Medicare and Medicaid

Medicare

Medicare is a multi-part federal health insurance program managed by the federal government. A person applies for Medicare through the Social Security Administration, but Medicare's rules are written by another federal agency, the Centers for Medicare and Medicaid (CMS), and Medicare claims are processed by private insurance companies, called "Fiscal Intermediaries" and "Medicare Carriers," that vary from state to state.

One part of Medicare is called Medicare hospital insurance, and is also called Medicare Part A or simply Part A. Part A primarily covers necessary hospital stays, but it also pays for certain home health care, hospice care, and, to a limited extent, skilled care in a nursing facility.

Another part of Medicare is called Medicare supplementary medical insurance or Medicare Part B or simply Part B. Part B primarily covers doctors' services, but it also covers many other miscellaneous services, including outpatient hospital services, diagnostic tests (such as lab work and x-rays), and medical supplies. The full extent of Part B coverage is described in detail, below.

Medicare Part C, initially known as Medicare+Choice and now called Medicare Advantage, has been available since 1997 as an alternative to “original” Part A and Part B coverage. Medicare Advantage plans typically offer reduced premiums, deductibles, and co-payments, but also provide differing services and charges, making it difficult to make an informed decision whether to forego Part A and Part B coverage in favor of Part C. Medicare Advantage plans also have the option to terminate their plan each year, making them a less stable form of Medicare coverage.

A relatively new part of Medicare coverage, Part D, was added starting in 2006. It provides beneficiaries with assistance paying for prescription drugs. Unlike coverage in Medicare Parts A and B (and more like Part C), Part D coverage is not provided within the traditional Medicare program. Instead, beneficiaries must affirmatively enroll in one of many hundreds of Part D plans offered by private companies.

Medicare does not cover some common health care expenses, including dental care, eyeglasses, hearing aids, and long-term care.

Medicare Eligibility

You are eligible for Part A (hospital insurance) if any of the following is true:

- You are 65 or older and qualify for Social Security or Railroad Retirement benefits, even though you are not actually receiving them
- You are a former federal employee who retired on or after 1983

- You are disabled and have met the Social Security or Railroad Retirement disability requirements for two years
- You have end-stage kidney disease and require dialysis or a kidney transplant.

You are eligible for Part B (medical insurance) if the following is true:

- You meet the requirements for Part A (listed above)
- You pay the monthly Part B premium ($96.40 in 2009; higher amounts for annual incomes greater than $85,000 for individuals, $170,000 for couples).

If you are 65 or older but not eligible under the above requirements, you may still choose to enroll in the Medicare program. You must live in the United States and be a citizen or legal alien at least five years. If you choose to enroll, you must pay monthly premiums (for Part A as well as Part B). You can sign up for Part A without having Part B. However, you cannot sign up for Part B without having Part A.

You are eligible to enroll in Part D (drug coverage) if you have either Part A or Part B coverage. You must enroll is Part D if you wish to enroll in Part C.

How to Enroll

You should enroll for Medicare benefits shortly before your 65th birthday, even if you are not planning to retire at 65. If you are going to sign up for Social Security benefits at age 65, you can sign up for Medicare at the same time. You can enroll at your local Social Security office or by mail.

If you are already receiving reduced, early retirement Social Security benefits when you reach age 65, you will receive a Medicare card showing your enrollment in Part A (hospital insurance) and Part B (medical insurance). The Part B premium is then deducted from your monthly Social Security check. You can refuse Part B medical benefits by returning the proper form that comes with your original Medicare Card. If you are not receiving Social Security benefits and do not plan to when you reach age 65 but wish to receive Medicare, you should enroll about three months before your 65th birthday. In this case, you will be billed for the Part B premiums. **If you wait to sign up for Medicare until after age 65, the monthly premiums will be higher unless you have coverage through an employer's group plan.**

Services Covered by Medicare

Part A

Services covered under Medicare Part A are:

1. **Hospital Stays**, which are covered if Medicare finds that they are **reasonable and necessary**. Medicare pays a hospital's charges for:

- meals and a semi-private room
- routine nursing services
- in-patient drugs
- supplies
- equipment normally furnished by the hospital
- operating and recovery room costs
- diagnostic, therapeutic, or rehabilitative services and items the hospital normally furnishes

2. **Skilled Nursing Facility (nursing home) Care** for a limited period of time and only after you have been in the hospital for at least three days :

- meals and a semi-private room
- skilled nursing care
- in-patient drugs
- physical, occupational and speech therapy
- medical social services.

A nursing facility may also provide intermediate or custodial care, which is not covered by Medicare. **Medicare pays for nursing home care only if you receive skilled services and pays only under very specific circumstances.**

3. Certain **Home Health Care**, when ordered by a doctor and given by a Medicare certified home health care agency:

- intermittent or part-time skilled nursing care
- physical therapy
- intermittent or part-time services of home health aides
- medical social services
- medical supplies
- equipment provided by the agency
- some speech and physical therapy

Medicare pays for home health care only if you need occasional skilled nursing care or rehabilitative services.

4. **Hospice services** to provide supportive care for terminally ill patients and their families, at home or in a facility:

- skilled nursing care
- physical and speech therapy
- medical social services
- home health aid and homemaker services
- medical supplies and appliances
- prescription drugs and physician services
- counseling and short term in-patient care

To get Medicare coverage for hospice services, you must sign a request choosing hospice **instead** of other Medicare-covered services. If you choose hospice, you can change your mind later.

Part B

Services covered under Part B include:

- physicians' services
- some hospital outpatient services and supplies (such as diagnostic tests, x-rays, and radiation treatment)
- ambulance services
- rental or purchase of durable medical equipment (such as wheelchairs and walkers)
- outpatient physical therapy and speech pathology
- surgical dressings, splints, and casts
- prosthetic devices and certain home health services

Part C

Services covered under Part C are similar to, but precisely the same, as those covered by Parts A and B.

Part D

The medications covered by Part D will vary depending on the drug plan chosen.

Services and Supplies not Covered by Medicare

Though Medicare has broad coverage, it does not pay for many services and supplies. These include:

- care in a nursing facility (unless it meets the Medicare requirements for skilled care, and it follows a hospital stay of at least three nights, and then only for a limited period of time)
- care in an adult foster home, residential care facility, or assisted living facility
- optional private hospital rooms and most in-home services
- routine check-ups, dental care, and personal comfort items
- hearing aids/examination and eyeglasses/examination, chiropractic services, cosmetic surgery, and orthopedic shoes
- services not reasonable or necessary as defined by Medicare, services the patient has no legal duty to pay for, and services paid by a government agency

Medicare's Basic Payment Policies

Like private insurance policies, Parts A and B have **deductibles** you must pay before Medicare pays anything. Parts A and B also have **co-insurance payments** for most services. You are responsible for paying the deductible and making those co-payments to the health care provider unless you have a private Medicare supplemental insurance policy or belong to a health maintenance organization (HMO) or similar Part C plan.

Part A

Medicare measures your use of Part A hospital insurance with **benefit periods**. Your first benefit period begins the first day you enter the hospital after your insurance goes into effect. A new benefit period begins after you have not been in the hospital (or skilled nursing facility) for 60 days in a row. There is no limit to the number of benefit periods you can have.

Hospital Care: With Part A, you receive up to 90 days of hospital care for each spell of illness. The following is what **you** must pay:

- The First 60 Days: You pay a deductible of $1,068 in 2009. Medicare pays the remaining covered expenses.
- The Next 30 Days: You pay a co-payment of $267 per day in 2009. Medicare pays the remaining covered expenses.
- After 90 Days: You may use some of your 60 **lifetime reserve days**. For each used lifetime reserve day, you pay the first $534 per day (in 2009) of the hospital's charges. Medicare pays the remaining covered expenses for each day up to a 60 lifetime day maximum. However, people rarely stay in the hospital for more than a few days at a time. Hospitals have a financial incentive to discharge Medicare patients as soon as possible. Medicare has developed a system of diagnosis related groups, or DRGs, that determines who much the hospital is paid. Medicare bases its payment to the hospital on the average length of stay for a patient with your diagnosis and not on the actual number of days you spend in the hospital.

Skilled Nursing Care: Medicare pays in full for the first 20 days of **covered** skilled nursing care in a Medicare facility. For days 21 to 100 days, you pay a co-payment of the first $133.50 per day (in 2009) and Medicare will pay the nursing home's remaining charges. After 100 days, you pay the full amount and Medicare pays nothing.

Home Health Visits: Part A pays for the full approved cost of home health visits by a licensed home health agency that follows a treatment plan prepared by a physician. However, strict requirements limit the coverage of home health services.

You must be homebound **and** you must need the skilled services only part-time (not every day) or only intermittently. If you meet the Medicare requirements, there is no deductible, no co-payment, and no limit on the number of visits.

Hospice Care: Medicare covers hospice care for what are called **periods of care**. Hospice coverage provides two periods of 90 days each, followed by an unlimited number of 60 day periods. The usual deductible and co-payments do not apply to hospice care. You will have a co-payment of up to pay $5 per prescription. You also will have a five percent co-insurance charge for any in-patient respite care you receive, up to five days per respite. There are no limits to the number of times you can get respite care.

Part B

Under Part B, Medicare pays 80 percent of the **approved charge** for covered services after you pay the $135 deductible each year. The approved charge is the value that Medicare has set for the service you received. It often is lower than the amount the provider bills you. You pay 20 percent of the Medicare approved charge, plus the difference between the approved charge and the actual bill. The provider cannot charge a difference which is more than 15 percent of the approved charge. For example:

The doctor bills you:	$100
The Medicare approved charge is:	$90
The difference is:	$10
You pay the difference:	$10
Plus 20 percent of $90:	$18
For a total of:	$28

If, however, the doctor accepts **assignment**, he or she has agreed to accept the amount of the Medicare approved charge as full payment. This often decreases the total you have to pay. For example:

The doctor bills you:	$100
The Medicare approved charge is:	$90
The difference is:	$10
You do **not** pay the difference:	$ 0
Plus 20 percent of $90:	$18
For a total of:	$18

The Social Security office has a list of doctors who have agreed to accept assignment.

Medicare Claims and Payments

Providers bill Medicare directly for services under Part A, and receive payments directly from Medicare. You do not have to file claims or send in any bills you receive from hospitals, skilled nursing facilities, or home health agencies. In Idaho, there are two Fiscal Intermediaries that process Part A claims: Regence Blue Shield of Oregon and Wisconsin Physician Services. You

will receive a notice showing what benefits you used, the amount that Medicare has paid, and any deductible or co-payment amounts.

Providers also bill Medicare directly for services under Part B. If the provider accepted assignment, he or she will receive payment directly from Medicare. If the provider did not accept assignment, you will receive the payment from Medicare and be responsible for paying the provider's bill. In Idaho, the Medicare Carrier that processes Part B claims is CIGNA Medicare. It will send you an Explanation of Medicare Benefits form showing whether the claim was approved or denied, whether the provider accepted assignment, the Medicare approved charge, the amount Medicare has paid, and the deductible and co-payment amounts. (Cigna Medicare also processes Medicare claims for durable medical equipment.)

Unless you have a private Medicare supplemental insurance policy or belong to a health maintenance organization (HMO), you pay the Medicare deductible amounts, plus any co-payments, directly to the provider.

If Medicare denies your claim, you have the right to appeal.

Medicare Denials and Appeals, Parts A and B

If you are in a hospital or a skilled nursing facility, your doctor or someone from the facility may tell you that Medicare will not pay for you to stay there any longer. If you disagree, you can appeal. You should get written notice of non-coverage which explains how to appeal the decision. Whether you get a written notice or not, the first step in the appeal process is to call Qualis Health's Beneficiary Hotline at (800) 445-6941 and ask for an immediate review.

If Medicare denies a claim for payment under Part A or Part B, the Medicare notice will include your appeal rights. Your first step is to ask for an informal review, called a "redetermination," from the Part A Fiscal Intermediary (Regence Blue Shield of Oregon or Wisconsin Physician Services). Your request must be in writing and made within 120 days.

If you disagree with the redetermination decision, you may request a “reconsideration” by a Qualified Independent Contractor (currently First Coast Service Options; for durable medical equipment reconsiderations the QIC currently is River Trust Solutions; and for Part D reconsiderations the QIC currently is Maximus Federal Services). A request for reconsideration must be made within 180 days.

If you remain dissatisfied and there is at least $120 at stake, you may ask for a hearing in front of a Social Security administrative law judge within 60 days. If you disagree with your hearing decision and the amount in dispute remains at least $120, then you may request review by the Medicare Appeals Council. And if the amount in dispute is at least $1,180, then you may pursue a further appeal to federal court within another 60 days.

Medicare Part C Denials and Appeals

Appeals from denials by HMO's and other Part C plans follow a different procedure. The initial levels of review are within the Part C plan, followed by a review by an external review organization (currently Maximus Center for Health Dispute Resolution). If you remain dissatisfied, then you may seek further review, as described above for Part A and B appeals, before an administrative law judge.

Private Medicare Supplemental Health Insurance: "Medigap"

Because Medicare does not pay all of your healthcare expenses, private insurance companies sell insurance to supplement (or fill in the "gaps" in) Medicare. These insurance policies are known as Medicare supplements or Medigap policies. Before buying such insurance, make sure it does not duplicate your Medicare coverage. Your local SHIBA office (at 800 247-4422) can be very helpful in sorting out the various Medigap choices.

Medicaid

Medicaid helps pay for health care for people who fit within certain categories (such as being a child or elderly or disabled or pregnant) and whose income and assets fall within certain limits (which vary depending on which category a person fits within). Idaho's Medicaid program covers many items and services, including the full range of long-term care. People who have Medicare coverage may also qualify for Medicaid. When they do, Medicaid pays for their Medicare premiums, deductibles, and co-payments, as well as for many health care items, such as dental care, not covered by Medicare.

Medicaid Eligibility

People who receive certain government benefits fit within one category of people who are automatically entitled to Medicaid (once they apply). For example, people who receive Supplemental Security Income (SSI) from the Social Security Administration and/or Aid to the Aged, Blind, and Disabled (AABD) from the Idaho Department of Health and Welfare are entitled to Medicaid. SSI is available to people who are age 65 or older or who are disabled if their countable income from other sources is no greater than $674 per month or, if married, $1,011 per month (for 2009). AABD is available to people who are age 65 or older or who are disabled if their countable income from other sources is no greater than $726 per month or, if married, $1,011 per month (in 2009). A married individual over age 64 or disabled is said to fall within the single person AABD income limit of 726 and is thereby income eligible for Medicaid (but not AABD's cash benefits) if the couple's combined income is no greater than $1,452 (for 2009). This "community property method" may be used by only one spouse per month, even if both are disabled or over age 64, but it can be alternated between the spouses as frequently as monthly if they are both otherwise eligible for Medicaid.

Certain other people qualify for Medicaid if they are disabled and they fall within the category of receiving long-term care, either in a nursing home, an assisted living facility, or in a private residence in the community. Such people may have much higher levels of income and still qualify for Medicaid. The 2009 income limit for long-term care Medicaid is $2,022 per month, but even people with incomes above that level can qualify for Medicaid. If the applicant is married, only half of the couple's total income is counted towards the $2,022 limit. As a last resort, if an applicant with more than $2,022 per month income is not married or if the couple's combined incomes exceed $4,044, then a portion of the applicant's income can be diverted into a special type of trust call a "Miller" trust, thereby bringing his income within the $2,022 limit. Such trusts must be in place no later than the month Medicaid eligibility is desired.

Regardless of which category a person fits within, not only must the person's income fall below the applicable Medicaid income limit, but their countable assets must be no greater than $2,000. Certain assets are exempt and are not counted in determining eligibility for Medicaid including:

- a person's home (or former home), but, in the case of a person without a spouse or minor or disabled child living in the home, the home can have no more than $750,000 of equity
- one vehicle (regardless of its value)
- household goods and personal effects up to a total value of $2,000 (as a practical matter, there is no limit on household items and personal effects, as Medicaid does not inquire into the value of such items)
- a burial fund of up to $1,500 or a pre-paid burial arrangement
- a burial plot
- for married individual's, the retirement accounts (such as IRA's) of the spouse

In the case of a married person receiving long-term care (which in 2008 the Idaho Department of Health and Welfare estimated to cost on average $5,813 per month), the person's spouse is also entitled to a "resource allowance" consisting of half of the couple's otherwise countable assets as they existed at the beginning of long-term care. For 2009, the spouse's half is limited to $109,560. At a minimum in 2009, the spouse is entitled to protect the first $21,912 of the couple's otherwise countable assets. **It is very important to recognize, however, that when a couple's combined incomes are relatively low, the spouse can protect even more than these amounts of assets, so it is important to learn how Medicaid's rules work as soon as long-term care begins (if not sooner).**

The well spouse of a long-term care recipient may also get a monthly income allowance from the ill spouse's income. For the first half of 2009 the spouse is said to need at least $1,750 per month income; if the well spouse's income is less than that, then enough of the ill spouse's income is made available to the well spouse to bring the well spouse's income up to that level. (In any event, the well spouse keeps all of his or her monthly income, regardless of its amount.)

If you are facing long-term care bills and think that you have too many assets to qualify for Medicaid, **do not give your assets away** in hopes of then qualifying. If you (or your spouse) give assets away and then apply for long-term care Medicaid within the following five years you will not be eligible for assistance for some period of time, based on the value of what was given away. Certain transfers are permitted. Talk to an elder law attorney or another lawyer who has

experience in this area. By doing so, you may find that you can keep more assets than you think or you may learn how you may spend some of your assets in ways other than solely paying for long-term care that will be of benefit to you and your spouse.

Medicaid Helps with Medicare Premiums, Deductibles, and Co-Payments

If you have both Medicare and Medicaid coverage, ordinarily you do not need to also purchase a private Medicare supplement. And, as noted above, Medicaid recipients have their Medicare premiums, deductibles, and co-payments paid for them by Medicaid. But there are some Medicare beneficiaries whose income or assets are not quite low enough to qualify for Medicaid, but whose ability to afford paying their Medicare premiums, deductibles, and co-payments is nonetheless limited. If you are such a low income and low asset Medicare beneficiary, you may be eligible for one of two limited forms of Medicaid called, QMB and SLMB. Although they do not provide "full-blown" Medicaid coverage, QMB and SLMB are the next best thing. QMB will pay all your Medicare premiums, deductibles, and co-payments, freeing up the $96.40 taken out of your Social Security benefits each month for your Part B premium and permitting you, in most cases, to drop your private Medicare supplement, freeing your premium for it as well. SLMB is somewhat less generous, paying only the Medicare Part B premium. QMB and SLMB will also pay your Part D premiums and co-payments (the Part D co-payments can be extensive), greatly enhancing the value of such coverage.

The income limit for QMB is $867 for an individual and $1,167 for a couple, with a resource limit of $4,000 for an individual and $6,000 for a couple (double the normal Medicaid resource limits). The income limit for SLMB is $1,040 for an individual and $1,400 for a couple, with the same doubled resource limit as for QMB.

How to Apply

You can apply for Medicaid through the Idaho Department of Health and Welfare. The eligibility worker can help you complete the application, but typically will not advise you on what steps you (or your spouse) may take to avoid having the well spouse become impoverished.

Services Covered

Medicaid covers a broad range of services, including:

- hospital and doctors' services
- prescription drugs and medical equipment and supplies (Medicaid does not cover drugs if Medicare Part D is available)
- eyeglasses and hearing aids, diagnostic tests, and mental health services
- dental care (for adults, emergency dental care only)
- ambulance services and medical transportation
- the full range of long-term care services

Payment for Services

Medicaid pays the health care provider directly. There are no claim forms to complete. If you have Medicaid, you should tell the doctor or other health care provider before you receive treatment or other items or services. You may need to get a referral from your primary physician or prior authorization from Medicaid before you receive a particular service. Health care providers are not allowed to charge you additional amounts for services covered by Medicaid; they must accept Medicaid's payment as payment in full.

Estate Recovery

After the death of a Medicaid recipient the state of Idaho seeks to recover its Medicaid expenditures from the recipient's estate. The state's "estate recovery" claim equals Medicaid benefits paid on the recipient's behalf after age 55 and all Medicaid benefits paid to recipients, regardless of age, who are considered to be permanently institutionalized. The state cannot collect its Medicaid claim, however, while the Medicaid recipient has a surviving spouse or a minor or disabled child. After the spouse passes away, the state make its claim against the spouse's estate to collect whatever it could have collected from the estate of the Medicaid recipient.

To assist in collecting on its estate recovery claim, the state of Idaho places a lien on the person's home or other pieces of property, but the state's lien cannot be imposed until after the recipient's death (except in cases of permanently institutionalized individuals). And any such lien must be released if the recipient's surviving spouse or minor or disabled child wishes to sell the property, in which case the surviving spouse or minor or disabled child keeps all the sale proceeds. If you have questions about how estate recovery will affect your property, or if you have received a Medicaid claim from the Department of Health and Welfare, contact an attorney for advice.

Medicaid Denials and Appeals

You will receive a written notice from the Department of Health and Welfare if your application for Medicaid is denied or if your benefits are being reduced or terminated. The notice must give the reason for the action, tell you which administrative rules are involved, and explain how and when to request the hearing that you are entitled to have if you disagree with the written notice. Hearings are held by a Hearing Officer on contract with the state of Idaho. They may be held in person at the local Department of Health and Welfare office or by telephone. You may want to have an attorney represent you at the hearing. You may be able to get representation through the Idaho Legal Aid Services, Inc. office near you. If you believe the hearing decision is wrong, you may request a review by the Director of the Department of Health and Welfare, and if you believe the Director's decision is also wrong, you may appeal your case to the state District Court in your county.

Medicare and Medicaid eligibility rules are complicated. Before taking steps you don't fully understand, you should get individualized legal advice.