

MEDICARE

By

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MEDICARE:

HOSPITAL, NURSING FACILITY, HOME HEALTH, PHYSICIAN COVERAGE, AND MANAGED CARE ORGANIZATIONS

Medicare is a federal health insurance program administered by the United States Department of Health and Human Services (HHS). Medicare eligibility is linked to eligibility for Social Security Title II benefits, but elderly individuals not eligible for Social Security benefits may enroll in Medicare by paying a premium.

Sources: 42 U.S.C. § 426 entitlement.
 42 U.S.C. §§ 1301 – 1320C-13 claims.
 42 U.S.C. §§ 1395 – 1395fff coverage/services.
 42 C.F.R. Part 405 – 430 coverage/services.
 Claims Manuals issued by the Center for Medicare and Medicaid
 Services (formerly the Health Care Financing Administration)

I. Eligibility

- A. Age 65 or older [42 U.S.C. § 426(a)]
 - 1. Eligible for Social Security Title II retirement benefits as wage earner or dependant spouse
- B. Permanent kidney failure [42 U.S.C. § 426 – 1(a)]
- C. Recipient of Social Security disability or Railroad Retirement disability [42 U.S.C. § 426(b) *et seq.*]
 - 1. Disabled at least 24 months or,
 - 2. Certain widows and widowers who are disabled twelve months
- D. If not otherwise eligible, can enroll if:
 - 1. Age 65 or older and,
 - 2. Citizen of United States or
 - 3. Legal alien resident for at least five years

- a. Must pay premiums each month:
 - i. \$410 (2007) for Part A premium if less than 30 quarters in Social Security earnings
 - ii. \$226 (2007) for Part A premium if 30 to 39 quarters in Social Security earnings
 - iii. \$93.50 (2007) for Part B premium

II. Part A and Part B Medicare Programs

A. Part A coverage

- 1. Inpatient hospital care
- 2. Skilled nursing facility care
- 3. Hospice care
- 4. Home health care

B. Part B coverage

- 1. Physician services
- 2. Outpatient hospital care
- 3. Therapy
- 4. Ambulance transportation
- 5. Durable medical equipment
- 6. Prosthesis
- 7. Home health care

III. Part A Inpatient Hospital Coverage

A. Conditions for coverage [42 C.F.R. § 424.1, *et seq.*]

- 1. Physician prescribes inpatient hospital treatment

2. Patient's condition requires hospital care
- B. Coverage
1. Patient deductible for "spell of illness" is \$992 (2007)
 - a. Begins when hospitalized and
 - b. Ends 60 days after last hospital or skilled nursing facility discharge
 2. Pays all but the deductible during first 60 days
 3. Daily co-payment between days 61-90 is \$248 (2007)
 4. 60 lifetime reserve days
 - a. \$496 (2007) daily co-payment, for days 91-150
 - b. Not renewable
- C. Prospective Payment System (PPS) [42 U.S.C. § 1395ww(d)]
1. Before PPS
 - a. Hospitalization's length plus services provided equaled higher Medicare reimbursement
 2. After PPS's first year of implementation in 1983
 - a. Payment based on average Diagnosis-Related Group (DRG) cost based on DRG at discharge.
 - b. The Diagnosis-Related Group (DRG) is used to classify hospital cases into a single diagnostic group on discharge from the hospital. There are approximately 490 diagnostic related groups. The DRG is then used to calculate the nationwide average cost of caring for individuals with that diagnosis on discharge.
 - c. If a hospital treats a person with a specific DRG in less time or uses fewer resources than that DRG required on average, the hospital retains the excess above its actual costs. If the hospital's costs are greater than the reimbursement for a particular DRG then they will lose money.
 - d. Only in a case where the actual costs of care greatly exceeds the DRG reimbursement amount due to complications, would a hospital be permitted to recover an outlier payment, even then the amount of this

payment is only a small portion of their actual extraordinary costs.

3. PPS consequences
 - a. Longer stays cost hospital money
 - b. More services cost hospitals money
 - c. Incentive to discharge within the time frame used to set DRG rates
 - d. Hospitals began to drastically reduce the time and resources allocated to treating Medicare patients

D. Review of the effect of DRGs on admissions and discharges

1. Quality Improvement Organization (QIO) were created to ensure PPS did not adversely affect hospital access [42 C.F.R. § 476.71]
2. QIO should ensure PPS does not adversely affect quality of care [*Id.*]
3. The Quality Improvement Organization for Ohio is KePRO, Inc.
 - a. Medicare Beneficiary Appeal/Complaint phone number: 800-589-7337
 - b. Address is PEPP/Review Department, Rock Run Center, Suite 100, 5700 Lombardo Center Drive, Seven Hills, Ohio 44131

E. Hospital admission denials

1. The patient must receive a written denial notice, stating
 - a. The reason for denial and the patient's right to appeal

F. Hospitals must also provide a discharge planning evaluation for

1. All patients likely to suffer adverse consequences without adequate discharge planning and
2. All other patients for whom a request is made by the patient, the patient's representative, or the physician
3. If the physician requests, the hospital must also initially implement the discharge plan

G. The hospital cannot charge the patient, unless:

1. The hospital determines that hospitalization is unnecessary or the PRO states in writing that hospitalization is unnecessary
 2. The hospital gives the patient written notice that states:
 - a. Hospital care is not necessary,
 - b. Patient liability begins the third day after the notice is received, unless the patient appeals the determination that hospital care is not needed, and
 - c. Detailed patient appeal rights and procedures
- H. Hospital discharge appeals [42 U.S.C. § 1320c-3(e), *et seq.*]
1. Written requests or telephone requests to 1-800-589-7337 (Ohio) for review by the QIO [42 C.F.R. § 412.42 (c)]
 2. Patient Liability
 - a. If the QIO rules against the beneficiary, the beneficiary can be charged for all services beginning the third day after the beneficiary received the written notice of non-coverage from the hospital
 - b. The QIO decision can be appealed through the Part A Medicare Appeal process

IV. Part A Skilled Nursing Facility Coverage

- A. Eligibility criteria [42 C.F.R. § 409.30, *et seq.*]
1. Hospitalized at least 3 consecutive calendar days not counting day of discharge before admission to a skilled nursing facility (SNF) [42 C.F.R. § 409.30(a)]
 2. Needs and receives daily skilled nursing or skilled rehabilitation services [42 C.F.R. §§ 409.31 & 409.34]
 3. The SNF participates in Medicare [42 U.S.C. § 1395cc]
 4. Custodial and intermediate care are not covered
- B. “Skilled nursing” and “skilled rehabilitation” services
1. Services directly provided by an RN, LPN, physical or occupational

therapist, speech pathologist or audiologist

2. Overall management and evaluation of care plan of the patient, where one or more of the above professionals initially directs and periodically inspects actual care

C. Principles that determine whether a service is “skilled”

1. The care is so complex that safety and effectiveness require skilled personnel
2. The need for skilled personnel is determinative, not the patient’s potential for recovery
3. Medical complications requiring skilled personnel may make a “non-skilled” service a “skilled” service

D. Skilled Nursing Facility reimbursement by Medicare

1. For the first 20 days of the stay, Medicare pays all charges
2. For each day 21 – 100, the beneficiary must pay a \$124 (2007) daily co-payment
 - a. A Medicare coverage determination is often the key factor in obtaining nursing facility benefits for the Medicare beneficiary’s skilled nursing facility co-payment for days 21-100 from a Medicare Supplemental insurance policy or a retirement health plan

V. Part A Appeals [42 U.S.C. § 1395ff]

- A. Uniform appeal procedures for both Part A and Part B claims created by Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)
- B. The patient is entitled to a written determination from the fiscal intermediary, AdminiStar Federal, Inc. in Ohio.
 1. Request re-determination within 120 days of the intermediary’s initial determination
 2. If \$110 or more is in dispute and redetermination is adverse, request a reconsideration by a Qualified Independent Contractor within 180 days of the redetermination [42 C.F.R. § 405.962]

3. If denied by the QIC, then request an Administrative Law Judge hearing within 60 days of an adverse reconsideration decision
4. If adverse Administrative Law Judge hearing decision, appeal by requesting a review by the Medicare Appeals Council within 60 days of the adverse ALJ decision [42 C.F.R. § 405.1100]
5. Judicial Review
 - a. If \$1,130 (2007) is in dispute, a beneficiary may file an appeal in federal court within 60 days of the Medicare Appeals Council's adverse action

VI. Part B Medicare Program

A. Enrollment and Part B Beneficiary Costs

1. Premium and Late Enrollment Penalty
 - a. If a person applies for Social Security Retirement at age 65 or for a determination of eligibility for Part A Medicare at age 65, enrollment in Medicare Part B program will be automatic unless the beneficiary executes a written request not to be enrolled in Part B Medicare
 - b. The beneficiary must begin to pay monthly Part B premium payment once enrolled (\$93.50 in 2007) unless their annual income triggers a new provision that assesses a higher monthly premium on certain high income individuals.
 - c. If the beneficiary didn't take Part B when they were first eligible, their initial enrollment period, the cost of Part B will go up 10% for each full 12-month period that they could have had Part B but didn't sign up for it, except in special cases. They will have to pay this penalty as long as they have Part B.
 - i. If an individual is covered through an employer that has 100 or more employees when they are eligible for Part B, they can defer Part B enrollment without penalty until their special enrollment period, the time that they are no longer covered by the employer's plan.
 - ii. This health coverage can be through an employer, association, union or employed spouse. No late enrollment penalty will be applied if the application is made within 8 months of the end of employment.
 - iii. Note that individuals using continuation coverage, such as COBRA are not entitled to a special enrollment period and should sign up for

Part B when COBRA begins.

- iv. The general enrollment period allows a beneficiary without Part B to sign up for coverage. Should an individual fail to sign up for Part B during their initial or special enrollment periods, the general enrollment period begins on January 1st and ends on March 31st every year. But benefits will not begin until July 1st of that year.
2. The Part B monthly premium, until 2007, was set by statute to cover 25% of the Part B program's annual cost and each beneficiary paid the same premium each month regardless of income or assets.
- a. As required in the Medicare Modernization Act, beginning in 2007, single beneficiaries with annual incomes over \$80,000 and married couples with incomes over \$160,000 will pay a higher percentage of the cost of Medicare Part B coverage, , i.e. a graduated rate, thus reducing Medicare's cost share.
 - b. These higher-income beneficiaries will pay a monthly premium equal to 35, 50, 65, or 80 percent of the total Part B cost, depending on their income level, by the end of the 3-year transition period.
 - c. For 2007, the higher-income beneficiaries will be responsible for one-third of the income-related monthly adjustment amount. The 2007 Part B monthly premium base rate increased to \$93.50 and the other rates are listed in the chart below.

Individual Annual Income	Income Related Monthly Adjustment	2007 Monthly Premium
Up to \$80,000	\$ 0	\$ 93.50
\$80,001 to \$100,000	\$ 12.30	\$ 105.80
\$100,001 to \$150,000	\$ 30.90	\$ 124.40
\$150,001 to \$200,000	\$ 49.40	\$ 142.90
Greater than \$200,000	\$ 67.90	\$ 161.40

- d. In 2007, approximately 4 percent of Medicare Part B enrollees with higher incomes will pay a higher Part B premium based on their income. These limits will reduce Medicare costs by an estimated \$7.7 billion over the next five years and \$20.8 billion over the next 10 years.
- i. This provision went into effect regardless of whether the beneficiary choose to participate in the Medicare Part D program.

- e. The Social Security Administration is using 2005 IRS income tax data (adjusted gross income plus tax-free income) to determine a beneficiary's 2007 Part B premium, which means it can be extremely inaccurate as a measure of current income for many recent retirees.
 - f. The Social Security Administration has developed a form to allow for the correction of inaccurate income data. If a beneficiary had a major life-changing event that has reduced her income, she may use Form SSA-44 entitled: Medicare Part B Income-Related Premium - Life-Changing Event, to request a reduction in her Medicare Part B income-related premium. See <http://www.ssa.gov/online/ssa-44.pdf>.
 - i. Through this form, the beneficiary can request that Medicare use a more recent tax year in SSA's calculation of her Part B premium amount.
 - g. A beneficiary dissatisfied with the calculation or the tax years used may appeal the decision initially through the Social Security appeal process.
 - i. If still dissatisfied with the Social Security Administration's reconsideration decision, the beneficiary can appeal it to an Administrative Law Judge hearing with the Office of Medicare Hearings and Appeal, then through the Medicare Appeals Council and on to judicial review.
3. The beneficiary must also pay the first \$131.00 (2007) of Medicare approved charges each calendar year as their Medicare B deductible
4. Once the deductible has been met, Medicare pays 80% of the Medicare approved charges for all Part B services and supplies
- a. The beneficiary is responsible for the remaining 20% of the Medicare approved charges as their Medicare Part B co-payment
 - b. Since Part B covers outpatient hospital procedures and treatments and surgeon fees this beneficiary co-payment can result in a beneficiary having thousands of dollars in out of pocket costs unless the beneficiary has retiree health coverage or has taken out a Medicare Supplement Insurance policy, that cost about \$150 to \$300 a month of additional monthly premiums.

B. Part B Covered Services [42 U.S.C. § 1395k]

1. Physician services

2. Outpatient hospital care
3. Outpatient physical therapy and speech pathology
4. Medical supplies
5. Home health care for beneficiaries, who are not enrolled in Medicare Part A, or do not meet 3 day hospitalization requirement or who have exceeded the 100 visit limit of the Part A home health benefit, but otherwise qualify for Medicare Home Health coverage
6. Artificial limbs and durable medical equipment
7. Ambulance services, and
8. X-ray treatment and diagnostic tests
9. Preventative Services
 - a. Once limited by statute to providing coverage only for diagnosis and treatment of an illness, injury, or impairment of a body part, the Medicare program, through a series of legislative changes, now covers a broad range of preventive and screening services for beneficiaries who are enrolled in Part B:
 - i. Flu Shots, Pneumococcal Shot, Hepatitis B Shots, Initial Preventive Physical Examination, Cardiovascular Disease Screenings, Diabetes Screenings, Pap Test and pelvic screening exams, Screening Mammograms, Colorectal Cancer Screening, Prostate Cancer Screening, Bone Mass Measurements, and Glaucoma Tests.
 - ii. The coinsurance and deductibles for Part B preventative and screening services varies by service as does how often and who and what is covered by each service. See www.cms.hhs.gov Fact Sheet released Wednesday, November 01, 2006, entitled: Preventive Services Covered By Medicare Calendar Year 2007.
 - iii. New for 2007, Medicare Part B enrollees who are at risk for abdominal aortic aneurysms may get a referral for a one-time screening ultrasound at their Welcome to Medicare Physical Exam. This Initial Preventive Physical Examination is for all new enrollees, one time only within the first 6 months of enrolling in Medicare Part B, and includes medical and social history review, and physical examination and electrocardiogram (ECG), with counseling, referral and a written plan for additional preventive services that are needed.

- C. Exclusions [42 U.S.C. § 1395y(a)]
 - 1. Expenses for items or services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
 - 2. Routine physical, dental and eye examinations
 - 3. Prescription medications
 - 4. Eyeglasses, hearing aids, or immunizations
 - 5. Dental services
 - 6. Routine foot care, including the treatment of flat foot conditions and the prescription of supportive devices

VII. Part B Appeals

- A. Request redetermination within 120 days of the carrier's initial determination
- B. If \$110 or more is in dispute and redetermination is adverse, request a reconsideration by a Qualified Independent Contractor (QIC) within 180 days of the redetermination [42 C.F.R. § 405.962]
- C. If denied by the QIC, then can request an Administrative Law Judge hearing within 60 days of an adverse reconsideration decision
- D. If adverse Administrative Law Judge hearing decision, can appeal within 60 days of the ALJ decision by requesting a review by the Medicare Appeals Council within 60 days of the adverse ALJ decision [42 C.F.R. §405.1100]
- E. Judicial Review
 - 1. If \$1,130 (2007) is in dispute, a beneficiary may file an appeal in federal court within 60 days of the Medicare Appeals Council's adverse action

VIII. Medicare Coverage of Home Health Care

- A. The Balanced Budget Act of 1997 created extensive changes in the Medicare Home Health benefit
 - 1. Established a prospective payment system (PPS) for both Part A and Part B home health services after October 1, 1999

- a. The PPS is based on a predetermined amount of reimbursement for a particular diagnosis and service regardless of the actual cost to a home health agency for providing the care needed by the patient
2. Imposed a 3 day hospitalization requirement prior to receiving Part A Home Health benefits
3. Established a 100-visit limit per spell of illness for Part A Home Health services
4. Created coverage under the Medicare Part B Home Health program to cover Medicare beneficiaries, who are in need of home health care services, but do not meet the new criteria for Part A Medicare Home Health coverage

B. Eligibility

1. The Medicare beneficiary must be confined to the home as a result of an illness or disease
2. The Medicare beneficiary's medical care requires intermittent or part-time skilled nursing care, physical therapy, or speech therapy
3. The doctor must determine that the beneficiary is in need of home health medical care and assistance

C. Amount of Coverage [42 C.F.R. § 409.40, *et seq.*]

1. Full coverage of part-time or intermittent skilled nursing care and part-time or intermittent physical or speech therapy services
2. Full coverage of part-time or intermittent home health aide services, medical supplies and social services
3. Services must be provided by, or under arrangements with, a home health agency that meets Medicare conditions of participation [42 C.F.R. § 484.10, *et seq.*]

D. Home Health Aide Services

1. Requirements
 - a. The reason for visits by the aide must be to provide hands-on personal care to the beneficiary or services that are needed to maintain the beneficiary's health or facilitate treatment of the illness or injury

- b. The physician's plan of care must order home health aide services and must indicate the frequency of visits
- c. Home health aide services are covered when such services are "reasonable and necessary"

E. Claims Submissions, Determination, and Appeals Process

1. Claims Submission and Determination

- a. Beneficiary requests medical services from home health agency
- b. Home health agency makes a preliminary determination whether service is covered by Medicare
- c. If the home health agency determines that the beneficiary requires services covered by Medicare, it submits a written claim for payment on behalf of the beneficiary to the fiscal intermediary
 - i. If the home health agency believes the beneficiary requires a service that is not covered, it must notify the beneficiary in writing prior to, or at the time the care commences, indicating that the care is not covered and that a claim will not be submitted to the fiscal intermediary unless the beneficiary so requests

IX. Medicare C or Medicare Advantage Programs (fna Medicare Plus Choice)

[42 U.S.C. § 1395 w-21, *et seq.*]

- A. This program offers a provider option that a Medicare beneficiary may elect in lieu of traditional Medicare Part A and Part B programs
 - 1. Primarily, the new choices are variations on managed care organizations and were intended by Congress to provide more flexible options with regards to, who, how, and where Medicare beneficiaries might receive services
 - 2. A Medicare beneficiary may elect to stay in the Medicare Part A and Part B programs simply by declining to elect to enroll in any of the options being offered under the Medicare Advantage Program
 - 3. This program changed in a number of ways beginning in 2006 including a name change for the contracting organizations to Medicare Advantage Programs. Most of the substantive changes are in the requirements for the offering of a drug benefit that are discussed in the Medicare Prescription Drug 2007 outline.

B. Medicare Advantage Plans usually provide enhanced drug coverage and additional benefits beyond traditional Medicare that, according to CMS, save seniors on average about \$100 a month, and these plans are much more widely available than ever before. CMS approved 163 new MAPs for 2006 in conjunction with the new Medicare Part D Prescription Drug Benefit. With this expansion, 74% of Medicare beneficiaries have access to HMO plans, 52% have access to a local PPO plan and 98% have access to private fee-for-service plans. Altogether there are more than 5 million beneficiaries currently enrolled in Medicare Advantage health plans, with an average of 50,000 beneficiaries per month joining the plans since 2004.

C. Eligibility [42 U.S.C. § 1395 w-21(a)(3)]

1. Entitled to Part A and enrolled in Part B of the Medicare program
2. The Medicare beneficiary must not have end-stage renal disease or a terminal illness at the time of enrollment

D. Types of Medicare Advantage Programs (MAPs) [42 U.S.C. § 1395w-21(a)(2)]

1. There are 5 types of MAPs

- Health Maintenance Organizations (HMO)
- Preferred Provider Organizations (PPO)
- Private Fee-for-Service Plans (PFFS)
- Medicare Special Needs Plans (SNP)
- Medicare Medical Savings Account Plans (MSA)

2. A Health Maintenance Organization (HMO) is a Managed Care Organization that covers enrollee's medical services only if they use the HMO's network of providers. If an enrollee gets health care outside the plan's network, she will have to pay the full cost of the services herself, unless the plan has a Point-of-Service (POS) option which allows out-of-network health care, but even then the cost will be more than for services in-network.

- a. In most cases the enrollee must see a primary care doctor to get a referral before she sees any other health care provider. In most cases, women don't need a referral for a yearly screening mammogram or an in-network pap test and pelvic exam (at least every other year).
- b. If you want prescription drug coverage, you must get it from the HMO. The cost for coverage will be included in the premium.
- c. Beneficiaries are permitted to seek emergency services from the nearest

- c. Some beneficiaries may find that a PFFS plan is less costly than Original Medicare with a Medigap policy. Additionally, plan members have the right under law to get a binding, written, advance determination as to whether the plan will cover the service.
 - d. On the other hand, it may not be as easy to obtain care from providers under PFFS as in Original Medicare. The provider will have to accept the terms and conditions of payment. Excluding emergency situations, a provider must be informed in advance of providing a service that a beneficiary is enrolled in a PFFS plan. Some providers may choose to not provide care to PFFS enrollees. PFFS enrollees have the right to get emergency care when and where they need it without any prior approval.
 - e. An appeal process (expedited within 72 hours if serious harm to health is possible) is available if a PFFS plan will not pay for, does not allow, stops, or limits a service that a member thinks should be covered or provided.
 - f. In 2007 there are 14 PFFSs offered in Hamilton County, Ohio.
5. Medicare Special Needs Plans (SNPs) are specially designed for people with certain chronic diseases and other specialized health needs. These plans must provide all Medicare Part A and Part B health care and services. They also must provide Medicare prescription drug coverage (Part D). Generally, they offer extra benefits and may have lower co-payments than the Original Medicare Plan.
- a. Medicare SNPs are designed to meet the needs of people:
 - i. who live in certain institutions (like a nursing home) or
 - ii. who continue to live at home, but require the same care as someone living in a nursing home,
 - iii. are eligible for both Medicare and Medicaid, or
 - iv. have one or more specific chronic or disabling conditions.
 - b. The plan may limit membership to people in one of these groups, but may enroll other people as well. A Medicare SNP may help manage and coordinate the many services and providers their members use to help them stay healthy, such as assigning a care coordinator to develop personal care plans to coordinate all health care provider efforts to meet the patient's needs. For example, a Medicare SNP for people with

diabetes might use a care coordinator to help members monitor blood sugar, follow their diet, get proper exercise, get needed preventive services such as eye and foot exams, and get the right medicines to prevent complications.

- c. Hamilton County, Ohio has two Medicare SNPs in 2007: one for institutionalized individuals and one for dual eligibles, those on both Medicare and Medicaid.
6. The Medicare Medical Savings Account (MSA) plan is a new plan type that combines a high deductible health plan with a medical savings account that beneficiaries can use to manage their health care costs.
- a. The Centers for Medicare & Medicaid Services (CMS) is implementing this new consumer-directed Medicare Advantage product beginning January 1, 2007, though there are neither regular nor demonstration MSA plans in Ohio.
 - b. CMS offers regular MSA plans (available in all states except Colorado, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, Virginia, and Wisconsin) and demonstration MSA plans (available in New York and Pennsylvania only) which provide Medicare beneficiaries with the freedom to exercise increased control over their health care utilization while providing them with important coverage against catastrophic health care costs. Generally, beneficiaries with other types of health insurance are precluded from enrolling.
 - c. How the MSA's Work:
 - i. The MSA plans cover all Medicare Part A and Part B benefits. MSA plans may also cover additional benefits for an extra cost, but no plans are offering optional supplemental benefits in 2007. There is no basic premium in regular or demonstration Medicare MSA plans. Enrollees still have to pay the part B premium.
 - ii. Members in an MSA plan will receive an annual deposit into an interest-bearing account from CMS to help them cover their health care costs. Members can use these funds to pay for medical services. When the money in the account is used to cover "qualified medical expenses" under IRS rules, it is not taxed.
 - iii. Once a member has reached his/her deductible (between \$2,000 and \$9,500 in 2007), the plan is responsible for all Medicare-covered costs. Under the MSA demonstration, a plan may provide cost-sharing after the deductible, up to an out-of-pocket maximum.

- iv. Any amount of the deposit that is left at the end of the year remains the property of the member and can be used to cover health care costs the following year.
 - v. MSA plans are statutorily restricted from covering Part D drugs, but MSA enrollees can join a stand-alone prescription drug plan (PDP). Funds in the MSA account cannot count as an IRS qualified expense if used to pay towards the Part D premium but they can be used to cover co-payments, coinsurance and deductibles for Part D drugs. Funds withdrawn from the MSA account used to pay for Part D drugs do count towards TROOP.
7. There are a number of other types of Medicare Advantage Plans that have never been created nor offered in Ohio prior to 2007
- i. Medicare Provider Service Organizations (PSO), Point Of Service Organizations (POS), Preferred Provider Organizations (PPO), and the Medicare Savings Account Plans were not available in most of the United State because no organization had applied for Medicare certification and approval
 - ii. In 2006, Anthem Blue Cross and Blue Shield and Humana Insurance Company both offered statewide PPOs and there are other local PPOs as well
- E. All of the Medicare Advantage plans, except the Medicare Savings Account Option, must provide their beneficiaries with the same quality, type, and frequency of medical benefits and services that the beneficiary would have qualified for under the traditional Medicare Part A and Medicare Part B programs
- 1. The out-of-pocket costs and co-payments and premiums and deductibles are fixed on an annual basis. The amount of contribution from the beneficiary among the different provider options will vary according to the plan's services
 - 2. Enrollment in a Medicare Advantage plan is in lieu of traditional Medicare Part A and Part B coverage
 - a. Medicare pays the Medicare Advantage Plan a monthly fee to provide all the medical services that a beneficiary would ordinarily get through Medicare Part A and Part B
- F. Disenrollment [42 C.F.R. §§ 422.62 – 422.66]
- 1. In 2007, a Medicare beneficiary, who is not institutionalized, will be

permitted to change their election to a Medicare Advantage Program or traditional Medicare only during the yearly Open Enrollment Period between January 1, 2007 and March 31, 2007.

G. Appeals [42 U.S.C. § 1395 w-22]

1. All Medicare Advantage Plans must meet the requirements for appeals and grievance processing under Subpart M of the Medicare Advantage regulations to the extent applicable. Additionally, as of January 2006, Cost and Health Care Pre-payment Plans will also be subject to Subpart M appeals and grievance rules
2. All Medicare Advantage Plans are required to put denials or terminations of services in a writing that specifies the reasons for the denial or termination of services and also provides the beneficiary with the rights and procedures for appealing the denial or termination
 - a. The beneficiary may request reconsideration of the denial or termination within 60 days of the receipt of the determination
 - b. If on a reconsideration appeal the Medicare Advantage Plan upholds their original denial, it must forward the appeal and its file to The Center For Health Dispute Resolution, 1 Fishers Road, 2nd Floor, Pittsford, New York, 14534 – 9597, the independent organization that contracts with Health and Human Services to conduct these second stage reconsideration reviews
3. If the denial, reduction, or termination of requested medical services could seriously jeopardize the life, health, or the enrollee's ability to regain maximum function, the beneficiary has a right to an expedited appeal of that decision. [42 U.S.C. § 1395w-22(d)]
 - a. The expedited appeal request can be either oral or in writing
 - b. In most cases, the Medicare Advantage Program must issue a determination no later than 72 hours after receiving the request for an expedited appeal
 - c. The Medicare Advantage Plan must submit a written explanation and the case file to the independent review entity within 24 hours of a decision affirming its original denial, reduction or termination
4. An adverse reconsideration decision may be appealed to an Administrative Law Judge if the amount in controversy is \$100 or more
5. An adverse ALJ decision may be appealed to the Medicare Appeals Council

within 60 days of receipt of the adverse ALJ decision

6. An adverse Medicare Appeals Council decision involving \$1,130 or more in controversy may be appealed to Federal Court within 60 days of the adverse decision