

Chapter 2

Medicare

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SYNOPSIS

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This chapter will clarify important information you need to know about Medicare. It also will answer your questions about eligibility requirements and enrollment processes. This chapter outlines the services that Medicare Part A, Part B, and Part C cover, and provides a discussion of the prescription drug program covered under Part D, which became effective in 2006. Medicare payment policies, payment methods, and appeal processes are explained, and the advantages and disadvantages of each are discussed.

2-1. Medicare

Medicare is a three-part federal health insurance program managed by the Social Security Administration. It helps pay hospital and medical costs for people who are 65 years or older, and for some people with disabilities who are under 65. Overall, Medicare is not a “means tested” program. This means that your eligibility for Medicare benefits (except for Medicare Parts B and D) does not depend upon the amount of your income or your resources. The monthly premium structure changed in 2007 for Medicare Part B benefits, and in 2011 for Medicare Part D. These premiums are now determined by your income (means determination). Medicare Part D has an income-related monthly adjustment amount that is paid to Medicare.

Medicare Hospital Insurance is called Medicare Part A. It usually covers medically necessary stays in the hospital. It also may cover skilled nursing care and rehabilitation in a nursing facility or health care in your home after you leave the hospital. It is very important to note that Medicare Part A does *not* cover doctors’ and ambulance services. Medicare Part B covers these services (see below).

Medicare Medical Insurance is called Medicare Part B. In order to get Part B coverage, you must choose it and pay a monthly premium. Medicare Part B reimburses at the rate of 80 percent of the reasonable charge for medically necessary covered services.

Medicare Part B covers doctors' services, ambulance and outpatient services, preventive services, and medical supplies. It also covers home health services prescribed by your physician even if you have not been hospitalized. It must be *medically necessary* based on such criteria as a change in your functional status — for example, due to a fall or illness.

The premium structure for Part B changed in 2007, and income is now considered. This is the income-related monthly adjustment amount. The monthly premium ranges from \$174.70 to \$594.00 for new enrollees. The monthly premium is significantly higher based on a lower income if a married beneficiary has an income greater than \$103,000 and files a separate tax return, rather than a joint return. Current Medicare Part B beneficiaries are notified by Social Security of their premiums for 2024. Most beneficiaries will pay a \$174.70 premium.

The Social Security Administration (SSA) automatically determines your Medicare Part B premium, based on tax returns filed with the Internal Revenue Service, usually two years prior to the determination of the premium or on the most recent federal tax return provided. You will receive a notice from the SSA each fall outlining your next year's Medicare Part B premium and containing instructions on how to appeal the premium amount. If you have had a significant change in income (especially a decrease in income) due to such major life-changing events as marriage, divorce, the death of your spouse, retirement, or loss of retirement income, you should provide the SSA with updated tax information and challenge the premium amount.

Medicare Part C is also called Medicare Advantage. It requires eligible participants to elect this coverage and assign their Medicare Part A and Part B benefits to a private company approved by Medicare. Technically, Medicare Advantage plans must cover the same medically necessary services and benefits that are covered under original Medicare Parts A and B. However, the criteria for determination of "medical necessity" and eligibility for services, such as for rehabilitation and therapy services, may differ. These plans also may provide additional benefits that are excluded under Medicare Parts A and B, such as wellness programs (for example, Silver Sneakers) and vision and dental care.

You either can elect to have original Medicare Parts A and B or you can elect to enroll in a Part C plan (health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service plan (PFFS)). If you are in a Medicare Advantage (Medicare Part C) plan and you want to change back to a Medicare fee-for-service plan, **you can disenroll between January 1 and March 31 of each year** (Medicare Advantage Open Enrollment Period).

Medicare Part D, which covers the prescription drug program, began in January 2006, and is intended to cover prescription drugs as a result of the Medicare Prescription Drug Improvement and Modernization Act of 2003. **The annual open enrollment period for Medicare Part D is from October 15 to December 7.** This is also the period in which you can change your plan enrollment. (See CMS Tipsheet No. 11219, page 4, "Understanding Medicare Advantage & Medicare Drug Plan Enrollment Periods" (revised Feb. 2024; published in English and Spanish).)

Kidney transplant patients whose full Medicare coverage ended 36 months after transplant, in certain situations, may elect to continue Medicare Part B for coverage of their immunosuppressive drugs. The 2024 monthly premium cost is \$103.00 for incomes up to \$103,000 and premiums are income adjusted.

MEDICARE PART B AND PART D PREMIUMS

Tax Return Income Individual)	Joint Tax Return Income (Married Couples)	Tax Return Income (Married Filing Separately)	2024 Monthly Part B Premiums (each person)	2024 Monthly Part D Premiums (each person)
Up to \$103,000	Up to \$206,000	Up to \$103,000	\$174.70 (Standard premium)	Plan premium
Over \$103,000 to \$129,000	Over \$206,000 to \$258,000		\$244.60 (Standard premium plus \$69.90)	Plan premium plus \$12.90
Over \$129,000 to \$161,000	Over \$258,000 to \$322,000		\$349.40 (Standard premium plus \$174.70)	Plan premium plus \$33.30
Over \$161,000 to \$193,000	Over \$322,000 to \$386,000		\$454.20 (Standard premium plus \$279.50)	Plan premium plus \$53.80
Over \$193,000 to less than \$500,000	Over \$386,000 to less than \$750,000	Over \$103,000 to less than \$397,000	\$559.00 (Standard premium plus \$384.30)	Plan premium plus \$74.20
\$500,000 or greater	\$750,000 or greater	\$397,000 or greater	\$594.00 (Standard premium plus \$419.30)	Plan premium plus \$81.00

Medicare Eligibility

You are eligible for Medicare if:

- ▶ You are age 65 or older and qualify for Social Security or Railroad Retirement benefits, even if you are not actually receiving them;
- ▶ You are disabled and have met the Social Security or Railroad Retirement disability requirements for 24 months or two years;
- ▶ You have end-stage kidney (renal) disease and have been treated with dialysis for three months (generally, you become eligible for Medicare benefits on the first day of the fourth month of dialysis treatment); or
- ▶ You have Lou Gehrig’s disease (ALS). You become eligible for Medicare benefits as soon as you are determined to be eligible for Social Security Disability Income (SSDI) benefits, without the requirement of the 24-month waiting period;
- ▶ You are a former federal employee who retired on or after January 1, 1983, and have the required years of federal or federal and private sector combined service.

If you are age 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 have been a citizen or legal alien for at least five years. If you choose to enroll, you must pay monthly premiums that are generally higher than those charged to eligible beneficiaries. The 2024 Medicare Part A monthly premium for voluntary enrollees is \$505 per month if you have paid into Social Security for 29 or fewer quarters, and \$278 per month if you have paid into Social Security for 30 to 39 quarters.

How to Enroll

People who elect and receive Social Security retirement benefits before they are 65 will be enrolled automatically in Medicare at age 65. People who have been receiving Social Security Disability benefits for 24 months also will be enrolled automatically in Medicare. These people will receive a Medicare card in the mail from the Social Security Administration three months before their 65th birthday (or on the 24th month of disability), along with a notice informing them of their Medicare Part A enrollment and that they automatically will be enrolled in Medicare Part B unless they refuse this coverage. If you are in one of these categories and do not receive your notice and card, contact the Social Security Administration.

If you have not chosen early retirement, you should apply for Medicare three or fewer months before your 65th birthday or up to three months after your birthday month, even if you plan to continue working. This seven-month period is the initial enrollment period. As the age of eligibility for full Social Security benefits is increasing, many people may need to enroll in Medicare at age 65 without also registering for Social Security benefits. If you do not apply at this time, you may miss your opportunity to timely enroll in Medicare Parts A and B, as you can only sign up between January 1 and March 31 of each year, with coverage beginning on July 1. This is known as the general enrollment period.

Also, there is a 10 percent penalty added to the premium for each full 12-month period an individual is late in enrolling for Medicare Part B, unless you qualify for the “Special Enrollment Period” (such as if you have group health plan insurance coverage based upon the current employment of you or a family member). So, it is very important that you enroll as soon as you are eligible, unless you are still covered by your own or your spouse’s employee health plan. Then, you can enroll for Part B at any time or during the eight-month period beginning when the employment or group health plan coverage ends, whichever first occurs.

Your monthly Medicare Part B premiums are deducted from your Social Security check. If you are not yet receiving Social Security, you will be billed for these premiums.

2-2. Medicare Benefits Covered

Benefits Covered Under Part A

Hospital Services

Hospital services (considered reasonable and medically necessary by Medicare) are covered for a hospitalization in an acute care hospital, an inpatient rehabilitation facility (IRF), or a long-term acute care hospital (LTAC). These services can include:

- ▶ Semi-private room and board, including special care units;
- ▶ General nursing services (not private duty nursing);

- ▶ Inpatient prescription drugs;
- ▶ Supplies;
- ▶ Use of equipment normally furnished by the hospital;
- ▶ Operating and recovery room costs;
- ▶ Blood transfusions after the first three pints;
- ▶ Diagnostic, therapeutic, or rehabilitative services and items the hospital normally furnishes; and
- ▶ Inpatient mental health care in a psychiatric hospital (lifetime maximum benefit of 190 days, subject to daily coinsurance of \$0 for days 1-60, \$408 for days 61-90, and \$816 for day 91 and beyond). You are responsible for all costs beyond the lifetime limit of 190 days. (See “Medicare & Mental Health Coverage” at <https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf>.)

Skilled Nursing Facility (SNF) Services

These include:

- ▶ Skilled nursing care;
- ▶ Semi-private room and board;
- ▶ Physical, occupational, and speech therapy;
- ▶ Medical social services;
- ▶ Inpatient prescription drugs; and
- ▶ Use of durable medical equipment such as wheelchairs, walkers, and special beds.

Note: Reimbursement for SNF rehabilitation significantly changed effective October 1, 2019, with the Patient-Driven Payment Model (PDPM). What this means is a Medicare beneficiary’s rehabilitation benefit has been decreased drastically.

A skilled nursing facility also may furnish intermediate and custodial care, which is not a covered benefit. Medicare only pays if you receive skilled nursing or therapy services or both and pays only under specific circumstances.

Hospice Services

Hospice care is concerned with maintaining a person’s quality of life as she or he approaches death. Hospice is appropriate for people with a terminal illness who have a life expectancy of six months or less if the disease process runs its normal course. Beneficiaries or their designees must sign a written hospice election form with the hospice organization of their choice, choosing hospice care over regular Medicare Part A covered benefits for the terminal illness. **This election can be cancelled at any time.** When in hospice care, you can continue receiving Medicare-covered services for medical conditions not related to your terminal illness.

The Medicare Part A hospice benefit *does not* include payment for room and board at a skilled nursing facility or hospice facility. However, if the beneficiary also has Medicaid benefits, Medicaid generally will cover this cost of room and board. Hospice benefits include:

- ▶ Physician services;
- ▶ Skilled nursing care;
- ▶ Physical, occupational, and speech therapy for purposes of symptom control or to enable the beneficiary to maintain functional skills;
- ▶ Durable medical equipment (DME) such as hospital bed and wheelchair rental;
- ▶ Pain-relieving medication and all other medications (*Note: Medicare Part D changes some of these reimbursements*) (See Exhibit 2C, “Hospice and Part D Prescription Medications”);
- ▶ Medical social services;
- ▶ Home health aide and homemaker services;
- ▶ Medical supplies and appliances;
- ▶ Spiritual, grief, and loss counseling; and
- ▶ Short-term inpatient care not for treatment of the terminal disease, but for management of symptoms and pain.

Benefits Covered by Part A and Part B

Home Health Care Services

Medicare benefits covered by Part A and Part B pay for home health care ordered by your physician and provided by a certified Medicare home health care agency of your choosing. This benefit is limited to “reasonable” and “medically necessary” intermittent care. The beneficiary may choose any Medicare-certified home health care agency, and there is no cost to the beneficiary for these home health care services.

Note: Reimbursement for home health services significantly changed effective January 1, 2020, with the Patient-Driven Groupings Model (PDGM). It changes the unit of home health care payment from a 60-day to a 30-day episode, eliminates payment based upon the number of therapy visits, and relies heavily on clinical characteristics and medical diagnoses to place Medicare beneficiaries into payment categories.

Overall, it may significantly decrease the number and availability of home health visits a beneficiary receives. Refer to the Center for Medicare Advocacy article, “Potential Impacts of New Medicare Payment Models on Skilled Nursing Facility and Home Health Care,” at www.medicareadvocacy.org/potential-impacts-of-new-medicare-payment-models-on-skilled-nursing-facility-and-home-health-care/.

Covered home health care services include:

- ▶ Skilled nursing care;
- ▶ Physical, occupational, and speech therapy;
- ▶ Limited services of a home health aide to assist the beneficiary with his or her activities of daily living (ADLs) such as bathing;
- ▶ Medical social services;

- ▶ Medical supplies; and
- ▶ Equipment provided by the agency.

Medicare Benefits Covered by Part B

After the yearly deductible of \$240 is met, Part B covers 80 percent of the Medicare-approved amount of the following medically necessary services and items:

- ▶ One-time “Welcome to Medicare” physical exam during the first 12 months of enrollment in Part B;
- ▶ Annual “wellness” visit, including a health risk assessment to:
 - Establish and update beneficiary’s medical history;
 - Create lists of current medical providers and medications;
 - Conduct routine measurements such as blood pressure, blood sugar, height, weight, and body mass index (BMI);
 - Assess cognitive status; and
 - Establish a 5- to 10-year schedule for preventive services and screenings.
- ▶ Physicians’ services;
- ▶ Ambulance services;
- ▶ Home health services prescribed by a doctor if you have not been hospitalized or met the required three-day hospitalization to trigger Medicare Part A benefits;
- ▶ Outpatient physical, occupational, and speech therapy. The maximum yearly benefit for 2024 was changed to \$2,330 for occupational therapy skilled services, and \$2,330 for physical and speech therapy combined. When \$2,330 is reached, a special code (KX Modifier) must be added to a beneficiary’s therapy claim. Therapy claims exceeding \$3,000 for physical therapy and speech therapy services, and \$3,000 for occupational therapy services, may be subject to a medical review process to determine if therapy services are “medically necessary”;
- ▶ Rental or purchase of durable medical equipment (DME) such as walkers, wheelchairs, and all-in-one commode chairs;
- ▶ Prosthetic and orthotic devices and medically necessary shoes such as for diabetics;
- ▶ Services in an emergency room, outpatient clinic, or ambulatory surgery center;
- ▶ Some hospital outpatient services and supplies (such as diagnostic x-ray tests, CT scans, EKGs, MRIs, and radium and radioactive isotope therapy);
- ▶ Opioid use disorder (OUD) treatment at opioid treatment programs (OTP) (effective Jan. 1, 2020);
- ▶ Expansion of telehealth benefits provided to treat behavioral health conditions, including substance use disorders (effective Jan. 1, 2020);
- ▶ Effective January 1, 2011, due to the Affordable Care Act (Health Care Reform of 2010), these preventive services and tests are provided free of charge to the beneficiary at specified intervals: vaccinations (flu, pneumonia, hepatitis B, and shingles vaccine); mammograms; Papsmears; HIV testing; and screening tests for abdominal aortic aneurysm, bone density, cardiovascular health, colorectal cancer, diabetes, and prostate cancer;

- ▶ Screening and/or counseling to address alcohol misuse, depression, sexually transmitted infections, and obesity;
- ▶ Smoking cessation counseling, as ordered by your physician, for up to eight face-to-face visits. You must be diagnosed with a smoking-related illness or using medication that may be affected by tobacco to claim this benefit;
- ▶ Diabetes education and some supplies;
- ▶ Surgical dressings, splints, and casts;
- ▶ Limited chiropractic care;
- ▶ A percentage of the cost of oxygen and equipment;
- ▶ Kidney dialysis services and supplies;
- ▶ Kidney disease education services;
- ▶ Medical nutritional therapy services for diabetic and kidney disease patients;
- ▶ Blood transfusions;
- ▶ Laboratory services;
- ▶ Cardiac rehabilitation programs;
- ▶ Pulmonary rehabilitation programs; and
- ▶ Outpatient mental health care — you pay 20 percent of the Medicare-approved amount, depending on the type of facility providing services. You also may have to pay an additional copayment or coinsurance amount to the hospital.

Services and Supplies NOT Covered by Medicare Parts A or B

Although Medicare has broad coverage, it does not pay for many services and supplies. These non-covered services include:

- ▶ Acupuncture;
- ▶ Custodial care in a skilled nursing facility or at home;
- ▶ Services not “reasonable” or “medically necessary” as defined by Medicare;
- ▶ Room and board costs for a person on hospice who resides at a skilled nursing facility or hospice facility (see the “Hospice Services” section, above);
- ▶ Services the patient has no legal duty to pay for;
- ▶ Services paid by a governmental agency;
- ▶ Personal comfort items;
- ▶ Routine check-ups other than the “Welcome to Medicare” one-time physical examination done within the first 12 months of enrolling in Part B;
- ▶ Homemaker services;
- ▶ Hearing aids/examinations (Medicare does cover some hearing tests);
- ▶ Eyeglasses/routine eye examinations;
- ▶ Most chiropractic services;
- ▶ Cosmetic surgery;
- ▶ Dental care;

- ▶ Optional private hospital rooms;
- ▶ Orthopedic shoes; and
- ▶ Health care while traveling outside the United States.

Medicare Benefits Covered by Part C (Medicare Advantage)

If you are entitled to benefits under Medicare Part A and also are enrolled under Part B, you may choose to receive Medicare Part C from a Medicare Advantage plan. Medicare Part C plans must provide the services currently available under original Medicare Parts A and B, and usually include a prescription drug benefit. These plans may offer supplemental benefits, for which a separate premium may be charged. Part C provides beneficiaries with alternatives to original fee-for-service Medicare.

Medicare Advantage plans may include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and private fee-for-service plans (PFFS). There are many different Medicare health plans available to Colorado residents, depending upon the person's county of residence.

Some Medicare beneficiaries choose to enroll in Medicare Advantage plans because the monthly premiums are lower and additional services are provided at lower costs to them. Before enrolling in a Medicare Advantage plan, investigate whether it will meet your particular health care and rehabilitation needs. **The annual open enrollment period to switch from original Medicare fee-for-service to a Medicare Advantage plan is October 15 to December 7. The annual Medicare Advantage open enrollment period is January 1 to March 31.**

Medicare Payment Policies

As with private insurance policies, Medicare Parts A and B have deductibles that you must pay before Medicare pays anything. Part B has a monthly premium, which is deducted from your Social Security check. Medicare Parts A and B also have co-insurance payments that go into effect after certain Medicare payments are made. You then must share some of the costs with Medicare.

Part A

The Medicare Part A hospitalization benefit has a deductible of \$1,632 (in 2024) for each "benefit period" or "spell of illness." Medicare measures your use of Part A hospital insurance with "benefit periods," which also are called "spells of illness." A benefit period is a period of consecutive days during which medical benefits for covered services, with certain maximum limitations, are available to you, the beneficiary. Your first benefit period begins the first day you enter a hospital after your insurance goes into effect.

A new benefit period of 90 days of hospitalization coverage (60 full benefit days and 30 co-insurance days) begins each time you are hospitalized, if it has been at least 60 consecutive days since your last discharge from a hospital or skilled nursing facility. Each benefit period is called a "spell of illness," and the number of benefit periods or spells of illness is unlimited. There is a deductible of \$1,632 for each new benefit period or spell of illness. For example, if you have two hospitalizations, or spells of illness, in 2024, your total deductible amount would be \$3,264.

Hospital Care

The Medicare Part A benefit allows you to receive up to 90 days of hospital care for each spell of illness. The following is what you must pay:

- ▶ For the first 60 consecutive days, Medicare requires you to pay only the deductible for the spell of illness, which in 2024 is \$1,632. Medicare pays the remaining covered expenses.
- ▶ For the next 30 days (days 61 to 90), Medicare requires that you pay a co-payment or co-insurance charge for each day you are in the hospital. For 2024, this daily co-insurance rate is \$408. Medicare pays the remaining covered expenses.
- ▶ Each beneficiary has a lifetime reserve of 60 days for days 91 to 150. This benefit is **not** renewable. Any number of the lifetime reserve days can be used for any spell of illness, up to the maximum the beneficiary has. So, after day 90, you may use some or all of your 60 lifetime reserve days. The 2024 co-insurance daily charge for each lifetime reserve day is \$816. Medicare pays the remaining covered expenses for each day, up to a 60-day maximum. A beneficiary can elect not to use these lifetime reserve days.

Skilled Nursing Care

Medicare Part A hospitalization insurance benefits provide up to 100 days of inpatient extended care benefit coverage for skilled nursing and skilled therapy services. However, there is no absolute right to payment for all 100 days unless they are “reasonable” and “medically necessary.”

Medicare Part A pays 100 percent of all costs for the first 20 days of covered skilled nursing care and skilled therapy services in a Medicare-certified facility after you are discharged from a hospital, following the required stay of at least three consecutive days, *which does not include the day of discharge*. Your care must begin within 30 days of the hospital discharge. There are a few exceptions to this 30-day admit rule.

Days 21 through 100 require a daily co-insurance rate of \$204 in 2024, and Medicare pays the remaining covered expenses. After 100 days, you are responsible for payment of the full amount and Medicare pays nothing. Your continued need for physical, occupational, and/or speech therapy might be covered by Medicare Part B. Your room and board is not a covered benefit. Also, you may be eligible for Medicaid payment for long-term care and during the application process (see Chapter 4, “Medicaid”). The level of care requirements for skilled nursing facility coverage are very restrictive. Rarely do individuals receive the full 100 days of coverage.

Home Health Visits

Home care services must start within 14 days of your discharge from the inpatient hospital or skilled nursing facility. Medicare Parts A and B pay for the *full* approved cost of home health visits by a Medicare-certified home health agency following a treatment plan of care prepared by a nurse or a physical, occupational, or speech therapist and approved by your physician. Strict requirements limit the coverage of home health services. The Medicare beneficiary receiving services must be “confined to her or his home” or “homebound” in order to receive home health services. This means it would take considerable and taxing effort to leave home. The person may be able to leave home for doctor appointments, an occasional walk or drive, or other limited trips outside the home. Another requirement is that the services are needed only on an intermittent basis, rather than continually.

Home health care agencies *must* give the beneficiary a minimum of two days' notice of their intent to either cut back or terminate services. This notice must also explain the procedure for seeking review of the termination or cut back in services. If Medicare refuses to cover you for these types of services, you have a right to appeal this decision.

You should appeal any discharge or termination of services decision with which you do not agree. You may want to ask an attorney or someone else knowledgeable about Medicare to help you through the appeal process.

Hospice Care

The usual deductibles and co-payments do not apply to hospice care. Unless your prescriptions are covered from some other source or Medicare Part D, you pay 5 percent of the cost for prescription drugs, up to \$5 per outpatient prescription. You also pay 5 percent of the cost of respite care, up to a maximum equal to the yearly inpatient hospital deductible. (See Exhibit 2C, "Hospice and Part D Prescription Medications.")

Part B

Medicare Part B payment rules for covered medical services:

- ▶ Services must be reasonable and medically necessary, as defined by Medicare; and
- ▶ Medicare pays 80 percent of the approved charge after you pay your yearly deductible of \$240 in 2024. You pay the remaining 20 percent, plus any difference between the doctor's charge and the approved charge. This 20 percent is paid by your separately purchased supplemental insurance.

The approved charge is the amount that Medicare considers to be the value of the services you received. It is not always the same as the amount that the provider bills you for the services.

Medicare Payment Methods

Under Medicare Part A, you do not have to send in any bills you receive from a participating hospital, skilled nursing facility, or home health agency. The health care provider will file the claim for you, and Medicare will pay its share directly to the provider. You will then receive a Medicare Summary Notice (MSN) explaining what Medicare paid. If you disagree with this payment, you have the right to appeal (see section 2-3, "Appeal Rights").

Payment is made two ways under Medicare Part B Medical Insurance:

- 1) **Assigned Claims.** Participating physicians and health care providers who accept assignment will bill Medicare directly. You are responsible only for 20 percent of the approved Medicare Part B charge and not for any additional amount above the approved charge. If the doctor is a participating physician who has agreed to take Medicare assignment, then he or she has agreed not to charge above the Medicare approved rate, and also to accept the Medicare approved rate as payment in full. The simplest way to find out if the doctor is a participating physician who has agreed to take Medicare assignment is to ask in advance.
- 2) **Non-Assigned Claims.** With this method, the physician or health care provider sends in a completed claim form, but the payment from Medicare is paid directly to you. You

are then responsible for paying the provider the full amount of the bill for the services provided to you. Under this method, a physician or health care provider may bill you for the full charges, even if it is more than the Medicare approved charge.

With non-assigned claims, you are responsible for payment of the difference between the Medicare approved charge and the actual charge. For example, if the bill was \$100 and the Medicare approved charge was \$90, you would be responsible for the difference of \$10 (\$100 minus \$90), plus 20 percent of the approved charge (20 percent times \$90 equals \$18), for a total payment of \$28. The doctor cannot charge more than 115 percent of the approved charge.

Under either payment system, as Medicare Part B pays a maximum of 80 percent of the approved charge, you must pay at least 20 percent of the approved charge plus any unpaid part of your \$240 (for 2024) annual Medicare Part B deductible. You pay your share directly to the physician or health care provider.

The Medicare Prescription Drug Plan: Part D (Under Title 16 of the Social Security Act)

On January 1, 2006, the Medicare prescription drug plan began. Medicare has contracted with private companies to offer this drug coverage. Colorado currently has 21 stand-alone prescription drug plans (plans that only cover drugs) provided by private insurance companies and approved by Medicare. These plans have varying premiums, deductibles, and benefits. There are numerous Medicare Advantage (HMO, PPO, PFFS) plans and other Medicare health plans that provide prescription drug coverage in conjunction with health care coverage. These companies offer a variety of options, with different covered prescriptions and different costs. Medicare prescription drug plans are voluntary. If you want to participate, you must choose a plan offering the coverage that best meets your needs and then enroll. In most cases, there is no automatic enrollment to get a Medicare prescription drug plan. (For more information, go to <https://doi.colorado.gov/colorado-medicare-health/drug-insurance-coverage-options>, and then click on the box for “2024 Part D Options” or the box for “2024 Medicare Plans offering Part D.”)

Medicare prescription drug plans vary, but in general, this is how they work. When you join, you will pay a monthly premium (cost ranges from \$0.00 to \$132.60 for Colorado plans) in addition to any premiums for Medicare Part A and Part B. Medicare prescription drug plans can offer basic coverage or more generous coverage for higher premiums. Joining is your choice. However, just as described above for enrollment in Part B, if you do not join when you are first eligible, you may have to pay a higher premium if you choose to join later. **You will have to pay this higher premium for as long as you have a Medicare prescription drug plan.**

Enrollment

To enroll, you must be eligible for Medicare Part A or Part B. You can first enroll three months before you become eligible for Medicare and until three months after you become eligible for Medicare. This is called the “initial enrollment period.” Enrolling is your choice. A counselor at the Colorado State Health Insurance Assistance Program (SHIP; (888) 696-7213) can assist you with the selection and enrollment process. *Note:* after your initial enrollment period, you can change your plan during the open enrollment period, which is from October 15 to December 7 each year. Your new Medicare prescription drug plan will begin January 1 of the following year.

You also can find up-to-date Medicare information and answers to your questions anytime on Medicare's official website, www.medicare.gov. Or, you can call (800) MEDICARE ((800) 633-4227; TTY (877) 486-2048). This toll-free help line is available 24 hours a day, seven days a week to answer your questions.

Plan Costs to You

In 2024, the standard drug benefit plan includes your payment of an annual maximum deductible of \$545 (the Colorado plans range from \$0.00 to \$132.60) prior to payment of any prescription drug costs. Also, effective January 1, 2012, higher income Medicare beneficiaries have an income-related adjustment to their Medicare Part D premiums. This new income means adjustment is estimated to affect less than 5 percent of Medicare beneficiaries. Refer to the "Medicare Part B and Part D Premiums" rate chart in section 2-1 for premium amounts.

- ▶ If your yearly drug costs are \$0 to \$545 (or your deductible), you pay 100 percent of these costs.
- ▶ If your yearly drug costs are \$ 545.01 to \$ 5,030 in the initial coverage, you pay (\$1,257.50 or) 25 percent of your yearly costs (plus your deductible) and your plan pays the other 75 percent.
- ▶ The Medicare Part D "donut hole," "coverage gap," or "coverage in the gap" closed completely in 2020. You are responsible for a total cost of \$6,333.75 to get through the former coverage gap or "donut hole." Effective January 1, 2011, the Affordable Care Act legislation (health care reform) worked to decrease this coverage gap by providing a "Medicare Gap Discount Program." In 2024, it provides a 75 percent discount on name-brand formulary drugs (Plan pays 5 percent and drug manufacturer gives 70 percent discount on costs) and a 75 percent discount on all generic formulary medications (Plan pays 75 percent). This means you actually pay 25 percent for name-brand formulary drugs or generic drugs while in the former donut hole.
- ▶ For catastrophic coverage, in 2024, when your total out-of-pocket expense on formulary drugs reaches \$8,000 (this is the total retail cost of all covered medications as well as your deductible, co-insurance, co-payments, and discounts), you pay nothing for prescription drugs for the rest of the calendar year. Your plan pays 20 percent and Medicare pays 80 per cent.

See the "Who Pays What Under Part D in 2024" chart from the National Council on Aging, attached as Exhibit 2A (www.ncoa.org/article/donut-hole-part-d), and "Medicare Part D Cost-Sharing Chart 2024," attached as Exhibit 2B (<https://www.ncoa.org/article/medicare-part-d-cost-sharing-chart>).

Additional Low-Income Assistance ("Extra Help")

The 2024 monthly income figures for Low-Income Subsidy eligibility are now available. Guidelines are published following the release of the Federal Poverty Guidelines each year at the end of January or February. The maximum income eligibility figure is set at 150 percent of the federal poverty guideline for an individual.

If your monthly income is below \$1,882.50 (\$22,590 annual income) for a single person or \$2,555 (\$30,660 annual income) if you are married and living with your spouse, you may qualify for extra financial assistance through the Low-Income Prescription Drug Subsidy Program. Slightly higher income levels may apply if you provide half-support to other family members living with you, or if you work or reside in Alaska or Hawaii.

Effective January 1, 2024, if your resources (including your bank accounts, stocks, bonds, IRAs, mutual funds, life insurance policies with face values over \$1,500, and real estate, but not counting your home, car, burial plots, or irrevocable burial plan contracts) are less than \$17,220 (for a single person) or less than \$34,360 (for a married couple), you may qualify for extra help paying for your Medicare prescription drug costs. You can apply for this Low-Income Subsidy through the SSA or your State Medical Assistance Office. If the SSA can determine your eligibility by its internal records, an application will be sent to you. For others, you must apply.

The amount of subsidy you get depends on your income and resources. You still must join a Medicare prescription drug plan for Medicare to pay for any of your drug costs.

If you qualify for the Low-Income Subsidy or “Extra Help” program, you will have continuous drug coverage and will pay only a small amount for your prescriptions. The SSA (at (800) 772-1213, TTY at (800) 325-0778, or www.ssa.gov) can provide more information on the Low-Income Subsidy for prescription drug costs and information on how to apply for it. See also <https://www.medicare.gov/basics/costs/help/drug-costs>.

2-3. Appeal Rights

Medicare beneficiaries are required to receive written notice of termination of services, non-coverage, and cutbacks in coverage pursuant to Medicare Parts A and B. Original Medicare Parts A and B Fee-For-Service Plans have five levels of appeals of the denial of payment of services. (See <https://www.cms.gov/medicare/appeals-grievances/fee-for-service?redirect=/OrgMedFFSAppeals>; see also www.medicareadvocacy.org for numerous articles.) The notice should state the appeal procedure you need to follow.

Most appeals must be written, and must be filed within the number of days stated on the notice. *Note:* The Covid-19 pandemic established alternative communication mediums in addition to submitting appeals via hard copy mail. It is recommended that all appeals and related correspondence be sent via certified mail, with a return receipt requested, so you have proof that you sent your appeal and it was done on time. Usually, the appeal forms are included with the notices. Otherwise, the appeal forms can be obtained from the Medicare website at www.medicare.gov. *Note:* if you have a Medicare Advantage Plan (Medicare Part C), you need to read your plan materials carefully to learn how to file an appeal and whether you have the right to an “expedited review” or fast appeal.

Parts A and B

Call the Colorado Quality Improvement Organization, Kepro, toll-free at (888) 317-0891 or (216) 447-9604 to appeal a denial of Medicare approval for a hospital admission, continued hospital stay, discharge, or termination of services.

If you feel your Medicare-covered services from a hospital, skilled nursing facility, home health care agency, comprehensive outpatient rehabilitation center, or hospice are ending too soon, you might have the right to a “fast” or “expedited” appeal with an independent reviewer to determine if your services should continue. You have by noon on the next calendar day after receiving the Notice of Discharge or Service Termination to appeal this decision for the Quality Improvement Organization Redetermination, which has 72 hours (3 days) to make its decision. Your second level of appeal is to the Qualified Independent Contractor for Colorado who is C2C Innovative Solutions, Inc. for Part A & B appeals. It must be done within 72 hours of the first denial. It also has 72 hours to give its decision.

If you still have concerns with this decision, your third level of appeal is to file an appeal within 60 days to the Office of Medicare Hearings and Appeals. You then follow the procedure and timelines as stated for a regular appeal. The Colorado State Health Insurance Assistance Program (SHIP), (888) 696-7213, (303) 894-7499, or (800) 930-3745 (toll-free), can assist you with filing an appeal.

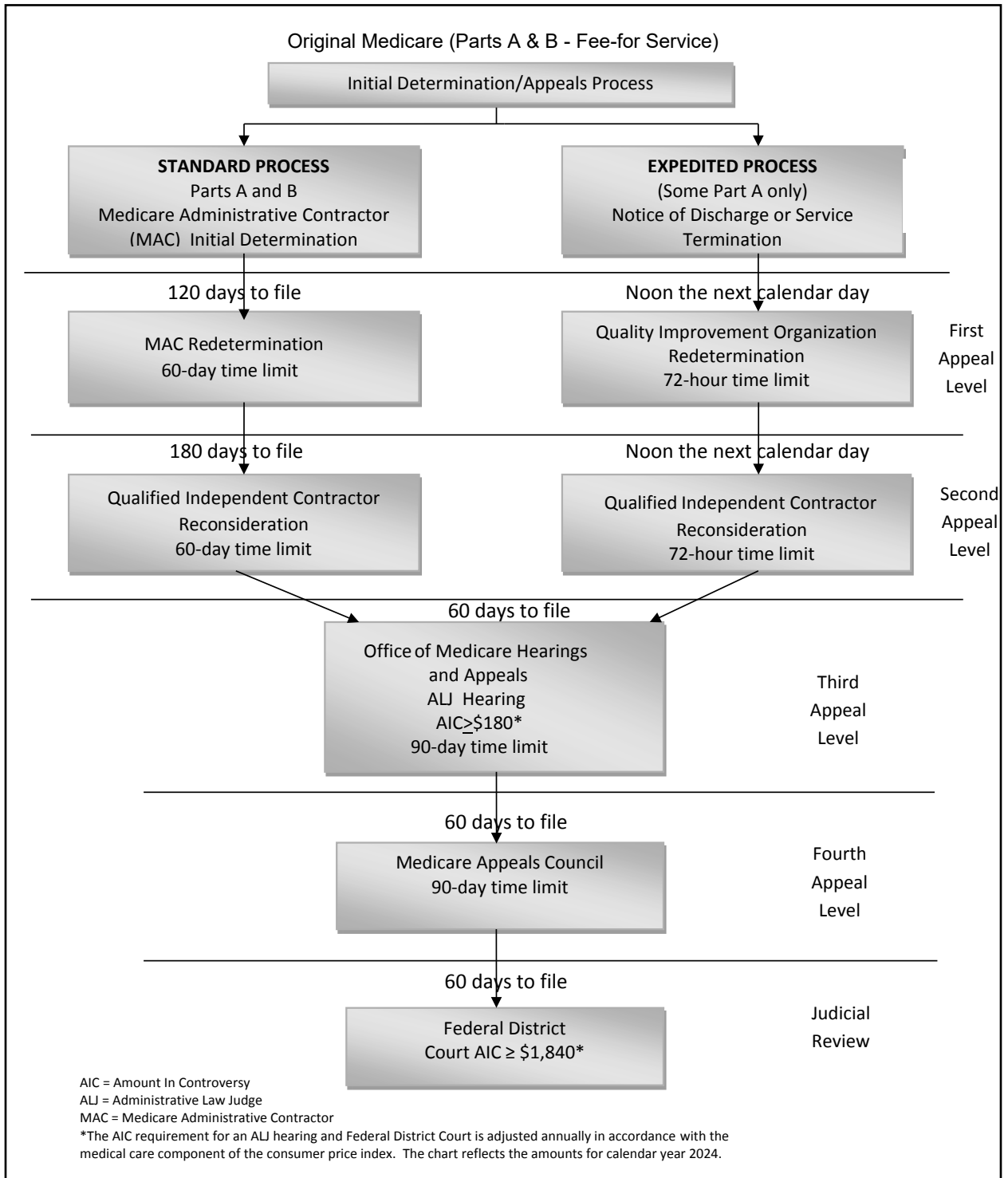


Diagram available at www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/Flowchart-FFS-Appeals-Process.pdf.

Original Medicare Parts A and B plans send you a Medicare Summary Notice (MSN) every three months. This MSN lists all the services you have had and states whether Medicare paid for these services. It also states your appeal rights. If Medicare denies payment of your claim, you may ask for an informal review or redetermination of the decision from the Medicare contractor by:

- 1) Circling the items you disagree with on the MSN;
- 2) Writing an explanation on the MSN, which is signed and dated;
- 3) Including your telephone number;
- 4) Attaching any supporting documentation to the redetermination request;
- 5) Sending the MSN or a copy by certified mail, return receipt requested, to the Fiscal Intermediary (FI), Carrier, or Medicare Administrative Contractor (MAC) listed in the appeals section of the MSN; and
- 6) Keeping a copy of all documents you send.

You must ask for that review within 120 days of the date of the decision in the MSN. If you still disagree with Medicare's decision of redetermination, you have 180 days from the date you receive this second denial of payment to submit a written request for review and reconsideration to the Qualified Independent Contractor (QIC). This is the second level of appeal. If you disagree with the independent review, and the amount in dispute is \$180 or more, in 2024, you may ask for a formal hearing from the Office of Medicare Hearings and Appeals from an administrative law judge (ALJ). This is the third level of appeal. You must do so within 60 days of Medicare's review decision. If you still disagree with the decision of the Office of Medicare Hearings and Appeals, you then can appeal within 60 days to the Medicare Appeals Council, which ultimately may decline a review. This is the fourth level of appeal.

Your fifth and final avenue of appeal is to the federal district court for judicial review if the amount in dispute is \$1,840 or more for appeals filed in 2024. If both you and Medicare maximize the time limits allowed for sending an appeal and giving a redetermination, your final appeal to the federal district court can take almost 23 months. Considering the present caseload of Colorado federal district court judges, it probably will take in excess of a year for your appeal to be determined, unless your appeal can be expedited.

Supplemental Health Insurance (Medigap)

Since Medicare does not pay all your medical or long-term care expenses, private insurance companies sell insurance to supplement Medicare, which is known as "Medigap" coverage. Supplemental Health Insurance is especially important to have for covering your daily co-insurance charges and deductibles, such as for hospitalization in days 61 through 150, skilled nursing facility days 21 through 100, and Medicare Part B 20 percent beneficiary responsibility for charges. It is highly recommended coverage. See Chapter 3, "Health Insurance Beyond Medicare," for information on Medigap or supplemental coverage. There is a six-month open enrollment period starting the first month you are 65 years old *and* enrolled in Medicare Part B.

Medicare Information Resources

If you need help or more information, an excellent Medicare resource is the nonprofit organization, the Center for Medicare Advocacy, Inc. Its website is www.medicareadvocacy.org.

org. It has a large library of excellent articles on a variety of Medicare topics. Another excellent resource is the National Council on Aging (www.ncoa.org).

You also can look at <https://www.medicare.gov>. This is Medicare's official consumer website, where you can find the most up-to-date Medicare information and answers to your questions anytime. You also can call (800) MEDICARE ((800) 633-4227; (877) 486-2048 for TTY users). This toll-free help-line is available 24 hours a day, 7 days a week, and has customer service representatives to answer your questions in either English or Spanish. These customer service representatives, however, may not be willing to answer any questions from currently non-eligible Medicare beneficiaries, such as family members of a beneficiary or educators.

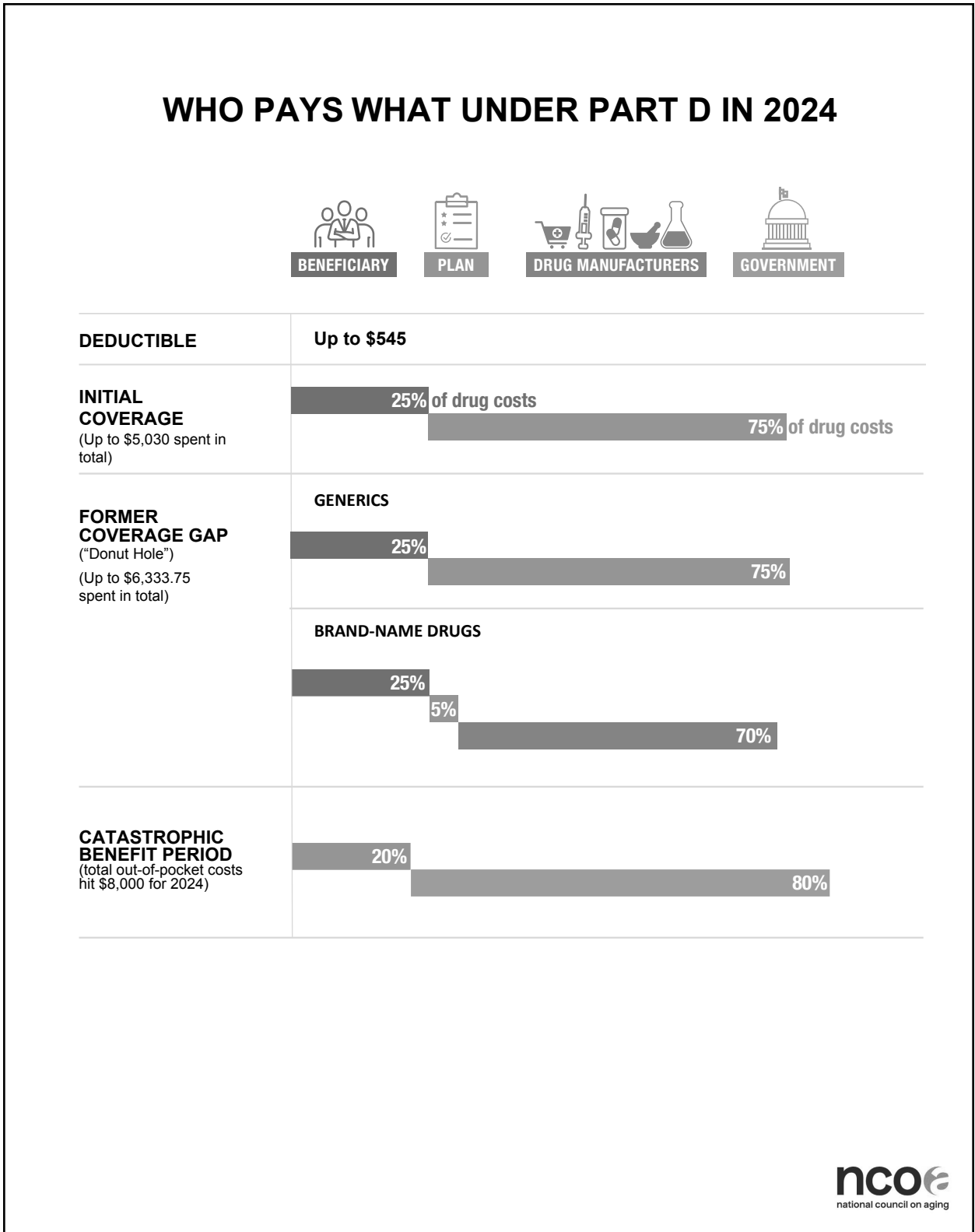
The SSA (Social Security Administration) sends free booklets providing detailed information on Medicare when you enroll. Also, the SSA provides periodic updates to information concerning Medicare Part A and Part B, as these programs are subject to change and review by Congress and the Centers for Medicare and Medicaid Services, formerly Health Care Financing Administration (HCFA).

The "Medicare & You 2024" handbook are mailed to each Medicare beneficiary between late October and late November 2023. You also can view and download it at <https://www.medicare.gov> (Click on "Basics," then "'Medicare & You' handbook," or call (800) MEDICARE (800) 633-4227 to request a copy. TTY users should call (877) 486-2048.)

2-4. More Information

For more information see Appendix A: Resources, Chapter 2. See also Appendix A: Resources, Chapter 5, "Government Programs and Financial Assistance," for a list of county Department of Human Services offices. Finally, see Appendix A: Resources, Chapter 24, "Arm Yourself with Consumer Protection Information," for a list of Area Agencies on Aging. For more information about Medicare and Medicaid, call your nearest senior center.

Exhibit 2A. Who Pays What Under Part D in 2024



<https://www.ncoa.org/article/donut-hole-part-d>

**Exhibit 2B.
Medicare Part D Cost-Sharing Chart 2024**

Medicare Part D Cost Sharing Chart 2024

Part D Benefit Cost Periods	Costs and Who Pays	Beneficiary Pays (TrOOP)	Plan Pays	Total Amount Spent on Plan-Covered Drugs
Initial Deductible	Beneficiary pays 100%	Up to \$545	\$0	\$545 (Amount spent on deductible, before ICP begins)
Initial Coverage Period (ICP)	Costs of covered drugs are shared: 25% by beneficiary, 75% by plan	Up to \$1,257.50* *maximum an individual would pay if in plan with no deductible	\$3772.50	\$5,030 (Amount spent during ICP, including applicable deductible, before Coverage Gap begins)
Former Coverage Gap ("donut hole")	<p>While the Part D coverage gap ("donut hole") officially closed in 2020, that does not mean beneficiaries don't have to share a portion of costs after the ICP:</p> <ul style="list-style-type: none"> The beneficiary will continue to pay 25% for both generic drugs and brand-name drugs, plus a small portion of the pharmacy dispensing fee (approx. \$1-\$3) The plan pays 75% of the cost of generic drugs and 5% for brand-name drugs. The drug manufacturer provides a 70% discount on brand-name drugs. <p>Note about True Out-of-Pocket (TrOOP) costs: The total amount spent in this period (up to \$6,333.75) includes:</p> <ul style="list-style-type: none"> The drug costs paid by the beneficiary, and The 70% discount on brand-name drugs provided by the drug manufacturer. <p>Payments made by the plan during this period (75% on generics, 5% on brand-name drugs) do not count toward TrOOP.</p>			<p>Up to \$6,333.75 (Total amount spent during the period between the end of the ICP and prior to the Catastrophic Benefit Period)</p> <p>\$12,447.11 (Total amount spent during both the ICP and this period, before Catastrophic Benefit Period begins)</p>
Catastrophic Benefit Period	When an enrollee's total out-of-pocket spending reaches \$8,000, they hit the catastrophic benefits period. After this point, the beneficiary does not have to pay anything for their prescription drugs for the rest of the year.	\$0	100%	Beneficiary will remain in the Catastrophic Benefit Period through December 31, 2024. Part D benefit will reset on January 1, 2025, starting again with a deductible.

Source: 2024 Call Letter (pp. 140-142) at:
<https://www.cms.gov/files/document/2024-announcement-pdf.pdf>



Exhibit 2C. Hospice and Part D Prescription Medications



Hospice and Medicare Part D Prescription Drugs

While hospice care is a covered service under Medicare Part A, it is important to understand how medications may be paid for when a beneficiary elects hospice, as outlined below.

How medications are supplied

Once a Medicare beneficiary elects the **hospice** benefit, the hospice provides all drugs to manage the pain and symptoms associated with the patient's terminal illness.

However, in many cases, hospice patients continue to take medications not directly related to their terminal illness. The hospice does not provide these medications; instead, the patient's **Part D drug plan** continues to fill medications for management of conditions not directly related to the terminal illness. The usual copays, coinsurance, and plan rules apply.

The Part D drug plan will require prior authorization (PA) for drugs that treat pain, nausea, constipation, and anxiety. PA is required because these drugs are typically related to the treatment of the patient's terminal illness and should be provided by hospice.

Hospice supplied drugs	Part D supplied drugs
<ul style="list-style-type: none"> • Ease suffering and manage patient's terminal condition • Cost no more than \$5 per prescription 	<ul style="list-style-type: none"> • Treat conditions unrelated to hospice • Obtain from local/mail order pharmacy • Part D copay/coinsurance, formulary restrictions apply • Require PA for drugs used to treat pain, nausea, constipation, and anxiety • Transitional fills do not apply

Prescription payment rules

The Centers for Medicare & Medicaid Services (CMS) provides guidance to ensure that the hospice and Part D plans correctly pay for prescription drugs covered under each respective Medicare benefit while ensuring timely access to needed prescription medications.

For those who elect the hospice benefit, it is important that Medicare beneficiaries and caregivers understand the rules that the hospice provider, pharmacy, and Part D plan must adhere to.

Hospice agrees to...	<ul style="list-style-type: none"> • Notify Part D plan at the time of hospice election or discharge • Proactively complete and submit <u>PA Form</u> to Part D plan for any drugs in the four categories noted above • Send PA information to Part D plan in the event of a claim denial • Provide "compassionate first fill" for those unable to get medication in the four categories
Pharmacies will...	<ul style="list-style-type: none"> • Receive claim denial and transmit the PA form or other documentation to the Part D plan • Contact hospice to determine if the denied drug will be covered by hospice

Part D plan must...	<ul style="list-style-type: none">• Fill prescription drugs not subject to prior authorization (PA)• Accept PA form or other documentation from hospice as proof of unrelated to terminal illness to override the PA requirement at point of sale (POS)• Accept evidence of hospice termination, PA form, or other documentation from prescriber, hospice or pharmacy to override PA requirement at POS• Process hospice/Part D complaints on claim denials for the four drug categories as the first step of the appeal process (coverage determination)<ul style="list-style-type: none">○ Standard appeal = 72 hours○ Expedited = 24 hours
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References

Center for Medicare & Medicaid Services, *Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice*

Centers for Medicare & Medicaid Services, *Medicare Hospice Benefits*