.
3. When a beneficiary who is enrolled in a Medicare Advantage Plan (MA or MA-PD) elects hospice coverage, the costs are covered by Original Medicare and not the MA. The MA would, however, continue to cover the costs of any services provided, not related to the terminal illness.

G. Services Not Covered

1. Treatment intended to cure the illness. (The beneficiary can stop hospice services to try to treat the illness again at any time.)
2. Prescription drugs to cure beneficiary’s illness instead of pain management and symptom control.
3. Care from any provider that was not set up by the hospice medical team.
4. Room and board.
5. Care in an emergency room, inpatient facility or ambulance transportation, unless either arranged by beneficiary’s hospice medical team or is unrelated to beneficiary’s terminal illness.
   Note: The family should contact the medical hospice team before getting any of the above listed services, or the beneficiary may be responsible for cost.

VII. Blood

A. Coverage

h. 1. Pints of blood received at a hospital or Skilled Nursing Facility during a covered stay
   i. 2. Pints of blood received as an outpatient, or as part of a Part B covered service

B. Beneficiary Cost

j. 1. For Part A covered services, the beneficiary pays for the first 3 pints, unless they or someone else donates blood to replace what was used.
   k. 2. For Part B covered services, the beneficiary pays for the first 3 pints, then 20% of the Medicare approved amount for additional pints, unless they or someone else donates blood to replace what was used.
VIII. Claim-Filing Procedures

A. Participating vs. Non-participating Hospitals

1. Participating hospitals are required to file all claims with Medicare.
2. Non-participating hospitals are not required to file claims with Medicare. In these cases, the beneficiary may file the claim themselves.

B. Medicare Summary Notice (MSN)

When a beneficiary uses a Part A service, they should receive a MSN. This statement provides detailed information regarding the service, such as dates of service, amount billed to Medicare, and amount the beneficiary owes the provider. This statement will also provide information on how to appeal any denied services. Medicare summary notices are currently mailed quarterly by the MAC.

IX. Prospective Payment System

A. Overview

The Prospective Payment System is how Medicare pays for all Part A and some Part B services. Procedures are reimbursed on a fixed-payment basis that takes into account geographical and patient medical differences. Rather than reimbursing health care providers on a per-service basis, Medicare determines an average charge for a particular service and reimburses according to a set formula.

B. Inpatient Hospital

When a claim is filed with the MAC for an inpatient hospital stay, the beneficiary is classified by their medical condition, or MSDRG (Medical Severity Diagnosis Related Groups). Medicare will then make payment to the hospital based upon this classification, regardless of the types of services provided or length of the stay.

**Exception** – Medicare may pay an additional sum to the hospital for “outliers.” An outlier payment would be considered if a patient has an extremely long admission or requires much more extensive care than usual for their diagnosis.

**Example:** Millie and Brian are admitted to the hospital on the same day with the same diagnosis (pneumonia). Millie is treated and discharged in 4 days. Brian does not respond well to the treatment and is discharged after 7 days. While in the hospital, both received different types of treatment even though their diagnoses were the same.
When the hospital receives payment from Medicare, they will receive the same amount for both Brian and Millie even though the patients received different types of treatment and had different discharge dates.

C. Outpatient Hospital (Covered by Part B)

1. The Balanced Budget Act (BBA) created the Prospective Payment System for outpatient hospital services. This will eventually reduce the beneficiary’s coinsurance to 20% of the Ambulatory Payment Classification (APC).
2. Outpatient hospital services are billed to Medicare using APCs, which are based on the actual service provided (e.g. stitches, casts, cataract surgery).

D. Skilled Nursing Facilities

1. Payment to SNFs by the MAC is based on the level of care required by the patient or Resource Utilization Groups (RUGs).
2. Level of care and payments are determined on a daily basis.

E. Home Health Care

1. The BBA created a Prospective Payment System for home health services.
2. Home health services are billed to Medicare based on a Home Health Resource Group, which corresponds to a prescribed plan of care. Home health agencies will receive higher payments for patients who require a higher level of care. The patient’s physician is responsible for developing the plan of care.
3. This payment system does not impact out-of-pocket cost for the beneficiary. However, there are the same concerns about receiving appropriate care as with inpatient hospital services. Quality of care issues should be referred to KEPRO at (855) 408-8557.

X. Admissions and/or Continued Stays Overview

A. Appeals (Fee-for-Service and Medicare Advantage)

Due to the nature of the Prospective Payment System (PPS), there was concern patients might not receive appropriate services or treatment, or might not be admitted to an appropriate level of care. There was also concern they might be discharged before they are medically ready. Beneficiary and Family Centered Care - Quality Improvement Organizations (BFCC-QIO) were given the task of monitoring these issues.

There are different types of notices a healthcare provider must issue depending on the types of services they provide.
B. Hospitals

1. If a patient believes they are being discharged from the hospital before they are ready, they have a right to appeal the discharge.
2. The facility should issue the **Important Message from Medicare**, which informs the beneficiary in writing of their right to appeal the discharge and how to go about doing so. In the event the facility does not offer to issue the notice, the patient or their representative should request the notice.
3. Once the patient or representative receives the notice, they should call KEPRO at (855) 408-8557 to request an appeal.
4. To request an appeal, KEPRO should be contacted by midnight of the day of discharge. The appeal will be completed within 24 hours of the receipt of the medical record. If contacted after midnight of the day of discharge, KEPRO can still proceed with the appeal, but will have two calendar days to complete the appeal.
5. KEPRO staff will explain the review process and begin the review.
6. KEPRO staff will request a copy of the patient’s medical record. Upon receipt of the records, a nurse and physician will review the records, along with comments received from the patient/representative, the patient’s doctor and the facility. A decision will be made as to whether the discharge is appropriate or not.
   - If KEPRO agrees that the patient is ready for discharge, financial liability for the patient does not begin until noon of the day after KEPRO has completed the review and notified the patient of the decision.
   - If KEPRO decides that the patient is not ready for discharge, the patient may remain in the hospital without incurring any additional financial liability (other than applicable deductible and coinsurance) until such time that it is again decided the patient no longer needs Medicare covered services. The Facility will then reissue another notice.
7. KEPRO staff will immediately notify the patient/representative of the decision by telephone and will follow up in writing.
8. If KEPRO staff agrees with the plan that discharge is appropriate, they will give the patient/representative information as to how they can ask for a reconsideration of the decision.
9. There are also appeals rights afforded to patients who believe they should be admitted to the hospital when their doctor or the hospital disagrees. In these cases, the hospital should issue a Preadmission or Admission Hospital Issued Notice of Non-coverage. There is little, if any, protection for the patient from the financial liability if KEPRO staff agrees with the hospital. The review process is similar to the one outlined above.
10. When a hospital determines that a patient no longer needs inpatient care, but is unable to obtain agreement of the physician, the hospital may request the QIO do a Hospital Requested Review (HRR). The hospital must notify the patient that the review has been requested. In these cases, the hospital should issue the **Notice of Hospital Requested Review**. KEPRO has two days to make a determination and notify the beneficiary, the hospital, and the physician. The appeal process is similar to the one outlined above.
C. Skilled Nursing Facilities (SNFs)

1. Medicare requires Medicare-certified SNFs to inform a patient at least two days before they end Medicare-covered services. This Notice of Medicare Provider Non-coverage tells the patient what day their Medicare covered services will end.

2. A patient has a right to disagree that Medicare services should end. If this is the case they have the right to ask KEPRO to review their case.

3. Once the patient or representative receives the notice, they should call KEPRO at (855) 408-8557 to request an appeal. KEPRO should be contacted by noon of the day before services are to end. If contacted after noon of the day before services are to end, KEPRO may or may not be able to proceed with the appeal.

4. KEPRO staff will explain the appeal process and begin the review. KEPRO staff will request a copy of the patient’s medical records. Upon receipt of the records, a nurse and physician will review the records, along with comments received from the patient/representative, the patient’s doctor and the facility. A decision will be made as to whether the ending of Medicare covered services is appropriate or not.

5. If KEPRO agrees with the SNF, financial liability does not begin until the day after the effective date indicated on the notice. If KEPRO disagrees with the SNF, the patient may remain in the SNF without incurring any additional liability (other than applicable deductibles and coinsurance) until such time that it is again decided that patient no longer needs Medicare covered services. The SNF will then issue another notice.

6. KEPRO staff will immediately notify the patient/representative of the decision by telephone and will follow up in writing.

7. If KEPRO staff agrees with the plan that ending Medicare-covered services is appropriate, they will give the patient/representative information as to how they can ask for a reconsideration of the decision.

D. Hospice

1. Medicare implemented a rule that requires Medicare-certified hospice to inform a patient at least two days before they end Medicare-covered services. The Notice of Medicare Provider Non-coverage tells the patient what day their Medicare-covered services will end.

2. A patient has a right to disagree that Medicare services should end. If this is the case, they have the right to ask KEPRO to review their case.

3. Once the patient or representative receives the notice, they should call KEPRO at (855) 408-8557 to request an appeal. KEPRO should be contacted by noon of the day before services are to end. If KEPRO is contacted after noon of the day services are to end, KEPRO may or may not be able to complete the review of their case.

4. KEPRO staff will explain the appeal process and begin the review. KEPRO staff will request a copy of the patient’s medical record. Upon receipt of the records, a nurse and physician will review the records, along with comments received from the patient/representative, the patient’s doctor and the facility. A decision will be made as to whether the ending of Medicare covered services is appropriate or not.
5. If KEPRO agrees with the hospice, financial liability does not begin until the day after the effective date indicated on the notice. If KEPRO disagrees with the hospice, the patient may continue to receive services from the hospice without incurring any additional liability (other than applicable deductibles and coinsurance) until such time that it is again decided that patient no longer needs Medicare covered services. The hospice will then issue another notice.

6. KEPRO staff will immediately notify the patient/representative of the decision by telephone and will follow up in writing.

7. If KEPRO staff agrees with the hospice that ending Medicare-covered services is appropriate, they will give the patient/representative information as to how they can ask for a reconsideration of the decision.

E. Comprehensive Outpatient Rehabilitation Facilities (CORFs)

1. Medicare implemented a rule that requires CORF’s to inform a patient at least two days before they end Medicare-covered services. The Notice of Medicare Provider Non-coverage tells the patient what day their Medicare covered services will end.

2. A patient has a right to disagree that Medicare services should end. If this is the case they have the right to ask KEPRO to review their case.

3. Once the patient or representative receives the notice, they should call KEPRO at (855) 408-8557 to request an appeal. KEPRO should be contacted by noon of the day before services are to end. If KEPRO is contacted after noon of the day services are to end, KEPRO may or may not be able to complete the review of their case.

4. KEPRO staff will explain the appeal process and begin the review. KEPRO staff will request a copy of the patient’s medical record. Upon receipt of the records, a nurse and physician will review the records, along with comments received from the patient/representative, the patient’s doctor and the facility. A decision will be made as to whether the ending of Medicare covered services is appropriate or not.

5. If KEPRO agrees with the CORF, financial liability does not begin until the day after the effective date indicated on the notice. If KEPRO disagrees with the CORF, the patient may remain in the CORF without incurring any additional liability (other than applicable deductibles and coinsurance) until such time that it is again decided that the patient no longer needs Medicare covered services. The CORF will then issue another notice.

6. KEPRO staff will immediately notify the patient/representative of the decision by telephone and will follow up in writing.

7. If KEPRO staff agrees with the CORF that ending Medicare-covered services is appropriate, they will give the patient/representative information as to how they can ask for a reconsideration of the decision.
F. Home Health Agencies (HHAs)

1. Medicare requires Medicare-certified HHAs to inform a patient at least two days before they end Medicare-covered services. This Notice of Medicare Provider Non-coverage tells the patient what day their Medicare-covered services will end.

2. A patient has a right to disagree that Medicare services should end. If this is the case they have the right to ask KEPRO to review their case.
   a. Once the patient or representative receives the notice, they should call KEPRO at (855) 408-8557 to request a review. KEPRO should be contacted by noon of the day before services are to end.

3. KEPRO clinical staff will explain the appeal process.
   a. If the patient has traditional Medicare, CMS requires a physician certify that termination of the patient’s home health services will place their health in significant risk. KEPRO staff will explain this to the patient/representative and how they can go about seeking this certification.
   b. If the patient is in a Medicare Advantage Plan, no physician certification is required and KEPRO can proceed with the appeal

4. KEPRO staff will request a copy of the patient’s medical record. Upon receipt of the records, a nurse and physician will review the records, along with comments received from the patient/representative, the patient’s doctor, and the HHA. A decision will be made as to whether ending the Medicare-covered service is appropriate or not.

5. If KEPRO agrees with the HHA, financial liability does not begin until the day after the effective date indicated on the notice. If KEPRO disagrees with the HHA the patient may continue to receive home health services without incurring any additional liability (other than applicable deductibles and coinsurance) until such time that it is again decided that patient no longer needs Medicare covered services. The HHA will then issue another notice.

6. KEPRO staff will immediately notify the patient/representative of the decision by telephone and will follow up in writing.

7. If KEPRO staff agrees with the plan that ending Medicare-covered services is appropriate, they will give the patient/representative information as to how they can ask for a reconsideration of the decision.

XI. Appeal of Claims

A. Explanation

1. When Medicare denies payment for a service, beneficiaries have the right to appeal the decision.
2. Each level of appeal has its own guidelines and time restraints.
3. Beneficiaries are always given information on how to appeal or further appeal a decision.
4. The appeal information in this manual is strictly for beneficiaries. Health care providers have their own information on how to file an appeal.
B. Contractor Redetermination – First Level

1. With Part A claims, an appeal must be started within 120 days of receipt of the initial determination. This determination is the Medicare Summary Notice.
2. Anyone can initiate reconsideration.
3. The request for reconsideration must be made in writing.
4. There is no limitation to the minimum dollar amount of a claim for reconsideration.
5. The MAC conducts the reconsideration.

C. Qualified Independent Contractor (QIC) – Second Level

1. A request must be filed within 60 days of the reconsideration denial.
2. The amount of the claim in question must be at least $140.
3. The Bureau of Hearings and Appeals schedules a hearing with an Administrative Law Judge.

D. Medicare Appeals Council – Third Level

1. A request must be filed within 60 days of the denial from the hearing.
2. The amount of the claim in question must be at least $140.
3. This council is a three-person panel in Washington, DC. They can choose whether or not to continue the appeal.

E. Judicial Review by the Federal Court – Fourth Level

1. A request must be filed within 60 days of the denial from the review council.
2. The amount in question must be at least $1,430.
3. A civil action must be filed in Federal court and may require an attorney’s services.

<table>
<thead>
<tr>
<th>Type of Action</th>
<th>Time Limit</th>
<th>Amount in Question</th>
<th>Jurisdiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractor Redetermination</td>
<td>120 Days</td>
<td>No minimum</td>
<td>MAC</td>
</tr>
<tr>
<td>QIC Review</td>
<td>60 Days</td>
<td>$140</td>
<td>Maximus Federal Services, Inc.</td>
</tr>
<tr>
<td>Medicare Appeals Council</td>
<td>60 Days</td>
<td>$140</td>
<td>Medicare Appeals Council</td>
</tr>
<tr>
<td>Judicial Review</td>
<td>60 Days</td>
<td>$1,430</td>
<td>Federal District Court</td>
</tr>
</tbody>
</table>
XII. Explanation of Terms

**Benefit Period** - the period of time that Medicare uses to determine cost-sharing for Part A services. It begins the day a beneficiary is admitted as an inpatient to a hospital and ends when the person has been out of the hospital or skilled nursing facility for 60 consecutive days.

**Beneficiary and Family Centered Care QIO (BFCC-QIO)** - a private organization that contracts with CMS to monitor the quality of medical services provided under the Medicare program. Beneficiaries with complaints on quality of care issues or disputing discharge orders contact their state’s QIO when it refers to Medicare-covered services. KEPRO holds the contract as Missouri’s Beneficiary and Family Centered Care QIO (BFCC-QIO).

**Deductible** - the amount that a person must pay for health care services before Medicare begins to pay. For Part A, this deductible is owed for each benefit period and can change each year.

**Coinsurance** - a percentage or specified dollar amount of a covered expense that a person is required to pay.

**Medicare Administrative Contractor (MAC)** - a private company that Medicare has contracted to process Part A and Part B claims under Original Medicare for a region.

**Utilization Review Committee** - Individuals employed by the health care provider (hospital or SNF) who review Medicare patients’ admissions. Based on Medicare’s regulations, they determine whether the stay meets Medicare’s criteria for reimbursement.
XIII. Section 3 Review

BENEFIT PERIOD AND COSTS – HOSPITAL AND SKILLED NURSING FACILITY

1. Mrs. Anderson enters the hospital as inpatient on January 2 and stays for 15 days. She is discharged to her home and after 40 days returns to the hospital for another 10 days. What are her out-of-pocket costs?

2. Mr. Baker enters the hospital (as an inpatient) on March 3 and stays for 15 days. He is discharged to his home and after three months is again hospitalized for eight days. What are his out-of-pocket costs?

3. Mrs. Carter enters the hospital on January 25 and stays for 64 days. She is discharged to her home but after only 10 days realizes she cannot manage alone and needs daily therapies. Her doctor recommends a SNF where she receives skilled care for two weeks. She then returns to her home where she stays for 55 days and is then hospitalized for three more days and is discharged to the SNF for another two weeks. What are her out-of-pocket costs?
SKILLED NURSING FACILITY BENEFITS

1. What conditions must be met by a Medicare beneficiary to qualify for coverage in a SNF?

2. What is the difference between skilled care and custodial care?

3. How many days are available in a benefit period in a SNF and what is the cost to the beneficiary?

4. What SNF services are covered by Medicare?
COUNSELING

Would you recommend appealing any of the following situations?

1. Mrs. Jones’ recent SNF stay charges were rejected by Medicare. The Medicare Summary Notice (MSN) stated that coverage was denied because Mrs. Jones’ SNF stay was not medically necessary.

2. Dr. Abel directed Mr. Parker to check in to the hospital for a battery of tests he believed Mr. Parker needed. At the time, Dr. Abel and the admitting clerk assured Mr. Parker that Medicare would cover the hospitalization. Medicare ultimately denied the claim, stating that “these services are covered only on an outpatient basis.”

3. On the advice of his doctor, Mr. Rogers entered Sunnybrook Nursing Home’s Intermediate Care Unit to recover from a massive stroke he suffered. The stroke left him unable to speak and almost totally paralyzed on his right side. His daughter said that the nursing home refuses to file a claim with Medicare.
PART A REVIEW QUESTIONS

1. How many parts are there to Medicare and what are they?

2. When can a person who is not automatically eligible enroll in Medicare and what government agency handles Medicare enrollment?

3. What four types of care are covered by Part A of Medicare?

4. How many days of inpatient hospitalization are covered in a benefit period under Part A and what out-of-pocket expenses is the beneficiary required to pay?

5. How many days are covered in a benefit period in a SNF and what out-of-pocket expenses is the beneficiary required to pay?

6. What requirements must a beneficiary meet in order to receive hospice coverage? What is the cost to the beneficiary?

7. What is a MAC and what does it do?

8. What types of services are covered under Medicare home health care benefits? What is the cost to the beneficiary?
Tab Divider named “Section 4 Medicare Part B”
# Section 4
## Medicare Part B

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>General Coverage</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>A. Coverage for Part B (Medical Insurance)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>B. Medicare Administrative Contractors (MAC)</td>
<td>1</td>
</tr>
<tr>
<td>II.</td>
<td>Beneficiary Costs</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>A. Monthly Premium</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>B. Deductible</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>C. Coinsurance</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>D. Excess Charges</td>
<td>2</td>
</tr>
<tr>
<td>III.</td>
<td>Assignment vs. Non-Assignment</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>A. Decision to Accept Assignment</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>B. Assignment</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C. Non-Assignment</td>
<td>3</td>
</tr>
<tr>
<td>IV.</td>
<td>Private Contracts</td>
<td>3</td>
</tr>
<tr>
<td>V.</td>
<td>“Reasonable and Necessary” Requirement</td>
<td>3</td>
</tr>
<tr>
<td>VI.</td>
<td>Physician Services</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>A. Qualifying Physicians</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>B. Qualifying Special Practitioners</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>C. Beneficiary Cost</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>D. Covered Services</td>
<td>4</td>
</tr>
<tr>
<td>VII.</td>
<td>Outpatient Hospital Services</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>A. Coverage</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>B. Beneficiary Cost</td>
<td>5</td>
</tr>
<tr>
<td>VIII.</td>
<td>Therapy</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>A. Types</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>B. Locations</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>C. Beneficiary costs</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>D. Therapy Caps</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>E. Exceptions to Therapy Caps</td>
<td>6</td>
</tr>
<tr>
<td>IX.</td>
<td>Home Health Care</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>A. Conditions for Coverage</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>B. Covered Days</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>C. Beneficiary Costs</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>D. Coverage</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>E. Non-Covered Services</td>
<td>8</td>
</tr>
<tr>
<td>X.</td>
<td>Ambulance Transportation</td>
<td>8</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>A. Conditions</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>B. Coverage</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>C. Beneficiary Costs</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>XI. Clinical Laboratory Services</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>XII. Blood</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>A. Coverage</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>B. Beneficiary Cost</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>XIII. Durable Medical Equipment (DME) and Supplies</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>A. Conditions</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>B. Covered items</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>C. Used DME</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>D. Beneficiary Cost</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>E. Competitive Bidding Program</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>XIV. Preventive Services</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>XV. Non-Covered Services</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>A. Filing a Part B Claim</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>B. Time Limits for Submitting Claims</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>XVII. Appeal of Denied Claims</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>A. Explanation</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>B. Contractor Redetermination – First Level</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>C. Qualified Independent Contractor – Second Level</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>D. Office of Hearings and Appeals – Third Level</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>E. Medicare Appeals Council – Fourth Level</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>F. Judicial Review by the Federal Court – Final Level</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>XVIII. Explanation of Terms</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>XIX. Therapy Caps Addendum (subject to Congressional Annual renewal)</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>XX. Section 4 Review</td>
<td>26</td>
<td></td>
</tr>
</tbody>
</table>
I. **General Coverage**

A. **Coverage for Part B (Medical Insurance)**

Physician services  
Outpatient hospital services and emergency room visits (observation)  
Therapy (physical, speech, occupational)  
Home health care  
Ambulance transportation  
Clinical laboratory services  
Blood transfusions  
Preventive services  
Durable medical equipment (DME), such as wheelchairs, walkers, canes, Diabetic supplies (lancets and test strips). Self-administered insulin and syringes covered under part D.  
The following self-administered drug types:  
- Certain oral cancer therapy drugs  
- Immunosuppressive drugs after Medicare covered organ transplant  
- Anti-emetic drugs (anti-nausea medications after chemotherapy)  
- Medications administered via a nebulizer

B. **Medicare Administrative Contractors (MAC)**

A Medicare Administrative Contractor (MAC) is a private company that Medicare contracts with to process Part A and Part B claims under Original Medicare.

II. **Beneficiary Costs**

A. **Monthly Premium**

1. For beneficiaries receiving Social Security (SS) benefits, this premium generally will be deducted from their monthly SS check.  
2. For beneficiaries not receiving SS benefits, this amount will be billed to the beneficiary on a quarterly basis.

B. **Deductible**

1. The beneficiary is responsible for the annual deductible for the calendar year. Only Medicare-approved charges count toward annual deductible.  
2. Any excess or non-covered charges do not apply toward this deductible.
3. The deductible does not apply to home health services, clinical laboratory services, and some preventive services.

C. Coinsurance

1. For some Part B services, Medicare pays 80% of the approved amount and the beneficiary is responsible for the remaining 20%.
2. For other Part B services, the coinsurance may vary such as with certain outpatient procedures.

D. Excess Charges

Physicians who do not accept assignment, the beneficiary may be billed up to 15% more than the approved charge.
For DME suppliers who do not accept assignment, the beneficiary may be responsible for the balance (difference between the approved amount and the amount actually billed).

III. Assignment vs. Non-Assignment

A. Decision to Accept Assignment

Most Medicare providers are allowed to decide annually whether to accept Medicare assignment. In general, a large majority of physicians accept assignment at any given time (80-90%, depending on geographical area).

B. Assignment

When a provider accepts assignment, they agree to accept Medicare’s approved amount as payment in full. Patients are responsible for coinsurance.

1. The following providers are required to always accept assignment:
   a. Hospitals
   b. Skilled Nursing Facilities (SNFs)
   c. Home Health Agencies (HHAs)
   d. Comprehensive Outpatient Rehabilitation Facilities (CORFs)
   e. Ambulatory Surgical Centers (ASCs)
   f. Providers of outpatient physical, occupational or speech therapy services
   g. Clinical laboratories
   h. Ambulance
2. When a provider accepts assignment, they cannot ask for payment in full at the time the service is provided. They may, however, request payment for applicable deductible and coinsurance.
3. Claims process:
   a. Service is provided to beneficiary
   b. Provider bills Medicare
c. Medicare sends payment to provider and MSN to beneficiary
d. Provider bills beneficiary for applicable charges

C. Non-Assignment

When a provider does not accept assignment, they may charge more than Medicare’s approved amount. Patients are responsible for coinsurance and excess charges.

1. DME suppliers – There is no limit to what may be charged over Medicare’s approved amount. The beneficiary is responsible for this charge.
2. Physicians – May only charge up to 15% more than Medicare’s approved amount (excess charge). The beneficiary is responsible for this charge.
3. Providers who do not accept assignment may choose to do so, on a case-by-case basis.
4. For physicians who do not accept assignment (even if they do so in individual cases), Medicare reduces the approved payment amount to the provider by 5%.
5. When a provider does not accept assignment, they may ask for payment from the beneficiary in full at the time the service is provided.
6. Claims process:
   a. Service is provided to beneficiary
   b. Provider bills beneficiary and they are responsible for up to 115% of Medicare’s approved amount
   c. Provider bills Medicare
   d. Medicare sends payment and MSN to beneficiary

IV. Private Contracts

1. Medicare beneficiaries may sign a private contract with a physician to provide services for which the beneficiary is financially responsible, such as cosmetic or Lasik surgery.
2. No claim may be filed with Medicare or supplemental insurance for any service provided under a private contract.
3. The beneficiary agrees that there is no limit to what amount may be charged for services.
4. Beneficiaries cannot be required to sign a private contract with a physician in an emergency situation.

V. “Reasonable and Necessary” Requirement

1. Part B will only pay for services determined to be “reasonable and necessary” or “medically necessary” for the diagnosis or treatment of an illness or injury.
2. MACs generally determine what is considered medically necessary.
3. Some services are exempt from this requirement, such as certain preventive services, i.e.: Mammogram
4. If a service is not covered by Medicare, or is questionable for coverage, the provider must issue an Advanced Beneficiary Notice (ABN). This notice informs the
beneficiary in advance of potential out-of-pocket costs, reason for non-coverage and ability to decide to proceed with or without the service.

VI. Physician Services

A. Qualifying Physicians

1. Physicians (MD or DO)
2. Dental surgeons
3. Chiropractors
4. Optometrists/ophthalmologists
5. Podiatrists

B. Qualifying Special Practitioners

1. Certified registered nurse anesthetist
2. Clinical psychologist
3. Clinical social worker
4. Physician assistant (PA)
5. Nurse practitioner and clinical nurse specialist

C. Beneficiary Cost

1. Annual deductible
2. Coinsurance (20% of approved amount) depending on service
3. Excess charge for non-assigned claims
4. Non-covered services

D. Covered Services

1. Medical services in any of the following settings are covered.
   a. Physician’s office
   b. Hospital
   c. Skilled nursing facility
   d. Nursing home, and/or
   e. Beneficiary’s home
2. Second opinion before surgery (third opinion, if the first two contradict each other).
3. Surgical services (including anesthesiology).
4. Mental health services (outpatient).
5. Certain chiropractic services.
   a. Part B will pay for manual manipulation of the spine to correct a subluxation – partial dislocation of a bone.
   b. Medicare used to require the subluxation be proven by x-ray, but now only requires documentation on a claim.
c. Goal of treatment is to return beneficiary to pre-injury/illness status. Subsequent treatments for maintenance would not be covered.

6. Certain podiatric services.
   a. Covered services include debridement of mycotic toenails, ingrown toenails, bunions, and heel spurs.
   b. Any routine services including hygienic care are covered only when related to a systemic disease such as diabetes.

Example #1: Ms. Bunn has diabetes. She has to go to the podiatrist to have her toenails trimmed because of the foot problems caused by her diabetes. Medicare will pay for her toenail trimmings because she has diabetes.

Example #2: Mr. Snodgrass goes to the podiatrist to have his toenails trimmed because he has had a hip replacement and cannot bend over to reach his feet. Medicare will not pay for his toenail trimming because he does not have a systemic disease that affects his feet.

7. Certain optometrist/ophthalmologist services.
   a. Part B will generally only cover these types of services if the test or exam is considered diagnostic (not screening or routine).
   b. Covers annual glaucoma screenings for all persons

8. Dental surgeon.
   a. Since no dental care is covered by Medicare, dental surgeons are only covered in very rare circumstances:
      • Setting a fracture of the jaw, and
      • Surgery to remove a tumor from the mouth, gums, etc.
   b. Medicare will not pay for any maintenance or follow-up dental care.

VII. Outpatient Hospital Services

A. Coverage

1. Emergency room
2. Outpatient surgery
3. Diagnostic testing that cannot be done in a physician’s office
4. In-hospital observation

B. Beneficiary Cost

1. Annual deductible
2. Coinsurance
   a. Outpatient department of a hospital
      • Beneficiaries pay approximately 20% or a co-payment based on the ambulatory payment classification system (APC)
         o Capped at the current year’s inpatient hospital deductible
If more than one APC is used at one time, there is a 50% reduction in payment to the provider for all APC’s after the first.

b. Comprehensive Outpatient Rehabilitation Facility (CORF)
   - Required to accept assignment
   - Beneficiary pays 20% of approved amount

c. Ambulatory Surgical Center (ASC)
   - Required to accept assignment
   - Beneficiary pays 20% of approved amount

VIII. Therapy

A. Types

1. Physical therapy
2. Occupational therapy
3. Speech pathology

B. Locations

1. Physician’s office
2. Outpatient hospital department
3. Skilled nursing facility
4. Home health agency
5. Independently practicing therapist

C. Beneficiary costs

1. Annual deductible
2. 20% coinsurance on approved amount (mandatory assignment)

D. Therapy Caps

Financial limitations have been placed on all Part B covered therapy services in outpatient settings:

- **Physical Therapy/Speech Pathology Services** – share a combined annual dollar limit
- **Occupational Therapy** – has an annual dollar limit

E. Exceptions to Therapy Caps

Exceptions to therapy caps for those that meet certain medical necessity requirements are subject to yearly reauthorization.
1. **Automatic Exceptions**
   a. Clinically complex situations can justify an automatic exception. Qualifying beneficiaries will not be required to submit requests for exception or supporting documentation. Covered situations include:
      - Beneficiary discharged from a hospital or SNF within 30 treatment days of starting a new period of outpatient therapy.
      - Beneficiary has, in addition to another treated disease or condition, generalized musculoskeletal condition or a condition affecting multiple sites that are not listed as qualifying for an automatic exception that will have a direct impact on the rate of recovery.
      - Beneficiary has a mental or cognitive disorder in addition to the condition being treated that will have a direct impact on the rate of recovery.
   b. For the above exceptions the provider should include documentation of all relevant disorders or conditions and describe the impact.
   c. See chapter addendum for the list of approved automatic exceptions.

2. **Manual Exceptions**
   If beneficiary does not have a condition or complexity that allows an automatic exception, but is believed to require medically necessary services exceeding the caps:
   a. Providers or beneficiary may fax a letter requesting up to 15 treatment days of service beyond the cap. The request must include why it is medically necessary for the additional days of service.
   b. Contractors will make a decision on the number of treatment days they determine to be medically necessary within 10 business days.

IX. **Home Health Care**

Home health care is part-time or intermittent skilled nursing care and/or therapy provided in the home.

A. **Conditions for Coverage**

1. A doctor must certify that a person needs care in the home and develop a plan of care.
2. Beneficiary must need skilled nursing care, physical therapy, or speech therapy.
   a. Occupational therapy can qualify a beneficiary for continued home health care if they were originally certified for physical or speech therapy.
3. A person must require part-time or intermittent care.
   a. Part-time care is less than 8 hours per day AND less than 28 hours per week.
   b. Intermittent care is less than 7 days per week OR less than 8 hours per day over a 21-day period.
4. Must be homebound.
   a. Homebound means the beneficiary can only leave home with considerable effort.
   b. Only infrequent or short trips are allowed.
   c. Allowable activities outside the home include attendance at religious services or doctor appointments.
5. The home health agency must be Medicare-certified.
B. Covered Days

1. There is no limit to the number of days covered under the home health benefit.
2. As long as a physician certifies medical necessity and homebound status, Medicare will pay for home health services.
3. Part A covers post-institutional home health services furnished during a home health spell of illness for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health spell of illness. The 100-visit limit does not apply if you are only enrolled in Part A. If you are enrolled only in Part B and qualify for the Medicare home health benefit, then all of your home health services are financed under Part B. There is no 100-visit limit under Part B.

C. Beneficiary Costs

1. There is no cost for home health services.
2. There is a 20% coinsurance for durable medical equipment.

D. Coverage

1. Part-time skilled nursing care
2. Physical therapy
3. Speech therapy
4. Occupational therapy, if initially certified due to physical or speech therapy
5. Part-time services of home health aides
6. Medical social services
7. Medical supplies and equipment supplied by the agency
8. Injectable drugs for the treatment of osteoporosis

E. Non-Covered Services

1. Full-time care at home
2. Prescription drugs
3. Meals delivered to the home
4. Homemaker services such as cleaning, washing dishes/clothes, and shopping
5. Custodial care (such as bathing), unless these services are performed along with medically necessary services

X. Ambulance Transportation

As a general rule, Medicare pays for ambulance services when someone requires emergency transportation. It will also pay for scheduled and unscheduled nonemergency ambulance transportation from home or a medical facility to obtain medical services in a hospital or other medical facility when a person’s medical condition requires such transportation.
A. Conditions

1. Ground Ambulance – Transportation in any other vehicle would endanger the beneficiary’s health.
2. Air Ambulance – Transportation in any other vehicle would endanger the beneficiary’s life. The ambulance company must document that a beneficiary’s medical condition required immediate and rapid ambulance transportation that could not have been provided by land ambulance, that the point of pickup was inaccessible by land ambulance and/or that great distance and/or other obstacles were involved in getting the beneficiary to the nearest hospital with appropriate facilities.

B. Coverage

1. Ambulance transport is generally covered only to the nearest facility that can appropriately treat the patient.
   a. From scene of an emergency or accident to a hospital or SNF
   b. From home to the hospital or SNF
   c. Between a hospital and SNF
   d. From a hospital or SNF to home
2. Medicare will not cover ambulance transport to the hospital of choice (by request), unless it is the closest.
3. Nonemergency ambulance transportation coverage is very stringent. The beneficiary must be “bed-confined” (unable to get up from bed without assistance, unable to walk or unable to sit in a chair or wheelchair) and the doctor or other medical professional must certify that ambulance transport was medically necessary with a Certificate of Medical Necessity.

C. Beneficiary Costs

1. Annual deductible
2. 20% coinsurance on approved amount
3. BBRA requires all ambulance companies to accept assignment

XI. Clinical Laboratory Services

1. Services - Blood tests, urinalysis, etc.
2. Conditions - Must be diagnostic (except certain preventive services)
3. Coverage - Covered at 100% by Medicare (no deductible or coinsurance)

XII. Blood

A. Coverage

1. Pints of blood received at a hospital or Skilled Nursing Facility during a covered stay
2. Pints of blood received as an outpatient, or as part of a Part B covered service
B. Beneficiary Cost

1. For Part A covered services, the beneficiary pays for the first 3 pints, unless they or someone else donates blood to replace what was used.
2. For Part B covered services, the beneficiary pays for the first 3 pints, then 20% of the Medicare approved amount for additional pints, unless they or someone else donates blood to replace what was used.

XIII. Durable Medical Equipment (DME) and Supplies

A. Conditions

1. A physician must order or prescribe the equipment or supplies (must sign a Certificate of Medical Necessity) if required.
2. The supplier must be Medicare-certified.
3. The equipment (not supplies) must be used in the beneficiary’s home.
4. Medicare will only pay for the following items when a beneficiary is residing in a nursing facility or skilled nursing facility:
   - Prosthetics, orthotics, and related supplies
   - Urinary incontinence supplies (catheters)
   - Ostomy supplies
   - Surgical dressings
   - Oral anticancer drugs
   - Oral anti-emetic drugs
   - Therapeutic shoes for diabetics
   - Parenteral/enteral nutrition and the IV pole used to administer the nutrition
   - Dialysis supplies for ESRD
   - Immunosuppressive drugs

B. Covered items

1. Inexpensive or routinely purchased items:
   - Walkers, commodes, seat lift chair mechanisms – rental or purchase basis
2. Items requiring frequent or substantial servicing:
   - Ventilators, aspirators, nebulizers – rental basis only
3. Customized items:
   - Equipment uniquely constructed or substantially modified, i.e.: arm, leg or back braces, shoe inserts – purchase basis only
4. Other prosthetics and orthotic devices:
   - Pacemakers, colostomy bags, corrective lenses needed after cataract surgery – purchase basis only
5. Capped rental equipment:
   - Hospital beds, wheelchairs – rental basis for 13 months, then the beneficiary will own the equipment

Counseling Note: Medicare will not pay for medications administered thru nebulizers (covered by Part D), diabetic test strips and lancets (self-pay) or oxygen (self-pay) when a beneficiary resides in a skilled nursing facility or nursing facility.
6. Oxygen and oxygen equipment:
   a. Depending on the patient’s testing values, they must be recertified and/or retested at three months or at one year. Once they have been recertified for lifetime, no other certification is needed unless the need for oxygen changes.
   b. As of January 1, 2009, the rental payments will end after 36 months, but the supplier continues to own the equipment. The new law then requires the supplier to provide the oxygen equipment and related supplies for 2 additional years (5 years total), as long as oxygen is still medically necessary. The provider is required to continue to maintain the oxygen equipment and furnish the equipment and any necessary supplies and accessories, as long as the need continues until the 5 year period ends. A new rental period will start over after the five year period ends.
      • For oxygen tanks or cylinders that need delivery of gaseous or liquid oxygen contents, Medicare will continue to pay each month for the refilling of contents after the 36 month rental period. The supplier that delivers this equipment the last month of the 36 month rental period must provide these items, as long as it is medically necessary, up to 5 years.

7. Diabetic supplies (lancets and test strips).

8. The following self-administered drug types:
   • Certain oral cancer therapy drugs
   • Immunosuppressive drugs after Medicare covered organ transplant
   • Anti-emetic drugs (anti-nausea medications after chemotherapy)
   • Medications administered via a nebulizer

C. Used DME

Medicare will reimburse for the purchase of used equipment at 75% of the fee schedule. Used equipment is considered equipment that has been rented or used by someone before the current purchase transaction or equipment that has been used for a trial period or as a demonstrator. Beneficiary must complete 1490S form and submitted to the DME MAC.

D. Beneficiary Cost

1. Annual deductible
2. 20% coinsurance of approved amount
3. Balance of bill (difference between Medicare’s approved amount and actual charge if supplier does not accept assignment, with no limiting charge)

E. Competitive Bidding Program

In January 2011, Medicare started a new Competitive Bidding Program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in 9 areas of the country including the Kansas City Missouri-Kansas area. In July 2013, Medicare expanded the Competitive Bidding Program to more areas of the country including St. Louis Missouri-Illinois area. This program changes the amount Medicare pays for certain
medical equipment and supplies, and makes changes to which suppliers Medicare will pay to supply these items to you.

Under this program, suppliers submit bids to provide certain medical equipment and supplies. Medicare uses these bids to set the amount it will pay for those equipment and supplies under the Competitive Bidding Program. Qualified, accredited suppliers with winning bids are chosen as Medicare contract suppliers. Beneficiaries that live in these areas are **required** to use these contracted suppliers for the below listed equipment and supplies for Medicare to pay. This also applies to beneficiaries traveling to a competitive bidding area and needs supplies or equipment.

The program:
- Helps the beneficiary and Medicare save money
- Ensures that the beneficiary has access to quality medical equipment, supplies, and services from suppliers they can trust
- Helps limit fraud and abuse in the Medicare Program

**Equipment and Supplies included in the Competitive Bidding Program**

**Round 1 areas equipment and supplies**
- Respiratory equipment and related supplies and accessories - includes oxygen, oxygen equipment, and accessories; Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories; and standard nebulizers
- Standard mobility equipment and related accessories - includes walkers, standard power and manual wheelchairs, scooters, and related accessories
- General home equipment and related accessories - includes hospital beds and related accessories, group 1 and 2 support surfaces, transcutaneous electrical nerve stimulation (TENS) devices, commode chairs, patient lifts, and seat lifts
- Enteral nutrients, equipment and supplies
- Negative Pressure Wound Therapy pumps and related supplies and accessories
- External infusion pumps and supplies

**Round 2 areas equipment and supplies**
- Oxygen, oxygen equipment, and accessories
- Standard (power and manual) wheelchairs, scooters, and related accessories
- Enteral nutrients, equipment, and supplies
- Continuous Positive Airway Pressure (CPAP) devices, Respiratory Assist Devices (RADs), and related supplies
- Hospital beds and related accessories
- Walkers and related accessories
- Negative Pressure Wound Therapy pumps and related supplies and accessories
- Support surfaces (Group 2 mattresses and overlays)

Medicare also has a **National Mail-Order Program for diabetic testing supplies**, which applies **no matter where you live**. Visit Medicare.gov for help finding out if a beneficiary lives in a competitive bid area and for a list of current suppliers.
## XIV. Preventive Services

<table>
<thead>
<tr>
<th>Part B Covered Preventive Services</th>
<th>Who is Covered?</th>
<th>What Does the Beneficiary Pay?</th>
</tr>
</thead>
</table>
| **Alcohol Misuse Screening & Counseling** | Medicare beneficiaries, including pregnant women:  
- Who misuse alcohol  
- Whose levels of alcohol consumption do not meet criteria for alcohol dependence  
- Who are competent and alert at the time of counseling  
- If counseling is furnished by qualified primary care providers in a primary care setting | Nothing if doctor or provider accepts assignment. |
|  
- Annual alcohol screening and  
- Up to four face-to-face counseling sessions |  
*The screening must be done in a primary care setting that can provide follow-up treatment and referrals. |  |
| **Behavioral Therapy for Cardiovascular Disease** | Risk factors include:  
- Being overweight  
- Physical inactivity  
- Diabetes  
- Cigarette smoking  
- High blood pressure  
- High cholesterol  
- Family history | Nothing if doctor or provider accepts assignment. |
| One CVD risk reduction visit per year that includes:  
- Encouraging aspirin use when benefits outweigh the risks  
- Screening for high blood pressure  
- Intensive behavioral counseling to promote healthy diet |  
*The screening must be done in a primary care setting that can provide follow-up treatment and referrals. |  |
| **Bone Mass Measurement** | Certain people at risk for losing bone mass | Starting January 1, 2011, nothing if doctor accepts assignment. |
| Varies with health status – usually once every 24 months |  |  |
| **Cardiovascular Screening** | All Medicare beneficiaries who have not been previously diagnosed with cardiovascular disease. | Nothing if doctor or provider accepts assignment. |
|  
- Cardiovascular blood screening test – Once every five years  
- Total cholesterol test  
- Cholesterol test for high density lipoproteins  
- Triglycerides test |  |  |
### Part B Covered Preventive Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Who is Covered</th>
<th>What Does the Beneficiary Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cologuard™ (Multi-target Stool DNA Test)</strong></td>
<td>Certain people with Medicare every 3 years if they:</td>
<td>No copays, deductibles or co-insurance.</td>
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<td></td>
<td>• are between ages 50-85,</td>
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<td></td>
<td>• show no signs or symptoms of colorectal disease, and are</td>
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<tr>
<td></td>
<td>• at average risk for developing colorectal cancer</td>
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</tr>
<tr>
<td><strong>Colorectal Cancer Screening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fecal Occult Blood Test – 12 months</td>
<td>All people with Medicare age 50 and older.</td>
<td>Nothing for the fecal occult blood test.</td>
</tr>
<tr>
<td>• Flexible Sigmoidoscopy – 48 months</td>
<td></td>
<td>Nothing for flexible sigmoidoscopy or screening colonoscopy, if doctor accepts assignment.</td>
</tr>
<tr>
<td>• Colonoscopy – 24 months</td>
<td></td>
<td>For barium enemas, 20% of the Medicare-approved amount for the doctor’s services with no Part B deductible. If it’s done in a hospital outpatient setting, you pay a copayment.</td>
</tr>
<tr>
<td>• Barium Enema – Substitute for colonoscopy or sigmoidoscopy</td>
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</tr>
<tr>
<td><strong>Depression Screening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to screening services.</td>
<td>All people with Medicare.</td>
<td>Nothing if doctor or provider accepts assignment.</td>
</tr>
<tr>
<td>*The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</td>
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<tr>
<td><strong>Diabetes Screening</strong></td>
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</tbody>
</table>
| • Diabetes screening test – Twice yearly (Calendar year) | Any individuals with one of the following individual risk factors for diabetes is eligible for this new benefit:  
  • Hypertension  
  • Dyslipidemia  
  • Obesity BMI equal to or over 30  
  • Previous identification of elevated impaired fasting glucose or glucose intolerance.  
  **Or, an individual with two of the following risk factors for diabetes is also eligible for this new benefit:**  
  • Overweight (a body mass index greater than or equal to 25 kg/m2)  
  • A family history of diabetes  
  • Age 65 years or older  
  • A history of gestational diabetes mellitus or giving birth to a baby weighing > 9 lbs. | Nothing if doctor or provider accepts assignment. |
| **Diabetes Self-Management Training** | All people with Medicare who have diabetes. | 20% of the Medicare-approved amount after Part B deductible. |
| **EKG Screening**                |                |                                |
| • A one-time screening EKG with interpretation  
  • Eligible beneficiaries must receive a referral for the screening as a result of their “Welcome to Medicare” physical exam. | | 20% of the approved amount after the Part B deductible. |
| **Glaucoma Screening**           | All persons determined to be high risk for glaucoma:  
  • Individuals with a family history  
  • Individuals with diabetes  
  • African-Americans, age 50 and older  
  • Hispanics, age 65 and older | 20% of the approved amount after the Part B deductible. |
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<tbody>
<tr>
<td><strong>Hepatitis C Screening</strong></td>
<td>All adults who do not meet the high-risk determination born from 1945 thru 1965.</td>
<td>Nothing as long as doctor or provider accepts assignment.</td>
</tr>
<tr>
<td>Single once in a lifetime screening test</td>
<td></td>
<td>Must be ordered by primary care physician or non-physician practitioner, in a primary care setting.</td>
</tr>
<tr>
<td>• High risk people (current or history of illicit injection drug use; history of blood transfusion before 1992)</td>
<td>High Risk people qualify for: • Yearly screening test only for beneficiaries with continued illicit injection drug use and previous negative screen.</td>
<td></td>
</tr>
<tr>
<td><strong>HIV Screening</strong></td>
<td>Pregnant women and people at increased risk for the infection including anyone who asks for the test.</td>
<td>Nothing for the test, but you generally have to pay your doctor 20% of the Medicare-approved amount for your doctor’s visit.</td>
</tr>
<tr>
<td>Human Immunodeficiency Virus (HIV) screening blood test</td>
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<tr>
<td>• Covered once every 12 months or up to 3 times during a pregnancy</td>
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</tr>
<tr>
<td><strong>Human Papillomavirus (HPV) test for Cervical Cancer Screening</strong></td>
<td>Females age 35-65 with no symptoms.</td>
<td>Nothing as long as doctor or provider accepts assignment.</td>
</tr>
<tr>
<td>HPV test performed in conjunction with the pap smear test once every five years.</td>
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<tr>
<td><strong>Immunizations</strong></td>
<td>All people with Medicare A different 2nd pneumococcal vaccine 1 year after the 1st vaccine was administered (11 full months have passed following the month in which the last vaccine was administered.</td>
<td>Nothing for flu, pneumonia and Hepatitis B shots, if provider accepts assignment.</td>
</tr>
<tr>
<td>• Flu – Once a year</td>
<td></td>
<td></td>
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<tr>
<td>• Pneumonia – Varies with health status</td>
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<td></td>
</tr>
<tr>
<td>• Hepatitis B – If at medium to high risk for hepatitis</td>
<td></td>
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</tr>
<tr>
<td><strong>Lung Cancer Screening</strong></td>
<td>People age 55-77, No signs/symptoms of lung cancer Current smoker or has quit within last 15 years, Smoking history of at least one pack a day for 30 years, Written order from physician or qualified non-physician practitioner</td>
<td>Nothing as long as doctor provider accepts assignment.</td>
</tr>
<tr>
<td>Low Dose Computed Tomography once per year for certain people with Medicare</td>
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<tr>
<td><strong>Mammogram Screening</strong></td>
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<tr>
<td>Once every 12 months</td>
<td>All women with Medicare age 40 and older. One baseline mammogram is covered between ages 35-39.</td>
<td>Starting January 1, 2011, nothing if doctor accepts assignment. Example: Mammogram performed on March 15; Medicare will pay for next Mammogram any time after March 1 of following year.</td>
</tr>
<tr>
<td><strong>Medical Nutrition Therapy</strong></td>
<td></td>
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</tr>
<tr>
<td>Services can be given by a registered dietitian or Medicare-approved nutrition professional and include a nutritional assessment and counseling to help you manage your diabetes or kidney disease. Medicare covers 3 hours of one-on-one counseling services the first year, and 2 hours each year after that.</td>
<td>Certain people who have any of the following: • Diabetes • Renal disease (people who have kidney disease, but aren’t on dialysis) • Had a kidney transplant within the last 3 years</td>
<td>Nothing if doctor accepts assignment. A referral from doctor is required.</td>
</tr>
<tr>
<td><strong>Obesity Screening and Counseling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive behavioral therapy includes: • Screening for obesity using BMI measurement • Dietary (nutritional) assessment • Intensive behavioral counseling and behavioral therapy o One face-to-face visit every week for the 1st month o One face-to-face visit every other week for months 2-6 o One face-to-face visit every month for months 7-12, if the beneficiary meets the 6.6 lbs weight loss requirement (within the last 6 months)</td>
<td>People with Medicare who have a body mass index of 30kg/m² or more.</td>
<td>Nothing if doctor accepts assignment.</td>
</tr>
</tbody>
</table>
### Part B Covered Preventive Services

<table>
<thead>
<tr>
<th><strong>One-Time “Welcome to Medicare” Physical Examination</strong></th>
<th><strong>Who is Covered?</strong></th>
<th><strong>What Does the Beneficiary Pay?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This physical examination is a once-a-lifetime benefit for a new beneficiary. Covers a physical exam, review of medical and social history, mental health screening, functional ability screening, end of life planning and body mass index measurement.</td>
<td>New Medicare beneficiaries and the exam must be done within 1 year of Part B coverage effective date.</td>
<td>Nothing if doctor accepts assignment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pap Smear and Pelvic Exam (includes a clinical breast exam)</strong></th>
<th><strong>Who is Covered?</strong></th>
<th><strong>What Does the Beneficiary Pay?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Once every 24 months or once every 12 months if at high risk</td>
<td>All women with Medicare</td>
<td>Starting January 1, 2011, nothing for pap test specimen collection or the pelvic and breast exams if doctor accepts assignment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Prostate Cancer Screening</strong></th>
<th><strong>Who is Covered?</strong></th>
<th><strong>What Does the Beneficiary Pay?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Digital rectal exam – 12 months</td>
<td>All men with Medicare age 50 and older</td>
<td>20% of the approved amount for the digital rectal exam after the Part B deductible Nothing for the PSA Test</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) Test – 12 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Preventive Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)</strong></th>
<th><strong>Who is Covered?</strong></th>
<th><strong>What Does the Beneficiary Pay?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A one-time preventive ultrasound screening for abdominal aortic aneurysms (AAA)</td>
<td>Beneficiaries who are at risk for AAA: • Family history of AAA and/or • Man - age 65-75 who has smoked at least 100 cigarettes (5 packs) in his lifetime</td>
<td>Nothing if doctor accepts assignment.</td>
</tr>
<tr>
<td>Eligible beneficiaries must receive a referral for the screening as a result of their “Welcome to Medicare” physical exam.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Sexually Transmitted Infections Screening and Counseling</strong></th>
<th><strong>Who is Covered?</strong></th>
<th><strong>What Does the Beneficiary Pay?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B.</td>
<td>These screenings are covered for people with Medicare who are pregnant and/or for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. Medicare covers these tests once every 12 months or at certain times during pregnancy. Medicare will only cover these counseling sessions if they’re provided by a primary care provider and take place in a primary care setting, like a doctor’s office.</td>
<td>You pay nothing for STI screenings or counseling if the primary care doctor or primary care practitioner accepts assignment. Behavioral counseling sessions conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service. (Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive benefit.)</td>
</tr>
</tbody>
</table>
### Part B Covered Preventive Services

<table>
<thead>
<tr>
<th>Tobacco Use Cessation Counseling</th>
<th>Who is Covered?</th>
<th>What Does the Beneficiary Pay?</th>
</tr>
</thead>
</table>
| Counseling from a “qualified doctor or other Medicare-recognized practitioner” who can help them stop using tobacco. The types of counseling are as follows:  
- Intermediate cessation counseling (3 – 10 minute session)  
- Intensive counseling (greater than 10 minutes per session) | Any person who uses tobacco  
- Must have a condition that is adversely affected by tobacco use or  
- The metabolism or dosing of a medication that is being used to treat a condition a person has is being adversely affected by the tobacco use  
- Medicare covers these counseling sessions as a preventive service if you haven’t been diagnosed with an illness caused by tobacco use. | Starting January 1, 2011, you pay nothing for the counseling sessions. |

### Yearly “Wellness” Exam

<table>
<thead>
<tr>
<th>Yearly “Wellness” Exam</th>
<th>Who is Covered?</th>
<th>What Does the Beneficiary Pay?</th>
</tr>
</thead>
</table>
| A yearly wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This includes the following:  
- Review of medical and family history  
- A list of current providers and prescriptions  
- Height, weight, blood pressure, and other routine measurements  
- Create a screening schedule for appropriate preventive services  
- A list of risk factors and treatment options for you  
- Screen for cognitive issues | Anyone who has had Part B for longer than 12 months.  
If you have had your “Welcome to Medicare” physical exam, you will have to wait 12 months before you can get your first yearly “Wellness” visit. | Nothing if doctor accepts assignment. |

*A primary care setting is defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospices are not considered primary care settings under this definition.*
XV. Non-Covered Services

1. Routine physicals
2. Routine or screening tests (except certain preventive services)
3. Routine foot care
4. Routine eye care
5. Routine hearing exams
6. Most immunizations
7. Cosmetic surgery (unless of an accidental injury or to improve the functioning of a malformed body part)
8. Dental care (except for surgery of the jaw or related structures, or setting fractures of the jaw or facial bones)
9. Acupuncture
10. Experimental medical procedures
11. Self-administered drugs and biologicals, with the exceptions of:
   - Certain oral cancer therapy drugs
   - Immunosuppressive drugs after organ transplants
   - Anti-emetic drugs (anti-nausea medications after chemotherapy)
12. Hearing aids
13. Orthopedic shoes (“Diabetic” or soft-sided shoes are covered for persons with diabetes)
14. Dentures

XVI. Claim Filing Process

A. Filing a Part B Claim

1. Providers participating in Medicare are required by law to file claims with Medicare, even if they do not accept assignment. However, there may be rare circumstances in which a beneficiary will have to file their own claim.
2. Form 1490S may be filed when:
   a. Services are not covered by Medicare for which a beneficiary wants a formal Part B determination (to submit to their supplement)
   b. Services are provided outside of the U.S.
   c. Used DME is purchased from a private source
   d. Services provided occur when Medicare is secondary payer
   e. Pharmacy must file claims with Medicare (supplies for diabetes)
   f. Request payment for Medicare covered services from non-Medicare providers, (i.e. eye glasses after cataract surgery or seat lift mechanisms)
B. Time Limits for Submitting Claims

1. Non-participating providers - 12 months
2. Participating providers
   a. 12 months (for full reimbursement)
   b. 18 months (for reduced reimbursement)
3. Beneficiaries - 18 months

XVII. Appeal of Denied Claims

A. Explanation

1. When Medicare denies payment for a service, a person has the right to appeal the decision.
2. Each level of appeal has its own guidelines and time restraints.
3. A beneficiary is always given information on how to appeal or further appeal a decision in the Medicare Summary Notice (MSN).
4. The appeal information in this manual is strictly for beneficiaries. Health care providers have their own information on how to file an appeal.

B. Contractor Redetermination – First Level

With Part B claims, an appeal must be started within 120 days of receipt of the initial determination. This determination is the Medicare Summary Notice (MSN).
- Anyone can initiate a review.
- Requests for a review must be made in writing.
- There is no minimum dollar amount of a claim for a review.
- The MAC conducts the review.

C. Qualified Independent Contractor – Second Level

1. A request must be filed within 180 days of the review denial.
2. The amount of the claim in question must be at least $140.
3. The MAC Hearing Office conducts the hearing.

D. Office of Hearings and Appeals – Third Level

1. A request must be filed within 60 days of the denial from the hearing.
2. The amount of the claim in question must be at least $140.
3. The Office of Hearings and Appeals schedules a hearing with an Administrative Law Judge.
E. Medicare Appeals Council – Fourth Level

1. A request must be filed within 60 days of the denial from the hearing.
2. This council is a three-person panel in Washington, D.C. They can choose whether or not to continue the appeal.

F. Judicial Review by the Federal Court – Final Level

1. A request must be filed within 60 days of the denial from the review council.
2. The amount in question must be at least $1,430.
3. A civil action must be filed in federal court, which may require attorney services.

<table>
<thead>
<tr>
<th>Type of Action</th>
<th>Time Limit</th>
<th>Amount in Question</th>
<th>Jurisdiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractor Redetermination</td>
<td>120 Days</td>
<td>No minimum</td>
<td>MAC</td>
</tr>
<tr>
<td>Qualified Independent Contractor</td>
<td>180 Days</td>
<td>$140</td>
<td>Qualified Independent Contractor</td>
</tr>
<tr>
<td>Office of Medicare Hearings and Appeals</td>
<td>60 Days</td>
<td>$140</td>
<td>Office of Medicare Hearings and Appeals</td>
</tr>
<tr>
<td>Medicare Appeals Council</td>
<td>60 Days</td>
<td>$140</td>
<td>Medicare Appeals Council</td>
</tr>
<tr>
<td>Judicial Review with the Federal Court System</td>
<td>60 Days</td>
<td>$1,430</td>
<td>U.S. District Court</td>
</tr>
</tbody>
</table>
XVIII. **Explanation of Terms**

**Actual Cost** - the amount the provider actually bills for services provided

**Approved Charge** - the payment amount that Medicare has “approved” for Medicare-covered services

**Assignment** - a provider who accepts assignment has agreed to accept Medicare’s approved amount as payment in full

**Advance Beneficiary Notice (ABN)** - Notice to beneficiary that a service may not be covered by Medicare and he/she may be responsible for payment of the service. ABN allows beneficiary to determine in advance whether or not to proceed with treatment.

**Excess Charge** - Physicians who do not accept assignment may charge the beneficiary up to 15% more than Medicare’s approved amount.

**Fee-for-Service** - When a beneficiary is in Original Medicare, they are charged a fee each time they use a service. These fees are regulated by Medicare’s approved charges and may include deductibles and coinsurance.

**Limiting Charge** - the highest amount that may be charged for a service by physicians who do not accept assignment; currently, the limit is 115% of Medicare’s approved amount. This does not apply to durable medical equipment (DME) suppliers.

**Medicare Administrative Contractor (MAC)** - private company Medicare contracts with to process both Part A and B claims for Original Medicare

**Non-Assignment** - a physician who does not accept assignment may charge up to the 115% limiting charge for a service. There is no limit on DME suppliers who do not accept assignment.
XIX. Therapy Caps Addendum (subject to Congressional Annual renewal)

Automatic Exceptions to Therapy Caps

Note: Conditions are represented in normal type and complexities are bold with asterisks (*).

Abnormality of gait
Acute, but ill-defined, cerebrovascular disease
**Acute/Chronic pulmonary heart disease***
Anterior horn cell disease
Aphasia and other speech disturbances
Arthropy associated with infections and other disorders*
Burns
**Cardiac dysrhythmias***
**Chronic Obstructive Pulmonary Diseases***
**Chronic ulcer of skin***
**Congestive Heart failure***
Contracture of hand, joint, or multiple sites
**Dementias***
**Depressive disorder NEC***
**Diabetes mellitus***
**Difficulty walking***
Diffuse diseases of connective tissue
Diseases of vocal cords or larynx
Dysphasia
Encephalitis, myelitis, and encephalomyelitis*
**Essential Hypertension***
Fractures, Multiple fractures
Head Injury
Hemiplegia and Hemiparesis
**Hypertensive heart disease***
Infantile cerebral palsy
Intracranial hemorrhages
Intracranial injury of other and unspecified nature
Joint replacement, hip, knee or shoulder
Lack of coordination
Late effects of cerebrovascular disease
Memory Loss
Multiple and unspecified open wound of upper limb with tendon involvement
Multiple sclerosis
Muscular dystrophies and other myopathies
**Neuritis or radiculitis or sciatica, unspecified***
Neurologic neglect syndrome
Neuropathies
Occlusion and stenosis of precerebral and cerebral arteries (for occlusion only)
Open wound of elbow, forearm, and wrist
Open wound of hand with tendon involvement
Osteoarthritis and allied disorders
Osteoporosis with wedging of vertebra
Other and unspecified disorders of the back, thoracic or lumbosacral
Other disorders of the cervical region, brachia neuritis or radiculitis NOS
Other extrapyramidal diseases and abnormal movement disorders
Other forms of Chronic Ischemic Heart Disease*
Other peripheral vascular disease*
Other venous embolism and thrombosis*
Overweight, Obesity, and other hyper-alimentation *
Parkinson's disease
Persistent mental disorders due to conditions classified elsewhere*
Pneumonia, organism unspecified*
Postmastectomy lymphedema syndrome and other lymphedema
posture*
Reflex Sympathetic Dystrophy
Rheumatoid arthritis and other inflammatory polyarthropathies*
Rotator cuff disorder and allied syndromes
Rupture of tendon, nontraumatic
Spinal cord injury without evidence of spinal bone injury
Spinal stenosis, lumbar region
Spinocerebellar disease
Spondylosis with myelopathy
Subarachnoid, subdural, intracranial and extradural hemorrhage, following injury
Symptoms involving nervous and musculoskeletal symptoms, abnormal
Traumatic amputation of arm, hand, or legs (complete) (partial)
Upper limb/Lower limb amputation status
Vertiginous syndromes and other disorders of vestibular system*
XX. Section 4 Review

MEDICARE PART B APPEALS

Would you recommend appealing any of the following situations? What questions do you need to ask?

1) Part B approved $150.00 for payment on Mrs. Jackson’s $300.00 bill from Dr. Hart Beet. Dr. Beet’s bill related to services he performed for Mrs. Jackson as an outpatient. Mrs. Jackson brought her MSN to you and wants to know what she can do, if anything, to avoid the out-of-pocket costs.

2) Before his recent surgery, Mr. Herman was examined on the same day by Dr. Cole D’Hands, his primary surgeon, and by Dr. D. O. Little, another surgeon. Mr. Herman is well on the road to recovery but has come to you with his MSN form in hand, feeling somewhat anxious, because Part B rejected his claim for payment on Dr. Little’s $150.00 bill for the brief examination (although Part B did approve a substantial amount on Dr. D’Hands’ bill). The MSN indicates that payment was not approved on the basis of “concurrent care.”

3) Mrs. Adams recently returned home following hospitalization for a stroke. She needs a wheelchair to get around. Her doctor prescribed a wheelchair with detachable footrests and armrests. Mrs. Adams comes to you saying she was shocked to learn that Medicare Part B did not approve all of her $700.00 wheelchairs bill. Her MSN form indicates that only $416.00 (for a standard wheelchair with fixed armrests and footrests) was approved for payment because the detachable armrests and footrests were not “medically necessary.”

4) Part B disapproved Mr. Harrison’s bill from the House of Serenity Clinic for podiatric acupuncture. The clinic provided acupuncture services to relieve pain in Mr. Harrison’s feet and ankles. He brings his MSN statement to you saying that the clinic did more to help his feet than all his combined visits to an orthopedic specialist and physical therapy. The MSN indicates that payment was not approved because the service is not covered under Medicare Part B.
MEDICARE PART B REVIEW QUESTIONS

1. Name six major services covered by Medicare Part B.

2. What is an approved charge?

3. What types of services are not covered by Medicare Part B?

4. What percent of the approved charge does Medicare Part B pay for covered services?

5. What costs is the beneficiary responsible for when the non-assigned method is used for Part B claims?

6. What costs is the beneficiary responsible for paying when the assigned method is used for Part B claims?

7. How does a beneficiary initiate a Medicare Part B appeal?

8. Who can assist beneficiaries with the Medicare Part B appeal process?
Tab Divider named “Section 5 Medicare Supplements”
I. Purpose of a Supplement Insurance .................................................................................. 1
II. Types .................................................................................................................................. 1
   A. Federal Employee Health Benefits (FEHB) ................................................................. 1
   B. Employer Group Health Plan (EGHP) ........................................................................... 1
   C. Consolidated Omnibus Budget Reconciliation Act (COBRA) ................................. 2
   D. Specific Disease or Accident Policy ............................................................................. 2
   E. Tri-Care for Life ............................................................................................................. 3
   F. Veterans Benefits .......................................................................................................... 3
   G. Long-term Care Insurance (LTC) .................................................................................. 3
   H. Medigap ........................................................................................................................ 4
I. Tips for Beneficiaries When Choosing a Medigap Policy .............................................. 11
III. Explanation of Terms ........................................................................................................ 12
IV. Section 5 Review .............................................................................................................. 13
I. Purpose of a Supplement Insurance

A person with Medicare buys or has supplemental insurance because:
  a. Medicare was never designed to pay all the health care costs for its beneficiaries.
  b. Medicare coverage has not kept pace with the rising costs of medical care.
  c. Medicare coverage has many gaps.
  d. Medicare cost sharing has continued to increase since 1965.
  e. The percentage of income that people pay for their health care has continued to increase.

II. Types

A. Federal Employee Health Benefits (FEHB)

  1. Overview
     a. Coverage for federal civilian employees and their dependents.
     b. Offers a choice of fee-for-service or health maintenance organizations.
     c. Check with the Office of Personnel Management about accepting Part B.
  2. Advantages
     a. An FEHB offers coverage for family members.
     b. An FEHB offers additional benefits beyond Medicare-covered services, such as prescription drugs and yearly physicals.
  3. Disadvantages
     a. Some options, such as the fee-for-service and the HMO, are limited in certain areas. People on Medicare must read through their handbooks carefully and make an informed decision.
     b. There are limitations to enrolling and dis-enrolling from a Federal Employee Health Plan. Members should read through their handbooks carefully or call the Office of Personnel Management at 1-888-767-6738.

B. Employer Group Health Plan (EGHP)

  1. Overview
     EGHP can refer to two different types of coverage. For those who are still employed, it refers to the health insurance they have with their employers. For retirees, it refers to the continuation or conversion health insurance policy offered as a retirement benefit.
  2. Advantages
     a. An EGHP may offer additional benefits beyond Medicare covered services, such as prescription drugs and yearly physicals.
     b. An EGHP has no health underwriting or waiting periods.
     c. The company may pay part of or the entire premium.
     d. An EGHP may offer coverage for family members.
  3. Disadvantages
     a. Premiums may be expensive. If a person is responsible for the entire cost, it may be more cost-effective to use a different type of supplement.
b. There may be limits to how long a person is allowed to continue coverage.
c. Coverage may not supplement Medicare well.

C. Consolidated Omnibus Budget Reconciliation Act (COBRA)

1. Overview
   a. COBRA coverage is an option to continue employer group health coverage for individuals that are terminated from work or have a reduction in work hours.
   b. COBRA may allow coverage for an employee and dependents.
   c. Coverage may be continued from 18 to 36 months, depending on the situation.
   d. If a person has COBRA and then becomes eligible for Medicare, his or her COBRA coverage will end.
   e. If a person is on Medicare and becomes eligible for COBRA, then COBRA is secondary to Medicare.
   f. The beneficiary has eight months after active employment ends to enroll in Part B. Beneficiaries who do not enroll in Part B within that time frame may face a penalty.

2. Advantages
   a. COBRA may offer additional benefits beyond Medicare covered services, such as prescription drug and yearly physicals.
   b. COBRA has no health underwriting or waiting periods.
   c. COBRA may offer coverage for family members.

3. Disadvantages
   a. Premiums may be expensive. The beneficiary is responsible for 100% of the premium and possibly a 2% administration fee.
   b. There are limits to how long a person is allowed to continue coverage.
   c. Coverage may not supplement Medicare well.

D. Specific Disease or Accident Policy

1. Overview
   This type of policy covers expenses associated with specific diseases, like cancer, or injuries.

2. Advantages
   a. It may not restrict coverage to Medicare approved expenses.
   b. Premiums tend to be inexpensive.

3. Disadvantages
   a. This type of policy only pays in the event of a specific disease or accident.
   b. It may duplicate Medicare coverage.
   c. It may not keep up with inflation.
   d. It may limit total amount of coverage.
E. Tri-Care for Life

1. Overview
   a. Tri-Care for Life is a health insurance for retired military service members and their immediate family.
   b. Tri-Care for Life is for those who served 20 or more years of active military service.

2. Tri-Care for Life
   a. Medicare beneficiaries who are eligible for Tri-Care can use its prescription drug benefit to assist with medication costs. They do not need to enroll in a Part D plan.
   b. Medicare beneficiaries who are eligible for Tri-Care can use it to supplement Medicare.
   c. Tri-Care has no premium but the beneficiary must enroll in Part B.
   d. For more information on Tri-Care, call 888-874-9378 or visit www.tricare.osd.mil

F. Veterans Benefits

1. Overview
   a. Some individuals discharged from active military service are eligible for health care benefits.
   b. There are many different programs administered by the Department of Veterans Affairs. This manual briefly discusses veterans’ medical benefits. For more information on these benefits, call 1-800-827-1000.

2. If eligible for both Medicare and Veterans Benefits, a person must choose where he or she will receive services.

3. Medicare will not pay for services received in a VA facility.

4. The VA will generally not pay for services received outside a VA facility. However, the VA may pay as primary to Medicare if the VA authorizes a service outside of the VA facility.

5. The VA does not require individuals to take out Part B. Keep in mind if a veteran does not have Part B, goes to an ER and is not admitted, he or she is responsible for the cost. Also if a veteran is hospitalized, doctors’ services are a Part B expense.

G. Long-term Care Insurance (LTC)

1. Overview
   a. These policies are designed to provide coverage for care in a nursing home or at a residence that is not covered by Medicare.
   b. Three possible levels of care may be included:
      - Skilled
      - Intermediate
      - Custodial

   Note: There is a Long-Term Care section of this manual.

2. Advantages
   a. Coverage is not restricted to Medicare covered services.
b. Applicants may choose what benefits are included in a policy. For higher premiums, additional benefits may be included.

3. Disadvantages
   a. Coverage is not standardized, so a consumer must carefully compare policies.
   b. Premiums vary according to the age at which a person applies for a policy. Generally, as a person gets older, long-term care policies become more expensive.
   c. This type of policy is subject to strict underwriting limitations.

H. Medigap

1. Overview
   a. Medigap policies are one of eleven standardized plans designed to fill in some of the “gaps” in Medicare. They are Medicare supplement policies.
   b. These policies must be guaranteed renewable.
   c. The benefits must be clearly disclosed.
   d. Benefits from the eleven standardized plans are the same from company to company.
   e. Companies must provide a 30-day “free look” period in which the buyer may cancel the policy without penalty.
   f. Companies may not sell a policy to a person who already has one.
   g. Premiums vary from company to company.

2. Enrollment
   a. Medicare beneficiaries who become eligible at age (65) have a six-month open enrollment period (MOEP) when they first become enrolled in Part B. During those six months, a person can choose whichever policy he/she wants and cannot be turned down.
   b. Disabled beneficiaries (under 65) have two six month open enrollment periods:
      • When they first enroll in Part B, and
      • Beginning the month they turn 65 and have Part B.
   c. All beneficiaries who already have a Medigap policy are eligible for an annual open enrollment. This would allow these beneficiaries to switch insurers each year if they do so during the 60 days surrounding the anniversary date of their policy. They may only change to a like plan – for example, from Plan F at Insurer XYZ to Plan F at Insurer ABC. Insurance companies do allow an individual to change at their discretion to a different plan.
   d. Some companies offer “guarantee issue” policies. These policies are issued to anyone at any age or any health status. These policies are good for those who are not within an open enrollment period and may be in bad health.
   e. Medicare beneficiaries who lose their Medicare Advantage plan or secondary insurance have special rights to purchase a Medigap policy. (See Guarantee Issue Table)

3. Limitations on Coverage
   a. Companies may limit payments on claims within the first six months of coverage if a beneficiary has not been covered by any other health insurance and has pre-existing conditions.
b. The six-month limit for pre-existing conditions must be reduced by the number of months that a person had prior credible health coverage. For example, if a person had Employer Group Health Coverage for 10 years before he retired and picked up Medicare and bought a supplement, then the six-month limitation on coverage would have to be reduced for each month he had coverage at work. Therefore, he would have no pre-existing condition limits.

4. Types of Policies
   a. **No Age Rated Policy** - The same premium for all people, regardless of age.
   b. **Issue Age Rated Policy** - Locks in a premium based on the buyer’s age at the time the policy is bought. People who buy a policy at age 65 will always pay the premium that a person age 65 pays.
   c. **Attained Age Rated Policy** - These are no longer available in Missouri, but they do exist elsewhere. There are still some older plans in Missouri. This type of policy had a scheduled premium increase based on age. A person could start with a lower premium at 65, but the cost would jump at 70 and again at 75, etc.

5. Medicare SELECT Policies
   a. Same 11 standardized policies as regular Medigaps.
   b. Only difference is the beneficiary must use certain providers for the Medigap policy to pay.
   c. Premiums may be lower than for regular Medigap policies.

6. **High Deductible Option Policies (Plans F & H)**
   With these options, the company may charge a lower monthly premium. The beneficiary pays a deductible each year before the supplemental policy pays for any services. Deductible may increase each year.

   As part of MIPPA, Medicare enacted changes to Medigap policies. Four plans (E, H, I and J) would no longer be sold. Beneficiaries with these policies can continue to have them as long as they choose. Two new plans were created M and N. For details on what these plans covered see the coverage charts further in this chapter.

8. **Right to Suspend Medigap Policies**
   a. Beneficiaries under age 65 have the right to suspend or turn off their Medigap policy if she/he becomes eligible for coverage under an Employer Group Health Plan (EGHP). The beneficiary will not pay the premium and the policy will not pay any benefits. With the loss of the EGHP, the beneficiary may reactivate the policy within 90 days without any pre-existing condition exclusions, waiting periods, or underwriting.
   b. Beneficiaries who become eligible for MO HealthNet also have this right within **30 days** of becoming approved. Beneficiaries are allowed to suspend a Medigap policy for up to two years. Again, the beneficiary must notify the Medigap Insurance Company within 90 days of the loss of Medicaid benefits to reactivate the policy without any pre-existing condition exclusions, waiting periods, or underwriting.
### Guarantee Issue Situations

In all below situations, the insurance company cannot:

- Deny you the policy
- Place conditions on the policy, such as waiting periods
- Apply a pre-existing condition exclusion
- Discriminate in the price of the policy based on your health status

### Enrollment Situation | Enrollment Option
--- | ---
You lost your health care coverage because:  
- You permanently moved outside your Medicare Advantage plan’s service area.  
- You were in an EGHP that terminated coverage and was secondary payer to Medicare.  
- You were in an EGHP and voluntarily terminated coverage.  
- Your Medigap insurance company coverage terminated because they were unable to meet financial obligations.  
- You voluntarily leave a plan because it failed to meet its contractual obligations to you. | You must be allowed to purchase Medigap policies A, B, C, F, K or L as long as you apply within 63 calendar days of losing your other health care coverage.

- Your Medicare Advantage plan terminated its Medicare contract or stopped providing services in your area. | You must be allowed to purchase Medigap policies A, B, C, F, K or L as long as you apply by March 4 of the following year.

- You dropped your Medigap policy to enroll in a Medicare Advantage plan or Medicare Select policy **AND**  
  - This was the first time you enrolled in a Medicare Advantage plan, **AND**  
  - You left the Medicare Advantage plan or Medicare Select policy within 1 year of joining. | You must be allowed to return to your original Medigap policy, if it is still available. If it’s not available, you must be allowed to purchase policies A, B, C, F, K or L within 63 calendar days of coverage ending.

- You enrolled in a Medicare Advantage plan when you first became eligible for Medicare and you dis-enrolled within 1 year of joining. | You must be allowed to purchase any Medigap policy (A-N) within 63 calendar days of coverage ending.

- You have Medigap policy E, H, I, or J after June 1, 2010. And wish to change plans. (Missouri protection) | You must be allowed to purchase Medigap policies A, B, C, F, K or L during the month before and month of your policy anniversary date.
### Explanation of Medigap Benefits

| **Basic Benefits (A-N)** | • Coverage for coinsurance for days 61-90  
| | • Coverage for coinsurance for Lifetime Reserve Days 91-150  
| | • Coverage for an additional 365 days of inpatient hospital care  
| | • Coverage for the first three pints of blood  
| | • Coverage for the 20% coinsurance for Part B services  
| | • Coverage of the hospice 5% coinsurance for Medicare-approved charges for inpatient respite care and 5% coinsurance for prescription pain medications |
| **Part A Deductible (B-G & N)** | • Coverage for the inpatient hospital deductible for each benefit period |
| **Skilled Nursing Coinsurance (C-N)** | • Coverage for the skilled nursing coinsurance for days 21-100 |
| **Part B Deductible (C, F)** | • Coverage for the yearly deductible |
| **Part B Excess (F & G)** | • Coverage for Part B charges over the approved amount  
| | • Plans F, I, and J pay for 100% of the excess charge  
| | • Plan G pays for 80% of the excess charge |
| **Foreign Travel Emergency (C-G, M & N)** | • Coverage for emergency care for the first 60 days of a trip outside the US  
| | • Beneficiary pays for a $250 deductible and 20% of the cost (up to $50,000) |

*High Deductible Option*--Plans F and J have a high deductible option. Plans with the high deductible option may have a lower monthly premium. For this type of plan, the beneficiary pays a deductible each year before the supplement pays for any services. This deductible amount is subject to increase each year.
### Medigap Benefits Effective June 1, 2010

<table>
<thead>
<tr>
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<th>C</th>
<th>D</th>
<th>F/F₁</th>
<th>G</th>
<th>K</th>
<th>L</th>
<th>M</th>
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<td>Basic Benefits</td>
<td>Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%*</td>
<td>Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%*</td>
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<td>Part A Deductible</td>
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<td>Part A Deductible</td>
<td>50% of Part A Deductible*</td>
<td>75% of Part A Deductible*</td>
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<td>Skilled Nursing Coinsurance</td>
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<td>75% of Skilled Nursing Coinsurance*</td>
<td>75% of Skilled Nursing Coinsurance*</td>
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<td>Part B Deductible</td>
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<td>Part B Deductible</td>
<td>Part B Deductible</td>
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*Note: Benefits paid at 100% after out of pocket limit is reached.*
## 2009 Medigap Plan Options

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<th>C</th>
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<th>E</th>
<th>F/F¹</th>
<th>G</th>
<th>H</th>
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# Explanation of Medigap Benefits

| Basic Benefits (A-J) | • Coverage for coinsurance for days 61-90  
|                      | • Coverage for coinsurance for Lifetime Reserve Days 91-150  
|                      | • Coverage for an additional 365 days of inpatient hospital care  
|                      | • Coverage for the first three pints of blood  
|                      | • Coverage for the 20% coinsurance for Part B services  
| Skilled Nursing Coinsurance (C-J) | • Coverage for the skilled nursing coinsurance for days 21-100  
| Part A Deductible (B-J) | • Coverage for the inpatient hospital deductible for each benefit period  
| Part B Deductible (C, F, J) | • Coverage for the yearly deductible  
| Part B Excess (F, G, I, J) | • Coverage for Part B charges over the approved amount  
|                        | • Plans F, I, and J pay for 100% of the excess charge  
|                        | • Plan G pays for 80% of the excess charge  
| Foreign Travel Emergency (C-J) | • Coverage for emergency care for the first 60 days of a trip outside the US  
|                            | • Beneficiary pays for a $250 deductible and 20% of the cost (up to $50,000)  
| At Home Recovery (D, G, I, J) | • Coverage for assistance with activities of daily living (bathing and dressing) if a person is receiving home health care paid by Medicare  
|                           | • Coverage for an additional 8 weeks of home health care after skilled care is no longer needed  
|                           | • This benefit is limited to $40 per visit and $1,600 per year  
| Preventive Care (E, J) | • Coverage up to $120 per year for preventive services not covered by Medicare  

*High Deductible Option*--Plans F and J have a high deductible option. Plans with the high deductible option may have a lower monthly premium. For this type of plan, the beneficiary pays a deductible each year before the supplement pays for any services. This deductible amount is subject to increase each year.
I. Tips for Beneficiaries When Choosing a Medigap Policy

**Things to Remember**

- Ask questions of friends and family.
- Insist on a simple outline of coverage from the company or salesperson. Know what you are buying.
- Choose the benefits you want and need. Benefits are standardized in Medigap policies. The “C” policy has exactly the same benefits with any company.
- Compare benefits for different policies before buying. Consider family and medical history.
- Call the Missouri Department of Insurance, Financial Institutions & Professional Registration to ask about the company’s rating.
- Read the policy carefully. If you are unsatisfied, you have a 30-day “free look” period.
- Keep any proof of prior creditable coverage.
- Keep the agent’s name and information for future reference.

**Things to Avoid**

- Don’t feel pressured to buy right away. You have a six month open enrollment period.
- Don’t drop a current insurance policy until you are sure about your new coverage.
- Don’t buy more than one Medigap policy.
- Never pay cash. Always use a check made out to the insurance company, NOT the agent.
- Don’t buy from agents that claim to be from the government. The government does not sell insurance.
- Don’t buy a Medigap policy if you are in a Medicare Advantage plan. They will not work together.
III. Explanation of Terms

**Co-Payment** - Set amount or set percentage you pay for a service.

**Creditable Coverage** - Certain kinds of previous health insurance coverage that can be used to shorten a pre-existing condition waiting period under a Medigap policy (see pre-existing conditions).

**Deductible** - The amount you must pay for a service before insurance begins to pay.

**Guarantee Issue Periods** - Set time frames that can apply when a person is able to purchase a Medigap policy without any medical or financial limitations and the application can not be rejected by a company.

**Guaranteed Renewable** - A right you have that requires your insurance company to automatically renew or continue your Medigap policy unless you make untrue statements to the insurance company, commit fraud, or don’t pay your premiums.

**Medigap Open Enrollment Period (MOEP)** - The six-month time period after enrolling in Medicare Part B in which a beneficiary is guaranteed to be able to buy any Medigap policy without being turned down for any reason. For a disabled beneficiary under 65, they receive two MOEPs: one when first taking Part B and another when turning 65 and have Part B. Once the open enrollment period is started, it can not be stopped.

**Pre-Existing Condition** - A medical condition that has been treated or diagnosed before the date a new insurance policy starts.

**Underwriting** - The process that an insurance company uses to decide, based on your medical history, whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

**Waiting Period** - The set amount of time that an insurance company will not pay benefits due to a pre-existing medical condition.
IV. Section 5 Review

MEDICARE SUPPLEMENTAL POLICIES REVIEW QUESTIONS

1. List three gaps in Medicare Part A coverage.

2. List three gaps in Medicare Part B coverage.

3. What are Medigap supplemental policies? Give one advantage and one disadvantage of these policies.

4. What is indemnity coverage? Give one advantage and one disadvantage of this type of coverage.

5. What are five key points that should be considered when selecting and comparing insurance policies to supplement Medicare coverage?

6. What are pre-existing conditions and waiting periods?

7. Where can an individual receive assistance in comparing insurance policies to supplement Medicare?
Tab Divider named “Section 6 Medicare Advantage”
# Section 6
## Medicare Advantage

<table>
<thead>
<tr>
<th>Section</th>
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<th>Page</th>
</tr>
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<tbody>
<tr>
<td>I.</td>
<td>Overview</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>History</td>
<td>1</td>
</tr>
<tr>
<td>II.</td>
<td>Medicare Advantage Enrollment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>A. Eligibility</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>B. Enrollment Time Frames</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>C. Ways to Enroll</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>D. Medicare Advantage Plan Disenrollment Period</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>E. Ways to Disenroll</td>
<td>4</td>
</tr>
<tr>
<td>III.</td>
<td>Medicare Advantage Options</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>A. Original Medicare</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>B. Health Maintenance Organization (HMO)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>C. HMO with a Point-of-Service Option</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>D. Private Fee-For-Service (PFFS)</td>
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</tr>
<tr>
<td></td>
<td>E. Provider Sponsored Organization (PSO)</td>
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<td>F. Preferred Provider Organization (PPO)</td>
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<td>G. Medical Savings Account (MSA)</td>
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<td>H. Special Needs Plan (SNP)</td>
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<td>IV.</td>
<td>Medicare Advantage Plans and Medicare Prescription Drug Coverage (Part D)</td>
<td>7</td>
</tr>
<tr>
<td>V.</td>
<td>Appeal of Discharge</td>
<td>7</td>
</tr>
<tr>
<td>VI.</td>
<td>Appeal of Denied Claims</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>A. Explanation</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>B. Review - The First Level</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>C. Qualified Independent Contractor (QIC) - The Second Level</td>
<td>8</td>
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<td>D. Administrative Law Judge (ALJ) Hearing</td>
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</tr>
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<td>E. Departmental Appeal Board Review</td>
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</tr>
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<td>F. Judicial Review by the Federal Court</td>
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</tr>
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<td>G. Tips for Beneficiaries When Choosing a Medicare Advantage Plan</td>
<td>10</td>
</tr>
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<td>VII.</td>
<td>Explanation of Terms</td>
<td>11</td>
</tr>
<tr>
<td>VIII.</td>
<td>Section 6 Review</td>
<td>12</td>
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I. Overview

History

1. On Aug. 5, 1997, President Clinton signed into law the Balanced Budget Act (BBA). This law was designed to balance the budget by 2002, cut taxes, and extend the solvency of the Medicare Trust Fund.
2. In an effort to shift costs away from the Medicare Trust Fund and respond to demands for more choices in healthcare, Medicare Advantage options were created.
3. Medicare Advantage plans are private insurance companies that contract with Medicare to replace standard Original Medicare benefits. These private companies are responsible for all aspects of a beneficiary’s health care: from enrollment in the plan, issuing proof of insurance, determination of medical necessity, processing claims, and payment to providers. This chapter explains the different types of plans available.
4. Medicare pays a set amount for every enrolled member to the Medicare Advantage plan.

II. Medicare Advantage Enrollment

A. Eligibility

1. Members must be entitled to Part A and enrolled in Part B.
2. Members must not have End Stage Renal Disease (ESRD) at the time of initial enrollment, unless enrolling in a Special Needs Plan (See section H, below).
3. Members must live within the defined service area.
4. Members enrolling in a Special Needs Plan must meet the plan’s enrollment criteria, i.e., have a particular medical condition or financial circumstance.

B. Enrollment Time Frames

1. The Annual Coordinated Election period is Oct. 15 through Dec. 7. Beneficiaries may choose to enroll in a Medicare Advantage plan, switch to another Advantage plan or return to Original Medicare. Changes become effective Jan. 1.
2. A beneficiary may enroll during their Initial Enrollment Period. This period begins three months before the beneficiary’s 65th birthday, and ends three months after.
3. If the beneficiary is younger than 65 and disabled, the enrollment period begins three months before she becomes eligible for Medicare and ends three months after.
4. Enrollment period rules do not apply when:
   a. A Medicare health plan leaves an area.*
   b. Beneficiary moves out of a plan’s service area.*
   c. Beneficiaries are new to Medicare or are newly-eligible to join a Medicare health plan.
   d. Beneficiaries qualify for the low income subsidy or Extra Help.
5. Beneficiaries who qualify may enroll a Special Needs Plan anytime during the year.
6. For plans ranked as five-star plans based on Medicare’s Plan Performance Ratings, individuals can enroll from Dec. 8 through Nov. 30 of the year the plan is so designated. Only one such enrollment is allowed annually.

7. Medicare has the ability to allow special enrollment periods (SEP) as necessary.

See Special Enrollment Period Table for additional opportunities (end of Section 7).

*Beneficiary qualifies for a Medicare supplement guarantee issue (see Guarantee Issue Situations chart in Section 5, Page 7).

C. Ways to Enroll

- Submitting a paper application to the plan
- Making a phone call to the plan
- Using the Medicare Plan Finder on the Medicare.gov website, if plan allows
- Calling 1-800-Medicare (800-633-4227)

D. Medicare Advantage Plan Disenrollment Period

During the Medicare Advantage Disenrollment Period (Jan. 1 – Feb. 14) a beneficiary can only change back to Original Medicare.

A beneficiary can disenroll from their current Medicare Advantage plan and return to Original Medicare with a prescription drug plan between Jan. 1 and Feb. 14 of every year. Changes are effective the first day of the following month. After the disenrollment period has closed, beneficiaries are usually locked into their plan choice until the next year. (See the table on the next page which shows the change options available.) They can also add a Stand Alone Part D plan if they have not been previously enrolled in one. This can be done in two steps if necessary.

**Example:** Beneficiary calls 1-800-Medicare to drop Advantage Plan and then calls us to enroll in Part D plan. The disenrollment and Part D enrollment must have the same effective date. Disenrollment in January and do Part D enrollment in January, effective date Feb. 1, 2011.

The exception to this rule is a beneficiary with Low-Income Subsidy or “Extra Help.” They are allowed to change every month if they want to. This allows them to switch from Original Medicare with a Part D plan to a Medicare Advantage Plan with Part D, one month and the next month switch to another Medicare Advantage Plan with Part D. Other special enrollment periods may apply.

Another possibility after the Medicare Advantage Disenrollment Period is for a person to join a Special Needs Plan. He or she must qualify to enroll in the plan and they can enroll at any time during the year. Only one enrollment a year is allowed.
<table>
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<tr>
<th>If coverage is</th>
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<tr>
<td>Medicare Advantage with prescription drug coverage (MA-PD)</td>
<td>• MA-PD</td>
<td>• Original Medicare and must enroll in Stand Alone PDP</td>
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<td></td>
<td></td>
<td>• and Medigap if approved by Medigap Company, {GI rules may not apply}</td>
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<tr>
<td>Medicare Advantage Plan with Stand Alone Drug Plan (PFFS with PDP)</td>
<td>• MA-PD</td>
<td>• Original Medicare</td>
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<td>• MA plan with stand alone drug plan</td>
<td>• Must keep Stand Alone Part D plan</td>
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<td>• and Medigap if approved by Medigap Company, {GI rules may not apply}</td>
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<td>• Original Medicare and Stand Alone PDP</td>
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<td>• MA-PD</td>
<td>• Original Medicare Only</td>
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<td>• MA-PD</td>
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<td>• PFFS with current drug plan</td>
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<td>Original Medicare, Medigap policy, and prescription drug plan (PDP)</td>
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<td>• Must stay in current coverage</td>
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<td>• PFFS with current drug plan</td>
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<td>Original Medicare only (No Part D coverage)</td>
<td>• MA-only</td>
<td>• Must stay in current coverage</td>
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<tr>
<td>Original Medicare and Medigap Policy only (No Part D coverage)</td>
<td>• MA-only</td>
<td>• Must stay in current coverage</td>
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</table>
E. Ways to Disenroll

1. **Online:** With the creation of Medicare Prescription Drug Coverage, it has become easier to drop Medicare Advantage plan coverage by enrolling in another plan via the Medicare website. Enrollment in another Advantage Plan or enrollment in a Medicare Prescription Drug Plan will send an automatic disenrollment notice to the previous plan and provide the beneficiary with a confirmation number for the new enrollment. As a back-up option to the enrollment, the beneficiary may send a registered letter to the previous Advantage Plan, informing them of the change to the new coverage/plan; along with the formal request to dis-enroll the beneficiary from that plan.

2. **Phone-Mail:** A beneficiary may also contact the Advantage Plan via phone and request a disenrollment. The Advantage plan will often request the beneficiary make the request in writing. A form may have to be used or a simple letter stating the facts may suffice. Always remind beneficiaries to keep copies.

3. **Call 800-Medicare (1-800-633-4227):** The beneficiary can also call the Medicare Help line to make a change. This will also generate notice to the plan that is being dropped.

III. Medicare Advantage Options

A. Original Medicare

1. Original Medicare continues to be the default option. If there are no Medicare Advantage organizations in an area, Original Medicare continues to provide health care coverage.
2. If a person does not want to change, no action is necessary.

Medicare Advantage plans are private insurance companies that contract with Medicare to replace standard Original Medicare benefits. The private company is responsible for all aspects of a beneficiary’s health care from enrollment in the plan, issuing proof of insurance, determination of medical necessity, processing claims, and payment to providers. Members may have to pay a monthly premium, in addition to the Part B premium they are required to continue paying. Medicare pays a set dollar amount for every enrolled member to the Medicare Advantage plan. Members are responsible for cost sharing as determined by their plan for services received.

**Counseling Note:** This MO HealthNet program will only pay for Medicare Advantage Plan cost sharing (deductibles, coinsurance, and copayment) for participants in QMB and QMB plus. QMB plus participants have resources at the MO HealthNet level.
B. Health Maintenance Organization (HMO)

1. These are Medicare plans offered by private insurance companies.
2. Member must coordinate all their care through primary care physicians and must receive a referral to see a specialist and for certain medical procedures.
3. A member must use network providers (physicians, hospitals, home health, etc.), except in an emergency.
4. The HMO may offer additional benefits beyond original Medicare, such as dental benefits.
5. If the HMO does not offer Prescription Drug Coverage a beneficiary cannot join a stand-alone Medicare Prescription drug plan.

C. HMO with a Point-of-Service Option

1. This plan operates very similar to the Health Maintenance Organization.
2. Point-of-Service allows a person to choose a provider outside the network.
3. Care received out-of-network will be subject to higher cost sharing.
4. If the HMO -POS does not offer Prescription Drug Coverage a beneficiary cannot join a stand-alone Medicare Prescription drug plan.

D. Private Fee-For-Service (PFFS)

1. This type of plan resembles Original Medicare in that it pays the provider for each service delivered. Enrollees are not limited to a set network of providers.
2. The Plan sets co-payment rates for the services members receive.
3. The insurance company determines reimbursement rates for providers. Providers decide on a per-visit basis if they will accept the plan’s payment terms and conditions. If the provider treats the beneficiary without agreeing to accept the plan’s terms, he or she must still bill the PFFS plan. (Plans are now establishing networks of providers to resolve per visit basis acceptance. Members will still be allowed to go out of network for higher cost sharing.)
4. The beneficiary is responsible for any co-payments, deductibles or coinsurance and up to 15% more than the plan’s payment amount for services, if the plan allows balance billing.
5. These may offer additional benefits beyond those of Original Medicare.
6. Private Fee for Service plans may or may not offer Prescription Drug (Part D) benefits. If a plan does not have prescription drug coverage a beneficiary may enroll in a stand-alone Medicare Prescription drug plan.
E. Provider Sponsored Organization (PSO)

1. A PSO is a health plan owned or controlled by a provider or group of providers within a community.
2. A PSO utilizes the managed care setting, while keeping local operating control.
3. A PSO may offer additional health care benefits.
4. Rules for forming PSOs are less stringent in order to encourage Managed Care Organizations to enter rural settings.
5. If the PSO does not offer Prescription Drug Coverage a beneficiary cannot join a stand-alone Medicare Prescription drug plan.

F. Preferred Provider Organization (PPO)

1. A PPO is a Medicare plan offered by private health insurance companies.
2. The insurance company is responsible for providing health care coverage to all members of this plan.
3. To receive benefits, members must choose from preferred providers but can also go to providers out of the network.
4. Health care received out of network will be subject to higher cost sharing.
5. Beneficiaries may see specialists without seeing a primary care physician first.
6. A PPO may offer additional health care benefits beyond those offered by Original Medicare, such as vision and hearing screenings.
7. If the PPO does not offer Prescription Drug Coverage a beneficiary cannot join a stand-alone Medicare Prescription drug plan.

G. Medical Savings Account (MSA)

1. A beneficiary will establish a Medical Savings Account with a financial institution and enroll in a high-deductible, catastrophic health plan.
2. Medicare will pay the premium for the health plan on a monthly basis.
3. Medicare will also make yearly deposits into the Medical Savings Account.
4. The beneficiary will use the money from the Medical Savings Account to pay for “qualified medical expenses” (as defined by the IRS).
5. Once medical expenses total more than the deductible, the insurance plan will make payments on health care services.
6. Money accumulates in the account each year, if unused.
7. Money from the MSA may be used for a broad range of medical expenses, not just the services covered by Medicare.

H. Special Needs Plan (SNP)

1. The Special Needs Plan will be one of the above options, other than a Medical Savings Account.
2. To enroll, a beneficiary must meet the special criteria set by the plan and Medicare. The special criteria could be a medical condition or financial status. The plan is responsible for verifying the beneficiary’s special need. Examples:
   a. The beneficiary has lived in nursing home for over 90 days
   b. The beneficiary has Chronic Heart Failure
4. Beneficiaries can join these plans at any time during the year.

IV. **Medicare Advantage Plans and Medicare Prescription Drug Coverage (Part D)**

All Advantage plans have the option to provide prescription drug coverage. If a plan decides to offer the coverage, it is bound by the same rules as all stand-alone Medicare prescription plans:
1. Out of pocket maximums
2. Having formularies
3. Pharmacy networks
4. Appeals and exceptions

Advantage plans may offer a plan with Part D coverage and a plan without Part D coverage. Medicare approves all Medicare Advantage Plan benefit packages, premiums, and co-pays on a yearly basis.

Counseling Note: Medicare Advantage Plans and MO HealthNet Benefits

Beneficiaries covered by MO HealthNet (Medicaid) should carefully consider Medicare Advantage plans before enrolling. Currently, MO HealthNet will only cover the Advantage Plan deductibles, co-payments, and co-insurance for beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program or the QMB plus program (resources must be low enough for full Medicaid benefits). Providers must participate in both the Advantage and MO HealthNet.

V. **Appeal of Discharge**

Due to the nature of the Prospective Payment System (PPS), there was concern patients might not receive appropriate services or treatment, or might not be admitted to an appropriate level of care. There was also concern they might be discharged before they are medically ready. Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) are given the task of monitoring these issues. Beneficiaries and/or their family members have the right to appeal any discharge from Medicare covered services. The detailed description of the discharge appeal process is located in Section 3.
VI. Appeal of Denied Claims

Medicare Advantage plans are responsible for processing all of their members’ claims. Benefits may be the same as Original Medicare coverage or better.

A. Explanation

1. When an Advantage Plan denies payment for a service, the beneficiary has the right to appeal the decision.
2. Each level of appeal has its own guidelines and time constraints.
3. A beneficiary is always given information on how to appeal or further appeal a decision. See the plan’s membership materials or contact the plan for additional details about Medicare appeal rights.
4. The appeal information in this manual is strictly for beneficiaries. Health care providers have their own information on how to file an appeal.

B. Review - The First Level

1. An appeal must be started within 120 days of receipt of the initial determination. This determination is the Medicare Summary Notice or the Explanation of Medicare Benefits.
2. Anyone can initiate a review.
3. The request for a review must be made in writing.
4. There is no minimum dollar amount of a claim for review.
5. The Advantage Plan conducts the review.

C. Qualified Independent Contractor (QIC) - The Second Level

1. A request must be filed within 180 days of the review denial.
2. The amount of the claim in question must be at least $150.
3. The Independent Review Entity conducts the reconsideration.

D. Administrative Law Judge (ALJ) Hearing

1. A request must be filed within 60 days of the denial from the hearing.
2. The amount of the claim in question must be at least $150.
3. The Bureau of Hearings and Appeals schedules a hearing with an ALJ.

E. Departmental Appeal Board Review

1. A request must be filed within 60 days of the denial from the hearing.
2. This council is a three-person panel in Washington, D.C. They can choose whether or not to continue the appeal.
F. Judicial Review by the Federal Court

1. A request must be filed within 60 days of the denial from the review council.
2. The amount in question must be at least $1,430.
3. A civil action must be filed in federal court, which may require attorney services.

<table>
<thead>
<tr>
<th>Type of Action</th>
<th>Time Limit</th>
<th>Amount in Question</th>
<th>Jurisdiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconsideration</td>
<td>120 Days</td>
<td>No minimum</td>
<td>Advantage Plan</td>
</tr>
<tr>
<td>QIC Review</td>
<td>180 Days</td>
<td>$150</td>
<td>QIC Review</td>
</tr>
<tr>
<td>ALJ Hearing</td>
<td>60 Days</td>
<td>$150</td>
<td>Bureau of Hearings and Appeals</td>
</tr>
<tr>
<td>Departmental Appeal Board Review</td>
<td>60 Days</td>
<td>$150</td>
<td>Office of Hearings and Appeals at SSA</td>
</tr>
<tr>
<td>Judicial Review with the Federal Court System</td>
<td>60 Days</td>
<td>$1,460</td>
<td>U.S. District Court</td>
</tr>
</tbody>
</table>
G. Tips for Beneficiaries When Choosing a Medicare Advantage Plan

**Things to Remember**

- Ask questions of friends and family.
- Insist on a simple outline of coverage. Know what you are buying.
- Choose the benefits you want and need. Remember, plans may offer additional benefits.
- Compare costs and benefits for different plans and different companies before enrolling in a plan.
- Read the plan carefully.
- Keep the agent’s name and information for future reference.
- Check with your medical providers to verify they accept your plan and are in network including doctor, hospital, skilled nursing facility, and/or durable medical equipment provider.
- Carefully consider before buying a Medicare Advantage plan if you have Mo Healthnet (Medicaid). Currently, MO HealthNet will only cover the Advantage Plan deductibles, co-payments, and co-insurance for beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program or the QMB plus program (resources must be low enough for full Medicaid benefits). Providers must participate in both the Advantage and MO HealthNet.

**Things to Avoid**

- Don’t feel pressured to buy right away.
- Don’t drop a current insurance policy until you are sure about your new plan.
- Don’t join more than one Medicare Advantage Plan.
- Never pay cash. Always use a check made out to the insurance company, NOT the agent.
- Don’t buy from agents that claim to be from the government. The government does not sell insurance.
- Don’t buy a Medigap policy if you already have a Medicare Advantage plan. They will not work together.
- Check with any EGHP coverage to see if it will work with an Advantage Plan.
VII. Explanation of Terms

Co-Payment - A set fee that an enrollee may be required to pay for covered services. This fee is usually outlined in the statement of benefits for the Medicare Advantage organization.

“Lock-In” - A term used to describe the restrictions of managed care members to only use network providers.

Managed Care Plan - A health insurance plan designed to coordinate benefits through primary care physicians and network providers.

Managed Care Plan with Prescription Drug Coverage (MA-PD) - A managed care plan that offers Medicare prescription drug coverage (Part D)

Medicare Advantage Open Enrollment Period (MA-OEP) - January 1 to March 31 of every year. A beneficiary can switch between Medicare health plans only one time during this time frame.

Network - A group of physicians, hospitals, and other health care professionals who provide health care services for managed care members.

Point-of-Service - An option in a managed care plan that allows members to receive health care services out of network for an additional cost.

Primary Care Physician - Also known as a gatekeeper, the primary care physician is the physician responsible for coordinating a person’s care in a managed care plan.

Prior Authorization - When a managed care member must obtain pre-approval for all elective surgeries and certain non-emergency procedures.

Qualified Independent Contractor (QIC) - Second level of Medicare appeals.

Service Area - A geographic area in which a beneficiary must live in order to be eligible for enrollment in a Medicare Advantage Organization.
VIII. **Section 6 Review**

**MEDICARE ADVANTAGE PLANS REVIEW**

1. List three advantages of Medicare Advantage Plans.

2. List three disadvantages of Medicare Advantage plans.

3. Define the following:
   - **Prior Authorization:**
   - **Lock-in:**
   - **Service area:**

4. What are the criteria for joining a Medicare Advantage Plan?

5. A disabled Medicare beneficiary under the age of 65 has approached you about Medicare Advantage plan. Will the Advantage plan enroll the beneficiary?

6. There are several oddities that occur in managed care. What are some things that you might educate your client about prior to their joining a Medicare Advantage Plan?
MEDICARE ADVANTAGE COUNSELING EXERCISES

1. Mr. Skip A. Lot joined Happy Health HMO five months ago but is now unhappy that his doctor is no longer a contracted provider. He is considering moving to Healthy Choice HMO. What should he do to disenroll from Happy Health HMO?

2. Ms. Ima Sickie is taking the drug Proscar. When she went to her pharmacy to pick up the drug she was told that her PPO no longer covered that drug and that she owed $56.00 for the drug. Ms. Sickie cannot afford the $56.00 per month for her drug what are some options that she has?

3. George Smith had Medicare and a Medigap policy “D.” He is interested in joining Medicare Advantage plan in his area. How would you help him compare costs and coverage? What other things should he consider before he switches coverage?
Tab Divider named “Section 7 Medicare Part D”
Section 7
Medicare Part D

I. Overview
   A. History

II. Basic Prescription Coverage
   A. Cost Sharing Requirements:
   B. Eligibility for Medicare Prescription Drug Coverage (Part D)
   C. Enrollment
   D. Utilization Management by Drug Plans
   E. Transition drug refills
   F. Low Income Subsidy (LIS or “Extra Help”)
   G. Missouri Rx (MORX) - Missouri’s State Pharmacy Assistance Program (SPAP)
   H. How do we help beneficiaries choose a drug plan?
   I. How to enroll/change plans
   J. Coordination of benefits with other drug coverage
   K. Coordination with other individual health insurance plans with prescription drug benefits

III. Appeals
   A. Explanation
   B. Re-Determination – The First Level
   C. Qualified Independent Contractor (QIC) – The Second Level
   D. Administrative Law Judge Hearing
   E. Medicare Appeals Council
   F. Judicial Review

IV. Explanation of Terms

The following documents are located at the end of this section:
- Special Enrollment Period Chart;
- Medicare Drug Coverage Under Parts A, B and D; and
- Model Coverage Determination Request Form
I. Overview

A. History

1. On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug Improvement and Modernization Act (MMA), which added coverage of prescription drugs to Medicare’s benefits and updated other areas of Medicare’s coverage.


II. Basic Prescription Coverage

Medicare has set a minimum level of coverage that all Medicare Prescription Drug Plans and Medicare Advantage Prescription Drug Plans are required to offer to beneficiaries. Basic Prescription Drug coverage provides access to covered Medicare prescription drugs selected by the plan for inclusion in its formulary.

A. Cost Sharing Requirements:

**Premiums** - All Medicare prescription drug plans have a premium. Beneficiaries with lower incomes and assets may qualify for assistance in paying the premiums and have lower cost sharing. Medicare Advantage Plans with drug coverage can charge a premium at the plan’s discretion.

**Annual Deductible** - Every year Medicare will establish the current year Drug Plan deductible. The beneficiary must pay this amount on covered medication before the plan will begin to pay. This amount is counted toward the yearly true out-of-pocket maximum (also called TROOP, see below). The deductible starts over every January.

**Co-Pays** - The beneficiary pays 25% of the cost of the drugs covered on the drug plan’s formulary or specific co-pay, until she/he has spent up to the yearly initial coverage limit while the plan pays 75% of the drug costs. This amount is counted toward the yearly out of pocket maximum (TROOP).

**Coverage Gap** - Period when the beneficiary pays 100% of the cost of his/her covered prescription drugs until he/she spends up to the yearly total out of pocket maximum on prescription drugs that are on the drug plan’s formulary. This amount is counted toward the yearly out of pocket maximum (TROOP).
**Catastrophic Benefit** - Period after the beneficiary has met the true out of pocket maximum (TROOP) cost for the year. Now the beneficiary has minimal cost sharing; either a 5% co-insurance or a small co-payment, whichever is greater. The drug plan covers the remainder of the cost of drugs covered on the plan’s formulary for the rest of the calendar year.

<table>
<thead>
<tr>
<th>Part D Costs During the Calendar Year</th>
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<tbody>
<tr>
<td><strong>Deductible Phase</strong></td>
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<tr>
<td>You meet your Part D deductible (if your plan has one), before your plan begins to cover the cost of your drugs.</td>
</tr>
</tbody>
</table>

**Doughnut Hole**: You fall IN, after you & your plan have paid a certain amount for your drugs. You get OUT, after you have paid a certain amount for your drugs.

Medicare Prescription Drug Plans and Medicare Advantage Prescription Drug Plans can also offer additional benefits or make changes to the basic coverage such as:

1. Eliminate the deductible
2. Set co-payments for medications, or
3. Offer coverage during the coverage gap.

All the above options are available in the Medicare Drug Plans and Medicare Advantage Prescription Drug Plans offered in Missouri. However, no matter what changes a plan makes to the basic coverage, once a beneficiary meets the out of pocket maximum, the coverage must change to the catastrophic level. At the catastrophic level plans cover the medications at 95%; the beneficiary is responsible for small co-pays or 5% of the medication cost whichever is greater.

**True Out-of-Pocket Costs Include:**

- Beneficiaries’ out-of-pocket expenses including the annual deductible and co-insurance amounts (including 100% of the cost of the prescription while in the coverage gap)
- Beneficiary spending using health savings accounts (HSAs), flexible spending accounts (FSAs), and medical savings accounts (MSAs)
- Contributions from friends or relatives
- Contributions from certain charitable foundations
- Waivers or reductions by pharmacies of the cost-sharing requirements of Medicare drug benefit plans
- Payments by federally qualified state-funded only programs (SPAPs) – Missouri Rx
- Amount paid by state programs that receive federal funding such as AIDS Drug Assistance Programs (ADAPs)
True Out-of-Pocket Costs Do NOT Include:

- Monthly premiums paid to the Part D plan
- Amount paid by other insurance plans
- Amount spent for prescription drugs that are not covered by the Medicare drug benefit plan
- Over the counter medications
- Drugs excluded by Medicare
- Medications not on the plans formulary unless a coverage exception has been granted.

1. What medications are covered?
   a. Must be available only by prescription
   b. Must be approved by the US Food and Drug Administration
   c. Must be used for a medically accepted indications
   d. Covered items include:
      - Prescription drugs
      - Biological products – Botox, estrogen, testosterone
      - Insulin
      - Medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs and gauze. (Diabetic testing strips and lancets are covered under Part B with the exception of beneficiaries residing in a skilled nursing facility or nursing facility).
   e. Medicare Part B pays for some medications that are “incident to” a physician service (i.e., the drug is furnished by the physician and administered either by the physician or a staff member under physician supervision). See additional chart regarding different medications and Part B/D coverage at end of section.

2. Medications excluded from Medicare Prescription Drug coverage include, but are not limited to, the following:
   a. Anorexia, weight gain and/or loss drugs
   b. Cosmetic purposes or hair growth drugs
   c. Drugs used for symptomatic relief of cough and colds
   d. Non-prescription or over the counter medications
   e. Prescription vitamins and minerals products with the exception of prenatal vitamins and fluoride preparations
   f. Drugs covered under Medicare Part A or Part B
   g. Fertility drugs
   h. Drugs that must be monitored by testing services that only the manufacturer provides, such as certain anti-psychotic medications

Additional listing of non-covered medications and medication coverage situations is included in a chart at end of section.
B. Eligibility for Medicare Prescription Drug Coverage (Part D)

1. Members must be entitled to and enrolled in Part A and/or Part B.
2. Members must live in defined region for a Medicare Prescription Drug Plan or Medicare Advantage Prescription Drug Plan. Missouri is its own region (Region 18).
3. Beneficiaries must enroll in a Medicare Prescription Drug Plan (PDP) or enroll in a Medicare Advantage Prescription Drug Plan (MA-PD) to get the drug coverage.
4. Individuals that qualify for coverage through both Medicare and Medicaid benefits (dual eligible) are required to join a Medicare Prescription Drug Plan or Medicare Advantage Prescription Drug Plan. Medicare has taken over the responsibility for paying for most prescription drugs for Medicare and Medicaid recipients.

C. Enrollment

1. The annual coordinated election period changed in 2011 to October 15th to December 7th. The new plan will take effect January 1st.
2. Once a person enrolls in a plan he/she will then be locked into their Medicare Drug Plan and the drug coverage for the next calendar year. They will be able to change Medicare Drug Plans or drop the drug coverage every year during annual coordinated election period. There are certain times when the lock-in rules do not apply and a person may change plans or enroll during the year:
   a. Medicare Drug Plan leaves an area
   b. Beneficiary leaves a plan’s service area
   c. Beneficiary is new to Medicare or newly eligible to join a Medicare Drug Plan
   d. Beneficiary is dual-eligible
      - Dual-eligible beneficiaries currently have continuous open enrollment
      - May change to a new drug plan every month in order to ensure they have coverage (Medicaid, QMB, SLMB and QI-1)
   e. People who recently became eligible for Medicare
      - Enrollment period is the same as signing up for Medicare at age 65 - seven months surrounding their initial enrollment period into Medicare; three months before eligibility, the month of eligibility and three months after eligibility.
3. **Special Enrollment Periods (SEP)** - the following situations allow an individual to change Prescription Drug Plans within 60 days of losing coverage unless noted.

   a. Individual permanently moves out of a plan’s service area
   b. Involuntary loss, reduction, or disclosure of non-credible coverage
      - Person with Medicare was not adequately informed that their coverage was not creditable or that their current coverage was reduced and is no longer creditable
      - This does not apply to loss of coverage due to non-payment of premiums
   c. When an individual is entering, residing in, or leaving a long-term care facility
      - Can change every month
   d. Exceptional circumstances - such as when a Prescription Drug Plan (PDP) terminates its contract or PDP violates its contract with Medicare
   e. Person is newly approved to receive the extra help in paying for the benefit
   f. Individuals whose Medicare eligibility determination is made retroactively
      - SEP begins the month the individual receive the notice of the Medicare entitlement determination and continues for two additional months
      - Enrollment cannot be retroactive. Enrollment will begin the month following the PDP receives a completed enrollment application
   g. Individuals who enroll in Part B only and do not qualify for premium-free Part A and enroll during General Open Enrollment (Jan-March)
      - Enrollment period begins April 1 and ends June 30 with the effective date being July 1
   h. Individuals who qualify for Extra Help but who are not dual eligible, receive SSI benefits or qualifies for the higher levels of Extra Help (15% co-payments)

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**Example:** Mrs. Sparrow is turning 65 on June 25th. She is eligible for Medicare June 1st. When is her initial enrollment period?

**Answer:** Three months before her Medicare enrollment date: March, April, and May (benefits start June 1st), the month of June (benefits start July 1st), and three months following June (July, August, and September). For July enrollment, benefits will start August 1st. For August enrollment, benefits start September 1st, and for September enrollment, benefits begin October 1st.

<table>
<thead>
<tr>
<th>Enroll Date</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>March</td>
<td>June 1</td>
</tr>
<tr>
<td>April</td>
<td>June 1</td>
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<td>May</td>
<td>June 1</td>
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<td>August</td>
<td>September 1</td>
</tr>
<tr>
<td>September</td>
<td>October 1</td>
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</tbody>
</table>
- If Medicare facilitated their enrollment in a plan, they may change to a different plan once from when the facilitated plan went into effect until December 31st of that year.
  i. Beneficiaries enrolled in State Pharmacy Assistance Programs (SPAP) or Missouri Rx can change plans once a year or those new to a SPAP can enroll in a Part D plan at any time during the year.
  j. Individuals can enroll in any Medicare Advantage plan or Part D plan beginning December 8th through November 30th of the year the plan is considered a five-star plan based on Medicare’s Plan Performance Ratings as listed on Medicare.gov.
  k. Medicare has the ability to allow special enrollment periods (SEP) as necessary.

A list of the current SEPs is located at the end of this chapter.

4. Penalty
   a. As with all Medicare coverage, if a beneficiary does not take advantage of the coverage offered, without having other coverage that is as good as or better than Medicare’s coverage, a late enrollment penalty will be accessed.
   b. The penalty is one percent (1%) per month of the year’s national average premium that a beneficiary does not enroll and does not have coverage by another insurance that is as good as or better than Medicare’s standard drug plan benefit. Medicare makes the final determination on the penalty amount. The beneficiary does have the right to appeal the determination.
   c. If you had to pay a Part D late enrollment penalty before you turned 65, the penalty will be waived once you reach 65.

Example: For the 2007 plan year the national average premium is $27.35. For beneficiaries that did not sign up before May 15, 2006, they will have a 7% penalty if they enrolled by December 31, 2006. The penalty will be $1.91 added on the monthly premium of his/her chosen drug plan. The penalty once assessed, will continue for as long as the beneficiary is enrolled in coverage.

D. Utilization Management by Drug Plans

In addition to the use of formularies (lists of preferred medications), Medicare Prescription Drug Plans and Medicare Advantage Prescription Drug Plans use “utilization management” to control costs. Utilization management includes special requirements like prior authorization, step therapy, or quantity limits to manage how drugs are provided to members and the cost of medications to members of a plan. Following is a description of each of these techniques.

1. Prior Authorization - Medications that require prior approval. These medications generally have:
   a. Adverse side effects
   b. Are rarely prescribed because other medications are available, or
   c. Are prescribed for special conditions.
Note: A member’s doctor must submit medical documentation to a drug plan regarding the reason for prescribing the medication before the plan agrees to authorize payment. The requirements for prior authorization will very by plan. Beneficiaries should review membership materials or drug plans’ website for details and instructions.

2. **Cost Sharing Tiers** - Allow a plan to charge the member larger co-pays for the medications that cost the plan more to cover. Frequently used medications that have been on the market for years typically cost less than those new to the market. Therefore, a less expensive medication is given a lower tier level. As the tier goes up, the member’s cost share increases.

   **Examples:**
   - Tier 1 medications - generics
   - Tier 2 medications - frequently used name brand medication
   - Tier 3 medications - name brand drug
   - Tier 4 medications - rarely prescribed name brand medication

3. **Quantity Limits** - Restriction(s) to the amount of medication issued at one time. These limits may be set by the drug manufacture or a drug plan. If the amount of medication prescribed is above the quantity limit, a drug plan will request medical documentation why the beneficiary requires the additional amount.

4. **Step Therapy** - requires documentation that a beneficiary has tried other lower cost treatment options without success, before a higher cost medication is authorized for payment.

Beneficiaries, along with their medical providers and pharmacists, can submit requests concerning all of these utilization management techniques. Assistance can also be provided by friends, family, and CLAIM volunteers.

All drug plans may have different processes to request exceptions to these measures. A beneficiary should follow the rules outlined by his/her drug plan. The request can be made orally and/or in writing. Forms for whatever type of exception necessary are often located on a drug plan’s website. General forms may also be used (provided at the end of this chapter). All drug plans are mandated to respond to these requests within certain timeframes. Standard requests should be answered within 72 hours and emergency requests within 24 hours. The clock on these times starts when the drug plan receives the supporting documentation for the request.

**E. Transition drug refills**

A transition refill, also known as a transition fill, is typically a one-time, 30-day supply of a drug that Medicare drug plans must cover when you’re in a new plan or when your existing plan changes its coverage. Transition fills let you get temporary coverage for drugs that aren’t on your plan’s formulary or that have special requirements on them. Transition fills aren’t for new prescriptions. You can only get transition fills for drugs the beneficiary was already taking before switching plans or before their existing plan changed its coverage.
All Medicare Part D drug plans (PDPs and MAPDs) must cover transition fills. When you use your transition fill, the beneficiary’s’ plan must send them a written notice within three business days. The notice will tell them that the supply was temporary and that they should either change to a covered drug or file a request with the PDP or MAPD (called an exception request) to ask for coverage. The Request for Medicare Prescription Drug Coverage Determination form can be found at end of this section.

The rules for transition fills are different depending on whether or not the beneficiary lives in a nursing home. The following situations describe when they can get a transition refill if you do not live in a nursing home and what action your plan must take.

1. The beneficiary is an existing member of a plan that is changing how it covers a Medicare-covered drug they have been taking.
   - If the plan is taking a drug off its formulary for the next calendar year for reasons other than safety, then the plan must either:
     - Help them complete the exceptions process (start an appeal) before January 1, or
     - Help them switch to a similar drug that is on their plan’s formulary before January 1, or
     - Give them a 30-day transition fill within the first 90 days of the new calendar year along with a notice that the drug is no longer covered.
   - If the plan is adding step therapy or prior authorization to the drug for the next calendar year, then the plan must:
     - Help them complete the exceptions process (start an appeal) before January 1, or
     - Help them switch to a similar drug that is on their plan’s formulary before January 1, or
     - Give them a 30-day transition fill without applying the restriction within the first 90 days of the calendar year along with a notice about the new restriction.

2. The beneficiary is new to a plan and the plan doesn’t cover a Medicare-covered drug they have been taking.
   - If it’s not covered because the drug isn’t on the new plan’s formulary, then the new plan must:
     o give them a 30-day transition fill within the first 90 days they’re enrolled in the plan, and
     o give them a transition notice that says they’re using the transition fill and informs them of their appeal rights.
   - If the drug is on their new plan’s formulary but isn’t covered because it has step therapy or prior authorization restrictions, then the new plan must:
     o give them a 30-day transition fill without applying the restriction during the first 90 days they’re enrolled in the plan, and
     o give them a transition notice that says they’re using the transition fill and informs them of their appeal rights.
When the beneficiary gets the transition fill, they should call their doctor right away to talk about switching to a drug that is on the plan’s formulary without restrictions. If no other drug will work for them, ask their doctor for help requesting an exception to their Medicare Part D drug plan’s formulary. Requesting an exception means to formally ask the plan to cover the drug.

If they request a coverage exception but it has not been processed by the end of the 90-day transition fill period, the plan must provide more temporary refills until the exception is completed.

If the beneficiary lives in a nursing home and joins a new Medicare drug plan that doesn’t cover their drugs or has restrictions on their drugs, then:

- Their plan must cover all the refills they get within the first 90 days in the plan without prior authorization or step therapy restrictions. It must cover monthly or weekly refills of the medication during those first 90 days, depending on how refills of the drug are normally provided in the beneficiary’s’ nursing home. They also get 90 days of transition coverage if their existing plan removes a drug they take from its formulary or puts restrictions on it.
- They should request an exception to the plan’s formulary right away to ask the plan to cover the drug with no restrictions.
- After the first 90 days in the plan, the plan must fill a 31-day emergency supply of the drugs if the exception request is still being processed.

F. Low Income Subsidy (LIS or “Extra Help”)

1. Assistance in paying for the Medicare Prescription Drug coverage (stand-alone plan or Medicare Advantage plan) is available to those with limited income and assets who qualify. Extra Help greatly reduces prescription drug co-payments. Depending on people’s income and asset levels, they may qualify for more or less assistance. (See Chart for more detailed information.)

2. Beneficiaries using other low-income assistance programs (food stamps, housing assistance, etc.)
   a. Enrollment in the Medicare Prescription Drug LIS will likely impact their current level of assistance from these programs.
   b. These programs take into account the amounts spent on prescription medications. Enrollment in the LIS should greatly decrease the amount they are paying out of pocket, thus decreasing their assistance levels with the other programs.
   c. Saving from LIS is usually greater than the loss of the other assistance.

3. Plans that qualify for full premium coverage through LIS are:
   a. Standard or Basic plans offered by a Prescription Drug Plan/Medicare Advantage Plan with drug coverage
   b. Below the region’s average yearly premium.

Example: Company Green offers three plans here in Missouri with three different premiums of $10.29; $16.36; and $56.43. Extra help will only pay the full premium for the $10.29 Standard plan. If a beneficiaries with extra help join the $56.43 plan, they must pay the difference in premiums $56.43 - $10.29 = $46.14.
4. Extra help will only pay the premiums for the drug coverage. If a beneficiary enrolls in a Medicare Advantage plan with drug coverage with a premium he/she will still have to pay the premium for the medical coverage.

**Example:** Sally Jones enrolls in the Purple Horizons Advantage Plan with Prescription Drug coverage. It has a monthly premium of $40 for the medical coverage portion and $15 for the drug coverage or $55 total monthly premium. Sally is a dual-eligible and thus qualifies for full extra help benefits for the prescription drug coverage. So her extra help will pay the $15 drug coverage premium only. She must pay the health plan premium.

5. Individuals with Extra Help are still bound by all the same rules as those beneficiary’s without extra help including:
   a. Pre-certification rules
   b. Excluded drugs
   c. Quantity limits
   d. Formulary rules
   e. Step therapy

6. Limited Income Newly Eligible Transition Program (LINet) – is designed to eliminate gaps in coverage for low-income individuals transitioning to Medicare Part D coverage. This program is designed to help ensure that individuals with Medicare’s low income subsidy (LIS), or “Extra Help,” who are not yet enrolled in a Part D prescription drug plan are still able to obtain immediate prescription drug coverage. This includes:
   - Beneficiaries with Medicare and MO HealthNet (Medicaid), or dual-eligible
   - Those with Medicare who also receive Medicare’s low income subsidy
   Medicare contracts with a Medicare Prescription Drug Plan company to provide this service. See your trainer for a copy of the current instructions to share with pharmacies.

**Example:** Mrs. Simpson has been on MO HealthNet benefits for the last two years due to a disability. Her Medicare benefits started last month. She did not realize she needed to join a Part D plan until she went to the pharmacy last month and was told she did not have any coverage for medications. Since she did not choose a Part D plan, Medicare has enrolled her into a plan that will not take effect until next month. The pharmacist should use the LINet Program to provide coverage for Mrs. Simpson medications for last month and this month until the plan Medicare has enrolled her in takes effect the first of next month. Mrs. Simpson will still owe the appropriate co-pays for her medications.

G. Missouri Rx (MORX) - Missouri’s State Pharmacy Assistance Program (SPAP)

1. Missouri RX coverage works with your Medicare Prescription Drug coverage (stand-alone plan or Medicare Advantage plan).
2. Enrollment is continuously open.
3. MORX eligibility: Missouri residents with incomes below current program guidelines.
4. MORX benefits: 50% of all drug plan co-pays including during the coverage gap.
5. MORX benefit requirements: 30/31 day supply, must use Missouri Pharmacy, medication must be on plan formulary or have an approved coverage exception.
6. MORX will not cover purchases from a mail-order pharmacy.
7. MORX will not cover drug plan premiums.
8. Applications must be submitted to MORX along with current required documentation.
9. Income limits are based upon annual gross income.
10. Resources or assets are not counted or considered.

11. Special Circumstance: MO HealthNet Spend Down Beneficiaries: Beneficiaries who have not met their spend-down in a new plan year (calendar year), resulting in a loss of their Extra Help benefits, will need to have their MO HealthNet case closed by the Family Support Division in order to receive maximum MORX benefits.

<table>
<thead>
<tr>
<th>Assistance Programs</th>
<th>Medicare Savings Program</th>
<th>Extra Help</th>
<th>MO Rx (State Pharmaceutical Assistance Program)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays for</td>
<td>Medicare Health Costs</td>
<td>Prescription Drug Costs</td>
<td>Prescription Drug Costs</td>
</tr>
<tr>
<td>Federal or State</td>
<td>State</td>
<td>Federal</td>
<td>State</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Depends on annual state guidelines</td>
<td>Depends on annual federal guidelines</td>
<td>Depends on annual state guidelines</td>
</tr>
<tr>
<td>Apply through:</td>
<td>Local Family Support Division office</td>
<td>Social Security Administration</td>
<td>State Pharmaceutical Assistance Program</td>
</tr>
</tbody>
</table>

H. How do we help beneficiaries choose a drug plan?

2. Compare drug plans to find the best option for each beneficiary. This requires the beneficiary to contribute information about his/her current medications including:
   a. Frequency
   b. Dosage
   c. Pharmacy-of-choice
3. The online Prescription Drug Plan search tool gives back information about the lowest cost plan or Medicare Advantage Prescription Drug Plan based on the beneficiary’s yearly estimated spending.
4. Also consider:
a. Coverage Gap  
b. Premium cost  
c. Co-pays  
d. Ability to absorb the increase in spending during the gap in coverage  
e. Amount of utilization management requirements by the plan  
f. Pharmacy acceptance of the PDP or MA-PD plan  

I. How to enroll/change plans  

1. Ways to enroll:  
   b. Call the drug plan directly (beneficiary must make the call)  
   c. Mail a paper application  
   d. Call 800-Medicare (800-633-4227)  
   e. Submit an online application for the appropriate Prescription Drug Plan via the plan’s website  
      Note: CLAIM Counselors are qualified to assist with a, b, c and e above.  

2. Ways to change plans:  
   a. Enroll in another plan using one of the methods above.  
   b. **Do not** call the present plan to cancel! This will count as an election and you usually only get one election.  

3. Totally dropping coverage:  
   a. Contact 800-Medicare (800-633-4227), or the drug plan, or Medicare Advantage Prescription Drug Plan.  
   b. We suggest that a registered letter also be sent to the plan confirming the request to completely cancel enrollment in Prescription Drug Coverage.  

J. Coordination of benefits with other drug coverage  

1. An Employer or union has the option to enhance or supplement Medicare Prescription Drug Plan benefits as a method to encourage their retirees to enroll in a prescription drug plan (PDP) or Medicare Advantage prescription drug plan (MA-PD). An employer or union may:  
   a. Wrap-around or supplement the coverage provided by the Medicare prescription drug plan by paying the monthly premium, assisting with the cost sharing requirements, or providing coverage for non-allowed drugs.  
   b. Contract with a specific Medicare prescription drug plan to offer enhanced benefits to their retirees only.  
   c. “Become” a Medicare prescription drug plan offering enhanced benefits to their retirees only.  

2. The Medicare drug plan will pay first. Retiree coverage will pay second.  
3. The retiree formulary may differ from the Medicare drug plan. It may be more open or more restrictive.  
4. Cost sharing paid by a former employer or union does not count toward TROOP.
5. An individual who drops an employer or union plan may not be allowed to re-enroll at a later date.

6. Beneficiaries should always check with their insurance plan administrators before enrolling in a Medicare prescription drug plan or MA-PD.

K. Coordination with other individual health insurance plans with prescription drug benefits

1. The Medicare prescription drug plan will pay first and the individual health insurance plan will pay second.
2. The Individual health plan’s formulary may differ (possibly be more open) than the Medicare prescription drug plans formulary.
3. Cost sharing paid by the individual plan does not count toward TROOP.
4. An employee who drops an individual health insurance plan to join a Medicare prescription drug plan would more than likely not be allowed to re-enroll at a later date.
5. Coordination with TRICARE or VA benefits:
   a. TRICARE and VA benefits are considered as good as or better than Medicare prescription drug plan benefits. This coverage is creditable to Part D.
   b. VA and TRICARE formularies are more open then Medicare’s prescriptions drug plan’s formularies.
   c. Cost paid by TRICARE or VA benefits will not count toward TROOP.
   d. An individual who drops TRICARE or VA benefits may not be allowed to re-enroll at a later date.

III. Appeals

A. Explanation

1. Medicare always allows an appeal of any type of denial of coverage.
2. At each level of appeal, the beneficiary will be informed of the next level and timeframes associated in requesting the next level.

B. Re-Determination – The First Level

1. If a coverage or exception request is turned down, a beneficiary can request a re-determination, the first level of appeal.
2. Re-determination is done by the drug plan.
3. Must be started within 120 days.
4. No minimum appeal amount.

C. Qualified Independent Contractor (QIC) – The Second Level

1. This level is a review of the situation by the IRE, a neutral third party Medicare has contracted to review appeal requests.
2. The IRE also reviews exception requests if a drug plan is not able to meet timeframe requirements.
3. Must be started within 180 days of re-determination.
4. Appeal must be over $140.

D. Administrative Law Judge Hearing

1. This third level of appeal must be requested within 60 days of the IRE decision.
2. The appeal must be worth at least $140.

E. Medicare Appeals Council

1. A three-person panel in Medicare that reviews coverage requests.
2. The appeal must be worth at least $140.
3. The appeals council will consider whether to continue the appeal.

F. Judicial Review

1. This final level requires a motion be filed in Federal Court.
2. Services of a lawyer may also be required.
3. The appeal must be worth at least $1,430.

<table>
<thead>
<tr>
<th>Type of Action</th>
<th>Time Limit</th>
<th>Amount in Question</th>
<th>Jurisdiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-determination</td>
<td>120 Days</td>
<td>No minimum</td>
<td>Drug plan</td>
</tr>
<tr>
<td>QIC Review</td>
<td>180 Days</td>
<td>$140</td>
<td>Independent Review Entity</td>
</tr>
<tr>
<td>ALJ Hearing</td>
<td>60 Days</td>
<td>$140</td>
<td>Bureau of Hearings and Appeals</td>
</tr>
<tr>
<td>Medicare Appeals Council</td>
<td>60 Days</td>
<td>$140</td>
<td>Office of Hearings and Appeals at SSA</td>
</tr>
<tr>
<td>Judicial Review with the Federal Court System</td>
<td>60 Days</td>
<td>$1,430</td>
<td>U.S. District Court</td>
</tr>
</tbody>
</table>
**IV. Explanation of Terms**

**Annual Coordinated Election Period** - Occurs from October 15 to December 7 of every year. During this time a beneficiary can enroll in a plan, switch plans, or drop coverage altogether. New plans take effect on January 1 of the following year.

**Co-Payment** - A co-payment is a set fee that an enrollee may be required to pay for a covered medication. The fee is usually outlined in the statement of benefits for the Medicare Prescription Drug Plan or Medicare Advantage Drug Plan. Co-payments may also vary by the amount of “extra help” an enrollee qualifies for financially.

**Initial Coverage Period** - Coverage period when beneficiary and Part D plan are jointly covering the cost of medications before the coverage gap is reached.

**Coverage Gap** - Portion of prescription drug coverage when the beneficiary pays for all drug costs (also called the “donut hole”).

**Catastrophic Coverage** - Coverage period after Coverage Gap where medication cost are reduced to 5% co-insurance or a small co-payment, whichever is greater.

**Creditable Coverage** - Drug coverage that is at least as good as or better than Medicare’s basic drug coverage.

**Deductible** - The amount a person must pay for prescriptions before the Medicare Drug plan begins to pay. Medicare Drug Plans may waive or reduce this, depending on the plan of choice. It can not be over the deductible amount set by Medicare.

**Dual Eligible** - A beneficiary who is enrolled in both Medicare and MO HealthNet, or a Medicare Saving Program (QMB; SLMB; QI-1).

**Exception** - Request to drug plan to make an exception to a coverage rule, such as covering a medication not on its formulary.

**Excluded Drug** - Medication that Medicare will not pay for under the Medicare Prescription Drug benefit (ex: barbiturates and benzodiazepines).

**Formulary** - List of medications covered by a particular drug plan.

**Open Enrollment Period** - Set period of time in which a beneficiary is able to enroll in a Medicare Prescription Drug Plan or change to another plan.

**Prior Authorization** - Cost saving measure by drug plans. Requests additional information from physician about why a beneficiary needs a particular medication.

**Quantity Limits** - Cost saving measure by drug plans. Restricts the amount of medication issued at one time. Restriction could be set by plan or by the drug manufacturer.
**Special Enrollment Period** - Set period of time in which a beneficiary may enroll in a Prescription Drug Plan or may switch to another drug plan due to special circumstances (ex: permanently moving to another state).

**Step-Therapy** - Cost saving measure by drug plans. Requires that a beneficiary try lower cost medications ex: generics or over the counter medication before the use of a higher cost/name brand medication.

**TROOP** - True Out Of Pocket maximum – amount that a beneficiary must pay before reaching catastrophic coverage.
Special Enrollment Periods for Medicare Advantage Plans and Medicare Part D Drug Plans

You’re limited in when and how often you can join, change or leave a Medicare Advantage plan (also known as a Medicare private health plan) or drug plan (Part D).

- You can enroll in a Medicare Advantage or Part D plan during the initial period when you first qualify for Medicare.
- During the first 45 days of each year (the Medicare Advantage Disenrollment Period, or MADP, January 1 through February 14), you can leave your Medicare Advantage plan and change to Original Medicare with or without also selecting a separate stand-alone Medicare drug plan. You can’t make any changes to your coverage during this period if you have Original Medicare. You can’t switch from one Medicare Advantage plan to another during this period.
- During Fall Open Enrollment, October 15 through December 7 of each year, you can change how you get your Medicare health coverage and enroll in, change or drop Medicare drug coverage.
- Outside of the above three periods, you can only change how you get your health coverage and enroll in, change or drop Part D drug coverage if you qualify for a Special Enrollment Period (SEP).

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1 The information in this chart comes from the “Medicare Prescription Drug Manual: Eligibility, Enrollment and Disenrollment, Section 30” and the “Medicare Managed Care Manual: Medicare Advantage Enrollment and Disenrollment, Section 30.”

2 Eligibility requirements and initial enrollment periods for Medicare Advantage and Part D are different. You’re eligible to enroll in a Medicare Part D drug plan if you have Part A, Part B or both and live in the service area of a Medicare Part D drug plan. The Part D Initial Enrollment Period is usually the same as the Initial Enrollment Period for Part B, which is the seven-month period that begins three months before you qualify for Part B and ends three months after the month you qualify. You’re eligible to enroll in a Medicare Advantage plan if you have both Parts A and B. You usually can’t get a Medicare Advantage plan if you have End-Stage Renal Disease. The Initial Coverage Election Period (ICEP) for Medicare Advantage begins three months before you are enrolled in both Parts A and B and ends either the last day of the month before you enrolled in both Parts A and B or the last day of your Part B initial enrollment period, whichever is later.

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Special Enrollment Periods

The length of the Special Enrollment Period (SEP) and the effective date of your new coverage vary depending on the reason for the SEP. The plan and, in some cases, the Centers for Medicare & Medicaid Services (CMS), determine whether you qualify for an SEP.

The SEPs in the tables below let you change your Medicare Advantage plan, Medicare drug plan or both. The rules for changing Medicare drug plans are the same whether you are in a stand-alone drug plan that only covers drugs or a Medicare Advantage plan that covers both health care and drugs.

Retroactive Disenrollment

In some cases, CMS may let you retroactively disenroll from your Medicare Advantage or drug plan. CMS decides the date the disenrollment starts. For example, if you thought you were enrolling in a stand-alone drug plan but instead were misled into joining a Medicare Advantage health plan that includes drug coverage, you can request for your plan disenrollment to go back to the date you first joined the Medicare Advantage plan.

If you’re granted retroactive disenrollment, it would be as if you never enrolled in the Medicare Advantage plan. The plan will likely take back any payments it made for your health care and drugs. In this case, you’ll want to make sure you have health and drug coverage for the period for which you were retroactively disenrolled. You may have another type of insurance that will pay bills from the retroactive period. Or you may request retroactive reinstatement into the Medicare coverage you had before enrolling in the plan you didn’t want. Bills for care and drugs you got while in the plan you didn’t want would have to be resubmitted to that other plan.

If you got a lot of health care and drugs while in the plan you didn’t want, think carefully about whether it’s a good idea to request retroactive disenrollment. You can also request prospective disenrollment, which will change your coverage going forward. In this case the plan won’t recoup payments it’s already made.

If you want to switch from one plan to another, it’s usually better to just enroll in the plan you want to enroll in. You’ll be automatically disenrolled from your old plan. It’s best to call 800-MEDICARE to enroll in a new plan rather than calling the plan directly.
Premium Penalty for Late Enrollment into Part D

If you don’t enroll in Part D when you’re first eligible, and you don’t have drug coverage that is at least as good as Medicare’s (creditable coverage) for 63 days or more, you’ll likely have to pay a premium penalty if you later enroll in a Part D plan.

While SEPs let you enroll in Part D outside of a standard enrollment period, you will still owe a premium penalty for late Part D enrollment in many cases. There are two exceptions: You won’t have a penalty if you qualify for Extra Help—a federal program that helps pay for most of the costs of the Medicare drug benefit—or if you show that you got inadequate information about the creditability of your other drug coverage.

Table of Contents

The table in the following pages explains when a Special Enrollment Period may apply to you, how long each SEP lasts, and when your new coverage will begin. If you qualify for different SEPs at the same time, pick the one that is most convenient for your circumstances.

1. You have creditable drug coverage or lose creditable coverage through no fault of your own
2. You choose to change employer/union coverage (through either current or past employment)
3. You’re institutionalized
4. You’re enrolled in a State Pharmaceutical Assistance Program (SPAP)
5. You have Extra Help, Medicaid or a Medicare Savings Program
6. You want to disenroll from your first Medicare Advantage plan
7. You enroll in/disenroll from PACE (Program of All-Inclusive Care for the Elderly)
8. You move (permanently change your home address)
9. You’ve had Medicare eligibility issues
10. You’re eligible for a Special Needs Plan (SNP) or lose eligibility for your SNP
11. You experience contract violations or enrollment errors
12. Your plan no longer offers coverage
13. You disenroll from your Medicare Advantage plan during the Medicare Advantage Disenrollment Period
14. You qualify for a new Part D initial enrollment period when you turn 65
15. You want to enroll in a five-star Medicare Advantage plan or Part D plan
16. You have been in a consistently low-performing Medicare Advantage or Part D plan
17. Your Medicare Advantage plan terminates a significant amount of its network providers
18. You experience an “exceptional circumstance”
## Special Enrollment Periods

### 1. You lose creditable drug coverage through no fault of your own or want to keep or enroll in creditable coverage.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
</table>
| You, through no fault of your own, lose drug coverage that is at least as good as or better than Medicare’s (creditable) or your drug coverage is reduced so that it is no longer creditable. (This does not include losing your drug coverage because you do not pay, or cannot afford, your premiums.) | Your SEP to join a Medicare Advantage plan with drug coverage or a stand-alone Medicare Part D drug plan begins the month you are told your coverage will end and lasts for  
- 2 months after you lose your coverage; or  
- 2 months after you receive notice, whichever is later. | The first day of the month after you submit a completed application; or Up to 2 months after your SEP ends, if you request it. |
| You want to disenroll from Medicare drug coverage to maintain or enroll in another type of creditable drug coverage such as VA, TRICARE or a state pharmaceutical assistance program (SPAP) that offers creditable coverage. | You can use this SEP to disenroll from a Medicare Advantage plan with drug coverage or a stand-alone Medicare Part D drug plan whenever you are able to enroll in another type of creditable coverage. | The first day of the month after your plan receives your disenrollment request. |

### 2. You join or drop employer/union health and/or drug coverage regardless of whether it is creditable. Employer coverage may be current or former (retiree plan).

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
</table>
| You choose to:  
- enroll in or disenroll from a employer/union-sponsored Medicare Advantage plan or Part D plan  
- disenroll from a Medicare Advantage plan or Part D plan to take employer/union-sponsored coverage.  
- disenroll from employer/union- | Your SEP to join or disenroll from a Medicare Advantage plan or Part D plan, or to switch Medicare Advantage plans or Part D plans is available to persons who have or are enrolling in an employer plan and ends two months after the month in which your employer or union coverage ends. | Up to three months after the month in which you submit a completed enrollment application. If your employer/union was late sending in the application, your coverage may begin retroactive to when you submitted the application. |
sponsored coverage of any kind (including COBRA³) to enroll in a Medicare Advantage plan or Part D plan.

<table>
<thead>
<tr>
<th>3. You’re institutionalized.</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You have an SEP if…</strong></td>
<td><strong>You qualify to enroll in a Special Needs Plan (SNP) for institutionalized people⁵</strong></td>
<td><strong>The first day of the month after you submit a completed application, but not before you become institutionalized or qualify to enroll in a Special Needs Plan for institutionalized people.</strong></td>
</tr>
<tr>
<td>You move into, reside in, or move out of a qualified institutional facility: a skilled nursing facility, nursing home, psychiatric hospital or unit, Intermediate Care Facility for the Mentally Retarded—ICF/MR, rehabilitation hospital or unit, long-term care hospital, or swing-bed hospital⁴;</td>
<td>Once you move to or reside in a qualified institution, <strong>you can enroll in or disenroll from a Medicare Advantage plan or Part D plan or change your plan once a month</strong>. (If you are in an Medicare Advantage plan, you may change to another Medicare Advantage plan or change to Original Medicare)</td>
<td></td>
</tr>
<tr>
<td>You qualify to enroll in a Special Needs Plan (SNP) for institutionalized people⁵</td>
<td>In addition, after you move out of the facility, you have two months to <strong>enroll</strong> in or <strong>disenroll</strong> from a Medicare Advantage plan or Part D plan, or to <strong>switch</strong> to another plan (including Original Medicare if you are in a Medicare Advantage plan).</td>
<td></td>
</tr>
<tr>
<td>You can enroll in or disenroll from the SNP for institutionalized people at any time.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

³ If you are disenrolling from COBRA and signing up for a Medicare Advantage plan you must already have enrolled in Parts A and B. You can only delay enrollment into Part B without penalty if you have health insurance from a current employer. COBRA is not considered current employer insurance. You do not need to have Medicare Part B to enroll in a Part D plan.

⁴ Only residents of a skilled nursing facility, nursing home, psychiatric hospital or ICF/MR will be eligible to pay a $0 copay for prescription drugs with Extra Help in 2010 and 2011.

⁵ You qualify for an institutional SNP if you: (1) Have lived, for at least 90 days, in a long-term care facility that is served by the SNP or (2) have met your state's guidelines for requiring an institutional level of care for at least 90 days, whether you live in an institution or in a community setting (for example, at home or in a group residence). You can still qualify for an institutional SNP before you have received care for at least 90 days if it is likely that you will need long-term care for at least 90 days.

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4. You’re enrolled in a qualified State Pharmaceutical Assistance Program (SPAP) or lose SPAP eligibility.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>You’re enrolled in a qualified SPAP (no matter how long you have been a member).</td>
<td>You have an SEP to choose <strong>once</strong> per year, at any time during the year, to <strong>join</strong> a Medicare Advantage plan or Part D plan for the first time or to <strong>change</strong> to another Medicare Advantage plan or Part D plan, including joining one that works with your SPAP. (If you are automatically enrolled in a Part D plan by your SPAP, you will not have this SEP.) You may <strong>not drop</strong> Part D coverage using this SEP.</td>
<td>The first day of the month after you submit a completed application.</td>
</tr>
<tr>
<td>You lose SPAP eligibility</td>
<td>You have an SEP to <strong>join</strong> or <strong>switch</strong> to another Medicare Part D plan or Medicare Advantage plan with drug coverage. This applies even if you didn’t have Part D before. The SEP starts the month you lose the SPAP because you’re no longer eligible or are notified of the loss (whichever comes first) and continuing for two months after you’re notified of the loss or lose the SPAP (whichever comes later).</td>
<td>The first day of the month after you submit a completed application.</td>
</tr>
</tbody>
</table>

6 This list of qualified SPAPs can be found at http://www.cms.gov/States/Downloads/QualifiedSPAP2.17.09.pdf

7 Don’t drop Part D coverage if you have Medicaid! In most cases you will lose your Medicaid benefits. For more information, call your local Medicaid office.

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5. You have Medicaid, a Medicare Savings Program (MSP) and/or Extra Help. (You will have no Part D premium penalty if you have Extra Help.)

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have Medicaid, a Medicare Savings Program (MSP) or Supplemental Security Insurance (SSI). (You get Extra Help)</td>
<td>You will get an SEP to <strong>join,</strong> <strong>disenroll from</strong> or <strong>switch</strong> Medicare Advantage plans or Part D plans beginning the month</td>
<td>The first day of the month after you submit a completed application to the Medicare Advantage plan or Part D plan.</td>
</tr>
</tbody>
</table>
| You have Extra Help because you applied for it. (You do not have Medicaid or a Medicare Savings Program.) | You will get an SEP to join, disenroll from or switch Medicare private drug plans beginning the month you become eligible for Extra Help. This includes stand-alone Part D prescription drug plans and Medicare Advantage plans with drug coverage. As long as you have Extra Help, you can | The first day of the month after you submit a completed application to the Part D plan.  
• If you do not select a Part D plan yourself, CMS will auto-enroll you in a Part D plan effective the first day of the second month after CMS identifies your Extra Help status. CMS will enroll you in the Limited Income NET (LINET) program through Humana from the month you qualified for Extra Help until the month your auto-enrolled plan starts.  
• If you recently qualified for Extra Help and choose your own Medicare Part D plan instead of waiting to be auto-enrolled in one by CMS, you may receive coverage of any uncovered months through the Limited Income NET program through Humana.  
• If you enroll in a Medicare Advantage plan without drug coverage, Medicare will automatically enroll you in a Medicare Advantage plan with drug coverage offered by that same company. Your Medicare Advantage plan with drug coverage enrollment could be retroactive. |
You lose Medicaid or MSP benefits⁸. You have one SEP to **switch** your Medicare Advantage plan or Part D plan that begins the month you’re notified that you will lose Medicaid or MSP benefits and continues for two months after. The first day of the month after you submit a completed application.

You will lose Extra Help for the next calendar year because you are no longer deemed eligible for it. (You are deemed eligible if you are enrolled in Medicaid, an MSP or SSI.) You have a one-time SEP to **disenroll from or switch** your Medicare Advantage plan or Part D plan from January–March if you were notified you lost Extra Help before January 1. The first day of the month after you submit a completed application.

You lose Extra Help during the calendar year (occurs in limited circumstances) You have a one-time SEP to **disenroll from or switch** your Medicare Advantage plan or Part D plan for two months after you are notified of losing Extra Help. The first day of the month after you submit a completed application.

---

### 6. You want to disenroll from your FIRST Medicare Advantage plan.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>You select a Medicare Advantage private health plan when you first qualify for</td>
<td>You can <strong>disenroll</strong> from your Medicare Advantage plan at any time during the 12-</td>
<td>Depends upon the situation.</td>
</tr>
<tr>
<td>Medicare Part B based on age (65 years old)⁹</td>
<td>months after your health plan coverage first started and go back to Original Medicare with or without joining a stand-alone Medicare Part D drug plan.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>You dropped your Medigap policy to enroll in a Medicare Advantage plan for the first time and want to re-enroll in a Medigap policy during your “trial period.”¹⁰ The trial period lasts for 12 months after you enroll in a Medicare private health plan for the first time.</td>
<td>You can disenroll from your Medicare Advantage plan at any time during the trial period – the 12-months after your Medicare Advantage coverage first started-- and go back to Original Medicare with or without joining a stand-alone Medicare Part D drug plan.</td>
<td>Depends upon the situation.</td>
</tr>
</tbody>
</table>

### 7. You enroll in/disenroll from PACE (Program of All-Inclusive Care for Elderly).

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>You disenroll from a Medicare Advantage plan or Part D plan to <strong>enroll in PACE.</strong></td>
<td>You can disenroll from your Medicare Advantage or Part D plan <strong>at any time</strong> to enroll in PACE.</td>
<td>Depends upon the situation.</td>
</tr>
<tr>
<td>You <strong>disenroll from PACE</strong> to join a Medicare Advantage plan or Part D plan.</td>
<td>Your SEP to join another Medicare Advantage plan or Part D plan lasts up to two months after the effective date of your disenrollment from the PACE program.</td>
<td>Depends upon the situation.</td>
</tr>
</tbody>
</table>

### 8. You move (permanently change your home address).

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>You move, permanently. You will have an SEP if you move out of your Medicare Advantage plan’s or Part D plan’s service area or if you move to an area covered by your plan but more plans are available to you in your new coverage area.</td>
<td><strong>If you notify your Medicare Advantage plan or Part D plan of a permanent move in advance,</strong> you have an SEP to switch to another Medicare Advantage or Part D plan beginning as early as the month before your move and lasting up to two months</td>
<td>You may choose to begin coverage any time between the first day of the month you moved (as long as you have submitted a completed application), and up to three months after your Medicare Advantage plan or Part D plan receives the completed application.</td>
</tr>
</tbody>
</table>

---

⁹ In this instance, under federal law if you joined a Medicare Advantage plan when you first qualified for Medicare at age 65, you would have guaranteed issue rights to buy certain Medigap policies. Laws in your state may offer additional protections.

¹⁰ In this instance, under federal law if you are 65 and over, you will have guaranteed issue rights to buy certain Medigap policies. Laws in your state may offer additional protections.

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If you notify your Medicare Advantage or Part D plan of a permanent move after you move, you have an SEP to switch to another private health or drug plan, beginning the month you tell your plan, plus two more full months thereafter.

If you did not notify your private health or drug plan about a move:
- and your Medicare Part D plan learns from CMS or the post office that you moved over twelve months ago, the plan should disenroll you twelve months after your move. Your SEP to switch to another Part D plan begins at the beginning of the twelfth month and continues through the end of the fourteenth month after your move.
- and your Medicare Advantage plan learns from CMS or the post office that you moved over six months ago, the plan should disenroll you twelve months after your move. Your SEP to switch to another Medicare Advantage plan begins at the beginning of the sixth month and continues through the end of the eighth month after your move.

<table>
<thead>
<tr>
<th>You become eligible to enroll in a Part D plan or a Medicare Advantage plan because you have:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Moved back to the U.S. after living abroad</td>
</tr>
</tbody>
</table>

You qualify for an SEP to enroll in a Part D plan or a Medicare Advantage plan. You have an SEP to join a Medicare Advantage or Part D plan beginning as early as the month before your move and lasting up to two months after the move.

You may choose to begin coverage any time between the first day of the month you moved (as long as you have submitted a completed application), and up to three months after your Medicare Advantage plan or Part D plan receives the completed enrollment application.
- You were released from prison (You aren’t eligible to enroll in Part D plans or Medicare Advantage plans if you live outside the U.S. or are in prison.)

### 9. You have had Medicare eligibility issues.

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have received retroactive enrollment into Medicare.</td>
<td>Your enrollment period to <strong>join</strong> a Medicare Advantage or Part D plan for the first time begins the month that you receive notice of your Medicare entitlement and continues for an additional two months after the month the notice is received.(^{11})</td>
<td>Depends on the situation.</td>
</tr>
<tr>
<td>You do not have premium-free Part A and you enroll in Part B during the General Enrollment Period (January 1 to March 31 of each year) with your Part B coverage beginning July 1.</td>
<td>You have an SEP to <strong>join</strong> a Medicare Part D plan from April 1-June 30 (after you have enrolled in Part B).</td>
<td>July 1 of that year.</td>
</tr>
<tr>
<td>You lost Part B but still have Part A and are involuntarily disenrolled from your Medicare Advantage plan.</td>
<td>You have an SEP to enroll in a Medicare Part D drug plan that begins when you learn you lost Part B and continues for two additional months.</td>
<td>The month following the month you applied.</td>
</tr>
</tbody>
</table>

### 10. You’re eligible to join a Special Needs Plan (SNP) or you lose SNP eligibility.

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You’re eligible to enroll in a Medicare SNP.</td>
<td>You can <strong>leave your Medicare Advantage plan or Part D plan</strong> at any time to enroll in a SNP if you are eligible.</td>
<td>The first day of the month after you submit a completed application.</td>
</tr>
</tbody>
</table>

\(^{11}\) This enrollment period serves as your initial enrollment period for Medicare drug coverage, so you will not face a premium penalty as long as you enroll in a plan within the time limits of your SEP.

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## You are eligible for an SEP

Join a chronic care SNP for which you are eligible, you can do so at any time. The SEP ends when you join the private health or drug plan. **Note:** If you have another chronic condition, you get another SEP to join a different SNP that covers this other condition.

### You lose eligibility to continue getting coverage through your SNP.

(SNPs must continue to cover you for at least one month if you become ineligible and for up to six months if it’s likely that you will re-qualify within six months.)

You can **join** another Medicare Advantage plan or Part D plan beginning the month you no longer qualify for the SNP and ending either three months after your continued period of enrollment ends or when you enroll in another plan, whichever comes first.

The first day of the month after you submit a completed application.

### You’re enrolled in a chronic care SNP, but your provider fails to confirm that you have the chronic condition required for eligibility by the end of the first month of enrollment.

You have an SEP to enroll in a Medicare Advantage plan or Part D plan. The SEP begins the month the SNP plan notifies you that you don’t qualify and ends two full months after the month of notification or when you enroll in another Medicare Advantage plan or Part D plan, whichever is earlier.

The first day of the month after you submit a completed application.

---

### 11. You experience contract violations (such as misleading marketing) or enrollment errors.

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
</table>
| Your Medicare Advantage plan or Part D plan violated a material provision of your contract such as:  
  - Failing to provide you on a timely basis with benefits available under the plan;  
  - Failing to provide benefits in accordance with applicable quality standards;  
  - Giving misleading information in the private health or drug plan’s | Your SEP to **switch** to another Medicare Advantage plan or Part D plan begins once the regional CMS office has determined that a violation has occurred. (If you are in an Medicare Advantage plan, your SEP allows you to **disenroll** from your plan and either **change** to Original Medicare or join another Medicare Advantage plan) You can **switch** to another Medicare Advantage plan or Part D plan during the | The effective date of the new Medicare Advantage plan or Part D plan will be the first of the month following the month the new private health or drug plan receives the completed application or up to three months after it receives the completed application. In some cases, CMS may process a retroactive disenrollment and/or retroactive enrollment in another Medicare Advantage plan. |
### Marketing to Get You to Enroll in the Plan

If you do not choose another private health or drug plan immediately, your SEP is extended for 90 days from the time of your disenrollment in the plan.

### A Federal Employee Made a Mistake in Your Enrollment or Disenrollment in a Medicare Part D Plan

You have one SEP to enroll in and/or disenroll from a Medicare Part D plan that begins the month of CMS approval and lasts two additional months.

### CMS Sanctions (Finds Fault With) a Medicare Advantage Plan or Part D Plan and You Disenroll in Connection with That Sanction

The length and start date of your SEP to join a new Medicare Advantage plan or Part D plan depends on the situation.

### CMS Determines That Your Previous Drug Coverage Did Not Adequately Inform You of a Loss of Creditable Coverage or That Your Drug Coverage Was Not Creditable

You have one SEP to enroll in or disenroll from a Medicare Part D plan that begins the month of CMS approval and lasts two additional months. (In this case, CMS may waive your premium penalties.)

### 12. Your Medicare Advantage Plan or Part D Plan No Longer Offers Medicare Coverage

#### You Have an SEP If...

- Your Medicare Advantage plan or Part D plan doesn’t renew its service. (Your Medicare Advantage plan or Part D plan must notify you by October 1 if it won’t offer Medicare drug or health coverage next year, and it must continue to provide coverage through the end of the current calendar year.)

- Mid-year, your Medicare Advantage plan or Part D plan closes or changes its contract with CMS so that you will be forced to disenroll from the plan. (Your Medicare Advantage plan or Part D plan coverage begins...)

#### Your SEP Lasts...

- Your SEP to switch to another Medicare Advantage plan or Part D plan lasts from December 8 of that year through the last day of February of the next year. (This SEP is in addition to the Fall Open Enrollment period from October 15 through December 7, when you can switch Medicare health coverage and enroll or disenroll from Part D drug coverage.)

- Your SEP to switch to another Medicare Advantage plan or Part D plan begins two months before the proposed closing or changes take place and ends one month after

#### Your Coverage Begins...

- Enrollments made from October 15 through December 31 are effective January 1.
- Enrollments made during January are effective February 1.
- Enrollments made in February are effective March 1.
Advantage plan or Part D plan must notify you 60 days before the proposed date of termination or modification.)

| Advantage plan or Part D plan coverage ends. |

CMS terminates your Medicare Advantage plan’s or Part D plan’s contract because of misconduct or other problems. (Your plan must give you 30 days notice before the termination date.)

| Your SEP to switch to another Medicare Advantage plan or Part D plan begins one month before the termination occurs and lasts for two months afterward. |
| You can choose to have your new Medicare Advantage plan or Part D plan coverage begin up to three months after the month your old coverage ended. |

CMS decides to immediately terminate its contract with your Medicare Advantage plan or Part D plan.

| CMS will notify you of the termination and your SEP. The termination may be mid-month. |
| Depends on the situation. |

13. You disenroll from your Medicare Advantage plan during the Medicare Advantage Disenrollment Period (MADP).

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You disenroll from your Medicare Advantage plan during the Medicare Advantage Disenrollment Period (January 1 – February 14 of each year).</td>
<td>You have an SEP to enroll in a Medicare stand-alone Part D drug plan when you disenroll from your Medicare Advantage plan. You can disenroll from your Medicare Advantage plan by submitting a disenrollment request or by simply enrolling in a stand-alone Part D drug plan. Know that if you disenroll from your Medicare Advantage plan during the MADP, you can only enroll in Original Medicare with a stand-alone Part D plan. You cannot switch your Medicare Advantage plan.</td>
<td>The month following the month you submit an enrollment request to a new plan.</td>
</tr>
</tbody>
</table>
### 14. You qualify for new Part D initial enrollment period when you turn 65.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>You qualify for new Part D initial enrollment period to join a stand-alone Medicare Part D drug plan because you are a person with a disability who is turning 65. (Note: If you are already enrolled in a Medicare Part D plan and are paying a late premium penalty, the penalty will end when the enrollment period starts.)</td>
<td>You have an SEP to disenroll from a Medicare Advantage plan (that does or does not include drug coverage) to join Original Medicare or to enroll in a Medicare Advantage plan that does not include drug coverage. You may also use your additional IEP to join a stand-alone Part D drug plan. The SEP begins and ends with the additional Part D IEP to join a Medicare Part D plan—usually the seven month period including three months before you turn 65, the month you turn 65, and the three months after you turn 65.</td>
<td>If you are not already enrolled in a Part D plan, your coverage will usually start the month following the month you submit an enrollment request to a new plan.</td>
</tr>
</tbody>
</table>

### 15. You want to enroll in a five-star Medicare Advantage plan or Part D plan.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
</table>
| You want to enroll in a Medicare Advantage or Part D plan that has an overall Plan Performance Rating of five stars and you're otherwise eligible to enroll in the plan. (For example, you live in the plan’s service area.) | Plan Performance Ratings are released every fall and apply to the following calendar year. Your SEP to join a five-star Medicare Advantage or Part D plan starts December 8 of the year before the plan is considered a five-star plan. It lasts through November 30 of the year the plan is considered a five-star plan. You can use this SEP to change plans one time per year. | • Enrollments December 8 through December 31 are effective January 1.  
• Enrollments January 1 through November 30 are effective the month following the month you submit an enrollment request. |

### 16. You have been in a consistently low-performing Medicare Advantage or Part D plan.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have been in a consistently low-performing plan, meaning that the plan has received an overall Medicare star rating of</td>
<td>You have an SEP to enroll into a higher quality plan throughout the year. You should receive a notice from CMS in late</td>
<td>The month following the month you submit an enrollment request to a new plan.</td>
</tr>
</tbody>
</table>
### 17. Your Medicare Advantage stops contracting with many of its providers.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Medicare Advantage plan stops contracting with many providers in its network during the course of the calendar year and CMS determines these terminations are substantial. If the terminations are significant enough, you will have a one-time SEP to enroll in a different Medicare Advantage plan (with or without Part D coverage) or switch to Original Medicare with or without a stand-alone Part D plan. Your plan will mail you a notice if CMS determines the terminations are substantial.</td>
<td>From the month you get notified of the network change and two additional months after that. You should be notified via mail at least 30 days in advance of the network terminations and of your SEP to switch to a new Medicare Advantage plan, or to join Original Medicare with a Part D plan. You do not have a guaranteed right to purchase a Medigap via this SEP.</td>
<td>The month following the month you submit an enrollment request to a new plan.</td>
</tr>
</tbody>
</table>

### 18. You experience an “exceptional circumstance”

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your circumstances do not fit into any of the other SEP categories, you have the right to ask CMS to grant you an SEP based on your particular exceptional circumstances. ¹²</td>
<td>Depends on the SEP.</td>
<td>Depends upon the circumstances.</td>
</tr>
</tbody>
</table>

¹² CMS can also grant “exceptional circumstance” SEPs to groups identified by a common problem or characteristic (for example, members of a particular plan who were all misled about the plan’s offerings). Many of the SEPs mentioned in this chart were created as “exceptional circumstance” SEPs.

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## MEDICARE DRUG COVERAGE UNDER PART A, PART B AND PART D

This table identifies Medicare coverage of medically-necessary drugs in some common situations. It provides general guidance only and does not cover all possible situations. For detailed coverage information, see appendix C-1 in chapter 6 of the Medicare Part D Manual, which is available online at [http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf](http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf).

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Care Setting*</th>
<th>Drug Type</th>
<th>Covered by**</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Original Medicare and a Medicare Prescription Drug Plan (PDP)</td>
<td>Hospital (in-patient) or skilled nursing facility</td>
<td>Any</td>
<td>Part A</td>
<td>Part A coverage is subject to certain limits; drugs may be covered by Part B or Part D for stays not covered by Part A</td>
</tr>
<tr>
<td></td>
<td>Doctor’s office</td>
<td>Injectable/IV drugs given by a doctor and not usually self-administered</td>
<td>Part B</td>
<td>Eligible for Part D coverage if purchased at a pharmacy and administered by a doctor</td>
</tr>
<tr>
<td></td>
<td>Doctor’s office</td>
<td>Vaccines: pneumococcal pneumonia, influenza, and (for intermediate- to high-risk people) Hepatitis B; and some other vaccines related to injury or illness</td>
<td>Part B</td>
<td>State for Part D coverage if purchased at a pharmacy and administered by a doctor</td>
</tr>
<tr>
<td></td>
<td>Home</td>
<td>Drugs that must be administered by Medicare-covered durable medical equipment (DME), e.g., nebulizer or infusion pump</td>
<td>Part B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Long-Term Care</td>
<td>Drugs that must be administered by Medicare-covered durable medical equipment (DME), e.g., nebulizer or infusion pump</td>
<td>Part D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home or Long-Term Care</td>
<td>Insulin and injection supplies (syringes, needles, alcohol swabs, and gauze)</td>
<td>Part D</td>
<td>Blood glucose testing supplies covered by Part B (DME)</td>
</tr>
<tr>
<td>Type of Coverage</td>
<td>Care Setting*</td>
<td>Drug Type</td>
<td>Covered by**</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>1. Original Medicare and a Medicare Prescription Drug Plan (PDP) (For coverage information for those in hospice, see Section 3)</td>
<td>Home or Long-Term Care</td>
<td>Immunosuppressive drugs for a person who received a Medicare-covered transplant</td>
<td>Part B</td>
<td>Eligible for Part D coverage for other situations</td>
</tr>
<tr>
<td></td>
<td>Home or Long-Term Care</td>
<td>Some oral anti-cancer drugs</td>
<td>Part B for cancer treatment</td>
<td>Eligible for Part D coverage for other situations</td>
</tr>
<tr>
<td></td>
<td>Home or Long-Term Care</td>
<td>Some oral anti-emetic drugs used within 48 hours of chemotherapy</td>
<td>Part B</td>
<td>Eligible for Part D coverage for other situations</td>
</tr>
<tr>
<td></td>
<td>Home or Long-Term Care</td>
<td>Erythropoietin (EPO) for anemia in people with chronic renal failure who are undergoing dialysis</td>
<td>Part B</td>
<td>Eligible for Part D coverage for other situations</td>
</tr>
<tr>
<td></td>
<td>Home or Long-Term Care</td>
<td>Parenteral nutrition or tube feeding for permanent dysfunction of digestive tract</td>
<td>Part B</td>
<td>Covered by Part D for other situations</td>
</tr>
<tr>
<td>2. Medicare Advantage Plan with drug coverage (MA-PD) (For coverage information for those in hospice, see Section 3)</td>
<td>Any</td>
<td>Any</td>
<td>Plan provides all Part A, Part B, and Part D covered services, including prescription drugs</td>
<td></td>
</tr>
<tr>
<td>3. Original Medicare or Medicare Advantage Plan AND elected hospice care</td>
<td>Any</td>
<td>Drugs for symptom control or pain relief</td>
<td>Part A</td>
<td>A person can stop hospice care and go back to his or her previous Medicare coverage at any time</td>
</tr>
<tr>
<td></td>
<td>Any</td>
<td>Drugs intended to treat the terminal illness</td>
<td>Not covered by Medicare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any</td>
<td>For a condition unrelated to the terminal illness (e.g., a non-related infection)</td>
<td>Same as for non-hospice care</td>
<td></td>
</tr>
<tr>
<td>4. Original Medicare with PDP or Medicare Advantage Plan AND Medicaid</td>
<td>Home or Long-Term Care</td>
<td>Drugs excluded by law from Part D</td>
<td>Not covered by Medicare</td>
<td>For optional state coverage of Medicare-excluded drugs, see <a href="http://www.medicare.gov">www.medicare.gov</a></td>
</tr>
<tr>
<td></td>
<td>Hospital or skilled nursing facility</td>
<td>Drugs excluded by law from Part D</td>
<td>Part A</td>
<td>Part A coverage is subject to certain limits; drugs may be covered by Part B or Part D for stays not covered by Part A</td>
</tr>
</tbody>
</table>

* Long-term care facilities include skilled nursing facilities (for stays not covered by Medicare), nursing homes which give skilled care, and institutions which give skilled care. Generally, “home” care setting includes Medicare-covered home health care, and “doctor’s office” care includes hospital outpatient care.

** Drugs are covered under Part D to the extent they are included on the formulary (list of covered drugs) for the person’s plan. If a person's drug is not covered, he or she can ask the plan for a coverage determination, but may have to pay full price for that drug. For more information, see “Your Guide to Medicare Prescription Drug Coverage,” CMS Publication Number 11109, at [www.medicare.gov/Publications/Pubs/pdf/11109.pdf](http://www.medicare.gov/Publications/Pubs/pdf/11109.pdf).
REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations)

Enrollee’s/Requestor’s Information

Enrollee’s Name
Enrollee’s Date of Birth
Enrollee’s Medicare Number
Enrollee’s Part D Plan ID Number

Requestor’s Name (if not enrollee)

Requestor’s relationship to Enrollee (attach documentation that shows authority to represent enrollee, if other than prescribing physician)

Enrollee/Requestor’s Address
City
State
Zip Code
Phone

Name of prescription drug you are requesting (if known, include strength, quantity and quantity requested per month):

Prescribing Physician’s Information

Name
Medical Specialty

Address
City
State
Zip Code

Work Phone
Fax
Office Contact Person

Type of Coverage Determination Request

☐ I need a drug that is not on the plan’s list of covered drugs (formulary exception).*

☐ I have been using a drug that was previously included on the plan’s list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*
☐ I request an exception to the requirement that I try another drug before I get the drug my doctor prescribed (formulary exception).*

☐ I request prior authorization for the drug my doctor has prescribed.

☐ I request an exception to the plan’s limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor prescribed (formulary exception).*

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐ My drug plan charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*

☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

*NOTE: If you are asking for a formulary or tiering exception, your PRESCRIBING PHYSICIAN must provide a statement to support your request. You cannot ask for a tiering exception for a drug in the plan’s Specialty Tier. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs.

Additional information we should consider (attach any supporting documents):

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician’s support, we will decide if your health condition requires a fast decision.

☐ I need an expedited coverage determination (attach physician’s supporting statement, if applicable)

Beneficiary/Requestor’s Signature ___________________________ Date ___________________________

Send this request to your Medicare drug plan. Note that your Medicare drug plan may require additional information. See your plan benefit materials for more information.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.
Tab Divider named “Section 8 Public Benefit Programs”
Section 8
Public Benefit Programs

I. Public Benefits Programs ................................................................. 2
II. Income and Resources ................................................................. 2
   A. Income .................................................................................. 2
   B. Resources .............................................................................. 2
III. Supplemental Security Income (SSI) .............................................. 2
   A. Description.............................................................................. 2
   B. Eligibility Criteria................................................................. 3
IV. MO HealthNet (Medicaid) ............................................................. 3
   A. Description.............................................................................. 3
   B. Eligibility Criteria................................................................. 3
V. MO HealthNet Spend-Down (Medicaid Spend-Down)..................... 3
   A. Description.............................................................................. 3
VI. Home and Community Based Services (HCB)............................... 5
   A. Description.............................................................................. 5
   B. Eligibility Criteria................................................................. 5
VII. Medicare Saving Programs ............................................................ 6
    A. Qualified Medicare Beneficiary (QMB) Program...................... 6
    B. Specified Low-Income Medicare Beneficiary (SLMB) Program .... 6
    C. Qualifying Individual–1 (QI-1 and/or SLMB Group 2)............... 7
    D. Low Income Subsidy (LIS or “Extra Help”)............................. 8
    E. Missouri Rx (MORX) - Missouri’s State Pharmacy Assistance Program (SPAP) 9
VIII. Section 8 Review ...................................................................... 10
I. Public Benefits Programs

In Missouri, the Family Support Division (FSD) provides financial assistance and health insurance coverage to those eligible. The division offers many different programs for families, the disabled, and the elderly. In this manual, we specifically address those programs most relevant to Medicare beneficiaries: MO HealthNet (Medicaid), MO HealthNet Spend-Down, Home and Community Based Services, and the Medicare Savings Programs - QMB, SLMB, and QI-1. Medicare beneficiaries who are eligible for any form of MO HealthNet benefits are known as dual-eligible. In addition, we address the Social Security Administration’s (SSA) SSI program.

II. Income and Resources

A. Income

1. Types of income
   a. Earned income (e.g. wages)
   b. Unearned income (e.g. Social Security, pension, bank interest)

2. Allowed exclusion - $20 general exclusion is applied against income (per individual or couple)

B. Resources

1. Countable resources - savings accounts, checking accounts, non-home real estate
2. Resource exclusions
   a. The homestead - The homestead, including adjoining land, is excluded as long as the individual; spouse; or minor, disabled, or blind child is living in it. If the person goes from their home to a nursing home, then the home is also exempt.
   b. Life insurance - The cash value of a life insurance policy is excluded up to $1,500.
   c. Automobile - The value of one automobile is excluded. Under Medicaid, an additional automobile may be excluded, if the need for the vehicle can be proven.
   d. Irrevocable Burial Trust (Fund/Account)
   e. Burial Space - Plots, crypts, or mausoleums of any value are excluded.

III. Supplemental Security Income (SSI)

A. Description

SSI is a federally funded income assistance program for those 65 or older, the blind, and the disabled. The purpose of the program is to ensure a minimum level of income for people who do not have enough income or resources to maintain a minimum standard of living. SSI “supplements” the individual’s income to bring them up to a set income level. Enrollment for SSI is done through the Social Security Administration. Beneficiaries who qualify for
this level of public benefits automatically qualify for “extra help” in paying for Medicare Prescription Drug coverage.

B. Eligibility Criteria

1. Must be over 65, blind, or disabled  
2. Must be a US citizen or resident of the US  
3. Must have limited income  
4. Must have limited resources

IV. MO HealthNet (Medicaid)

A. Description

MO HealthNet (Medicaid) is a public assistance program that pays for certain health care costs. For Medicare beneficiaries, MO HealthNet supplements Medicare benefits. MO HealthNet (Medicaid) is always the payer of last resort. Enrollment for MO HealthNet is done through the Missouri Family Support Division (FSD).

If eligible for Medicare, individuals who qualify for this level of public benefits automatically qualify for “extra help” in paying for Medicare Prescription Drug coverage. These individuals will pay the lowest co-pays offered. When becoming eligible for Medicare, if they do not enroll in Medicare Prescription Drug plan or Medicare Advantage with drug coverage, they will automatically be enrolled in a plan. This level of “extra help” also allows for a continuous open enrollment period and the ability to change plans every month if necessary.

B. Eligibility Criteria

1. Must be a U.S. citizen or resident of the U.S.  
2. Must have income below 85% of the federal poverty level for the assistance group size (household size)  
3. If single, owns cash, securities, or other total non-exempt resources with a value of less than $1,000  
4. If married and living with spouse, individually or together, $2,000 or less

V. MO HealthNet Spend-Down (Medicaid Spend-Down)

A. Description

MO HealthNet Spend-Down is a public assistance program that pays for certain health care costs of qualified persons. This program is for those with income above the MO HealthNet limits. It allows them to “spend down” or “pay down” their income to the Medicaid limit in order to receive benefits. The spend-down amount is determined on a monthly basis. In order for MO HealthNet to pay for medical expenses a person must
meet or exceed their spend-down amount for that month. A person is not required to pay or meet that amount every month. Enrollment for MO HealthNet Spend-Down is done through FSD.

B. Eligibility Criteria

To determine the spend-down amount, the FSD Eligibility Specialist first determines the total monthly gross income based on the following:

- Earned income (e.g. wages)
- Unearned income (e.g. Social Security, pension, bank interest)

Then the FSD Eligibility Specialist subtracts the following:

- $20 personal income exemption (included in amounts listed in Money Tip Sheet)
- Amount paid each month for Medicare and certain types of medical insurance
- 85% of the current federal poverty level (MO HealthNet ceiling) for 2014 which is $827/mo (single) and $1,114/mo (couple)
- The remainder is the spend-down amount.

### MO HealthNet Spend-Down Example

<table>
<thead>
<tr>
<th>Recurring Expenses</th>
<th>Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Exemption Amount</td>
<td>-$20.00</td>
</tr>
<tr>
<td>Medicare Premium</td>
<td>-$104.90</td>
</tr>
<tr>
<td>Medigap Premium</td>
<td>-$105.00</td>
</tr>
<tr>
<td>Recurring Expenses Subtotal</td>
<td>-$229.90</td>
</tr>
<tr>
<td>Medicaid Income Limit</td>
<td>-$827.00</td>
</tr>
<tr>
<td><strong>Monthly Spend-Down Amount</strong></td>
<td><strong>$143.10</strong></td>
</tr>
<tr>
<td>Potential Drug Spending</td>
<td>-$30.00</td>
</tr>
<tr>
<td>Other Potential Medical expenses (Part B deductible)</td>
<td>-$147.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,463.80</strong></td>
</tr>
</tbody>
</table>

To meet a spend-down, gather the following receipts or bills for month to give to the FSD Eligibility Specialist: prescription drugs, hospitalization, and doctor care, and other medical services. Another option is to pay the spend-down amount directly to the state. A paid-in spend-down amount will be refunded after 13 months if there were no medical claims for that month. The alternative to submitting receipts would be to pay the spend-down amount in full directly to the state.

On the day medical expenses equal the spend-down amount, the FSD Eligibility Specialist will activate medical benefits. MO HealthNet benefits will be available to pay for covered services above the spend-down amount. Coverage will end on the last day of the month.

If eligible for Medicare, individuals that qualify for Medicaid, automatically qualify for “Extra Help” in paying for Medicare Prescription Drug coverage. If your spend-down is
met at least once prior to July, your Extra Help will continue for the rest of the calendar year. If met after July through December, it will continue through the entire following calendar year.

| Example: If met in February 2014, Extra Help will continue through December 2014. If met in November 2014, Extra Help will continue through December 2015. These individuals will pay the lowest co-pays offered. |

When becoming eligible for Medicare, if they do not enroll in Medicare prescription drug plan or Medicare Advantage with drug coverage, they will automatically be enrolled in a plan. This level of “Extra Help” also allows for a continuous open enrollment period and the ability to change plans every month if necessary. If a beneficiary does not meet their spend-down he or she will need to complete the Social Security extra-help application to ensure continued assistance in paying for their prescription drugs.

VI. Home and Community Based Services (HCB)

A. Description

This program is for individuals 63 years and older who are unable to live in their homes independently without services of homemaker chores or respite care. These individuals must meet nursing home criteria based on an assessment of needs for care, by Missouri Health and Senior Services. Once the assessment determines services are needed in the home to delay or prevent placement in a nursing home, the Family Support Division is contacted to determine eligibility to receive coverage under MO HealthNet. Once approved, Health and Senior Services will develop and administer home and community delivery services to meet unmet needs. Some services that can be provided may include personal care, homemaker chores, nursing, respite, adult day care, and counseling. The beneficiary does have the option to direct these services under consumer-directed care. A family member or friend could be hired by the beneficiary to fulfill the services approved under the care plan by Health and Senior Services.

B. Eligibility Criteria

1. 63 years or older
2. Monthly income $1,260.00 (Jan. 1, 2014) or lower and assets under $1,000
3. Meets nursing home level of care according to the Needs of Care Assessment completed by Missouri Health and Senior Services
4. Authorization of services given by Missouri Health and Senior Services
5. Meets the requirements of eligibility of MO HealthNet
VII. Medicare Saving Programs

A. Qualified Medicare Beneficiary (QMB) Program

1. Description

The QMB program is a federal and state funded assistance program that assists certain low-income Medicare beneficiaries by paying their Medicare premiums, deductibles, and coinsurance. Enrollment in QMB is done through Missouri Family Support Division (FSD).

This MO HealthNet program will only pay for Medicare Advantage Plan cost sharing (deductibles, coinsurance, and copayment) for participants in QMB and QMB Plus. QMB Plus participants have resources at the MO HealthNet level.

2. Eligibility criteria

a. Income must not exceed 100% of the federal poverty level for the assistance group size (household size)
b. See “Money Tip Sheet” for current resource limits
c. The effective date of QMB benefits is the month following the month of approval by Family Support Division.

Individuals that qualify for QMB automatically qualify for “extra help” in paying for Medicare Prescription Drug coverage. These individuals will pay the medium level of co-pays. When becoming eligible for Medicare, if they do not enroll in Medicare prescription drug plan or Medicare Advantage with drug coverage, they will automatically be enrolled in one. This level of “extra help” also allows for a continuous open enrollment period; the ability to change plans every month if necessary.

B. Specified Low-Income Medicare Beneficiary (SLMB) Program

1. Description

The SLMB program is a federal and state funded assistance program that assists certain low-income Medicare beneficiaries by paying their Medicare Part B premiums. Enrollment in SLMB is done through the Missouri Family Support Division (FSD).

2. Eligibility criteria

a. Must have limited incomes between 100% of the federal poverty level and 120% of the federal poverty level for the assistance group size (household size)
b. See “Money Tip Sheet” for current resource limits
c. The effective date of SLMB benefits is the month of application to Family Support Division and prior quarter may be considered.

Individuals that qualify for SLMB automatically qualify for “extra help” in paying for Medicare Prescription Drug coverage. These individuals will pay the medium level co-pays. When becoming eligible for Medicare, if they do not enroll in a Medicare prescription drug plan or Medicare Advantage with drug coverage, they will be automatically enrolled in one. This level of “extra help” also allows for a continuous open enrollment period; the ability to change plans every month of necessary.

C. Qualifying Individual–1 (QI-1 and/or SLMB Group 2)

Counseling Note: Even if beneficiaries have been automatically assigned a Part D plan, the counselor should run a personal comparison of their drug plan options. This will make sure the plan they have been assigned will cover their medications and to see if another plan may be less expensive. There could also be a delay of up to two months before an assigned plan will take effect. By doing an enrollment, the waiting period will be eliminated.

1. Description

The QI-1 program is a federally funded assistance program that assists certain low-income Medicare beneficiaries by paying their Medicare Part B premiums. Enrollment in QI-1 is done through the Missouri Family Support Division (FSD).

2. Eligibility criteria

a. Must have a limited income that does not exceed 135% of the federal poverty level of the assistance group size (household size)
b. See “Money Tip Sheet” for current resource limits
c. The effective date of QI-1 benefits is the month of application to Family Support Division and prior quarter may be considered.

Individuals that qualify for QI-1 automatically qualify for “extra help” in paying for Medicare Prescription Drug coverage. These individuals will pay the medium level co-pays. When becoming eligible for Medicare, if they do not enroll in Medicare prescription drug plan or Medicare Advantage with drug coverage, they will automatically be enrolled in one. This level of “extra help” also allows for a continuous open enrollment period - the ability to change plans every month of necessary.
D. Low Income Subsidy (LIS or “Extra Help”)

1. Assistance in paying for the Medicare Prescription Drug coverage (stand-alone plan or Medicare Advantage plan) is available to those with limited income and assets who qualify. Extra Help greatly reduces prescription drug co-payments. Depending on people’s income and asset levels, they may qualify for more or less assistance. (See Chart for more detailed information.)

2. Beneficiaries using other low-income assistance programs (food stamps, housing assistance, etc.)
   a. Enrollment in the Medicare Prescription Drug LIS will likely impact their current level of assistance from these programs.
   b. These programs take into account the amounts spent on prescription medications. Enrollment in the LIS should greatly decrease the amount they are paying out of pocket, thus decreasing their assistance levels with the other programs.
   c. Saving from LIS is usually greater than the loss of the other assistance.

3. Plans that qualify for full premium coverage through LIS are:
   a. Standard or Basic plans offered by a Prescription Drug Plan/Medicare Advantage Plan with drug coverage
   b. Below the region’s average yearly premium.

**Example:** Company Green offers three plans here in Missouri with three different premiums of $10.29; $16.36; and $56.43. Extra help will only pay the full premium for the $10.29 Standard plan. If a beneficiaries with extra help join the $56.43 plan, they must pay the difference in premiums $56.43 - $10.29 = $46.14.

4. Extra help will only pay the premiums for the drug coverage. If a beneficiary enrolls in a Medicare Advantage plan with drug coverage with a premium he/she will still have to pay the premium for the medical coverage.

**Example:** Sally Jones enrolls in the Purple Horizons Advantage Plan with Prescription Drug coverage. It has a monthly premium of $40 for the medical coverage portion and $15 for the drug coverage or $55 total monthly premium. Sally is a dual-eligible and thus qualifies for full extra help benefits for the prescription drug coverage. So her extra help will pay the $15 drug coverage premium only. She must pay the health plan premium.

5. Individuals with Extra Help are still bound by all the same rules as those beneficiary’s without extra help including:
   a. Pre-certification rules
   b. Excluded drugs
   c. Quantity limits
   d. Formulary rules
   e. Step therapy
6. **Limited Income Newly Eligible Transition Program (LINet)** – is designed to eliminate gaps in coverage for low-income individuals transitioning to Medicare Part D coverage. This program is designed to help ensure that individuals with Medicare’s low income subsidy (LIS), or “Extra Help,” who are not yet enrolled in a Part D prescription drug plan are still able to obtain immediate prescription drug coverage. This includes:
   - Beneficiaries with Medicare and MO HealthNet (Medicaid), or dual-eligible
   - Those with Medicare who also receive Medicare’s low income subsidy

Medicare contracts with a Medicare Prescription Drug Plan company to provide this service. See your trainer for a copy of the current instructions to share with pharmacies.

**Example:** Mrs. Simpson has been on MO HealthNet benefits for the last two years due to a disability. Her Medicare benefits started last month. She did not realize she needed to join a Part D plan until she went to the pharmacy last month and was told she did not have any coverage for medications. Since she did not choose a Part D plan, Medicare has enrolled her into a plan that will not take effect until next month. The pharmacist should use the LINet Program to provide coverage for Mrs. Simpson medications for last month and this month until the plan Medicare has enrolled her in takes effect the first of next month. Mrs. Simpson will still owe the appropriate co-pays for her medications.

---

**E. Missouri Rx (MORX) - Missouri’s State Pharmacy Assistance Program (SPAP)**

1. Missouri RX coverage works with your Medicare Prescription Drug coverage (standalone plan or Medicare Advantage plan).
2. Enrollment is continuously open.
3. MORX eligibility: Missouri residents with incomes below current program guidelines.
4. MORX benefits: 50% of all drug plan co-pays including during the coverage gap.
5. MORX benefit requirements: 30/31 day supply, must use Missouri Pharmacy, medication must be on plan formulary or have an approved coverage exception.
6. MORX will **not** cover purchases from a mail-order pharmacy.
7. MORX will **not** cover drug plan premiums.
8. Applications must be submitted to MORX along with current required documentation.
9. Income limits are based upon annual gross income.
10. Resources or assets are **not** counted or considered.
11. **Special Circumstance:** MO HealthNet Spend Down Beneficiaries: Beneficiaries who have not met their spend-down in a new plan year (calendar year), resulting in a loss of their Extra Help benefits, will need to have their MO HealthNet case closed by the Family Support Division in order to receive maximum MORX benefits.
VIII. Section 8 Review

PUBLIC BENEFITS AND MEDICARE REVIEW

1. What is SSI, who administers it, and who is it for?

2. What are the income and resource limits for SSI?

3. What is the difference between Medicare and MO HealthNet (Medicaid)?

4. Who determines eligibility and accepts applications for MO HealthNet (Medicaid)?

5. What are the allowed exclusions for MO HealthNet beneficiaries?

6. If a Medicare beneficiary is MO HealthNet eligible who would be the primary payer for the medical bills?
7. What do QMB and SLMB stand for? What do they do for the beneficiary? What are the eligibility requirements?

8. If a Medicare beneficiary is eligible for QMB, do they need to continue to pay for their supplemental insurance policy? Explain why or why not. Are there any other options?
Tab Divider named “Section 9 ESRD”
Section 9
End-Stage Renal Disease (ESRD)

I. Medicare Basics for ESRD Patients ................................................................. 1
   A. Is the beneficiary eligible for Medicare benefits? ........................................ 1
   B. Who is considered a dependent child? ....................................................... 2
   C. Can a grandparent’s work record be used for eligibility? ......................... 2
   D. Medicare A and Part B ............................................................................ 3
   E. Medicare Advantage Plans ...................................................................... 3
   F. Should the beneficiary stay in his/her Medicare Advantage plan if he/she has ESRD? .................................................................................. 3
   G. How can a beneficiary leave his/her Medicare Advantage Plan and return to Original Medicare? ........................................................................ 4
   H. How does a beneficiary enroll in Medicare Part A & B, and what is the cost? ...... 5
   I. When will Medicare coverage begin? .......................................................... 6
   J. When will Medicare coverage end? ............................................................. 8
   K. Beneficiary has an employer group health plan (EGHP) ........................... 8
   L. Termination of Medicare due to non-payment of premiums .................... 10

II. Kidney Dialysis ........................................................................................... 11
    A. Where does the beneficiary get his/her dialysis treatments? .................... 11
    B. How does the beneficiary find a dialysis facility? ..................................... 11
    C. Medicare covered dialysis services and supplies ................................... 12
    D. Non-covered dialysis services and supplies ........................................... 13
    E. How does the beneficiary get his/her dialysis treatment if he/she travels? ...... 13

III. Kidney Transplants ...................................................................................... 14
    A. How does the beneficiary find an approved transplant hospital? ............. 14
    B. Medicare-covered kidney transplant services ........................................ 14
    C. Immunosuppressive drugs ...................................................................... 15
    D. Blood .................................................................................................... 15

IV. Will the Medicare Part D Prescription Drug Benefit affect the beneficiary? ...... 16

V. Appeals and Grievances ............................................................................. 17
    A. Background ............................................................................................ 17
    B. Grievances ............................................................................................. 17

VI. Other Kinds of Health Insurance ................................................................ 17
    A. Other health coverage .......................................................................... 17
    B. Medigap Policies (Medicare Supplement) ........................................... 18
C. Public Benefits .................................................................................................................. 19
D. Beneficiary has Medicare and MO HealthNet ............................................................... 19

VII. Related Information ...................................................................................................... 19
   A. Medicare Easy Pay ...................................................................................................... 19
   B. Family and Medical Leave Act (FMLA) .................................................................... 20
   C. Americans with Disabilities Act ................................................................................ 20
   D. Missouri Vocational Rehabilitation (VR) ................................................................. 20

VIII. Other Sources of Information .................................................................................... 21
   A. Missouri Kidney Program .......................................................................................... 21
   B. Heartland Kidney Network (ESRD Network No. 12) ................................................ 21
   C. Centers for Medicare and Medicaid Services (CMS) ................................................ 21
   D. Life Options Rehabilitation Program ....................................................................... 22
   E. National Kidney Foundation ...................................................................................... 22
I. Medicare Basics for ESRD Patients

End-Stage Renal Disease (ESRD) is defined as permanent kidney failure that requires a regular course of dialysis or kidney transplant to maintain life.

In 1972, Medicare coverage was extended to people with disabilities and those with ESRD. In 2013, over 500,000 people were enrolled in Medicare based on ESRD. Since ESRD program began, more than 1 million Americans have received dialysis and/or a kidney transplant for renal failure.

A. Is the beneficiary eligible for Medicare benefits?

1. Beneficiaries can receive Medicare Part A without paying a premium no matter how old they are if they meet the following criteria:
   a. Are a United States citizen or permanent legal resident, and
   b. Kidneys no longer work and the beneficiary needs regular dialysis, a kidney transplant or has had a kidney transplant
   c. Have to have worked the required amount of time under Social Security, the Railroad Retirement Board, or as a government employee (usually 40 credits)
      • Those 65 years old or older that have earned less than the required credits and do not meet any of the other requirements listed below can receive Medicare Part A by paying a premium. Premium amount would be based on their work history.
   d. Everyone eligible for Part A can also receive Medicare Part B

2. Younger workers’ eligibility is determined by the work credit requirements from the chart below. Generally, the only way children under 20 can become eligible for Medicare is under the ESRD provision of the law.

<table>
<thead>
<tr>
<th>Your Age</th>
<th>Work Credits You Need for Social Security (unless blind)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 24</td>
<td>Six credits in the last three years before disability</td>
</tr>
<tr>
<td>24 – 31</td>
<td>Worked half the time from age 21 until disabled</td>
</tr>
<tr>
<td>31 – 42</td>
<td>20 credits in the last 10 years before being disabled</td>
</tr>
<tr>
<td>44 – 60</td>
<td>20 credits in the last 10 years, plus two credits for every two years over 44</td>
</tr>
<tr>
<td>62 &amp; older</td>
<td>40 credits</td>
</tr>
</tbody>
</table>

3. The person is the spouse or surviving spouse of a person who is receiving benefits or has worked the required amount of time are eligible.

4. The person is the ex-spouse or surviving ex-spouse of a person who is receiving benefits or has worked the required amount of time is eligible if:
   a. The person was married at least 10 years, and
   b. The person has not remarried

5. The person is a dependent child of a person who is receiving benefits or has met the work requirements is eligible when:
   • One parent has earned at least six credits within the last three years under Social Security, the Railroad Board, or as a federal government employee.
   **Important:** Both parents cannot combine credits to meet the requirements.
6. Both Part A and Part B are needed for Medicare to cover certain dialysis and kidney transplant services. Part D is also recommended for medication coverage for both dialysis and transplant treatment.

B. Who is considered a dependent child?

1. Usually a dependent child is an unmarried person under the age of 22 who is the beneficiary’s child, legally adopted child, or stepchild for at least one year prior to enrollment.
2. Someone age 22 or older is considered dependent if he/she has a disability that began before he/she turned 22.
3. Someone over age 22 but not yet 26 can be considered dependent if he/she received at least one-half of his/her support from a parent from the time he/she turned 22.

C. Can a grandparent’s work record be used for eligibility?

1. A child can have Medicare based on his/her grandparent’s or step-grandparent’s work record if the grandchild meets both a relationship and a dependency requirement.
   a. Relationship
      • The grandchild has been legally adopted by the grandparent or step-grandparent. This is true even if the adoption took place after the grandparent started drawing Social Security benefits.
      • If the grandchild is not adopted, he/she can still qualify for benefits by meeting all three of the following requirements:
         o Both parents of the child must be deceased or disabled before the grandparent starts receiving Social Security benefits, or in the case of survivor benefits, before the grandparent dies
         o The grandchild must have been living with the grandparent before age 18
         o The grandchild must have lived with the grandparent for an entire year before the grandparent became entitled to Social Security benefits, became permanently disabled, or died
      • The child lived with the grandparent in the United States.
      • The child has received at least one-half of his/her financial support from the grandparent.
   b. Dependency
      • The grandchild is under age 22.
      • The grandchild is over age 22, but was disabled before age 22.
      • The grandchild is over age 22, not yet 26, and has been receiving at least one-half of his/her financial support from the grandparent since age 22.
D. Medicare A and Part B

1. All services provided under Medicare apply to ESRD patients; however, there are some additions and exceptions specific to ESRD that will be addressed in this section.
   a. **Part A helps pay for:**
      - Inpatient hospital care
      - Skilled nursing facility care
      - Hospice care
      - Home health care
      - Other services such as kidney transplant surgery and hospitalization (MUST be in a Medicare-approved transplant center)
   b. **Part B helps pay for:**
      - Doctors’ services
      - Home dialysis training
      - Outpatient hospital care
      - Dialysis treatment at home or in a facility
      - Home dialysis equipment and supplies
      - Certain home support services (may include visits by trained technicians to help during emergencies and to check your dialysis equipment and water supply)
      - Preventive services such as diabetes self-management training, nutrition therapy training, flu shots, etc.

E. Medicare Advantage Plans

Medicare Advantage Plans can be HMOs, PPOs, PFFSs and SNPs. Not all plans are available in all areas. With the exception of an ESRD Special Needs Plan (currently not available in Missouri), Medicare Advantage Plans are not usually an option for people with ESRD unless:

1. The patient was already enrolled before diagnosis, then
   a. He/she may stay on the plan.
   b. He/she may join another plan if that plan is discontinued.
2. He/she may be able to join a plan after a successful kidney transplant.
3. He/she may “age in.” This means that the patient was in a non-Medicare health plan and then became eligible for Medicare on any basis (ESRD, disability, or age). He/she could join a plan offered by the same organization that provided the non-Medicare plan.

F. Should the beneficiary stay in his/her Medicare Advantage plan if he/she has ESRD?

**Advantages:**
1. The beneficiary is familiar with the providers in his/her network.
2. Treatment for ESRD is expensive. Medicare Advantage plans generally have caps on out-of-pocket costs, which are likely to be met.
3. If the beneficiary qualifies for QMB or QMB +, MO HealthNet will pay the co-pays, deductibles, and coinsurance charged by the Medicare Advantage Plan.

**Disadvantages:**
1. The beneficiary must use providers in the HMO network.
2. The beneficiary will have higher co-pays if using out-of-network providers in a PPO.
3. It is the beneficiary’s responsibility to ask if a provider will accept the PFFS plan before a service is provided.
4. Vacationing may be difficult since you must stay within the plan’s service area.
5. The beneficiary may pay a plan premium, plus the Part B Medicare premium and co-pays and/or coinsurance. Co-pays and/or coinsurance add up fast when you have 13 or more dialysis treatments per month.
6. Should the beneficiary become eligible for Missouri HealthNet, it will not pay second to a Medicare Advantage Plan and co-pays, and deductibles cannot be applied to SpendDown amounts.

**Counselor Note:**
If the beneficiary will be receiving MO HealthNet or purchasing a Medigap policy as a supplement to Original Medicare, he/she should have that paperwork in place before dropping the Medicare Advantage plan to be sure there is no lapse of coverage. Tell the beneficiary to be sure to notify the billing office of any changes in providers. It should also be noted, that with Original Medicare only, there is no maximum out-of-pocket limit.

**G. How can a beneficiary leave his/her Medicare Advantage Plan and return to Original Medicare?**

1. Write or call the Medicare Advantage plan.
2. Call 1-800-MEDICARE (1-800-633-4227).

The beneficiary can only leave a Medicare Advantage Plan during the Annual Coordinated Election period (October 15 thru December 7). Beneficiaries can also disenroll from a Medicare Advantage plan during the Medicare Advantage Disenrollment Period (January 1st thru February 14th) and can only return to Original Medicare. Some beneficiaries may qualify for a SEP at other times during the year. See Medicare Advantage section of this manual.

The beneficiary will receive a letter from the plan stating the date his/her coverage ends, usually the first day of the following month.
H. How does a beneficiary enroll in Medicare Part A & B, and what is the cost?

1. The beneficiary can enroll in Medicare Part A and B based on ESRD at the local Social Security office. The beneficiary will need to bring:
   a. Birth certificate (original or certified copy)
   b. Social Security Card
   c. Form 2728 - End Stage Renal Disease Medical Evidence Report (from the dialysis clinic or transplant program)

2. If the beneficiary is presently receiving Medicare for another reason (age or disability), the beneficiary should re-enroll under ESRD if:
   a. He/she already has Medicare Part A, but did not take Part B, or Part B was stopped (ex. non-payment of premiums). The patient can enroll in Part B without paying a higher premium at the time he/she enrolls under ESRD.
   b. The beneficiary is paying a higher premium because he/she didn’t enroll in Part B when first eligible based on age or disability (10% for each full 12 months), the premium will be reduced to the base rate upon enrollment under ESRD.

3. The Medicare Part B premium is deducted from the monthly S.S., R.R., or federal retiree payment. If the beneficiary is not receiving any of these payments, Medicare will bill the patient every three months for the premiums. Beneficiaries can sign up for the Easy Pay Plan to have premiums deducted from their checking or savings account.

**Important:** If the beneficiary does not pay the Part B premium or chooses to cancel, Part B coverage will end.

Example: Mary did not sign up for Part B when she first became eligible for Medicare Part A at 65 because she was working and had an employer group health plan. She retired in September of 2013 at age 67, and her EGHP ended. Mary forgot about signing up for Part B until she was diagnosed with ESRD in April 2015. Her social worker told her she needed both Part A and B for Medicare to cover some of her treatments and supplies. Mary missed her Special Enrollment Period of eight months (ended May 2014). She also missed the General Enrollment Period (Jan - March annually) in 2015. Under normal circumstances, Mary would have to wait until the General Enrollment Period for 2016, and she would be charged a higher premium for late enrollment; if Mary goes to the local Social Security office now and enrolls in Medicare based on her ESRD and signs up at that time for Part B, she will not have to pay a higher premium.

Example: When Mary started dialysis at age 67, she was already receiving Medicare benefits Parts A and B, but was paying a higher premium because she didn’t sign up for Part B until she was 66. If she goes to her Social Security Office and enrolls in Medicare based on ESRD, her Part B premium will be reduced to the base rate for the current year.
I. When will Medicare coverage begin?

Medicare coverage usually begins the first day of the fourth month of in-center hemodialysis treatment if the patient’s coverage is solely based on ESRD. For example, if in-center treatments started in July, Medicare coverage would begin the first day of October. This four-month period is called a qualifying period or waiting period. During this time period, expenses must be paid by a beneficiary’s employer group health plan, or out-of-pocket if there is no other insurance.

If the patient had Medicare coverage prior to ESRD diagnosis due to age or disability, there is no waiting period. If a beneficiary has an employer group health plan, a 30-month coordination period begins the month that Medicare eligibility starts. During this time:

1. The employer group health plan will pay healthcare bills first.
2. Medicare will pay second.
3. An ESRD patient can have multiple 30-month coordination periods. If Medicare ends due to transplant or regained kidney function, treatments can begin again later.

There are four ways coverage might begin sooner than the fourth month.

1. Coverage can start as early as the first month of dialysis if:
   a. The beneficiary takes part in a home or self-care dialysis training program in a Medicare-approved training facility.
   b. The beneficiary begins the training before the fourth month of dialysis.
   c. The doctor certifies that the patient is expected to finish training and do home dialysis or self-care dialysis in a clinic.
2. Coverage can start the month of admittance to a Medicare-approved hospital for a kidney transplant or for healthcare services needed before the transplant. This applies if the transplant takes place that same month or within the two following months.
3. Coverage can start two months before the month of a transplant. This applies if the transplant is delayed more than two months after admittance to a hospital for the transplant or healthcare services needed before the transplant.
4. If the beneficiary has had a prior period of Medicare coverage based on ESRD, the coverage starts the first month.
<table>
<thead>
<tr>
<th><strong>Course of Dialysis Service</strong></th>
<th><strong>March</strong></th>
<th><strong>April</strong></th>
<th><strong>May</strong></th>
<th><strong>June</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gene, age 12, starts dialysis in a facility in March.</td>
<td>Waiting/qualifying period</td>
<td>Waiting/qualifying period</td>
<td>Waiting/qualifying period</td>
<td>Coverage &amp; 30-month coordination period begins*</td>
</tr>
<tr>
<td>Debbie, age 40, begins home dialysis in March.</td>
<td>Coverage &amp; 30-month coordination period begins*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John, age 68, has Medicare and a retiree medical policy. He begins dialysis in March.</td>
<td>Coverage &amp; 30-month coordination period begins*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sara, previously enrolled based on ESRD, begins dialysis in March.</td>
<td>Coverage &amp; a new 30-month coordination period begins*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Course of Transplant Service</strong></th>
<th><strong>March</strong></th>
<th><strong>April</strong></th>
<th><strong>May</strong></th>
<th><strong>June</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane was admitted to the hospital and had a transplant in March.</td>
<td>Jane’s coverage begins the same month as transplant &amp; 30-month coordination period begins*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jack was admitted to the hospital in March. His transplant was delayed until May.</td>
<td>Jack’s coverage begins the month of admittance to the hospital &amp; 30-month coordination period begins*</td>
<td></td>
<td>Received transplant</td>
<td></td>
</tr>
<tr>
<td>Joe was admitted to the hospital in March. His transplant was delayed until June.</td>
<td></td>
<td>Joe’s coverage begins two months before the transplant &amp; 30-month coordination period begins*</td>
<td></td>
<td>Received transplant</td>
</tr>
</tbody>
</table>

* If the beneficiary has individual health coverage, there is no 30-month coordination period because the coordination period applies to EGHPs only.
J. When will Medicare coverage end?

1. If Medicare coverage is based only on ESRD, coverage will end when:
   a. 12 months have passed after dialysis treatments stop (home hemodialysis or peritoneal dialysis).
   b. 36 months have passed after a successful kidney transplant.

2. Coverage will not end if:
   a. Dialysis is started again within the 12 months.
   b. A kidney transplant is performed within 12 months after the month dialysis was stopped.
   c. Dialysis is started within 36 months after a transplant.
   d. Another kidney transplant is performed within 36 months after the first transplant.
   e. If the beneficiary qualifies for Medicare based on age or other disability, coverage may not end.

K. Beneficiary has an employer group health plan (EGHP)

It is critical that the beneficiary talk to the benefits coordinator of his/her EGHP before dropping or adding coverage.

1. If Medicare eligibility is based only on ESRD:
   a. Months 1-3 (waiting period) is paid by EGHP for in-center dialysis patients (see above for the four ways coverage may start sooner). The beneficiary pays any costs not covered by EGHP.
   b. Months 4-33 (30 months) are the coordination period, Medicare is secondary payer for in-center dialysis patients. The 30-month coordination period starts the first month you are able to get Medicare, even if you have not sign up yet. If your EGHP pays all your healthcare cost with no deductibles or coinsurance you may want to delay enrolling in Medicare until shortly before the 30-month ends.
   c. After the 30-month coordination period, Medicare will pay primary and EGHP secondary. The EGHP may pay for services not covered by Medicare.
   d. During the 30-month coordination period, Medicare may help pay for deductibles and coinsurance. Having Medicare keeps providers who accept Medicare assignment from billing the patient more than the Medicare allowable charges.

Example: Jan is 64-years-old and is covered under an EGHP through her husband who is retired from Ford Motor Company. Jan started dialysis in December of 2014. She has applied for Medicare A & B based on ESRD. Jan will turn 65 in August of 2015.

Jan’s EGHP will be the only payer from December 2014 through February 2015. Her 30-month coordination period will begin March 2015 when her EGHP will be the primary payer and Medicare will be the secondary payer. The fact that she turns 65 during this period will have no effect on who pays first or second. Jan will want to talk to the benefits administrator of her EGHP to see if the plan...
will pay for any Medicare non-covered services. If it will, she may want to consider keeping the EGHP after the 30-month coordination period even though she would be covered under Medicare based on both age and ESRD.

2. Medicare coverage has stopped, but the beneficiary needs to go back on dialysis:
   a. The patient will need to re-enroll for Medicare based on ESRD.
   b. There is not a three month waiting period. Coverage starts when dialysis starts.
   c. If the beneficiary has coverage under an EGHP, there will be a new 30-month coordination period starting when coverage begins.

Example: Bill, age 50, continued to work after his successful kidney transplant in June 2010. He has health coverage through his employer. Bill’s Medicare coverage ended June 30, 2013 (36 months). In March 2015, Bill needed to begin dialysis treatments again. He re-enrolled for Medicare based on ESRD. Medicare coverage started in March 2015. Bill’s new 30-month coordination period started in March 2015.

3. Does the beneficiary have to get Medicare if he/she already has an employer group health plan?
   a. The answer is no, but there are several things that should be carefully considered:
      • If the EGHP does not cover all of the expenses, the patient will need to pay for them.
      • Medicare Parts A and B could help pay the costs of the yearly deductible and coinsurance for the EGHP. If it’s an HMO, it might pay out-of-network providers.
      • If the EGHP does not have a yearly deductible or a coinsurance and will pay all of the healthcare costs, enrollment could be delayed until the 30-month coordination period is over. Delaying enrollment means the beneficiary will not be paying the Part B premium. After the 30-month coordination period, you should enroll in Medicare Parts A and B.
      • Having Medicare coverage limits what health care providers who accept Medicare assignment can charge the beneficiary. The savings could more than make up for the Medicare Part B premiums.
      • After a kidney transplant, immunosuppressive drug therapy is covered if:
         o The beneficiary had Part A at the time of transplant and Medicare made payment for the transplant or Medicare was secondary to an EGHP.
         o The transplant surgery must have taken place in a Medicare-approved facility.
         o The beneficiary had Medicare Part B coverage at the time he/she received the immunosuppressive drugs.

Note: Medicare coverage can be backdated if the patient delayed Medicare enrollment too long and did not have coverage at the time of the transplant surgery that created the need for immunosuppressive drugs. The patient would need to pay the Part B premiums from the requested coverage date. If the patient needs to purchase a Medigap policy, be careful not to backdate further than the six month window for his/her eligibility.
Example: Mr. Johnson was 45-years-old when he had a kidney transplant in August 2014. He did not apply for Medicare until October 2014, and Medicare did not process his paperwork until December 2014. He was awarded coverage retroactive to August 2014, the month of his transplant. Part B coverage was awarded effective December 2014, the month that the paperwork was processed. He will be billed premiums from that date. For Medicare to help pay for his immunosuppressive drugs, Mr. Johnson must have both Part A & B at the time the drugs are prescribed. He asks that his Part B coverage be made retroactive to August 2014 and sends payment for all the back premiums August-December 2014.
If Mr. Johnson wants to purchase a Medigap policy, he will need to do it before the end of January 2015. He has only a six-month open window for purchases beginning with the month of Part B coverage.

L. Termination of Medicare due to non-payment of premiums

1. A beneficiary will be sent three billing notices (over three months) before he/she is terminated. The letters will include:
   a. The initial billing notice.
   b. A second notice labeled “Second Request” sent approximately 60 days after the initial billing.
   c. A final notice labeled “Delinquent Notice” sent early in the 3rd month with a 30 day due date.
2. If the past-due amount (over 90 days) is not paid or is partially paid, leaving a balance of more than $10, Medicare coverage will end by the billing due date.
3. Once termination has occurred, the beneficiary can re-enroll only during the General Enrollment Period (January through March) each year. The only exceptions are: coma, extreme financial hardship, hospitalization, and mental competency.
4. Enrollment in Part B during GEP starts coverage July 1 of the year enrolled.
5. A penalty will be assessed if a full 12 months has passed since coverage lapsed. The penalty will be waived if the beneficiary is eligible for a Medicare Savings Program.

Example: Brenda received her initial billing notice on June 27, 2015. She received the second notice on August 27, 2015. She received the “Delinquent Notice” on September 27, 2015. She did not pay her premium and Medicare Part B was terminated. Brenda paid the full amount owed in December 2015. She will have to wait until January 2016 to re-enroll (General Enrollment Period January–March). Her coverage will not begin until July 1, 2016.

Note: The Missouri Kidney Program can help qualifying transplant patients pay private premiums through a contract facility. The American Kidney Fund’s Health Insurance Premium Program can help qualifying dialysis patients pay Medicare and private premiums.
II. Kidney Dialysis

A. Where does the beneficiary get his/her dialysis treatments?

Dialysis is a treatment that cleans the blood when the kidneys don’t work. It gets rid of harmful wastes, extra salt, and excess fluids that build up in the body. Treatments can be done in:

1. Dialysis center
   a. Must be Medicare approved.
   b. A nurse or trained technician usually gives the treatment. However patients can be taught to do self-care in the clinic.
2. Home/self-care dialysis
   a. Treatment at home can be done by the patient alone, or with the help of a trained family member or friend.
   b. Both the patient and helper will receive training at the dialysis clinic. The training time depends on the type of home dialysis and machine, if needed.
   c. There are two types of dialysis that can be used at home, hemodialysis and peritoneal dialysis.

B. How does the beneficiary find a dialysis facility?

1. The patient’s kidney doctor can tell him/her about facilities where he/she practices.
2. The patient can locate a facility by going to www.medicare.gov and selecting “Dialysis Facility Compare.” This website provides information about:
   a. Facility characteristics
   b. Location
   c. Size
   d. How long the facility has been Medicare approved
   e. Services the facility is approved to offer
   f. Whether dialysis is offered after 5:00 p.m.
   g. Quality measures
   h. Percent of patients who got adequate hemodialysis
   i. Percent of patients treated for anemia, whose anemia was adequately managed
   j. Whether patient survival is as-expected, better-than-expected, or worse-than-expected
3. The patient can find clinics that offer home dialysis in the “Find a Center” database on Home Dialysis Central at www.homedialysis.org. This lists:
   a. Facility characteristics
   b. Location
   c. Phone number
   d. Fax number
   e. Owner
   f. Approved services offered
C. Medicare covered dialysis services and supplies

1. Inpatient dialysis treatments as part of hospitalization
   a. As part of a hospital stay
   b. Covered by Medicare Part A
2. Outpatient dialysis treatments
   a. Treatments are given in a Medicare-approved dialysis facility
   b. Medicare Part B pays 80% of the facility’s Medicare-approved rate after deductible
   c. The beneficiary or his/her insurance pays 20% co-insurance
3. Self-dialysis training
   a. Training is for beneficiary and helper
   b. Training is provided on an outpatient basis
   c. Medicare Part B pays 80% of the approved training rate after deductible
   d. Beneficiary pays 20% coinsurance
4. Home dialysis equipment and supplies
   a. The beneficiary will receive all services, equipment, some kidney-related medications and supplies from the dialysis facility. Medicare pays for home dialysis equipment, medications and supplies at the same rate as dialysis you get in a facility.
   b. Medicare pays doctors on a monthly basis, to help people with Medicare who perform home dialysis treatments manage their care.
5. Outpatient doctors’ services. This is a monthly payment based on the number of times an in-center patient is seen each month or a set amount for home dialysis patients called a capitation fee.
   e. Medicare Part B pays 80% after deductible
   f. The beneficiary pays 20% coinsurance
6. Inpatient doctors’ services. The doctor can choose to be paid in one of two ways:
   a. Receives the same monthly payment as he/she received for outpatient doctors’ services. Part B pays 80%, the beneficiary pays 20% coinsurance
   b. Bill Medicare separately for covered services while patient is hospitalized and reduces the monthly doctors’ fee by 1/30 for each day in hospital

Example: Dr. Smith receives $120/month to provide outpatient doctor services to Jane for her dialysis. Part B pays 80%, or $96. Jane pays $24 coinsurance. Jane was hospitalized for 10 days this month. This month Dr. Smith billed Part B $80 for outpatient doctor services and submitted a separate bill to Medicare for the covered inpatient services he provided in the hospital. Part B will pay $64 and Jane will pay $16 coinsurance this month. This is for seeing the doctor at the dialysis facility and an additional fee for seeing the doctor in the hospital.
D. Non-covered dialysis services and supplies

1. Medicare does not pay for:
   a. Paid dialysis aides to help with home dialysis (except during training).
   b. Lost pay due to self dialysis training
   c. Lodging during treatment
   d. Blood or packed red blood cells for home/self dialysis
   e. Transportation to a dialysis facility, unless the doctor indicates ambulance service is medically necessary (written order must be dated no earlier than 60 days before service)

   **Important:** Medicare will not cover surgery or other services that are needed to prepare for dialysis (such as surgery for a blood access) if it is done before Medicare coverage begins.

E. How does the beneficiary get his/her dialysis treatment if he/she travels?

1. The patient should plan ahead for treatments at least 1-3 months, unless it is an emergency.
2. The patient’s dialysis facility can help find a Medicare-certified facility.
4. The patient should make sure the chosen facility has the space and time to give him/her the treatment.
5. The patient should check on the facility charges or added expenses to him/her.
6. The patient’s dialysis facility needs to send medical records and insurance information to the temporary facility.
7. If the patient is doing peritoneal dialysis, they can ask their dialysis facility to ship supplies to the destination if he/she can’t carry enough with him/her.
8. Medicare will only pay for hospital or medical care, including dialysis, received in the United States.

   **NOTE:** If you get dialysis services from a Medicare Advantage Plan, your plan may be able to help you arrange to get dialysis while you travel. Contact your plan first. Also check with Medicare Advantage Plan for any additional cost sharing.
III. Kidney Transplants

A. How does the beneficiary find an approved transplant hospital?

1. Kidney transplants must be done in a Medicare-approved transplant hospital.
2. The patient’s doctor can give information on hospitals in the area.
3. The patient can locate a Medicare-approved transplant hospital anywhere in the United States through the Scientific Registry of Transplant Recipients website www.srtr.org. It is administered by the University Renal Research and Education Association (URREA) with the University of Michigan. The statistics are arranged to allow comparisons to national averages.
4. The information includes:
   a. Number of transplants performed
   b. Waiting time
   c. Waiting list outcomes
   d. Post transplant experience of patients

B. Medicare-covered kidney transplant services

<table>
<thead>
<tr>
<th>Beneficiary’s Service or Supply</th>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital services in a Medicare-approved hospital</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Kidney registry fee</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Laboratory and other tests in a Medicare-approved hospital to evaluate beneficiary’s medical condition are fully covered</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The costs of finding the proper kidney if there is no kidney donor are fully covered</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Doctors’ services for kidney transplant surgery</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Immunosuppressive drugs</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Blood</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Donor Service or Supply</th>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory and other tests done in a Medicare approved hospital to evaluate the medical conditions of potential kidney donors</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The full cost of care for the kidney donor (includes all reasonable Preparatory, operation, and postoperative recovery costs)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Any additional inpatient hospital care in case of problems due To the surgery</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Doctors’ services during hospital stay</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

Important: All donor medical services and supplies are fully covered. No coinsurance or deductibles apply. Travel and daily living expenses are not covered.
C. Immunosuppressive drugs

These drugs are necessary to reduce the risk of the body rejecting the new kidney after transplant. Taking the drugs is a life-time commitment as long as the kidney works. Beneficiaries are always responsible for the annual Part B deductible.

1. Medicare pays 80% for immunosuppressive drug costs with no time limit if:
   a. If the beneficiary already had Medicare because of age or disability, or
   b. The beneficiary became eligible because of age or disability after receiving a transplant that was:
      • Paid for by Medicare
      • Medicare made no payment, Medicare was secondary payer
      • The beneficiary had Medicare Part B at the time the drugs were dispensed
      • The beneficiary had the transplant in a Medicare approved hospital

2. Medicare pays 80% for immunosuppressive drugs for 36 months after the transplant if:
   a. the beneficiary has Medicare only because of ESRD, and:
   b. The beneficiary was entitled to Part A at the time of transplant, and
      • Medicare paid for the transplant, or
      • Medicare made no payment, Medicare was secondary payer
   c. The beneficiary had Medicare Part B at the time the drugs were dispensed
   d. The beneficiary had the transplant in a Medicare-approved hospital

Example: Marsha is 55 years old. She has Medicare Part A and B based on a disability, a Medicare supplement, and no EGHP. She has just been diagnosed with ESRD and knows that she will probably need a kidney transplant in the future. She will be on immunosuppressive drug therapy for the rest of her life after surgery. She applies for Medicare based on ESRD and is happy that it will cover the drug therapy for as long as her new kidney works. If her kidney fails and she gets another kidney, Medicare will pay for immunosuppressant for that kidney too.

Example: Jeff is 48 years old and has just applied for Medicare based on ESRD. He signed up for Medicare Part B because he knows he will soon have a kidney transplant and need to take immunosuppressive drugs for the rest of his life. He thinks that Medicare will cover them, but his social worker tells him that Medicare will only cover the drugs for 36 months after his transplant. Luckily he lives in Missouri and qualifies for the Missouri Kidney Program to help pay for immunosuppressive drugs.

D. Blood

1. Medicare Part A
   a. The beneficiary pays for the first three pints of whole blood or units of packed red cells received during a benefit period.
   b. The beneficiary or someone else can donate blood to replace the blood used.
   c. Medicare Part A will pay 80% of the approved charge for extra pints of blood.
   d. The beneficiary will pay the remaining 20% coinsurance plus deductible.
2. Medicare Part B
   a. The beneficiary pays for the first three pints of whole blood or units of packed red cells received during a calendar year.
   b. The beneficiary or someone else can donate blood to replace the blood used.
   c. Medicare Part B will pay 80% of the approved charge for extra pints of blood.
   d. The beneficiary will pay the remaining 20% coinsurance plus deductible.

Note: If the beneficiary has a Medigap policy, it will cover the first three pints of blood under either Part A or Part B.

Note: If the beneficiary paid for or replaced three units of blood once during a calendar year, under either Part A or Part B, he/she will not need to do it again that year.

Example: George has Medicare Part A and B, but no Medicare supplement. He was admitted to the hospital for surgery in May. He received four pints of blood. George will pay 100% for three pints and 20% for one pint. If he needs blood again during this calendar year, he will pay 20%. If George would have had a Medicare supplement, it might have paid for his first three pints of blood.

Example: Mary had an outpatient procedure in June and received one pint of blood for which she paid 100%. She was admitted to the hospital the following January for her transplant and received two pints of blood. Mary will pay 100% for the two pints because the second pint was not received in the same calendar year as the first.

IV. Will the Medicare Part D Prescription Drug Benefit affect the beneficiary?

1. The majority of drugs covered under Part B are not good candidates for coverage under Part D because they are:
   a. Dispensed in a physician’s office or similar provider setting
   b. Injectable or intravenous and cannot be self-administered by the beneficiary
2. Immunosuppressive drugs will:
   a. Remain covered by Part B if the kidney transplant beneficiary was enrolled in Medicare Part A at the time of transplant
   b. Be covered by Part D if the kidney transplant occurred prior to enrollment in Medicare Part A
3. Any prescription drugs not covered by Part B will be covered by Part D if they are on the list of covered drugs for the plan you choose
V. Appeals and Grievances

A. Background

1. Every Medicare recipient has a guaranteed right to a fair, efficient, and timely process for appealing decisions about health care payment or services. Some reasons a beneficiary may appeal:
   a. The patient disagrees with the amount paid
   b. A service or item isn’t covered and he/she thinks it should be covered
   c. A service or item is denied and he/she thinks it should be paid

   The process for appeals is explained in the Sections on Medicare Part A and B.

B. Grievances

1. If the beneficiary has a problem with the service he/she received:
   a. Talk to the doctor, nurse, or facility administrator to see if they can help resolve the problem.
   b. If that doesn’t help, the beneficiary should get a copy of the facility’s grievance/complaint policy and follow it.
   c. If the problem still is not solved, the beneficiary has the right to file a grievance with the ESRD Network at 1-800-444-9965 or www.esrdnetworks.org.
   d. The beneficiary can report the problem to the Bureau of Health Facility Regulation in Missouri at (573) 751-6303. For Spanish, dial (573) 526-1863.

VI. Other Kinds of Health Insurance

There are several kinds of health insurance, both private and public that may help pay for services and supplies not covered by Medicare.

A. Other health coverage

1. Employer group health plans
2. Refer to the Medicare Supplement section for information on the following:
   a. Federal employee health benefits
   b. Consolidated Omnibus Budget Reconciliation Act (COBRA)
      i. When ESRD-based Medicare entitlement begins before COBRA eligibility, the employer plan cannot terminate coverage. COBRA pays first, and Medicare pays second for the time that COBRA overlaps the 30-month coordination period.
      ii. If Medicare entitlement occurs after COBRA begins, then the employer may terminate existing COBRA coverage. The employer can voluntarily offer to continue the coverage.
3. Indemnity policies
   a. Specific disease or accident policies
   b. Medical/surgical policies
   c. Long-term care policies
4. Tricare
5. Veterans benefits
6. Marketplace Plans
   a. In general people who are eligible for Medicare may not purchase Marketplace plans. However, IRS guidance released in June 2013 clarifies that two sub-populations of Medicare eligible individuals may be able to forgo Medicare coverage to buy Marketplace plans.
      i. People who must pay for Part A premiums (also called “voluntary enrollees”)
      and
      ii. Those entitled to Medicare based on entitlement of ESRD
   b. Non enrollment in Part A & Part B potential pitfalls and unanswered questions
      i. Medicare beneficiaries could encounter unanticipated adverse consequences from foregoing Medicare coverage to enroll in a Marketplace plan.
      ii. May face a financial penalty should they later decide to enroll in Medicare.

B. Medigap Policies (Medicare Supplement)

1. There are 11 standardized plans designed to fill some of the “gaps” in Medicare, such as deductibles, coinsurance, and the first three pints of blood.
2. Individuals age 65 and older have an initial enrollment period during the first six months in which they sign up for Medicare Part B coverage.
3. Companies offering Medigap policies in Missouri must offer policies (guarantee issue) to people younger than 65 during the initial enrollment period if they are disabled or have ESRD.
4. Younger patients can be charged a slightly higher premium than people age 65 and older.
5. When ESRD or disabled policyholders reach age 65, they will have another six month open enrollment period in which:
   a. They can choose any plan they want from any company offering Medigap plans.
   b. Companies can’t refuse them because of their disability or other health problems.
   c. The premium will be the same as other policyholders age 65 and over.
6. Current policyholders have the right to switch companies once a year. Annual open enrollment is the policy’s anniversary month and the first month after the policy’s anniversary date. For example, if a policy expires on June 30, then open enrollment is June and July.
7. Enrollees can only change to a similar plan without the possibility of denial.
8. Enrollees will need to show the new company a renewal notice from the old company, an invoice or the old policy.
9. If the patient has a Medigap policy and goes on Missouri HealthNet, he/she can suspend the policy, rather than dropping it for up to two years. During that time:
a. He/she will pay no premiums.
   b. The policy would pay no benefits.
10. The patient can restart policy without new medical underwriting or pre-existing condition waiting periods.

C. Public Benefits

Refer to the Public Benefits Section for information on the following programs that may assist persons with lower income in paying for their healthcare.
1. Beneficiaries with Supplemental Security Income (SSI) must file a separate application for MO HealthNet in Missouri.
2. MO HealthNet is for people who meet state income and resource guidelines.
3. MO HealthNet SpendDown is for those with higher income and medical bills.
4. Qualified Medicare Beneficiary (QMB)
5. Specified Low-Income Medicare Beneficiary (SLMB)
6. Qualifying Individual-1 (QI-1) also known as SLMB2

D. Beneficiary has Medicare and MO HealthNet

Does the beneficiary need a Medigap policy?
1. Medicare beneficiaries, who qualify for full MO HealthNet coverage, or those in the QMB program, do not need a Medigap policy.
2. If MO HealthNet pays only the Part B premium (SLMB or QI-1), then the beneficiary can buy any Medigap policy.
3. Keeping MO HealthNet Spend Down case active and paying in the Spend Down once a year to receive extra-help for Part D may be cost beneficial to ESRD patients.

VII. Related Information

A. Medicare Easy Pay

1. Easy Pay is an electronic payment option for beneficiaries who are directly billed for their Medicare premiums.
2. Premiums can be deducted from either a checking or savings account
3. Beneficiaries can sign up any time by:
   a. Completing an Authorization Agreement for Preauthorized Payment Form
   b. Mail the completed form to:
      Centers for Medicare & Medicaid Services
      Medicare Premium Collection Center
      P.O. Box 790355
      St. Louis, MO 63179-0355
4. The beneficiary will receive a monthly notice of the amount deducted.
B. Family and Medical Leave Act (FMLA)

1. If the beneficiary is unable to work for a period of time because of kidney failure or other serious health conditions, he/she can take up to 12 weeks of unpaid leave.
2. If a family member needs to care for a person with a serious health problem, such as kidney failure, he/she may also be able to take unpaid leave.

Note: The beneficiary should check the company’s FMLA policy for specific information.

C. Americans with Disabilities Act

1. People with disabilities that limit their ability to do significant life activities (like kidney failure) are protected in hiring, firing, raises, promotions, job training, etc. If an employer has 15 or more employees they must provide:
   a. “Reasonable accommodation” (time to do dialysis at work or shift flexibility to go to dialysis, a job change to a less physically demanding job if available, etc.).
   b. The patient must ask for it.
   c. A company doesn’t have to offer an accommodation that is too burdensome.

D. Missouri Vocational Rehabilitation (VR)

1. Social Security considers kidney failure a severe impairment, which makes you eligible for VR services.
2. VR can assess the patient, offer help with education or training, or help him/her get a job.
3. Working with VR can postpone when the patient’s disability check will stop after a transplant if he/she only gets disability because of ESRD.
4. Beneficiaries can locate a Missouri office at www.dese.mo.gov or by calling 877-222-8963. Under “Adult Learning & Rehab. Services” select “Vocational Rehabilitation,” then scroll down and select “VR Offices.” They will find addresses and contact numbers throughout the state.
VIII. Other Sources of Information

A. Missouri Kidney Program

Website: http://som.missouri.edu/mokp/
Phone: 800-733-7345 or 573-882-2506
Fax: 573-882-0167

The Missouri Kidney Program is based in Columbia, Missouri. It is a part of the University of Missouri–Columbia. The state-funded program was founded in 1968 to help meet the needs of ESRD patients in Missouri. On the website you will find planned educational programs, links to other websites of interest to ESRD patients, and other useful information.

B. Heartland Kidney Network (ESRD Network No. 12)

Website: www.heartlandkidney.org
Phone: 800-444-9965 or 816-880-9990

The Heartland Kidney Network, formerly ESRD Network No. 12, is a not-for-profit organization that contracts with the Centers for Medicare and Medicaid Services (CMS) to provide data management, quality improvement and grievance mediation services for kidney dialysis and transplant patients. The Network is for patients in Missouri, Iowa, Kansas, and Nebraska. Patient Service Specialists handle questions and concerns received by mail, phone or email. The website contains useful information for both providers and consumers. An online patient newsletter is produced quarterly.

C. Centers for Medicare and Medicaid Services (CMS)


The Centers for Medicare and Medicaid Services (CMS) website offers information of interest to both consumers and providers. Consumers can locate a healthcare service anywhere in the United States and compare the quality of the service delivered by all providers in that area. Medicare beneficiaries can find information about the companies that offer Medigap and Medicare Advantage coverage in their area. Consumers can get the latest information about changes to Medicare that have taken place or will take place in the near future. Many publications about Medicare subjects are available to download and print, and there are links to other websites containing information on Medicare related services and issues.
D. Life Options Rehabilitation Program

Website: www.lifeoptions.org
Phone: 800-468-7777


E. National Kidney Foundation

National Kidney Foundation of Eastern Missouri and Metro East
Website: www.kidney.org/site/308/index.cfm
Phone: 800-489-9585 or 314-961-2828

National Kidney Foundation of Kansas and Western Missouri
Website: www.kidneyksmo.org
Phone: 800-596-7943 or 913-262-1551

The National Kidney Foundation of Kansas and Western Missouri is a major voluntary health organization dedicated to preventing kidney and urinary tract diseases, improving the health and well-being of individuals and families affected by these diseases, and increasing the availability of all organs for transplantation. National Kidney Foundation affiliates offer a wide variety of educational materials and programs for the public, patients, and professionals.
Tab Divider named “Section 10 Long-Term Care”
# Section 10
## Long-Term Care

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>What is Long-Term Care?</td>
<td>1</td>
</tr>
<tr>
<td>A.</td>
<td>Definition</td>
<td>1</td>
</tr>
<tr>
<td>B.</td>
<td>Levels of Long-Term Care</td>
<td>1</td>
</tr>
<tr>
<td>C.</td>
<td>Long-Term Care Settings</td>
<td>2</td>
</tr>
<tr>
<td>D.</td>
<td>Prevalence of Long-Term Care</td>
<td>2</td>
</tr>
<tr>
<td>E.</td>
<td>Cost and Who Pays</td>
<td>3</td>
</tr>
<tr>
<td>F.</td>
<td>Planning Ahead</td>
<td>4</td>
</tr>
<tr>
<td>G.</td>
<td>Why Don’t People Plan Ahead?</td>
<td>4</td>
</tr>
<tr>
<td>II.</td>
<td>Public Financing of LTC Services</td>
<td>5</td>
</tr>
<tr>
<td>III.</td>
<td>Long-Term Care Insurance</td>
<td>5</td>
</tr>
<tr>
<td>A.</td>
<td>What is Long-Term Care Insurance?</td>
<td>5</td>
</tr>
<tr>
<td>B.</td>
<td>Benefits of LTC Insurance</td>
<td>6</td>
</tr>
<tr>
<td>C.</td>
<td>To Buy Or Not To Buy?</td>
<td>6</td>
</tr>
<tr>
<td>IV.</td>
<td>Types of Long-Term Care Insurance Plans</td>
<td>7</td>
</tr>
<tr>
<td>A.</td>
<td>Market Segments</td>
<td>7</td>
</tr>
<tr>
<td>B.</td>
<td>Payment Methods</td>
<td>7</td>
</tr>
<tr>
<td>C.</td>
<td>Tax Treatment Of LTC Insurance</td>
<td>8</td>
</tr>
<tr>
<td>V.</td>
<td>Features and Benefits of LTC Insurance</td>
<td>9</td>
</tr>
<tr>
<td>A.</td>
<td>Covered Services</td>
<td>9</td>
</tr>
<tr>
<td>B.</td>
<td>Daily Coverage Amounts</td>
<td>10</td>
</tr>
<tr>
<td>C.</td>
<td>LTC Insurance Premiums</td>
<td>11</td>
</tr>
<tr>
<td>D.</td>
<td>Coping With a Rate Increase</td>
<td>11</td>
</tr>
<tr>
<td>E.</td>
<td>Underwriting</td>
<td>12</td>
</tr>
<tr>
<td>F.</td>
<td>Typical Uninsurable Conditions</td>
<td>12</td>
</tr>
<tr>
<td>G.</td>
<td>Most Common Uninsurable Conditions</td>
<td>13</td>
</tr>
<tr>
<td>H.</td>
<td>Underwriting Tools</td>
<td>13</td>
</tr>
<tr>
<td>I.</td>
<td>Acceptance and Denial</td>
<td>14</td>
</tr>
<tr>
<td>J.</td>
<td>Qualifying For Claims</td>
<td>14</td>
</tr>
<tr>
<td>K.</td>
<td>Exclusions and Limitations</td>
<td>15</td>
</tr>
<tr>
<td>L.</td>
<td>More About Mental/Nervous Exclusions</td>
<td>15</td>
</tr>
<tr>
<td>M.</td>
<td>Pre-Existing Condition Exclusion</td>
<td>16</td>
</tr>
<tr>
<td>N.</td>
<td>Outline of Coverage</td>
<td>16</td>
</tr>
<tr>
<td>O.</td>
<td>Other Private Financing Options for Long-Term Care</td>
<td>17</td>
</tr>
<tr>
<td>P.</td>
<td>Other Financing Options</td>
<td>22</td>
</tr>
</tbody>
</table>
I. What is Long-Term Care?

A. Definition

1. Long-term care (LTC) is the medical and non-medical support services needed by an individual with a prolonged illness or disability to perform activities of daily living (ADLs) or instrumental activities of daily living (IADLs)
2. Activities of Daily Living (ADLs)
   a. Bathing, dressing, eating, using the toilet, transferring (e.g. getting out of bed), continence (bladder/bowel control)
3. Instrumental Activities of Daily Living (IADLs)
   a. Grocery shopping, laundry, meal preparation, housework, managing medication, transportation
4. Individuals with cognitive impairments may also require LTC
5. Long-term care services are intended primarily to maintain health status
6. Acute care aims to improve or correct a medical condition

B. Levels of Long-Term Care

1. Long-term care encompasses many different types of services, which are sometimes grouped into the following levels:
   a. Skilled care is medical or nursing care (such as help with medications, caring for bandages and or wounds) and therapies (such as occupational, speech, respiratory and/or physical therapy). Skilled care is delivered by a nurse, therapist, or other specially trained or licensed professional. Many people think of skilled services when they think of LTC but less than 15% of all people who need LTC require skilled care.
   b. Personal care or custodial care is assistance with the ADLs, such as bathing and dressing. The goal of personal care is to provide help with activities that individuals are unable to perform on their own. Most people who need LTC need personal care.
   c. Supervisory care provides monitoring and supervision, a safe or controlled environment and stand-by help with ADLs to ensure that individuals do not harm themselves or others. Supervisory care is often needed because of a severe cognitive impairment.
C. Long-Term Care Settings

1. Long-term care services can be provided in a wide range of settings including:
   a. **Informal Care** is usually provided by family or friends who may provide a
      variety of services to assist their relatives or neighbors to do things such as paying
      bills, preparing meals, or helping them bath or dress.
   b. **Formal Care** is for individuals requiring skilled, professional LTC services and
      can receive them in a variety of settings. In many cases, individuals will use a
      combination of different services in order to meet their LTC needs. For example, an
      individual may receive both formal home health care services and informal
      care from a family member, or they may attend an adult day care program in
      addition to receiving home health care services.

D. Prevalence of Long-Term Care

Approximately 60% of those 65 and older will require LTC at some point in their lives. About 43% will require nursing home care. There are many factors that increase a person’s risk, including those listed below.

1. **Age** – Age is the single most important risk factor for needing LTC services.
   However, younger people can also need LTC.
2. **Marital Status** – Single individuals are more likely to require LTC services. Singles are less likely to live with someone who can provide informal care.
3. **Gender** – Women are more likely to require LTC services. Women often outlive men.
4. **Lifestyle** – Smoking, poor diet, stress, and/or a sedentary lifestyle can lead to chronic health conditions.
5. **Health** – Chronic conditions increase the risk of needing LTC.
6. **Family History** – Individuals with a family health history of physical or mental illness have an increased risk of needing LTC.

Sources:
“Long-term Care Insurance, Baby Boom or Bust?” Conning & Company, 1999
B.C Spillman & J. Lubitz. “New Estimates of Lifetime Nursing Home Use: Have Patterns Changed?”
E. Cost and Who Pays

Long-Term care services are paid for by many different sources including Medicaid, personal savings, Medicare, and private LTC insurance.

Most people who need LTC pay out of their own income and savings; however, on an aggregate basis, Medicaid is the largest single payer for both LTC services in general and nursing home services specifically. Once a person uses up his or her financial resources paying for LTC, Medicaid becomes responsible for paying for the care. Payment for individual’s LTC services is usually more complicated than it may appear. Since individuals requiring LTC usually need an array of services, a person may have some of their services paid by more than one source. In addition, the payment source for certain services may change over time as the person’s needs change or as they exhaust their health care benefits or personal resources.

Example #1 - Sam is an 82 year old widower with an income of $2,000 per month and savings of $14,500. He suffered a stroke and was hospitalized for several weeks. Following his hospital stay, he is discharged to a skilled nursing facility, where he will stay indefinitely. The nursing home charges $150 per day or $4,500 per month.

His nursing home stay is paid for as follows:

First 20 days: Medicare covers all costs.

Days 21 to 34: Medicare and personal income pay for care. Sam pays $114. Per day and Medicare pays the rest. He uses his regular monthly income to cover his portion of the costs.

Days 35 to 199: Personal Income/Savings. On Day 35, Sam’s doctor decides he no longer needs skilled care (only personal care) so his care is no longer covered by Medicare. Sam will be responsible for the cost of his nursing home care. His monthly nursing home bill is $4,500 and his monthly income is $2,000, so he must pay $2,500 per month from his savings. With $14,500 in savings, Sam must spend-down $13,500.01 in savings before he is eligible for Medicaid. He can pay approximately five and half more months (165 days) of his stay.

Days 199 and beyond: Personal Income/Medicaid. Sam has exhausted his savings. His nursing home costs are now covered by a combination of his income and Medicaid.

The case study illustrates how Sam’s nursing home care was paid for by several different sources as he first exhausted the benefits available to him under Medicare and then his personal savings. At the end his nursing home costs are being paid by two sources: Medicaid and his personal income.
Example #2—Margaret is an 85 year old woman who lives alone, but within a short drive of her adult daughter, Allison. She has a LTC insurance policy. Margaret has begun to experience difficulty in performing some activities of daily living, including bathing and dressing herself, and some instrumental activities of daily living, including grocery shopping, paying her bills, and preparing meals. Margaret, with the help of her daughter, makes the following arrangements to address her LTC needs:

**Bathing and Dressing:** Because Margaret does not need skilled nursing care or therapy services; she does not qualify for home health care coverage under Medicare. However, her LTC insurance policy will cover up to $50 per day for home care, allowing Margaret to have a home health aide come to her home each day to help her bathe and dress.

**Grocery Shopping:** Margaret’s daughter, Allison, will help her do most of her grocery shopping. But because Allison sometimes travels for business, they contact Margaret’s church to find a volunteer who will take Margaret shopping and look in on her when Allison is out of town.

**Paying Bills:** Allison will now pay Margaret’s bills and keep her financial, legal, and medical records in order.

**Preparing Meals:** Margaret and Allison have dinner together twice a week. To supplement this, they make arrangements with the local home delivered meal program to have lunch delivered to Margaret’s home three times a week. For her other meals, Allison prepares meals on the weekend that Margaret can reheat for herself during the week.

The case study illustrates how Margaret has used a combination of formal care (provided by her home health aide) and informal care (provided by her daughter, a church volunteer, and local social service agencies) to meet her current LTC needs.

**F. Planning Ahead**

1. Preserving assets and income for uses other than paying for LTC services. This allows one to ensure quality of life for a spouse or other family member and allows one to preserve and pass on an estate to heirs.
2. Providing choice over care options and control over where and how one receives LTC.
3. Improving quality of life. This results in less emotional and financial stress on individuals and their families.
4. Easing the burden of providing care by loved ones. Family members can still be involved in the daily care routine, but they can be a supplement rather than being the only source of care, which is emotionally and physically demanding.
5. Maintaining independence. Choices for care outside a facility and being able to stay at home as long as possible are enhanced if individuals plan ahead, including a plan for how to pay for care options that are less likely to be covered by payers of last resort, such as Medicaid.

**G. Why Don’t People Plan Ahead?**
1. Lack of awareness of the risks of needing care
2. Lack of awareness of the costs of care and who pays
3. Most people do not realize that if they need LTC for an extended time, it is most likely to be paid for out of their pocket
4. Denial
5. Competing planning priorities
6. Difficulty in discussing LTC issues
7. Not understanding the benefits of planning
8. Not understanding how to plan

II. Public Financing of LTC Services

1. Medicare - Medicare provides limited coverage for LTC services. Skilled care is the only type of nursing home care covered by Medicare, but coverage is limited. Medicare does not cover other types of LTC.
2. Medicaid - Medicaid provides substantial coverage for LTC. However, income and resource limits must be met before someone can qualify to receive Medicaid benefits for LTC. Also, not all LTC providers accept Medicaid payments, so LTC options and choice may be limited under Medicaid.

III. Long-Term Care Insurance

A. What is Long-Term Care Insurance?

1. LTC insurance is designed to protect against the potentially catastrophic costs of LTC. It helps pay for LTC expenses up to a pre-set amount. An individual selects this amount when purchasing a policy.
2. Typically, LTC insurance pays for care in a wide variety of settings including facility care, home care, and community-based care, although some people purchase more limited coverage that focuses only on one type of care setting.
3. In some respects, LTC insurance is similar to auto or homeowner’s insurance – it is bought in advance and with hope that it is never used. LTC insurance is there to pay for the catastrophic expenses associated with an unanticipated need, in case it should occur. It provides peace of mind and financial protection.
4. Unlike health insurance or term life insurance, LTC insurance is a cash accumulation insurance product that has significant prefunding requirements. Prefunding means that coverage is bought in advance of needing it. In the early years, individuals pay more for the coverage than the actual “term” risk faced in those earlier years; however, in the later years, individuals pay much less than what one would have paid to reflect the actual value of the risk.
B. Benefits of LTC Insurance

1. Help pay some or all of the cost of an individual’s LTC needs.
2. Help protect all or a portion of accumulated assets.
3. Provide financial security for spouses, should one spouse require costly LTC.
4. Enable one to pass their home or estate onto an heir.
5. Provide peace of mind.
6. Reduce or eliminate the reliance on Medicaid.
7. Provide control over LTC choices and care options, including expanding alternatives to nursing home care (e.g. assisted living facility care, home health care, or adult day care).
8. Provide an alternative to relying on family or friends to provide needed care.
9. Provide a way to “pre-pay” for future LTC needs which costs less since risks and costs are pooled with many other insured persons. This means that an individual pays much less over time than if paying for care without insurance. This can help protect income, in order to live comfortably in later years, rather than draining that income to pay for care needs.

C. To Buy Or Not To Buy?

1. **To Buy:** Generally, individuals should consider buying LTC insurance if they:
   a. Have assets to protect.
   b. Are not eligible (or close to qualifying) for Medicaid.
   c. Can afford the premiums for the type and amount of coverage they believe best suits their needs. Individuals should take into account whether their current income is expected to increase, decrease, or remain constant over time. It is also important for individuals to consider if they can afford the premium today and in the future.
   d. Are in reasonably good health in order to qualify for the insurance.
   e. Are concerned with the possibility of someday needing LTC.
   f. Someone who does not want to or cannot rely on family or friends for care may believe it is more important to have insurance to cover the costs of paid care.

2. **Not to Buy:**
   a. Already qualify for Medicaid.
   b. Already in need of long-term care.
   c. No assets to protect.
   d. No heirs to pass assets on to.
IV. Types of Long-Term Care Insurance Plans

A. Market Segments

Most LTC insurance is sold directly to individuals age 55 and over by agents, brokers, or financial planners meeting one-on-one with consumers. This “individual market” represents 80% of all LTC policies currently sold. This also includes individual LTC policies that are sold through a sponsoring association (such as the American Bar Association and Aircraft Owners’ and Pilots’ Association) and policies that are sponsored by a Continuing Care Retirement Community (CCRC) for sale to its residents.

A smaller but growing segment of the market is the group market, where LTC protection is sold to younger, working age adults as an “employee-pay-all.” Since LTC insurance premiums are based on the age at the time of purchase and are designed to remain constant over one’s lifetime, average premiums are much lower in the employer-sponsored group market than in the individual market, where buyers are older.

Only a small portion of LTC policies today (approximately 5%) is provided as a rider to a life insurance policy.

B. Payment Methods

1. Reimbursement Approach: This is the most prevalent approach because it is also the least costly. The policy pays 100% of LTC expenses up to a preset amount chosen when coverage is purchased. If an individual has chosen a nursing home daily benefit of $150/day, and is receiving care in a nursing home that costs $100/day, the policy will pay $100/day. But if an individual was in a nursing home that costs more than the $150/day benefit amount selected, the policy would pay, but only up to the $150/day benefit limit.

2. Indemnity Approach: Some policies pay a set amount per day for care, based on the amount chosen when coverage is purchased. The amount paid in this approach does not vary based on the costs of care. If an individual is in a nursing home that costs $100/day, and has chosen a policy with an indemnity benefit of $150/day, the policy would pay $150/day. However, the additional $50 can be used as the individual wishes. Most insurers who use an indemnity approach will only use that approach for facility care; the policy would use the reimbursement approach for home and community care expenses.

3. Disability Approach: Some policies offer a “disability payment approach.” This type of policy makes a cash payment for each day that an individual is disabled (i.e. need help with ADLs or have a cognitive impairment), even if the individual does not receive any paid care or LTC services on that day. The “cash” can be used to pay for non-licensed or family caregivers, or anything an individual wants. While the disability approach allows more flexibility to use the benefit payments in any way one wishes, it also costs more – about 40% more than the reimbursement approach.
C. Tax Treatment Of LTC Insurance

1. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 clarified the favorable tax treatment for LTC insurance plans meeting certain requirements. Most companies selling LTC insurance today offer a policy that qualifies for certain federal tax advantages. These tax-qualified LTC plans include some important consumer protection features. Over 80% of all the LTC policies sold currently are tax-qualified plans. With a tax-qualified LTC policy, the benefit payments received are tax-free and the premiums paid may be tax-deductible under certain circumstances. Specifically, the cost of premiums can be combined with other itemized medical expenses to exceed 7.5% of the adjusted gross income.

2. There are allowable differences between tax-qualified (TQ) and non-tax qualified (NQ) LTC plans. This difference may only impact access to short-term, recuperative, or skilled-type LTC, but are not especially relevant for extended care needs, which typify LTC. While some insurance companies still sell both TQ and NQ LTC plans, the majority of companies today only sell TQ plans. Also, NQ LTC plans do not have to differ from TQ plans in all these ways; they can use the same definition of benefit triggers and other provisions. If they do not completely conform to the TQ requirements, they cannot claim the tax-favored treatment that TQ plans have. The LTC insurance policy must state prominently on the policy face page (and the Outline of Coverage) whether it meets the requirements to be a federally tax-qualified LTC policy, or if it is not a tax-qualified plan.

An example of the “tax disclosure statement” is found below. LTC policies that were issued before 1-1-1997 are automatically granted TQ status, even though they do not have to meet the current requirements for TQ policies.

Note: This Policy is intended to be a tax qualified LTC insurance contract under section 7702B (b) of the Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996-Public Law 104-191).

3. Tax Qualified vs. Non-Tax Qualified LTC Policies

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>TAX QUALIFIED</th>
<th>NON-TAX QUALIFIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium</td>
<td>Tax deductible in certain circumstance</td>
<td>Premium is not tax deductible</td>
</tr>
<tr>
<td>Benefits</td>
<td>Benefits do not count as taxable income</td>
<td>No IRS decision on whether benefits are taxable</td>
</tr>
<tr>
<td>Duration of Disability</td>
<td>Expected to last at least 90 days</td>
<td>Can cover short term disability (last less that 90 days)</td>
</tr>
<tr>
<td>Criteria for Receiving Benefits</td>
<td>Loss in ADLs, based on standardized definitions. Sever cognitive impairment</td>
<td>Can use “medical necessity” or other criteria as an addition basis for paying benefits</td>
</tr>
</tbody>
</table>
“Medical necessity” does not mean “your physician says you need LTC.” The LTC policy often defines “medical necessity” and has the right to assess whether the definition and criteria have been met. Because “medical need” has little to do with needing LTC, a “medical necessity” criterion may actually make it more difficult to receive benefits under a LTC policy, not easier.

4. Tax Treatment Q&As
   a. **Should I buy a tax-qualified plan or a non-tax qualified policy?** Many companies only offer tax-qualified plans. But if you are considering buying from a company that offers both options, here are some things to consider. In the long run, it is probably best to buy a TQ plan. If you buy an NQ plan, you are taking a chance that you may be required to pay taxes on the benefit payments you receive. You also would not be able to deduct premium payments (even if you otherwise qualify for the 7.5% medical expense deduction). There are small differences between a TQ and NQ plans, but the potential tax advantages outweigh these differences.
   b. **Besides tax treatment, how are tax-qualified and non-tax qualified plans different?** There are small differences in the criteria for when you can receive benefits.
      - A TQ plan may not pay benefits if you only need care for a short time and are expected to recover from your current condition (e.g., if your disability or illness is not expected to last more than 90 days). This is an IRS requirement of all tax-qualified plans. A NQ plan does not have this requirement. However, remember that your Medicare, health plan, or Medicare supplement may pay for short-term, recuperative care. Most LTC needs are not short-term.
      - NQ plans can include “medical necessity” as additional criteria for receiving benefits, but LTC is not really “medically” related. There are not many situations where someone would have a “medical need” for LTC yet still be able to perform their ADLs, which is the standard used in TQ plans.
      - Finally, TQ plans must meet a greater number of additional consumer protection standards than those required of NQ plans.

**V. Features and Benefits of LTC Insurance**

A. Covered Services

Long-term care policies vary in terms of the specific services they will cover and the nature and extent of coverage provided for those services. The vast majority of coverage sold today is “comprehensive” in that it provides benefits both for facility-based care and for care at home or in the community. This is in contrast to the earliest LTC policies, which emphasized institutional care and provided little or no coverage for care at home. Today about 70% of policies sold are “comprehensive” in terms of the care settings and services covered.

The best way to understand what services are covered and what is not covered is to review the Outline of Coverage and, if necessary, a specimen policy. The Outline of
Coverage will summarize the services covered and the benefit amounts for each service, and will list any important exclusions or limitations on coverage (e.g., whether care provided by immediate family can be covered or is excluded). Marketing literature is useful, but the “full story” is found in the Outline of Coverage in the actual policy language.

B. Daily Coverage Amounts

1. People can select the amount they want their LTC policy to pay for care each day. All policies provide a choice of the amount paid for nursing home care. Many policies pay the same amount for care in an assisted living facility as for nursing home care. Benefit amounts for “facility care” generally range from $50 per day to $300 per day or more. Some states specify the minimum benefit amount that can be offered.

2. Many policies also allow consumers to choose the amount they want the policy to pay for care at home. These amounts range from $50 to $300 per day, or they may simply decide whether they want the “benefit amount” for home care to be the same as the facility care amount (100%) or if they want the home care benefit to be lower than the facility care amount. Some policies simply have one benefit amount that applies to all covered services. While this is simpler to understand, it can be more costly than a policy that lets the consumer select a lower payment amount for home care.

3. While most LTC policies pay expenses up to the daily benefit amount selected, some policies are more flexible. These policies have a weekly or monthly limit, not a daily limit, on how much they will pay. This allows you to spend more on care on days when you might not have any family care and spend less or nothing on days when family care is available. A weekly or monthly limit approach results in a greater amount of home care costs being covered than a daily benefit limit approach.

4. How should individuals decide what daily benefit amount (DBA) is best? It is important to look into how much care costs in their area (or where they plan to live when needing care). Ask friends or family who have needed care, or call some nursing homes, assisted living facilities, or home care agencies to get a sense of area costs. Costs can vary quite a bit from one provider to another.

5. Most policies pay LTC expenses up to a total coverage amount (or lifetime maximum benefit). Most LTC policies specify an overall dollar amount that applies to all covered services as the “total coverage amount”.

6. Older policies limit coverage to a specified number of days or years, rather than dollars. Or they specify separate limits by each type of service (e.g., pay for up to two years of home care and up to four years of nursing home care).

7. The policies today provide more flexibility, allowing consumers to decide how they want to spend the overall dollar limit on any of the covered services. Generally, consumers can choose from as little as two years worth of coverage to as much as 10 years of coverage. In addition, a popular choice is “lifetime” or “unlimited” coverage, which does not have any dollar limit. Coverage continues for as long as the person continues to need care.

8. While 80% of people who enter nursing homes stay five years or less, lifetime coverage can provide peace of mind that care needs will not outlast benefits. However, not everyone can afford lifetime/unlimited coverage. Each person has to select the coverage amount that best meets their comfort level and their ability to
afford the insurance. There is no “one size fits all.”

C. LTC Insurance Premiums

Long-term care insurance premiums are designed to remain level over an individual’s lifetime, based on the age of the buyer at the time the policy is purchased. Thus, it is wise to purchase coverage at a younger age. When people buy many years in advance of when they need the insurance, there is time for the premiums they pay in (which are set aside in “reserves”) to build up with investment and inflation. That way, consumers can pay much less than if they began paying into the policy for coverage much closer to the time that care is needed. LTC insurance premiums are also designed to remain level even as people age and begin to need care so that people will not face prohibitively unaffordable premium increases precisely at the time when they most need to maintain and use their coverage.

The phrase, “designed to remain level,” is important. While the vast majority of insurance companies have raised rates, they also cannot guarantee that they will not do so. Some have imposed premium increases, but the right of insurers to raise rates after a buyer has taken out a policy is limited. The circumstances under which they can typically raise rates are:

1. The increase is actuarially justified based on claims experience for an entire class of insured individuals. A class refers to a group of individuals with the same characteristics, such as age, geographic location, and similar coverage.
2. No one person can be singled out for a rate increase based on age or health.
3. The increase must be approved by the state’s Department of Insurance, or DOI (most states require this, but not all).

D. Coping With a Rate Increase

If there is a rate increase you should:

1. Check the policy
2. Call the company to ask if the following options are available:
   a. **Contingent Nonforfeiture** - Newer policies include this provision, which offers a limited amount of coverage in the event of a rate increase, even if consumers do not continue to maintain their coverage by paying the increase.
   b. **Nonforfeiture Option** - This optional feature provides limited coverage if a consumer chooses to drop the policy rather than accept the rate increase.
   c. **Decrease Coverage** - Some policies allow a consumer to give up some elements of coverage in return for keeping the premium affordable. For example, consumers might reduce the daily benefit amount or shorten their lifetime maximum coverage to offset the amount of the premium increase. The easiest change to make is to reduce the daily benefit amount, since a decrease in that feature is roughly equal to a 10% premium savings. It is vital to ensure the consumers understand that the new decreased coverage should still provide meaningful protection. Certain changes may be more appropriate than others, given the consumer’s situation and preferences.
If the consumer does not want to accept the rate increase under any circumstances, and does not like any other option available with the current insurer, then it may be advisable to seek alternative coverage. This should be a last resort and it is critical that, before dropping coverage, they determine:

- Whether they are still insurable
- The cost of new coverage at their current age
- Not to drop existing coverage until they are approved and issued an acceptable level of alternative coverage

E. Underwriting

The purpose of underwriting is to assess the current functional and cognitive abilities of applicants and their risk of future disability. Premiums for a LTC product are based upon accepting individuals who are currently functional, independent, and have reasonable prospects of remaining that way for many years. The goal is to approve as many applicants as possible, while managing the risk effectively so that the premiums that have been established can remain fair and sustainable over time.

Underwriting for LTC insurance takes into account more than simply the presence or absence of certain medical conditions. The underwriting criteria generally focus on a combination of medical, functional, and cognitive conditions or the interaction of conditions, which are known to represent a high-risk for needing LTC.

Criteria vary from one insurer to the next. Some insurers decline to offer coverage to people with conditions that might require more investigation in order to determine the extent of their illnesses. Other insurers take additional time to look into applicants’ health conditions; this tends to make them more likely to accept someone with a given health condition, if that condition is otherwise stable and well managed.

F. Typical Uninsurable Conditions

Some medical conditions will disqualify someone from being accepted into the program because of their usual and predictable progressive course. These conditions include chronic degenerative conditions such as Parkinson’s disease, multiple sclerosis, and dementia. Other medical conditions, such as cancer or heart attacks, may or may not disqualify an individual, depending in large part on other factors. Additional information on medical treatment, physical functioning, and cognition is often needed to make a final determination in these situations. Taking the time to obtain additional information often means that the insurance companies can accept someone that they might have otherwise been inclined not to accept. So, this additional underwriting information is important to benefit both the consumer and the insurance program.

Every insurance company has a list of conditions that the company considers uninsurable. Uninsurable conditions are specific conditions that have a strong predictive value for unstable or failing health and carry an equally strong probability of resulting in significant limitations in one’s ability to carry out ADLs in the next 48 to 60 months.
This can be a single condition such as an Alzheimer’s type dementia, or a condition such as Parkinson’s disease that might currently be stable, but where there is a significantly elevated risk of functional decline in the future. There are also combinations of medical conditions that present an increased risk of future disability, such as a history of poorly controlled diabetes, hypertension, and stroke. Insurers differ in terms of the conditions that they consider uninsurable. The definition of uninsurable also depends upon whether an insurer offers only one rate class, or if it has a sub-standard risk category. A sub-standard risk category may allow an insurer to take applicants with conditions that another carrier might decline.

G. Most Common Uninsurable Conditions

1. Current or recent use of LTC services
2. Help required with ADLs
3. Weight outside “acceptable” ranges
4. AIDS or AIDS Related Complex (ARC)
5. Alzheimer’s type dementia, organic brain syndrome, and all other forms of dementia and cognitive dysfunction
6. ALS (Lou Gehrig disease)
7. Diabetes with complications
8. Progressive neurological conditions (MS, Muscular Dystrophy, Myasthenia Gravis or Parkinson’s)
9. Stroke or TIA within the past 12 to 24 months or a history of multiple strokes or TIA’s
10. Metastatic cancer
11. Use of certain adaptive devices; wheelchair, walker, four pronged or quad cane, scooter, Hoyer lift, or hospital bed

Insurers will also consider the type and amounts of medication the applicant takes, as this can play an important role in assessing an applicant’s insurability. The applicant’s medication history is carefully evaluated during the underwriting process, so it is important that all of the applicant’s medications be listed on their application.

H. Underwriting Tools

The decision to accept or decline an applicant is generally made based on information from a variety of sources. Usually insurers will collect more information on older applicants, since they are likely to have more medical and other conditions that must be fully explored before making an appropriate decision. The tools that are used to collect underwriting information are as follows:

1. Application
2. Attending Physician Statement (APS)
3. Phone History Interview (PHI)
4. Face-to-Face Assessment (F2F)
I. Acceptance and Denial

Underwriting acceptance rates vary across insurance companies due to differences in their philosophy and experience, the types of products they market, their target markets, and their distribution systems.

Any consumer that is declined for insurance is entitled to know the reasons why. The insurance company may communicate the reason(s) to the applicant directly or release the information to the applicant’s physician. Applicants retain the right to appeal or request reconsideration. They must make the request for an appeal in writing.

J. Qualifying For Claims

All tax-qualified LTC policies use the following criteria for receiving benefits:

1. Need the help of another person with a specified number of ADLs. Needing help refers to both hands-on and stand-by help (supervision), although some policies may use the narrower requirement of hands-on help only.
2. Severe Cognitive Impairment. This refers to problems with memory and orientation to person, place, or time. It is measured by objective tools and tests. Alzheimer’s disease is an example of severe cognitive impairment.
   a. Most tax-qualified policies pay benefits when the insured individual needs help with two or more ADLs or has a severe cognitive impairment. Older policies refer to cognitive impairment; the addition of the word “severe” was imposed by tax-qualified plans. Insurers do not define or measure cognitive loss any differently today than they did prior to the addition of the word “severe”. The word is used for consistency only.
   b. Non-tax qualified policies often use these same benefit criteria, but they are also free to include medical necessity as an additional or alternative benefit criterion.
   c. “Medical necessity” is an older and ill-defined term that does not correlate well with the need for LTC. If someone has a “medical need” for LTC (e.g., they are paralyzed or have severe movement restrictions due to phlebitis or arthritis), then they are most likely also to be unable to perform their ADLs. Some older policies and policies that are not tax-qualified may use medical necessity as a condition for receiving benefits. It is important to review how that term is defined in the policy and who can evaluate when medical necessity exists. Medical necessity is not determined by the insured’s physician exclusively; the language of the policy may actually give the right to evaluate medical need to the insurance company. This term is seldom used today and is not included as an appropriate benefit criterion in a federally tax-qualified policy.
3. Degree of Loss: Most policies have a single threshold for all benefits – typically loss in two or more of the six ADLs or severe cognitive impairment. Some policies may require a higher degree of loss for nursing home benefits.
4. Processing Claims: The claims process generally begins with a phone call to a special claims or customer service line the company has specified. Customer service staff may do some “intake” over the phone to understand the insured’s care needs.
5. **Handling Claim Denials:** The most common reasons for denying a claim request are:
   a. The condition(s) for which the claim is being made does not meet the definition of ADL or cognitive loss.
   b. Policy coverage has lapsed.
   c. The service is not a covered service.
   d. There is a duplicate claim for the same event.
   e. The claim amount exceeds the coverage amounts in the policy.
   f. If a claim is denied, the policyholder is entitled to know the reason for denial and has the right to an appeal or reconsideration. It is important for the policyholder to understand the reason for the denial. The policyholders should also be familiar with the language of the policy so that they are aware of the extent of their coverage under the policy.

K. Exclusions and Limitations

1. The most common policy exclusions are:
   a. War, felony, riot
   b. Attempted suicide
   c. Care for which no expense is incurred (provided free)
   d. Care provided in a government facility or paid for by workers’ compensation or similar insurance
   e. Medicare co-payments and deductibles (tax-qualified plans are not allowed to pay for these)
2. Exclusions less frequently used are:
   a. Mental/nervous disorders (does not include Alzheimer’s disease)
   b. Alcohol or drugs
   c. Care received outside the U.S.
   d. Care provided by family
   e. Care paid for under other LTC insurance or health insurance

L. More About Mental/Nervous Exclusions

In newer policies, mental/nervous exclusions generally refer to psychiatric conditions, such as bipolar disorder or schizophrenia, as these conditions are already covered by health insurance and are not “long-term care.”

Many of the leading insurers do not have this exclusion; however, that does not mean that they will pay for purely psychiatric care. It does mean that if a policyholder needs LTC, regardless of whether they also have a mental health condition, their care in a nursing home or at a home (as specified by the policy) will be covered without any exclusion or limitation because of the associated psychiatric condition.
M. Pre-Existing Condition Exclusion

The Pre-Existing Condition Exclusions in a policy limit, postpone, or deny coverage if the policyholder requires LTC within the first six months of coverage due to the pre-existing condition. This exclusion might take one of two approaches:

1. Postpone coverage and not pay for care until after the first six months of coverage if the need for care emerges within the first six months and is due to the pre-existing condition. With this approach, coverage would begin in month seven.

2. Not pay for care related to a pre-existing condition if care needs develop in the first six months after the policyholder obtains coverage. Even if the claim extends beyond the first six months, it would continue to be excluded with this approach.

Most insurers today do not impose a pre-existing condition exclusion. The policy language will generally indicate whether or not such an exclusion is a part of the policy. Some employer group plans that issue coverage without any underwriting might employ pre-existing condition exclusions, but most individual plans do not.

N. Outline of Coverage

The Outline of Coverage (OC) is a summary of policy definitions, covered services, benefits, exclusions, and other policy provisions. It is a vitally important consumer disclosure document. Insurers are required to follow a state-mandated format and use specific language to explain coverage features in the OC. Insurers are required to provide a potential buyer with the OC before the agent can accept an application from that individual. This requirement is intended to encourage the individual to read the OC and learn what is covered and what is not covered before they buy a policy. It is also designed to help consumers compare policies. Some key elements which are included in the OC:

1. **Caution Statement** - Reminds consumers that the insurer can deny benefits or rescind coverage if the applicant provides false information. It reminds the consumer of the importance of fully disclosing and accurately answering all questions on the application.

2. **Tax Statement** - Must indicate whether the LTC policy is tax-qualified or non-tax qualified.

3. **Guaranteed Renewable** - States that coverage is guaranteed renewable.

4. **Limited Right to Change Premiums** - The terms under which premiums can change are summarized.

5. **Free Look Provision** - Reminds consumers that they can return their policy within the first 30 days and receive a full return of the premium they paid.

6. **Definitions** - Defines key terms in the policy.

7. **Benefits and Exclusions** - Briefly describes each benefit in the policy.

8. **Benefit Eligibility** - The conditions for receiving benefits are described. This includes specifics about the nature and degree of functional and cognitive loss that must exist in order to receive benefits.

9. **Limitations and Exclusions** - Lists the exclusions and limitations that apply. The OC must explicitly state that Alzheimer’s disease is covered.
10. **Inflation Protection** - Details on how the policy keeps pace with inflation under all the scenarios available to the buyer with the policy. Typically, the OC shows how benefits and costs would change under each option over a 20-year period.

11. **Premium Information** - The OC generally provides a summary of the premium costs for various coverage choices or specifically for the options the individual is interested in choosing.

12. **SHIP Contact** - Some states require the OC to inform people how to contact their SHIP for advice and counseling about LTC insurance.

# O. Other Private Financing Options for Long-Term Care

1. **Reverse Mortgage (Home Equity Conversion):** A reverse mortgage (RM) is a type of home equity loan that enables homeowners age 62 and over to convert some of the equity in their home (single family or condominium) into cash and continue to own and live in the home.

Unlike home equity loans, RM’s do not require repayment of the principle, interest, or servicing fees as long as you live in the home. Since the borrower retains ownership, he or she is responsible for taxes and repairs. When the homeowner dies or moves out, the loan is paid off by the sale of the property or repaid by a one lump payment. An individual can never owe more that the home’s value. Any leftover equity goes to the heirs or the homeowner.

The amount borrowed is based on age, life expectancy, the equity in the home, location of the home, and the interest rate. Maximums range from 50-75% of the home’s fair market value (depending on the lender). There are no income or credit qualifications. However, the home must be completely or nearly paid off to qualify.

The RM funds may be paid in a lump sum, monthly advances, through a line of credit, or a combination of the three. This money is non-taxable. It does not count towards income or affect Social Security, Medicare, or Medicaid benefits as long as the RM payments are spent within the month they are received. However, interest on the reverse mortgage is not tax deductible until the debt is paid.

There are three types of reverse mortgages:

a. **FHA Insured** - Reverse mortgages insured by the Federal Housing Administration are offered by banks, mortgage companies, and other private sector lenders. Since they are insured the government is required to make the payments if the lender goes out of business.

b. **Lender Insured** - These reverse mortgages offer monthly loan advances or monthly loan advances plus a line of credit for as long as an individual lives in his/her home. One example is the federal National Mortgage Association’s Home keeper product.

c. **Uninsured** - Most private reverse mortgages are not insured. Only the strength of the lender backs whatever promises it makes as to payments and other terms. Thus, if the objective of a RM is future income rather than a lump sum up front, a federally insured program is better.
d. Consumer tips:
   - One size does not fit all.
   - Examine ALL options.
   - Compare TOTAL costs.
   - Credit lines are not equal.
   - A reverse mortgage is a non-recourse loan, which means that when seeking repayment the lender does not have recourse to anything other than the collateral securing the loan – in other words, THE HOUSE. The loan amount is limited to the value of the house.

2. Reverse Mortgage Annuity: Part of the lump sum loan amount obtained from the RM is used to purchase an annuity. Even if the borrower sells or moves from the home, annuity payments will continue. The loan must be paid off when the owner dies, sells, or moves from the home. The annuity payments from the separately purchased annuity can continue.

3. Sell Home and Move: One way of using one’s home to pay for LTC is to sell it. The proceeds can be invested to produce a continuous income, to pay for LTC expenses, or to purchase a LTC insurance policy.

4. Leaseback: Occurs when an investor purchases a home below market value and the investor agrees to rent the house to the seller on a long-term lease. The seller no longer has to worry about maintenance, repairs to the home, or paying taxes, and the proceeds of the sale can be used as desired.

5. Life Insurance: There are financing options that allow access to the death benefit of a life insurance policy prior to death. Certain conditions and requirements apply; therefore, they are not appropriate for all consumers.

6. Accelerated Death Benefits: Provides cash advances against the death benefit while the insured is still alive. It is accomplished by adding an Accelerated Death Benefits (ADB) rider to the life insurance policy for little or no cost.

There are different types of ADB for different purposes. For example, a catastrophic illness ADB is paid when the insured suffers one of several specified medical conditions that require extensive or extraordinary treatment. The ADB must be used to pay for the medical expenses not covered by health insurance. A LTC accelerated death benefit is paid when the insured needs LTC and the money must be used to pay for that care.

Consumers should check their policies to determine whether they are tax-qualified. Those that meet the criteria of the Health Insurance Portability and Accountability Act of 1996 will receive the benefits income tax free because they are treated as proceeds payable on account of death. However, non-qualified policies are being sold, so consumers need to understand what they have purchased and how the benefits are treated.

ADB policies will specify what condition(s) must occur in order to trigger accelerated benefits as well as how benefits may be used. Consumers should review their policy to determine when the ADB applies and what benefits will be paid. The amount of the ADB is based on the provisions of the insurance contract and conditions triggering
Typically, the accelerated benefit payment amount is capped at 50% of the death benefit, although some policies allow the full amount to be used. For ADB policies that cover LTC, the monthly benefit is typically equal to 2% of the face value for nursing home care and 1% for home care. Some policies may pay the same monthly amount for care, regardless of the setting. Newer policies tend to be reimbursement based. This means they pay actual charges up to the available benefit.

ADB’s paid to terminally or chronically ill people are not subject to income tax. The amount of the ADB is subtracted from the amount payable to beneficiaries on the death of the insured. Also, the insurance company charges for the expense they incur by paying benefits early instead of keeping the money invested. The insurer charges for this benefit in three ways:

a. **Additional Premium** - charges for including the ADB option
b. **Discounted Death Benefit** - the amount paid as ADB is less than what would have been paid at death
c. **Interest** - benefits are treated as a lien against the policy and interest is charged

### 7. Life Settlements:

Also known as Senior Settlements, Elder Settlements, or High Net Worth Settlements; give older individuals the ability to adapt to changes in health, goals, or life circumstances by selling their life insurance policy. They may no longer need the death benefit because the original reason they purchased the insurance no longer exists or the insurance premium may be unaffordable after retirement.

Women 74 or older and men 70 or older that have any type of life insurance can sell their policies to a life settlement company for the present value of the policy. Some companies may purchase a life insurance policy of a 65 year old if the life expectancy is in the 12 year range. The type of policies that can be sold are: group, individual, term, whole life, universal life, policies held in irrevocable life insurance trusts, buy-sell agreements, and “key-man” policies. In addition, one need not be dying or in poor health to take advantage of a life settlement.

The use of the proceeds is unrestricted and can be used for anything the person wishes. There are tax implications for this type of option. The difference between the settlement payment and the cash surrender value is taxed as a capital gain, while the difference between the total premiums paid and the cash surrender value is taxed as ordinary income.

### 8. Viatical Settlements:

Is the sale of a policy by someone who has a life expectancy of two years or less while someone with a life settlement has a life expectancy of greater than two years but less than 13 years. The tax consequences also differ. Viatical settlements are usually tax free.

Under a viatical settlement, the insured assigns the proceeds of his/her life insurance policy to an investor in exchange for a cash settlement, which is less than the value of the death benefit. The life expectancy of the insured is used to compute the cash settlement, with a higher percentage payout for those closer to death. The investor pays the premiums until the death of the insured, at which time the investor receives the death benefit of the policy.
The National Association of Insurance Commissioners (NAIC) has developed a Viatical Settlements Model Act governing the licensing and regulation of viatical companies. Many states have adopted this act in whole or in part. If adopted by states, viatical companies would be licensed by state insurance departments. Full disclosure, especially regarding tax implications, would be required. People using viatical settlements would need to be informed that the sale of their death benefit may disqualify them for public assistance.

In 1995, legislation was passed that exempts both viatical settlements and accelerated death benefits from federal income tax. Under HIPAA 1996, viatical settlements are not subject to income and capital gains taxes. Also in 1995, The Securities and Exchange Commission ruled that viatical settlements are securities and require registration. SEC maintains that if a firm solicits investors and represents viatical settlements as an investment, the firm is selling an unregistered security. It also ruled that if an agent refers a consumer to a viatical settlement firm, the person is considered to be selling insurance and is therefore not currently affected by SEC rulings.

9. **Single Premium Life/LTC Policies:** Single premium life long-term care policies are funded through a lump sum payment, which is guaranteed not to change. The single premium deposit can be made with cash, CDs, money market accounts, non-qualified and qualified annuities, or IRAs and Keogh plans. Issue ages can vary based on the source of the premium. For example, an issue age of 59 ½ or higher might be required for transfers from qualified annuities, IRAs and Keoghs. In addition, the cash value from a life insurance policy may be able to be moved into a combined policy without adverse tax consequences.

Minimum deposits can be in the $10,000 - $20,000 range, but for a meaningful benefit based on today’s costs, the deposit should be in the $100,000 range for a 60 year old couple. If a person is willing to self-insure a portion of LTC expenses or have other ways of financing LTC, a smaller deposit can be made. Inflation coverage may be included in the lump sum deposit or paid separately and on a continuing basis, depending on the insurance company.

10. **Long-Term Care Annuities:** An annuity is a series of regular payments over a specified and defined period of time. Annuities can help people pay for LTC who cannot qualify for LTC insurance due to age or health problems. There are two types of LTC annuities:

a. **Deferred Annuity with LTC Benefits:** Available for those up to age 85 and have seven broad health questions that most people can satisfy. One example of this hybrid product might consist of two funds. The first fund is for LTC expenses and it grows at a high interest rate with a five year guarantee. It then grows at the current interest rate thereafter. The second fund grows at 3% guaranteed and is a regular cash fund.

The purpose of the separate LTC fund is to allow immediate use of the funds for licensed LTC services. An individual may make annual withdrawals of 10% from the cash fund to pay for additional expenses, such as prescription drugs, not covered as eligible expenses under the LTC fund.
Earnings on the money are tax deferred; however, the individual is taxed on the gain as withdrawals are made. These hybrid-deferred annuities are non-tax qualified LTC policies; therefore, there is a risk of being taxed on the money from the fund that is used to reimburse LTC expenses.

b. **Immediate Annuity:** Available to people with uninsurable health conditions or those who may already be receiving LTC, as well as those in good health. A single premium payment is converted to a monthly income stream guaranteed for the life of the policyholder or even a joint and survivor annuity option. The named beneficiary(ies) would receive a portion of the money if the policyholder died earlier than the expiration of the minimum guarantee period.

The annuity pay-out schedule is based on age and gender. With immediate annuities that are not medically underwritten, all things being equal, if a male and a female of equal age purchase identical life annuities, the male will get a higher monthly income than the female, since the female will be expected to live longer than the male.

If the annuity is medically underwritten, the person with impaired health would receive a larger monthly payout because of the actuarially-determined shorter life span of the individual. However, medically-underwritten annuities are fairly new to the U.S. and not available in every state.

11. **Trusts:** Is a legal arrangement by which one person, the grantor, transfers assets to another, the trustee, for the benefit of one or more third parties, the beneficiary(ies). The trustee holds title to the assets and manages them, acting in the best interest of the beneficiary(ies). Trusts may provide some options to partially fund LTC needs. Primary examples are Medicaid Disability Trusts and Charitable Remainder Trusts.

12. **Medicaid Disability Trusts:** This is the only type of trust exempt from rules regarding trusts and Medicaid eligibility. All other irrevocable trusts currently created with the intent to transfer assets without spending down run the risk of being disqualified. There are two types of Medicaid Disability Trusts; both are limited to disabled individuals:
   a. **Trust for Disabled Person Under Age 65:** Can be established by a parent, grandparent, or legal guardian for the benefit of a disabled individual under 65. This trust might be set up to provide benefits to enhance the life of an individual who is qualified for public benefits. If Medicaid benefits are paid on behalf of the disabled individual, any amount remaining in the trust at the individual’s death is recoverable by the state up to the amount of such benefits.
   b. **Pooled Trust Managed by a Non-Profit Association:** The purpose is to be able to use trust assets to enhance the life of the disabled individual while maintaining eligibility for public benefits. A separate account must be maintained for each beneficiary although funds are pooled for investment and management. Upon the beneficiary’s death, the state must be reimbursed for the Medicaid benefits paid on behalf of the beneficiary. The account is for the benefit of a disabled person who can be over 65 at the time of the establishment of the trust.

13. **Charitable Remainder Trusts:** These trusts allow individuals to use their own assets for LTC with an added benefit of reducing taxes. This trust is limited to affluent people with specific types of assets that are gifted to a public charity at fair market
value. The grantor receives a tax deduction based on the market value of the amount
gifted.

The payments to the grantor from the charity are also based on the current market
value. These payments can be used to fund LTC expenses while reducing taxes. Upon
the grantor’s death, the charity received the balance of the trust.

14. **Using Own Assets and Income (Self-Pay):** Individuals with considerable investment
assets and income may consider paying for their LTC needs as they arise or save for
future LTC services. If an individual wanted to save enough money for LTC costs, an
adequate level of assets would need to be set aside – in today’s dollars, approximately
$286,000, is needed to fund a five year nursing home stay. These assets should be
invested to assure growth that will keep up with the rising costs of LTC.

Self-insuring is not the same as insurance. It does not provide the short-term
protection that an insurance policy does. Insurance protects you from the possible risk
of needing LTC before adequate resources are accumulated.

**P. Other Financing Options**

1. **Continuing Care Retirement Community (CCRC):** (CCRC) provides a full continuum of
care in a variety of settings, allowing an individual to “age in place”. As the needs of
the resident change, the services the CCRC provides change from independent living
to assisted living to nursing home care, all in the same location.

Usually, a resident pays an entrance fee and monthly payments to the community in
exchange for housing and defined LTC services for the life of the resident. These fees
vary by the size of the unit (studio, one/two bedroom, larger) and by the location and
type of the CCRC. A percentage of the entrance fee is usually reimbursed to the
residents or their estates when they move or die. Typical refund rates may be 70-90% and
is specified in the contract. The interest earned is not paid to the resident,
although the resident may be responsible for paying income tax liability on the
interest income.

The monthly service fee may be level for all residents or increase as the amount of
care increases. Even under a uniform fee, it normally increases over time as costs rise.
In many cases, LTC insurance is bundled into the monthly fee. The CCRC collects a
benefit to provide LTC to the resident. Since the CCRC is planning on residents not
needing care for a certain amount of time, residents must be relatively healthy to enter
in order to keep fees reasonable. Consumers must be aware that contracts and fees
vary with each CCRC.

2. **Medicaid Estate Planning:** In order to qualify for Medicaid, individuals must first
spend down their assets and use the proceeds to pay for LTC before Medicaid begins
to pay. Spend down means liquidating assets. States have different maximum asset
levels that individuals may keep.
Some people reduce their assets by gifting them to family members or others, or set up irrevocable trusts instead of using these assets to pay for care. They hope to continue using the assets with the cooperation of their relatives or enable others to benefit from the assets. Medicaid planning is the legal practice of rearranging finances so that the Medicaid program pays for nursing home care and the individual’s assets are preserved through change of ownership.

Medicaid “look back” rules apply when assets are transferred for less than fair market value by applicants for Medicaid and to transfers made by the applicant’s spouse or someone else acting on their behalf. Medicaid benefits may be withheld for a period of time determined by the amount of the transfer. These rules apply to “gifts” made 36 months or less before the application for Medicaid and 60 months or less for transfers to irrevocable trusts. A qualified elder law attorney should be consulted when considering this type of LTC financing option.

3. **Special Purpose Loans**: There are many loans available in the public sector known as deferred payment loans (DPLs), property tax deferrals, or split loans. These low interest loans are available to those with low to moderate income.

Local government agencies offer DPLs, which provide a one time, lump sum payment to be used for home repair or improvements. The types of improvements are usually specified. They include things such as the installation of ramps, grab bars, and rails. These loans are low interest and usually do not have the fees and premiums of reverse mortgages. The loan is repaid when the borrower no longer lives in the home. These loans cannot be used to finance LTC, but they may help finance home modifications so that someone can remain independent at home and/or receive care there.
Important Information Regarding “Missouri’s Long-Term Care Insurance Partnership” Program

Disclosure Notice

Partnership policy status.
Insurance companies can voluntarily agree to participate in the Missouri long-term care insurance partnership program by offering long-term care insurance policies that meet certain state and federal requirements (partnership plan). Our company has chosen to participate in this program. Therefore, the long-term care insurance policy you are considering purchasing qualifies as a partnership plan.

What does this mean to you?
Under the partnership program, if you own a long-term care insurance policy that qualifies as a partnership plan, you may be able to protect some of your assets from Medicaid’s “spend down” requirements if you should ever have to apply for Medicaid benefits. For example, if you have a policy that qualifies as a partnership plan, you may be able to shield one dollar of your assets under Medicaid for every dollar of benefits the policy pays for your long-term care. Please note that the purchase of a partnership plan does not automatically qualify you to receive benefits under Medicaid. Medicaid has certain requirements that must be met in order to receive benefits under a state Medicaid program.

What could disqualify a plan as a partnership plan?
If any changes are made to the plan once it has been purchased, these changes could affect whether the plan will continue to be qualified as a partnership plan. Therefore, if you purchase a partnership plan, before you
If you have questions about Missouri’s long-term care partnership program or questions about long-term care insurance in general, please call the Missouri Department of Insurance, Financial Institutions & Professional Registration at 1-800-726-7390. You may also access more information at the following web sites.

http://www.difp.mo.gov
http://www.dss.mo.gov
[Company’s web site]
What is a long-term care partnership policy?
A partnership policy makes it easier to qualify for Medicaid if you have exhausted the benefits of your long-term care insurance policy. For example, a consumer with a $200,000 coverage limit on his long-term care policy might exhaust the benefits after three years in a nursing home. If that consumer needs continued care, he may need to turn to Medicaid.

What benefits must be included in a partnership policy?
A partnership policy has three basic requirements:

1. The policy must have the same provisions as the National Association of Insurance Commissioners (NAIC) model law. Since 2004, all plans sold in Missouri must comply with the model and be approved by the Department of Insurance, Financial Institutions & Professional Registration (DIFP) before they can be sold to consumers.
2. The policy must be tax-qualified. This means the IRS does not tax the policy’s benefits.
3. The policy must contain certain inflation protection provisions at the time it is sold:

<table>
<thead>
<tr>
<th>Age</th>
<th>Compound annual inflation protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 61</td>
<td>Company must offer 5 percent. If rejected by the consumer, a minimum of 3 percent or changes based on the consumer price index must apply.</td>
</tr>
<tr>
<td>61 – 75</td>
<td>Some level of inflation protection must apply. No minimum level is established.</td>
</tr>
<tr>
<td>Over 75</td>
<td>No inflation protection required for partnership policies.</td>
</tr>
</tbody>
</table>

How does a long-term care partnership policy work?
States are required to develop partnerships using the “dollar for dollar” model. For every dollar that a long-term care partnership insurance policy pays out in benefits, a dollar of personal assets can be protected if you apply for Medicaid. In other words, if your long-term care partnership policy paid out $200,000 for your long-term care, an additional $200,000 of your assets would be disregarded when determining your Medicaid eligibility.

What are the Medicaid eligibility requirements?

- Medicaid eligibility is complex and is determined on a case by case basis.
- Medicare eligibility determinations are completed by the applicant’s local department of social services office.
- Medicaid eligibility has both financial and non-financial requirements. Financial requirements include evaluation of both income and assets. Non-financial requirements
include proof of Missouri residency, citizenship and identity, Social Security Number and proof of a required level of care for long-term care services.

- Medicaid eligibility has special rules for married people when only one is receiving long-term care services.
- Medicaid eligibility has special rules that apply to home property in which the applicant resides, vehicles and burial arrangements.

If you have any more questions about Medicaid eligibility, please contact MO HealthNet Division.

What if I already have a long-term care policy?
If your current policy fits the three basic requirements above and you purchased it before Feb. 8, 2006, call your insurance agent or company and ask that it be designated a partnership policy. If your current policy does not meet the three basic requirements, federal law will not allow it to be "grandfathered." You may need to buy additional coverage for that designation.

How do I know if I have a partnership policy?
This information will be included with the policy, but may not be printed on the policy itself. If there is any doubt, ask your insurance agent or call the insurance company.

Which insurance companies offer partnership policies?
Every insurance company authorized to sell health insurance in Missouri is eligible to sell partnership policies, but the policies must be approved by the Department of Insurance, Financial Institutions & Professional Registration.

Will my Missouri partnership policy qualify me for dollar-for-dollar asset protection in other states?
Yes. Missouri participates in a national reciprocity agreement, but not all states participate. You will also need to meet all Medicaid requirements of the new state of residence.

When should partnership policyholders apply for Medicaid?

- When the partnership policyholder exhausts the benefits of the long-term care partnership policy (policy exhaustion is not required in Missouri).
- When the partnership policyholder (or spouse, family or friend) feels that the individual is having a difficult time paying for care. Everyone has the right to apply for Medicaid at any time.

If I exhaust my long-term care partnership policy, will I automatically qualify for Medicaid?
No. You must still meet the level of care, income and resource requirements for long-term care.

What makes Missouri's partnership program unique?

- It allows conversion of policies that already meet the partnership criteria.
- Inflation protection will be a base 3 percent annual compound level, but it could be based on the Consumer Price Index.
- Insurance agents must take an eight-hour training course before selling partnership policies. Agents will also need to take a four-hour continuing education course every other year.

**Where can I buy a partnership policy?**
Visit [http://insurance.mo.gov/consumers/LongTerm/partnership.php](http://insurance.mo.gov/consumers/LongTerm/partnership.php) to view a list of long-term care insurers selling these Medicaid-approved policies in Missouri.

**Source:** [http://insurance.mo.gov/consumers/LongTerm/FAQPartnership.php](http://insurance.mo.gov/consumers/LongTerm/FAQPartnership.php)
Tab Divider named “Section 11 Acronyms/Glossary”
# Abbreviations and Acronyms

## A

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AARP</td>
<td>American Association of Retired Persons</td>
</tr>
<tr>
<td>ADB</td>
<td>Accelerated Death Benefit</td>
</tr>
<tr>
<td>AEP</td>
<td>Annual Enrollment Period</td>
</tr>
<tr>
<td>ADA</td>
<td>American with Disabilities Act</td>
</tr>
<tr>
<td>ADL’s</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>ALJ</td>
<td>Administrative Law Judge</td>
</tr>
<tr>
<td>ALS</td>
<td>Amyotrophic Lateral Sclerosis</td>
</tr>
<tr>
<td>APC</td>
<td>Ambulatory Payment Classification</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory Surgery Center</td>
</tr>
<tr>
<td>APS</td>
<td>Attending Physician Statement</td>
</tr>
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</table>

## B

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>BBA</td>
<td>Balanced Budget Act</td>
</tr>
<tr>
<td>BBRA</td>
<td>Balanced Budget Refinement Act</td>
</tr>
<tr>
<td>BFCC-QIO</td>
<td>Beneficiary Family Centered Care – Quality Improvement Organization</td>
</tr>
<tr>
<td>BIPA</td>
<td>Benefits Improvement and Protection Act</td>
</tr>
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</table>

## C

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>CLAIM</td>
<td>Community Leaders Assisting the Insured of Missouri</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>COB</td>
<td>Coordination of Benefits</td>
</tr>
<tr>
<td>COBRA</td>
<td>Consolidated Omnibus Budget Reconciliation Act</td>
</tr>
<tr>
<td>CCRC</td>
<td>Continuing Care Retirement Community</td>
</tr>
<tr>
<td>CORF</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
</tr>
</tbody>
</table>

## D

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DBA</td>
<td>Daily Benefit Amount</td>
</tr>
<tr>
<td>DPLs</td>
<td>Deferred Payment Loans</td>
</tr>
<tr>
<td>DHSS</td>
<td>Department of Health and Senior Services</td>
</tr>
<tr>
<td>DIFF</td>
<td>Department of Insurance Financial Institutions &amp; Professional Registration</td>
</tr>
<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>DMERC</td>
<td>Durable Medical Equipment Regional Carrier</td>
</tr>
<tr>
<td>DMS</td>
<td>Division of Medical Services</td>
</tr>
<tr>
<td>DO</td>
<td>Doctor of Osteopathic Medicine</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis Related Group</td>
</tr>
<tr>
<td>DSS</td>
<td>Department of Social Services</td>
</tr>
<tr>
<td>Acronyms</td>
<td>Description</td>
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<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>EGHP</td>
<td>Employer Group Health Plan</td>
</tr>
<tr>
<td>EOB</td>
<td>Explanation of Benefits</td>
</tr>
<tr>
<td>EOMB</td>
<td>Explanation of Medicare Benefits</td>
</tr>
<tr>
<td>ER</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>ESRD</td>
<td>End Stage Renal Disease</td>
</tr>
<tr>
<td>F2F</td>
<td>Face-to-Face Assessment</td>
</tr>
<tr>
<td>FEHB</td>
<td>Federal Employee Health Benefits</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee-for-Service</td>
</tr>
<tr>
<td>FI</td>
<td>Fiscal Intermediary</td>
</tr>
<tr>
<td>FNP</td>
<td>Family Nurse Practitioner</td>
</tr>
<tr>
<td>FSD</td>
<td>Family Support Division</td>
</tr>
<tr>
<td>HCB</td>
<td>Home and Community Based Service Programs</td>
</tr>
<tr>
<td>HHA</td>
<td>Home Health Agency</td>
</tr>
<tr>
<td>HIAA</td>
<td>Health Insurance Association of America</td>
</tr>
<tr>
<td>HIC</td>
<td>Health Insurance Claim Number</td>
</tr>
<tr>
<td>HINN</td>
<td>Hospital Issued Notice of Noncoverage</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>ICF</td>
<td>Intermediate Care Facility</td>
</tr>
<tr>
<td>IEP</td>
<td>Initial Enrollment Period</td>
</tr>
<tr>
<td>IADLs</td>
<td>Instrumental Activities of Daily Living</td>
</tr>
<tr>
<td>LEP</td>
<td>Late Enrollment Penalty</td>
</tr>
<tr>
<td>LTC</td>
<td>Long-Term Care</td>
</tr>
<tr>
<td>MA</td>
<td>Medicare Advantage Plans</td>
</tr>
<tr>
<td>MAPD</td>
<td>Medicare Advantage Prescription Drug Plan</td>
</tr>
<tr>
<td>MA-OEP</td>
<td>Medicare Advantage Open Enrollment Period</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
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</tr>
<tr>
<td>MD</td>
<td>Medical Doctor</td>
</tr>
<tr>
<td>MIPPA</td>
<td>Medicare Improvements for Patients &amp; Providers Act</td>
</tr>
<tr>
<td>MORx</td>
<td>Missouri Rx</td>
</tr>
<tr>
<td>MMA</td>
<td>Medicare Modernization Act</td>
</tr>
<tr>
<td>MMAP</td>
<td>Medicare and Medicaid Assistance Program</td>
</tr>
<tr>
<td>MSA</td>
<td>Medical Savings Accounts</td>
</tr>
<tr>
<td>MSN</td>
<td>Medicare Summary Notice</td>
</tr>
<tr>
<td>MSP</td>
<td>Medicare as Secondary Payer</td>
</tr>
<tr>
<td>NAIC</td>
<td>National Association of Insurance Commissioners</td>
</tr>
<tr>
<td>NH</td>
<td>Nursing Home</td>
</tr>
<tr>
<td>NODMAR</td>
<td>Notice of Discharge and Medicare Appeal Rights</td>
</tr>
<tr>
<td>NONC</td>
<td>Notice of Noncoverage</td>
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<tr>
<td>NQ</td>
<td>Non-Tax Qualified</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
<tr>
<td>OC</td>
<td>Outline of Coverage</td>
</tr>
<tr>
<td>PA</td>
<td>Physician Assistant</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Physician</td>
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<tr>
<td>PDP</td>
<td>Prescription Drug Plan</td>
</tr>
<tr>
<td>PFFS</td>
<td>Private Fee-for-Service</td>
</tr>
<tr>
<td>PHI</td>
<td>Phone History Interview</td>
</tr>
<tr>
<td>POS</td>
<td>Point of Service</td>
</tr>
<tr>
<td>POV</td>
<td>Physician Office Visit</td>
</tr>
<tr>
<td>PPO</td>
<td>Preferred Provider Organization</td>
</tr>
<tr>
<td>PPS</td>
<td>Prospective Payment System</td>
</tr>
<tr>
<td>PSO</td>
<td>Provider Sponsored Organization</td>
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<tr>
<td>QI-1</td>
<td>Qualifying Individual-1</td>
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<tr>
<td>QIC</td>
<td>Quality Independent Contractor</td>
</tr>
<tr>
<td>QIO</td>
<td>Quality Improvement Organization</td>
</tr>
<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
</tr>
<tr>
<td>Acronym</td>
<td>Explanation</td>
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<td>---------</td>
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<tr>
<td>RCF</td>
<td>Residential Care Facility</td>
</tr>
<tr>
<td>RFB</td>
<td>Religious Fraternal Benefit Society Plan</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>RM</td>
<td>Reverse Mortgages</td>
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<tr>
<td>RRB</td>
<td>Railroad Retirement Board</td>
</tr>
<tr>
<td>SEP</td>
<td>Special Enrollment Period</td>
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<tr>
<td>HIP</td>
<td>State Health Insurance Assistance Program</td>
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<tr>
<td>SLMB</td>
<td>Specified Low-income Medicare Beneficiary</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>SORT</td>
<td>SORT: The Missouri SMP</td>
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<tr>
<td>SSA</td>
<td>Social Security Administration</td>
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<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
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<tr>
<td>SSDI</td>
<td>Social Security Disability Insurance</td>
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<td>SSN</td>
<td>Social Security Number</td>
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<tr>
<td>TQ</td>
<td>Tax-Qualified</td>
</tr>
<tr>
<td>TROOP</td>
<td>True Out of Pocket Expense</td>
</tr>
</tbody>
</table>
### Glossary

**A**

**Accelerated Death Benefit:** A feature of a life insurance policy that lets you use some of the policy’s death benefit prior to death.

**Activities of Daily Living (ADL):** Basic actions performed by a normally functioning person on a daily basis: bathing, dressing, toileting, transferring, eating, continence. Many long term care insurance policies use the inability to perform a certain number of ADLs to decide when to pay benefits.

**Acute Care:** Care that has recovery as its primary goal. It generally requires the services of a physician, nurse, or other skilled professional, usually short term.

**Adult Day Health Care:** Care provided during the day at a community based center for adults who need assistance or supervision during the day, including help with personal care, but who do not need round-the-clock care. The purpose is to enable individuals to remain at home and in the community and to encourage family members to provide for them by offering the family members relief from the burden of constant care.

**Alzheimer’s Disease:** A progressive degenerative form of dementia that causes severe intellectual deterioration.

**A.M. Best Rating:** Independent rating by the A.M. Best Company, a private organization that evaluates and monitors the financial strength of life insurance companies.

**Ambulatory Payment Classification (APC):** The Prospective Payment System classification used for outpatient hospital claims. The fiscal intermediary determines the APC classification for the outpatient hospital service based on the beneficiary’s medical condition. Medicare will then make payment to the hospital based on this classification, regardless of the specific services provided.

**Assisted Living Facility:** A residential living arrangement that provides individualized personal care and health services for people who require assistance with ADLs. They vary in size and levels of care and services that can be provided. Assisted living facilities provide a way for people to retain a relatively independent lifestyle, and they are for individuals who do not necessarily need the level of care provided by nursing homes.

**Attending Physician’s Statement (APS):** A report from your doctor or from a medical facility which has treated you. It provides information about medical history, medications, diagnoses, etc.
**Attained Age Rating Policy**: Refers to any Medigap policy that has a scheduled premium increase based on age. A person could start with a lower premium, but the cost would increase at various age increments (e.g. increases when the individual turns age 70, 75, etc.). These policies are no longer available in Missouri, but you may encounter individuals who have these policies if they bought them in the past when such policies were available in Missouri.

**Bathing**: Washing oneself. This activity includes the task of getting into or out of the tub or shower.

**Beneficiary Family Centered Care – Quality Improvement Organization** – KEPRO is the BFCC-QIO for Area 4 which includes Missouri. You (or the beneficiary) may need to contact KEPRO when the beneficiary wants to lodge a complaint on a quality of care issue concerning a specific Missouri provider.

**Benefit Period**: Periods of time that Medicare uses to determine cost-sharing.

**Benefit Triggers (Triggers)**: Term used by insurance companies to describe the criteria and methods they use to determine when you are eligible to receive benefits. Triggers may be based on limitations in ADLs and/or degree of cognitive impairment.

**Benefits**: Monetary sum paid or payable to a recipient for which the insurance company has received the premiums.

**Cahaba**: A private health insurance company that serves as Medicare Administrative Contractor for the state of Missouri (processing home health and hospice claims). [For contact information, see the resource section.]

**Caregiver**: Person providing care to someone with chronic illness or disability. The caregiver, who can be unpaid (family, friend, or volunteer) or paid, provides care in the home or community.

**Care Management Services**: A service in which a professional, typically a nurse or social worker, may arrange, monitor, or coordinate long term care services (also referred to as care coordination services).

**Cash Surrender Value**: The amount of money you may be entitled to receive from the insurance company when you terminate a life insurance or annuity policy.

**Centers for Medicare & Medicaid Services (CMS)**: The federal government agency within the U.S. Department of Health and Human Services that administers Medicare and Medicaid. CMS contracts with other organizations to provide specific services to Medicare beneficiaries, such as processing claims.
**Chronically Ill:** A term used in a tax qualified long term care contract to describe a person who needs long term care either because of an inability to perform ADLs without assistance or because of a severe cognitive impairment.

**Chronically Ill Individual:** Someone who needs assistance with ADLs or who suffers from a cognitive impairment and whose conditions is expected to last for at least 90 days.

**CLAIM:** CLAIM is the State Health Insurance Assistance Program (SHIP) for Missouri. CLAIM’s office is located in Columbia, MO (within Primaris).

**Co-Payment:** A co-payment is a set fee that an enrollee may be required to pay for covered services. This fee is usually outlined in the statement of benefits for the Medicare Advantage organization.

**Cognitive Impairment:** A deficiency in a person’s short or long term memory; orientation to person, place and time; deductive or abstract reasoning, or judgment as it related to safety awareness.

**Community Based Services:** Services designed to help older people stay independent and in their own homes; such as adult day care or meals on wheels.

**Continence:** The ability to maintain control of bowel and/or bladder function; or the ability to perform associated personal hygiene due to lack of control (including caring for a catheter or colostomy bag).

**Contingent Nonforfeiture:** A policy provision automatically included in many newer long term care policies. This feature provided a limited amount of continuing coverage even if the policy lapses due to non payment of the premium, if the non payment is due to a “significant” increase in premium rates. The policy defines what is a “significant” increase in premiums based on your age at the time you bought the policy.

**Continuous Payment Options:** An option that requires the consumer to pay premiums for the life of the policy or until they begin to receive benefits. The policy is not cancelable except in the event of non payment of premiums. The insurance company can increase premiums on an entire class of policies. Premiums with this approach are usually the lowest available compared to the limited pay method.

**Custodial Care (Personal Care):** Care to assist individuals meet personal needs such as ADLs. Someone without professional training may provide the care.

**Coinsurance:** A percentage or specified dollar amount of a covered expense that a person is required to pay.

**Consolidated Omnibus Budget Reconciliation Act (COBRA):** COBRA coverage is an option to continue employer group health coverage for individuals that are terminated from work or have a reduction in work hours. If a person has COBRA and then becomes eligible for Medicare,
their COBRA coverage will cease. If a person is on Medicare and becomes eligible for COBRA, then COBRA functions as a Medicare supplement.

**Coordination Period:** A period of time (30 months for ESRD) when the beneficiary’s employer group health plan or other private insurance will pay first on health care bills and Medicare will pay second.

**Creditable Coverage:** Certain kinds of previous health insurance coverage that can be used to shorten a pre-existing condition waiting period under a Medigap policy (see pre-existing conditions).

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<tr>
<td><strong>Daily Maximum (or Daily Benefit Maximum):</strong> A specified dollar amount which is the maximum amount paid per day for covered services.</td>
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<tr>
<td><strong>Deductible:</strong> The amount that a person must pay for health care services before Medicare begins to pay. For Part A, this deductible is owed for each benefit period. This amount can change each year.</td>
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<tr>
<td><strong>Deductible Period:</strong> A specified amount of time at the beginning of a disability during which covered services are received but for which the policy will not pay benefits (also known as an elimination period or Benefit Waiting Period).</td>
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<tr>
<td><strong>Dementia:</strong> Deterioration of intellectual faculties due to a disorder of the brain.</td>
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<tr>
<td><strong>Disability Method:</strong> Method of paying benefits that only required you to meet the benefit eligibility criteria.</td>
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<tr>
<td><strong>Diagnosis Related Group (DRG):</strong> The Prospective Payment System classification used for inpatient hospital claims. The fiscal intermediary determines the DRG classification for each hospital stay based on the beneficiary’s medical condition. Medicare will then make payment to the hospital based on this classification, regardless of the specific services provided or the length of hospitalization.</td>
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<tr>
<td><strong>Dialysis:</strong> A treatment that cleans the blood when the kidneys don’t work. It gets rid of harmful wastes and extra salt and fluids that build up in the body. It helps control blood pressure and helps the body keep the right amount of fluids.</td>
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<tr>
<td><strong>Durable Medical Equipment (DME):</strong> Equipment used in the treatment of health conditions and impairments, such as an oxygen machine or pacemaker.</td>
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<tr>
<td><strong>Eating:</strong> Feeding oneself by getting food into the body from a receptacle or by a feeding tube or intravenously.</td>
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</table>
Elimination Period: A type of deductible; the length of time the individual must pay for covered services or be disabled before the insurance company will begin to make payments.

Expense Incurred Method: The policy or certificate will pay benefits when you receive eligible services. Once you have incurred an expense for an eligible service, benefits are paid either to you or your provider.

Employer Group Health Plan (EGHP): Health insurance coverage provided to an individual by their employer (or former employer in the case of a retiree). EGHP is one type of supplemental policy that a Medicare beneficiary may have to cover the gaps in their Medicare coverage.

End Stage Renal Disease (ESRD): Irreversible and permanent damage to the kidneys that requires regular dialysis or a kidney transplant.

Explanation of Medicare Benefits (EOMB): See Medicare Summary Notice

F

Family Support Division (FSD): The Missouri state agency that provides financial and health insurance coverage to individuals who are in need and meet specific eligibility requirements. FSD is the agency that processes the following programs relevant to Medicare beneficiaries: Medicaid, Medicaid Spend-Down, QMB and SLMB.

Federal Employee Health Benefits (FEHB): Health insurance coverage for federal civilian employees and their dependants. FEHB is one type of supplemental policy that a Medicare beneficiary may have to cover the gaps in their Medicare coverage.

Free Look: A 30 day period following your receipt of your policy during which you may return it for any reason for a full refund of any premiums paid.

Future Purchase Option (FPO): A form of inflation protection where the insured has the right to increase benefits periodically to reflect increases in the cost of care. Terms of the FPO vary from company to company.

G

Guaranteed Renewable: When a policy cannot be cancelled by an insurance company unless benefits have been exhausted or premiums have not been paid. In a guaranteed renewable policy, the insurance company may increase premiums, but only on an entire class of policies, not only on your policy.
**Hands On Assistance:** Physical assistance (any level) without which the individual would not be able to perform the activity of daily living.

**Health Insurance Portability and Accountability Act (HIPAA):** Passed in 1996. Allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits.

**Home Health Care:** A broad range of services delivered in the home, including: skilled nursing services; speech, occupational, physical and respiratory therapies; nutrition and medical services; administering of medication; personal care (help with ADLs), chore and homemaker services.

**Homemaker Services:** Basic services provided at home to help a person with a chronic illness or disability to be as independent as possible. These services may include housekeeping, laundry, meal preparation, transportation and shopping.

**Hospice Care:** Supportive care for the terminally ill which focuses on pain management, emotional, physical, and spiritual support for the patient and family. Hospice is typically paid for by Medicare and is not usually considered “long-term care.”

**Health Maintenance Organization (HMO):** One type of Medicare Advantage option available to Medicare beneficiaries (availability depends on where the beneficiary lives). HMOs consist of a network of providers (physicians, hospitals, home health agencies, etc.) and the beneficiary must use providers in the network to receive coverage. The beneficiary must also coordinate all of his/her care through a primary care physician, and may require a referral in order to see a physician.

**Hemodialysis:** A treatment that uses a special filter to clean the blood. The filter connects to a machine. During treatment, the blood flows through tubes into the filter to clean out wastes and extra fluids. Then newly cleaned blood flows back into the body through another set of tubes.

**Home Health Care:** Part-time or intermittent skilled nursing care and/or therapy provided in the home. Home health care claims may fall under Medicare Part A or Part B.

**Home Health Resource Group:** The Prospective Payment System classification used for home health services. Home health services are billed to Medicare based on a Home Health Resource Group, which corresponds to a prescribed plan of care. Home health agencies receive higher payments for patients who require a higher level of care.

**Hospice:** An establishment or program that provides for the physical and emotional needs of a terminally ill patient. Care is usually provided in the home or place of residence. Hospice claims are processed under Medicare Part A.
**I**

**Indemnity Method:** Method of paying benefits where the benefit is a set dollar amount without regard to the amount of the expense incurred. The insurance company will pay benefits directly to you, up to the limit of the policy.

**Inflation Protection:** Provision that provides that benefits increase over time, either automatically or at the option of the policyholder, to help offset future increases in service costs.

**Informal Care:** Care provided by family or friends who are not paid for their service.

**Immunosuppressive drug therapy:** Drugs used to reduce the risk of the body rejecting a new organ after transplant. These drugs must be taken for life.

**Indemnity Policy:** A type of health insurance policy that pays a fixed dollar amount to the insured for expenses covered in the policy. The indemnity policy is one type of Medicare supplement.

**Issue Age Rating Policy:** Refers to Medigap policies that lock in a premium based on the buyer’s age at the time the policy is bought. If a person buys a policy at age 65, he/she will always pay the premium that a person age 65 pays.

**L**

**Lapse:** Termination of a policy when the premium is not paid.

**Limited Payment Option:** A premium payment option in which the person pays premiums for a set time period. After the last premium payment, neither the company nor the person can cancel the policy. These plans are more expensive than continuous payment policies.

**Lock-in:** A term used to describe the restrictions of managed care members to only use network providers.

**Long Term Care:** A variety of services that help people with health or personal needs and activities of daily living over a period of time.

**Long Term Care Insurance:** A specific type of insurance policy designed to offer financial support in paying for necessary long term care services rendered in a variety of settings.

**M**

**Medicare Supplement Insurance:** A private insurance policy that covers many of the gaps in Medicare coverage (also called Medigap insurance coverage).
**Medicaid**: A public assistance program that pays for certain health care costs of persons. For Medicare beneficiaries who meet Medicaid eligibility requirements, Medicaid serves as a Medicare supplement.

**Medicaid Spend-Down**: A public assistance program that pays for certain health care costs of qualified persons. This program is intended for individuals with income above the Medicaid limits, allowing them to “spend down” their income to the Medicaid limit in order to receive Medicaid benefits.

**Medical Savings Account (MSA)**: One type of the Medicare Advantage options available to Medicare beneficiaries (availability depends on where the beneficiary lives). With this plan, the beneficiary establishes a Medical Savings Account with a financial institution and enrolls in a high-deductible catastrophic health plan. Medicare will make yearly deposits into the MSA and the beneficiary will use the money from the MSA to pay for “qualified medical expenses”. Currently, the MSA is not an option for Medicare beneficiaries in Missouri.

**Medicare Administrative Contractors (MAC)**: A private insurance company that contracts with Medicare (CMS) to process Part A claims (hospital, skilled nursing facility - SNF, hospice, and home health care claims) and outpatient hospital claims and Part B claims. The MAC issues Medicare Summary Notices (MSN) to beneficiaries for Medicare claims.

**Medicare Advantage (MA)**: An alternative form of Medicare coverage established in 1997 in an effort to offer beneficiaries more choices and reduce overall costs. Medicare Advantage options include HMOs, private fee for service organizations, provider sponsored organizations, preferred provider organizations, medical savings accounts, and religious fraternal benefit societies. When a beneficiary is enrolled in a Medicare Advantage plan, the Medicare Advantage organization processes the beneficiary’s Part A and Part B claims. Beneficiaries may have access to a limited number or a substantial number of Medicare Advantage organizations depending on their location.

**Medicare Advantage Plans with Medicare Prescription Drugs (MA-PD)**: A managed care plan that offers Medicare prescription drug coverage benefits (Part D)

**Medicare SELECT Policy**: An option of the same 12 standardized Medigap policies. However, the beneficiary must use network providers for the Medicare SELECT policy to pay. Premiums for these policies may be lower than for regular Medigap policies.

**Medicare Summary Notice (MSN)**: The statement a beneficiary receives from the fiscal intermediary or carrier for each Medicare claim. This statement provides detailed information regarding the service, such as dates of service; amount billed by the provider to Medicare, the amount the beneficiary owes the provider, and information on how to appeal any denied services.

**Medicare Supplement**: An additional insurance policy designed to fill the gaps in Medicare coverage (such as inpatient hospital deductibles, 20% coinsurance on Part B claims, Part B yearly deductible, etc.). There is a wide range of Medicare supplemental policies, including
Medigap plans, Federal Employee Health Benefits (FEHB), Employer Group Health Plans (EGHP), etc.

**Medigap**: Medigap policies are one of twelve standardized health insurance plans designed to fill in some of the “gaps” in Medicare (e.g. another type of Medicare supplement). The standardized Medigap policies are labeled as Plan A – Plan L, and the benefits for each lettered plan are always the same from company to company (though the premiums may differ).

**N**

**National Association of Insurance Commissioners (NAIC)**: Membership organization of state insurance commissioners. One goal is to promote uniformity of state regulations and legislation related to insurance.

**Network**: A network is a group of physicians, hospitals, and other health care professionals who provide health care services for managed care members.

**No Age Rating Policy**: Refers to any Medigap policy that has the same premium for all people, regardless of age.

**Non-Cancelable Policies**: Insurance contracts that cannot be canceled by the insurance company, nor can the rates be changed.

**Nonforfeiture Benefits**: Policy features that return at least part of the premiums to you if you cancel your policy or let it lapse.

**Nursing Home**: A licensed facility that provides general nursing care to those who are chronically ill or unable to take care of daily living needs.

**Noridian**: A private health insurance company that serves as the DME Medicare Administrative Contractor (MAC) for the state of Missouri. Noridian processes durable medical equipment claims. [For contact information, see the Resources Section.]

**O**

**Outline of Coverage**: A description of benefits, exclusions and provisions to each insured. Most state insurance laws specify the format and content of the Outline of Coverage. This must be provided to a prospective applicant for insurance before the application is taken.

**P**

**Part A**: The part of Medicare that provides coverage for inpatient hospitalization, skilled nursing facilities (SNF), home health care, and hospice. Part A is often referred to as Medicare’s “hospital insurance.” Part A claims are processed by Medicare Administrative Contractors (MACs).
**Part B**: The part of Medicare that provides coverage for most outpatient and other medical services (including physician services, outpatient hospital services, therapy, home health care, ambulance transportation, clinical laboratory services, blood, durable medical equipment, and preventive services). Part B is often referred to as Medicare’s “medical insurance.” Part B claims are processed by the Medicare Administrative Contractor (MAC).

**Palmetto GBA**: Private health insurance company that serves as a carrier for the state of Missouri (processes Part B claims for Railroad Retirement beneficiaries). [For contact information, see the Resources Section.]

**Partnership Policy**: A type of private long term care insurance policy that allows you to protect some or all of your assets if you apply for Medicaid after using up your policy’s benefits. This type of policy is not available in all states.

**Peritoneal Dialysis**: A treatment that uses a cleaning solution called dialysate to clean the blood. The solution flows through a special tube into the abdomen. After a few hours, the solution gets drained from the abdomen taking the wastes from the blood with it.

**Personal Care**: Help with ADLs such as bathing and dressing. The goal of personal care is to provide help with these everyday activities when a person is unable to perform them independently.

**Point-of-Service**: An option in a managed care plan that allows members to receive health care services out of network for an additional cost.

**Post Acute**: Care needs following an acute illness or medical event such as surgery, stroke, or other short-term hospitalization. Post acute care might include rehabilitation and therapy, wound care, IV therapy and other support services.

**Pre-Existing Condition**: A condition for which medical advice or treatment was recommended by or received from a health care provider with in a stated time period prior to the effective date of insurance coverage.

**Pre-Existing Condition Exclusion**: Policy provision that excludes coverage for a period of time immediately following the effective date of coverage if the care needed is the result of a pre-existing condition.

**Preferred Provider Organization (PPO)**: One type of Medicare Advantage option available to Medicare beneficiaries (availability depends on where the beneficiary lives). A PPO is a Medicare plan offered by private health insurance companies. The insurance company is responsible for providing health care coverage to all members of this plan, and members may choose from a list of preferred providers to receive benefits. But can choose to see non-preferred providers for higher cost sharing responsibility.
Preventive Services: Medical tests or procedures that are performed in the absence of any signs or symptoms of a disease. If an individual has signs or symptoms of a disease, the medical tests or procedures would be considered “diagnostic.” Medicare only covers very specific preventive services within specified time frames, as determined by Congress (such as mammogram screening once every 12 months).

Primaris: The quality improvement organization (QIO) for the state of Missouri. The QIO (formerly known as PRO) was established in 1984 through a contract from Medicare (CMS). The purpose of Primaris is to help protect the rights and improve the quality of care provided to Medicare beneficiaries in Missouri. The CLAIM program is a department of Primaris.

Private Fee-for-Service (PFFS): One type of Medicare Advantage option available to Medicare beneficiaries (availability depends on where the beneficiary lives). PFFS is a Medicare Advantage plan offered by a private health insurance company. This insurance company is responsible for providing health care coverage to all members of this plan, and the insurance company sets copayment rates for the services members receive. Beneficiary may see any provider that is willing to accept the plans payment.

Prospective Payment System: The payment system Medicare uses to pay for all Part A and some Part B claims. Procedures are reimbursed on a fixed-payment basis that takes into account geographical and patient differences. Rather than reimbursing health care providers on a per-service basis, Medicare determines an average charge for a particular service and reimburses according to a set formula.

Provider Sponsored Organization (PSO): One type of Medicare Advantage option available to Medicare beneficiaries (availability depends on where the beneficiary lives). A PSO is a health plan owned or controlled by a provider or group of providers within a community.

Q

Quality Improvement Organization (QIO): See Beneficiary Family Centered Care – Quality Improvement Organization

Qualified Medicare Beneficiary (QMB) Program: A federal and state funded assistance program that assists certain low-income Medicare beneficiaries by paying the following Medicare costs: Medicare premiums, deductibles, and coinsurance.

R

Railroad Retirement Board: A federal agency that determines cash benefits, eligibility and enrollment for Medicare, an issues Medicare replacement cards for railroad retirees.

Reduced Paid-up Benefits: A nonforfeiture option that reduces your daily benefit but retains the full benefit period on your policy until death.
**Rescind**: When the insurance company voids a policy.

**Respite Care**: Temporary care in a nursing home, Adult Day Care Center, or by a Home Health Care Agency which is intended to provide time off for those informal caregivers who ordinarily care for you on a regular basis. Respite Care is usually short term.

**Rider**: Addition to an insurance policy that changes the provisions of the policy.

**Riverbend**: A private health insurance company that serves as a Medicare Administrative Contractor for the state of Missouri (rural health clinic claims). [For contact information, see the Resources Section.]

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**S**

**Service Area**: The geographic area in which a beneficiary must live in order to be eligible for enrollment in a Medicare Advantage Organization.

**Shortened Benefit Period**: A nonforfeiture option that reduces the benefit period but retains the full daily maximum applicable until death. The period of time for which benefits are paid will be shorter.

**Skilled Care**: Nursing care (e.g., help with medications or caring for bandages and wounds) and therapies (e.g., occupational, speech, respiratory, and physical therapies). Skilled care usually requires the services of a licensed professional.

**Skilled Nursing Facility (SNF)**: A specially qualified health care facility that provides skilled nursing care or rehabilitation services, as well as other health-related services. Skilled care consists of nursing care provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), or skilled rehabilitation services. Generally, skilled nursing care immediately follows a hospital stay, and claims for SNFs fall under Medicare Part A.

**Social Security Administration (SSA)**: The federal government agency that administers Social Security benefits. SSA also handles Medicare eligibility and enrollment and distributes Medicare cards.

**Social Security Disability Insurance (SSDI)**: Pays benefits to you and certain members of your family if you are "insured," meaning that you worked long enough and paid Social Security taxes.

**SORT: The Missouri SMP**: A federally funded grant program that is designed to fight fraud, waste and abuse in the Medicare and Medicaid programs in the state of Missouri. [For contact information, see your list of Resources.]

**Special Needs Plans**: A Medicare Advantage Plan option that will only enroll beneficiaries with certain types of diseases or conditions.
Specified Low-Income Medicare Beneficiary (SLMB) Program: A federal and state funded assistance program that assists certain low-income Medicare beneficiaries by paying their Medicare premiums. The income limits for this program are slightly higher than for the QMB program. Income must be more than 100% of federal poverty level (FPL) but not exceed 120%.

In Missouri the SLMB program also includes the Qualifying Individual 1 (QI-1) program (also known as SLMB group 2) provides payment of Medicare Part B premium for people whose income is more than 120% of FPL, but does not exceed 135%.

Stand By Assistance: Caregiver stays close to the individual to watch over them and to provide physical assistance if/when necessary.

State Health Insurance Assistance Program (SHIP): The nationwide program that provides free counseling and assistance to Medicare beneficiaries. SHIPs receive federal funding through a grant from Medicare (CMS). SHIPs usually provide counseling services through a system of volunteer counselors in each state. CLAIM is the SHIP for the state of Missouri.

Substantial Assistance: Hands-on or standby help required to do ADLs or IADLs.

Substantial Supervision: The presence of a person directing and watching over another who has a cognitive impairment.

Supervisor Care: Type of long term care that is sometimes needed due to problems with memory or orientation such as Alzheimer’s disease.

Supplemental Security Income (SSI): A federally funded income assistance program for the aged (65 or older), the blind, and the disabled. The purpose of the program is to ensure a minimum level of income for people who do not have enough income or resources to maintain a minimum standard of living.

Tax-Qualified Long Term Care Insurance Policy: A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

Term Life Insurance: Covers a person for a period of one or more years. It pays a death benefit only if you die during that term. It generally does not build cash value.

Third Party Notice: A benefit which lets you name someone whom the insurance company would notify if your coverage is about to end due to lack of premium payment.

Transferring: Moving into and out of a bed, chair or wheelchair.

TriCare: A health insurance program for retired military service members and their immediate families.
**TriCare for Life:** A TriCare program for members over age 65. For eligible TriCare members, TriCare for Life serves as a supplement to Medicare.

**Underwriting:** The process that an insurance company uses to decide, based on your medical history, whether or not to take your application for insurance; whether or not to add a waiting period for pre-existing conditions (if your state law allows it); and how much to charge you for that insurance.

**Universal Life Insurance:** A kind of flexible policy that lets you vary your premium payments and adjusts the face amount of your coverage.

**Viatical:** refer to the sale of a life insurance policy when the insured is terminally ill or chronically ill.

**Waiting Period:** A set amount of time that an insurance company will not pay benefits due to a pre-existing medical condition.

**Waiver of Premium:** A policy provision of a long term care insurance contract that suspends premium payment after a specified period of time during which the insured is receiving policy benefits for long term care services. The suspension continues until recovery at which time resumption of premium payment is expected.

**Wisconsin Physician Services:** A private health insurance company that serves as the Medicare Administrative Contractor for Missouri. [For contact information, see the Resources Section]

**Whole Life Insurance:** Policies that build cash value and cover a person for as long as they live, if premiums continue to be paid.
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<th>Organization/Agency</th>
<th>Program/Topic</th>
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<tbody>
<tr>
<td>Missouri Department of Insurance Financial Institutions &amp; Professional Registration</td>
<td>Insurance Regulation for State of Missouri</td>
<td>Consumer Affairs Division PO Box 690 Jefferson City, MO 65102-0690</td>
<td>800-726-7390 <a href="http://www.insurance.mo.gov">www.insurance.mo.gov</a></td>
</tr>
<tr>
<td>Heartland Kidney Network (formerly ESRD Network #12)</td>
<td>ESRD quality improvement network</td>
<td>920 Main St. Suite 801 Kansas City, MO 64105</td>
<td>Toll Free: 800-444-9965 Local: 816-880-9990 Fax: 816-880-9088 <a href="http://www.heartlandkidney.org">www.heartlandkidney.org</a></td>
</tr>
<tr>
<td>Missouri Vocational Rehabilitation (VR)</td>
<td>Kidney Failure</td>
<td>Check website for local address</td>
<td>877-222-8963 <a href="http://www.dese.mo.gov/vr/vroffices.htm">www.dese.mo.gov/vr/vroffices.htm</a></td>
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<tr>
<td>Wisconsin Physician Services (WPS)</td>
<td>Medicare Part A Medicare Administrative Contractor Appeals and Claims</td>
<td>WPS Medicare Part A Claims Department P.O. Box 8890 Madison, WI 53707-8890</td>
<td>800-MEDICARE (633-4227) <a href="http://www.wpsmedicine.com">www.wpsmedicine.com</a></td>
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<tr>
<td></td>
<td>Medicare Part B Medicare Administrative Contractor/Claims</td>
<td>WPS Medicare Part B Claims Department PO Box 14260 Madison, WI 53708-0260</td>
<td>800-MEDICARE (633-4227) <a href="http://www.wpsmedicine.com">www.wpsmedicine.com</a></td>
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<td></td>
<td>Medicare Part B Appeals</td>
<td>WPS Medicare Part B Appeals Department PO Box 14260 Madison, WI 53708-0260</td>
<td>800-MEDICARE (633-4227) <a href="http://www.wpsmedicine.com">www.wpsmedicine.com</a></td>
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<tr>
<td>Noridian Mutual Insurance Company</td>
<td>Durable Medical Equipment Regional Contractor</td>
<td>Medicare Part B Attn: Noridian Administrative Services P.O. Box 6727 Fargo, ND 58108-6727</td>
<td>800-MEDICARE (633-4227) <a href="http://www.noridianmedicare.com">www.noridianmedicare.com</a></td>
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<tr>
<td>Missouri HealthNet (Medicaid)</td>
<td>Claims and coverage status only</td>
<td></td>
<td>800-392-2161</td>
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<td></td>
<td>Application and Eligibility Information</td>
<td></td>
<td>800-392-1261</td>
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<td></td>
<td>Resource Center</td>
<td></td>
<td>855-373-4636</td>
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<td></td>
<td>Report Medicaid Fraud</td>
<td></td>
<td>573-751-3285</td>
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<tr>
<td>Missouri Attorney General’s Office</td>
<td>Medicaid Fraud or Abuse and Neglect</td>
<td>Missouri Attorney General's Office</td>
<td>800-286-3932 <a href="mailto:attorney.general@ago.mo.gov">attorney.general@ago.mo.gov</a></td>
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<td>Medicaid Fraud Control Unit</td>
<td><a href="http://www.ago.mo.gov/divisions/medicaid-provider-fraud/abuse-neglect">www.ago.mo.gov/divisions/medicaid-provider-fraud/abuse-neglect</a></td>
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<td>Jefferson City, MO 65102</td>
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<tr>
<td></td>
<td>Medicaid Participant Fraud</td>
<td>Department of Social Services – Investigations Unit</td>
<td>877-770-8055 <a href="mailto:ask.mhd@dss.mo.gov">ask.mhd@dss.mo.gov</a></td>
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<td>P.O. Box 1527</td>
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<tr>
<td>MO HealthNet</td>
<td>Applications processing by County Family Support Division Office</td>
<td>Use the web to find your local office:</td>
<td><a href="http://www.dss.mo.gov/fsd/office/index.htm">www.dss.mo.gov/fsd/office/index.htm</a></td>
</tr>
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| Social Security Administration | • Replace Medicare Card  
• Change Address for SS and Medicare  
• Eligibility Determination for Medicare, SSI and SSDI  
• Find a local SSA Office  
• Apply for Extra Help with Part D | Use the web to find your local office:                                  | 800-772-1213  
TTY: 800-325-0778  
[www.socialsecurity.gov](http://www.socialsecurity.gov) |
| Railroad Retirement Board    | US Railroad Retirement Board  
• Benefit & Forms  
• Publications  
• Information | Local Offices:  
Robert A. Young Fed Bldg  
1222 Spruce Street  
Room 7.303  
St. Louis, MO 63103-2846  
Richard Bolling Fed Bldg  
601 E 12th Street  
Room G47  
Kansas City, MO 64106 | [www.rrb.gov](http://www.rrb.gov)  
St. Louis  
Toll Free: 877-772-5772  
Fax: 314-539-6229  
Kansas City  
Toll Free: 877-772-5772  
Fax: 816-426-5334 |
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<tr>
<td>Champus/TRI-Care</td>
<td>Military Health Insurance (North Region)</td>
<td></td>
<td>888-874-2273 <a href="http://www.tricare.mil">www.tricare.mil</a> <a href="http://www.hnfs.com">www.hnfs.com</a></td>
</tr>
<tr>
<td>Department of Veterans Affairs</td>
<td>Veterans Benefits</td>
<td></td>
<td>800-827-1000 <a href="http://www.va.gov">www.va.gov</a></td>
</tr>
<tr>
<td>Missouri SMP</td>
<td>Medicare and Medicaid Fraud</td>
<td>106 W. Young P.O. Box 1078 Warrensburg, MO 64093</td>
<td>800-748-7826 Fax: 660-747-3100 <a href="http://www.goaging.org">www.goaging.org</a></td>
</tr>
<tr>
<td>Medicare</td>
<td>Report Fraud to MAC</td>
<td></td>
<td>800-633-4227 (800-Medicare)</td>
</tr>
<tr>
<td>Department of Health and Senior Services</td>
<td>Information and Referrals</td>
<td>PO Box 570 Jefferson City, MO 65102-0570</td>
<td>Legal Helpline: 800-235-5503 Local: 573-751-6400 <a href="http://www.dhss.mo.gov">www.dhss.mo.gov</a></td>
</tr>
<tr>
<td>Long-Term Care Ombudsman</td>
<td>Nursing Home Patient Advocates</td>
<td>State Office of Long-Term Care Ombudsman Program Missouri Dept of Health and Senior Services P.O. Box 570 Jefferson City, MO 65102-0570</td>
<td>Toll Free: 800-309-3282 Local: 573-526-0727 Fax: 573-751-6499 Email: <a href="mailto:LTCOmbudsman@health.mo.gov">LTCOmbudsman@health.mo.gov</a> <a href="http://www.health.mo.gov/seniors/ombudsman">www.health.mo.gov/seniors/ombudsman</a></td>
</tr>
<tr>
<td>DHSS Section for Long-Term Care Regulations</td>
<td>Missouri Board of Nursing Home Administrators Report Nursing Home Complaints</td>
<td>3418 Knipp Drive PO Box 570 Jefferson City, MO 65102-0570</td>
<td>Toll Free: 800-392-0210 Local: 573-751-3511 Fax: 573-526-4314 Email: <a href="mailto:bnha@health.mo.gov">bnha@health.mo.gov</a> <a href="http://www.dhss.mo.gov">www.dhss.mo.gov</a></td>
</tr>
<tr>
<td>Bureau of Health Services Regulations</td>
<td>Health Services Regulation MO Dept. of Health and Senior Services P.O. Box 570 Jefferson City, MO 65102-0570</td>
<td></td>
<td>573-751-6303 Fax: 573-526-3621 Email: <a href="mailto:info@health.mo.gov">info@health.mo.gov</a> <a href="http://www.health.mo.gov/safety/healthservregs">www.health.mo.gov/safety/healthservregs</a></td>
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| Bureau of Home Care and Rehabilitative Standards | Regulation of therapy service in - Hospitals, ambulatory surgery center, dialysis, rural health clinics, labs, and radiology equipment, home health. OPT, hospice and CORP | MO Dept. of Health and Senior Services  
P.O. Box 570  
Jefferson City, MO 65102-0570 | 573-751-6336  
Fax: 573-751-6315  
Home Health/Hospice Hotline: 800-392-0210 (for filing complaints)  
Email: info@health.mo.gov  
www.health.mo.gov/safety/homecare/ |
| Bureau of Emergency Medical Services | ambulances (ground/air), trauma centers | MO Dept. of Health and Senior Services  
P.O. Box 570  
Jefferson City, MO 65102 | 573-751-6356  
Fax: 573-751-6348  
Email: emsinfo@health.mo.gov  
www.health.mo.gov/safety/ems/ |
| Missouri Board of Registration for the Healing Arts | Regulation of Physicians and complaints | Board of Registration for the Healing Arts  
3605 Missouri Boulevard  
P.O. Box 4  
Jefferson City, MO 65102 | Phone: 573-751-0098  
Fax: 573-751-3166  
TTY: 800-735-2966  
Voice Relay: 800-735-2466  
Email: healingarts@pr.mo.gov  
www.pr.mo.gov/healingarts.asp |
| Rehabilitation Services for the Blind/Older Blind Services | Services for Blind | See web for District Offices  
www.dss.mo.gov/fsd/rsb/rhabofc.htm | Toll Free: 800-592-6004  
Email: askrsb@dss.mo.gov  
www.dss.mo.gov/fsd/rsb/ |
| Region X Area Agency on Aging | Area Agency on Aging | 531 E. 15th Street  
P.O. Box 3990  
Joplin, MO 64803 | Local: 417-781-7562  
Fax: 417-781-1609  
www.aaaregionx.org |
| Care Connection-Warrensburg | Area Agency on Aging | Care Connection for Aging Services  
106 W. Young  
PO Box 1078  
Warrensburg, MO 64093 | 800-748-7826 or 660-747-3107  
Fax: 660-747-3100  
Email: information@GoAging.org  
www.goaging.org |
| Central MO AAA | Area Agency on Aging | 1121 Business Loop 70 East  
Suite 2A  
Columbia, MO 65201 | 800-369-5211 or 573-443-5823  
TTY: 573-443-0105  
Fax: 573-875-8907  
www.cmaaaa.net |
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<tr>
<td>Mid-America Regional Council – Kansas City</td>
<td>Area Agency on Aging</td>
<td>Mid-America Regional Council Dept. of Aging Services 600 Broadway, Ste. 200 Kansas City, MO 64105</td>
<td>800-593-7948 or 816-474-4240 Fax: 816-421-7758 Email: <a href="mailto:marcinfo@marc.org">marcinfo@marc.org</a> <a href="http://www.marc.org">www.marc.org</a></td>
</tr>
<tr>
<td>Mid-East AAA</td>
<td>Area Agency on Aging</td>
<td>14535 Manchester Rd. Manchester, MO 63011-3960</td>
<td>800-243-6060 or 636-207-1323 Email: <a href="mailto:info@mid-eastaaa.org">info@mid-eastaaa.org</a> <a href="http://www.mid-eastaaa.org">www.mid-eastaaa.org</a></td>
</tr>
<tr>
<td>Northeast AAA</td>
<td>Area Agency on Aging</td>
<td>815 N Osteopathy Kirksville, MO 63501</td>
<td>800-664-6338 or 660-665-4682 Email: <a href="mailto:nemoaaa@sbcglobal.net">nemoaaa@sbcglobal.net</a> <a href="http://www.nemoaaa.com">www.nemoaaa.com</a></td>
</tr>
<tr>
<td>Northwest AAA</td>
<td>Area Agency on Aging</td>
<td>504 E Highway 136 P.O. Box 265 Albany, MO 64402</td>
<td>888-844-5626 or 660-726-3800 Fax: 660-726-4113 Email: <a href="mailto:nwmoaaa@nwmoaaa.org">nwmoaaa@nwmoaaa.org</a> <a href="http://www.nwmoaaa.org">www.nwmoaaa.org</a></td>
</tr>
<tr>
<td>Aging Matters (Southeast AAA)</td>
<td>Area Agency on Aging</td>
<td>1219 N Kingshighway Suite 100 Cape Girardeau, MO 63701</td>
<td>800-392-8771 or 573-335-3331 <a href="http://www.agingmatters2u.com">www.agingmatters2u.com</a></td>
</tr>
<tr>
<td>Southwest AAA</td>
<td>Area Agency on Aging</td>
<td>1735 S Fort Ave. Springfield, MO 65807</td>
<td>800-497-0822 or 417-862-0762 <a href="http://www.swmoa.com">www.swmoa.com</a></td>
</tr>
<tr>
<td>St. Louis AAA</td>
<td>Area Agency on Aging</td>
<td>1520 Market Room 4086 St. Louis, MO 63103</td>
<td>877-612-5918 or 314-612-5918 Fax: 314-612-5915 <a href="http://www.slaaa.org/">www.slaaa.org/</a></td>
</tr>
<tr>
<td>Eastern Missouri</td>
<td>Legal Services</td>
<td>St. Louis (Main Office) 4232 Forest Park Ave. St. Louis, MO 63108 See web for local offices</td>
<td>800-444-0514 or 314-534-4200 Fax: 314-534-1425 Email: <a href="mailto:info@lsem.org">info@lsem.org</a> <a href="http://www.lsem.org/">www.lsem.org/</a></td>
</tr>
<tr>
<td>Mid-Missouri</td>
<td>Legal Services</td>
<td>1201 West Broadway Columbia, MO 65203</td>
<td>800-568-4931 or 573-442-0116 Fax: 573-875-0173 <a href="http://www.lsmo.org">www.lsmo.org</a></td>
</tr>
<tr>
<td>Southern Missouri</td>
<td>Legal Services</td>
<td>Springfield (Headquarters) 809 N. Campbell Ave. Springfield, MO 65802 See web for local offices</td>
<td>800-444-4863 or 417-881-1397 Fax: 417-881-2159 <a href="http://www.lsosm.org/">www.lsosm.org/</a></td>
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| Western             | Legal Services | Central Office  
1125 Grand Blvd., #1900  
Kansas City, MO 64106  
See web for local offices | 816-474-6750  
www.lawmo.org |
| C2C Solutions, Inc. | Qualified Independent Contractor  
– Part A Appeals | QIC Part A West  
PO Box 45105  
Jacksonville, FL 32232-5105 | 904-224-7446  
www.c2cinc.com/qicpartawest.aspx |
|                     | Qualified Independent Contractor  
– Part B Appeals | QIC Part B North  
PO Box 45208  
Jacksonville, FL 32232-5208 | 904-224-7426  
www.c2cinc.com/QICPartBNorth.aspx |
|                     | Qualified Independent Contractor  
– DME Appeals | PO Box 44013  
Jacksonville, FL 32231-4013 | 904-224-7433  
www.c2cinc.com/QICdme.aspx |
| Maximus Federal Services, Inc. | Medicare Managed Care & PACE Reconsideration Project (Part C Appeals) | 3750 Monroe Ave., Suite 702  
Pittsford, NY 14534-1302 | Phone: 585-348-3300  
www.medicareappeals.com  
www.maximus.com |
| Maximus Federal Services, Inc. | Qualified Independent Contractor  
– Part D Appeals | Medicare Part D QIC  
3750 Monroe Ave., Suite 703  
Pittsford, NY 14534-1302 | 877-456-5302 toll free  
Fax for Part D plans: 585-425-5301  
Fax for enrollees: 866-825-9507 or 585-425-5390  
www.medicarepartdappeals.com |
|                     | Part D Late Enrollment Penalty (LEP) reconsideration | Medicare Part D QIC  
3750 Monroe Ave., Suite 704  
Pittsford, NY 14534-1302 | 877-456-5302 toll free  
Fax for Part D plans: 585-869-3330  
Fax for enrollees: 866-589-5241 or 585-869-3320  
www.medicarepartdappeals.com/ |
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<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
<td>Medicare Premium Collection</td>
<td>CMS MPCC PO Box 790355 St. Louis, MO 63179-0355</td>
<td>800-MEDICARE (633-4227)</td>
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<tr>
<td>MSPRC Special Projects</td>
<td>Medicare Secondary Payer Recovery Contractor</td>
<td>PO Box 138868</td>
<td>Main : 855-798-2627 TTY/TTD: 855-797-2627 Monday – Friday, 7 am – 7 pm</td>
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**Other Resources:**