Helping Older Persons With Legal & Long-Term Care Problems

MEDICARE HMOs and the MEDICARE + CHOICE PROGRAM

1. What is the Medicare + Choice program?

The Medicare + Choice program is the name for some managed care provider options to the traditional Medicare Part A and Part B programs. A Medicare beneficiary may choose to participate in this Medicare program instead of the traditional Medicare program.

2. Does a Medicare beneficiary have to enroll in one of the new options?

No. A Medicare beneficiary may elect to stay in the traditional Medicare Part A and Medicare Part B programs simply by not enrolling in any of the options being offered.

3. What are the options under the Medicare + Choice program?

(1) **A Health Maintenance Organization (HMO)** – a for-profit managed care organization that covers enrollees' medical services only if they use its network of providers. However**, Medicare HMOs are required to cover *urgent or emergency medical services*** even if non-network providers provided the care.

(2) **Preferred Provider Organization (PPO)** - this is a for-profit insurance plan that permits its members to go outside their network of health care providers and will still cover at least part of the cost of that provider's care. The plan determines how much to reimburse for services provided and may charge a premium or have co-payments and deductibles, just like the Medicare HMOs. Some areas of Greater Cincinnat I can choose between two zero premium HMOs, two premium HMOs, and by July, 2003, two PPOs.

Obviously, careful attention must be paid to the different benefits and costs offered by each choice. The remaining four options under the Medicare + Choice program, Provider Sponsored Organizations (PSO), Private Fee For Service Organizations (PFFS), Point Of Service Organizations (POS) and the Medicare Savings Account, are not generally available in Ohio in 2003.

4. Who can enroll in a Medicare + Choice plan?

You must be entitled to Part A and enrolled in Part B of the Medicare program. The Medicare beneficiary must live in the geographical area that the plan serves. The Medicare beneficiary must not have end stage renal disease or a terminal illness at the time of enrollment.

5. What is covered under each choice?

All Medicare + Choice (M + C) organizations must provide the same medical care that would be available to a beneficiary under the traditional Medicare program.

6. Does a beneficiary have a right to appeal a medical decision by a Medicare HMO or Medicare + Choice (M + C) organization or one of their providers?

Yes. A Medicare beneficiary has an absolute right to appeal an M + C organization's or one of their medical provider's actions or failure to act that denies, reduces or terminates medically necessary care or reimbursement for such care.

A request for reconsideration must be made within 60 days of an organization's or their medical provider's notice of denial or their refusal to make a decision to provide needed health services. If on appeal the M + C organization upholds the denial, it must forward the appeal request and its file to an independent organization that will review whether the denial was proper. If this reconsideration results in a denial, then the beneficiary has a right to appeal to an Administrative Law Judge (ALJ). If the ALJ decision is adverse, the Medicare beneficiary may appeal that determination to the Medicare Departmental Appeals Board.

7. What if I need a more immediate review of a decision?

A Medicare beneficiary has a **right to** *request* **an expedited decision if the usual time for a M + C organization to make a decision (14 days) could seriously jeopardize the life, health or the enrollee's ability to regain maximum function.** *The expedited appeal request may be made either orally or in writing.*

In most cases, the M + C organization must issue a decision no later than 72 hours after receiving the request for an expedited decision.

If the M + C organization upholds its denial or termination, it then must submit a written explanation and *the case file to the independent review entity within 24 hours of its decision*. If the expedited appeal denial is not changed, the Medicare beneficiary would have the same right to seek further appeal by following the steps and procedures described in Question 6.

8. How much of your hospital stay will an HMO or Medicare + Choice organization pay?

Except for emergency hospitalizations and treatments, the M+C Organization will usually pay for your hospitalization only if you obtain prior approval from the MMCO or from your primary care physician or you use only the MMCO's hospitals.

Your out of pocket cost will depend on your M+C Organization's hospital deductible and co-payment policy for that year. For example, one M +C Organization may charge $350 a day for each day of hospital care up to a maximum of $2500 per year, while another one may charge a flat $400 for each hospital stay in a calendar year. It is therefore crucial that the hospital deductible, co-payment and maximum co-payment policies be closely reviewed when selecting an HMO or M+ C Organization.

9. What if my Medicare HMO or + Choice organization wants me discharged from a hospital and says that I will have to pay for all additional care?

You have an absolute right to a written discharge notice of noncoverage and to also appeal a Medicare + Choice organization's hospital discharge decision to the Quality Improvement Organization (QIO). You appeal the proposed discharge in Ohio by calling KePro at 1-800-589-7337. If you do not request an appeal, the hospital may bill for all of the cost of your additional stay beginning on the third day after you receive the discharge notice of noncoverage.

If your doctor agrees with the hospital that your continued hospital stay is no longer necessary, you may **request, by noon of the first workday after you receive the written notice of noncoverage, the QIO to review this decision.** If the QIO reviews and agrees with the notice of noncoverage, you will only be held financially responsible for the cost of your continued stay **if you do not leave the hospital by noon of the day after you received the QIO's decision on your appeal.** You would have to pay any M+C Organization's additional **daily co-payments**.

10. What if a Medicare beneficiary decides that she no longer wants to be in the M+ C organization?

Medicare beneficiaries can disenroll from the M + C Plan and return to traditional Medicare by obtaining and submitting a signed and dated request for disenrollment to their M + C Organization, local Social Security Office, or by calling 1-800-MEDICARE. The Medicare beneficiary will be disenrolled and then returned to traditional Medicare on the first day of the next month after their request to disenroll was **received.**

11. Where can I get help?

If you live in Hamilton, Clermont, Butler, Clinton or Warren County, **contact Pro Seniors for legal advice and representation** with your questions, denials or terminations of needed medical care.

If you live in Ohio but outside this five-county area, Pro Seniors can still provide free advice, information and referral services on denials. **For more information, call Pro Seniors' free Legal Hotline at (513) 345-4160 or (800) 488-6070.**

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Pro Seniors' Legal Hotline for Older Ohioans provides free legal information and advice by toll-free telephone to all residents of Ohio age 60 or older. If you have a concern that cannot be resolved over the phone, then the hotline will try to match you with an attorney who will handle your problem at a fee you can afford.

In southwest Ohio, Pro Seniors' staff attorneys and long-term care ombudsmen handle matters that private attorneys do not, such as nursing facility, adult care facility, home care, Medicare, Medicaid, Social Security, protective services, insurance and landlord/tenant problems.

This pamphlet provides general information and not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Hotline or consult an attorney in elder law.

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