

**Teleconference July 10, 2003**

**Handout #1**

## APPENDIX 1

### MEDICARE COVERAGE, 2003

BENEFIT	MEDICARE PAYS FOR:	PATIENT IS LIABLE FOR:
<b><u>PART A</u></b>  Hospital Care	<u>Benefit Period:</u> <ul style="list-style-type: none"> <li>• First 60 days, except for deductible of \$840</li> <li>• Days 61-90, except for daily copayment of \$210</li> <li>• Days 91-150, except for daily copayment of \$420</li> </ul>	Deductible of \$840  Copayment of \$210  Copayment of \$420  Cost of hospital days in excess of 150 days
Skilled Care in a Nursing Facility	<ul style="list-style-type: none"> <li>• First 20 days of skilled care after 3-day hospital stay</li> <li>• Days 21-100 of skilled care, except for daily copayment of \$105</li> </ul>	Nothing  Copayment of \$105  All skilled care after 100 days  All custodial care
Home Care	First 100 home health visits following a hospital stay of at least 3 days or a skilled nursing facility stay and initiated within 14 days of discharge	Nothing
Blood	All blood after the first three pints	first three pints of blood

<b><u>PART B:</u></b>  Physician Services, Durable Medical Equipment and Diagnostic Tests	80% of the "approved charge" after annual deductible of \$100 (50% for mental health services)	Annual deductible of \$100 20% of "approved charge" (50% for mental health services)  Cost of Part B services in excess of "approved charge" (unless physician accepts assignment) up to the limiting charge
Home Care	Home health visits not following a hospital or skilled nursing facility (SNF) stay or visits exceeding 100 and following a hospital or SNF stay	Nothing
Clinical Diagnostic Laboratory Tests	100% of the "approved charge"	Monthly Part B premium of \$58.70

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**Handout #2**

## APPENDIX 6

### MEDICARE PART B CARRIERS

INSURANCE COMPANY	TYPE OF CLAIMS PROCESSED	COUNTIES SERVED
<b>Empire Medicare Services</b> P.O. Box 2280 Peekskill, NY 10566 800-442-8430 www.empiremedicare.com	Medical services, including doctors and diagnostic tests outside of hospital	New York City (except Queens), counties of Columbia, Delaware, Dutchess, Greene, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster and Westchester
<b>Group Health, Inc. (GHI)</b> P.O. Box 1608 Ansonia Station New York, NY 10023 800-632-5572 www.ghimedicare.com	Medical services	Queens
<b>Upstate Medicare Division</b> 33 Lewis Road P.O. Box 5200 Binghamton, NY 13902 800-252-6550 www.umd.nycpic.com	Medical Services	Rest of New York State not serviced by Empire and GHI
<b>HealthNow NY, Inc.</b> DMERC Division P.O. Box 6800 Wilkes-Barre, PA 18773 800-842-2052 www.umd.nycpic.com	Durable medical equipment (i.e. wheelchair, hospital bed) and related services	Entire New York State

### MEDICARE PART A INTERMEDIARIES

INSURANCE COMPANY	TYPE OF CLAIMS PROCESSED	AREA SERVED
<b>Empire Medicare Services</b> P.O. Box 4846 Syracuse, NY 13221 800-442-8430 www.empiremedicare.com	Most hospital inpatient and outpatient services and all skilled nursing facility (SNF) claims	Most of New York State
<b>United Government Services</b> P.O. Box 2019 Milwaukee, WI 53201 800-531-9695 www.ugsmedicare.com	home health and hospice claims	Entire New York State

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**Handout #3**

# THE BROOKDALE SENIOR RIGHTS REPORT

SAMUEL SADIN INSTITUTE ON LAW / BROOKDALE CENTER ON AGING OF HUNTER COLLEGE / CITY UNIVERSITY OF NEW YORK / JULY – AUG 2002

## ADVANCE DIRECTIVES AND GUARDIANSHIP

by Debra Sacks, L.P.N., J.D.

Consistent with New York State's policy of encouraging the creation and use of advance directives (durable powers of attorney, health care proxies and living wills), the New York State adult guardianship law, located in Article 81 of the Mental Hygiene Law, specifically prohibits guardians from revoking them. A court may modify or revoke these documents, but only if they were signed while the alleged incapacitated person lacked capacity.

Court evaluators, appointed during guardianship proceedings to assist the court, are required to include in their reports whether such advance directives exist. To prevent duplication of powers, guardianship courts must consider advance directives before appointing a guardian.

Often a court appoints a personal needs guardian because no advance directives exist, and the incapacitated person can no longer legally sign such documents. As seen in the two cases described below, the boundaries between the guardian and the surrogate decision-maker, where advance directives exist prior to the appointment of a guardian, can be

## MEDICARE HOMEBOUND CRITERIA CLARIFIED

by Andrew Koski, M.S.W.

In July 2002, the Centers for Medicare and Medicaid Services (CMS) issued new instructions to clarify Medicare's "homebound criteria," one of the factors used to determine a beneficiary's eligibility for home health services. The instructions, available at [www.hcfa.gov/pubforms/transmit/R302HHA.pdf](http://www.hcfa.gov/pubforms/transmit/R302HHA.pdf), direct certified home health agencies and the private insurance companies that administer the Medicare home health benefit to be

more flexible in determining if a patient is homebound.

Currently, in order to receive Medicare-covered home health services, beneficiaries must be confined to their homes. This homebound requirement does not mean that the beneficiaries are bedridden, but that leaving the home

requires a "considerable and taxing effort." They can still be considered homebound if they leave their home for absences which are "infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment." Attendance at adult day programs for the purpose of "participating in

therapeutic, psychosocial, or medical treatment" will not adversely affect the beneficiary's homebound status.

In addition, current instructions state that occasional absences from the home for non-medical purposes, such as an occasional trip to the barber, attending a religious service, a walk around the block or a drive, are considered infrequent

*(Continued on page 14)*

**Newsflash!**

**See page 12 for the  
new hardship  
exemptions to  
Medicaid estate  
recovery**

(Continued from page 1, column 3)

or of relatively short duration and should not disqualify beneficiaries from receiving Medicare-covered home health services.

CMS has now added attendance at a family reunion, funeral or graduation as additional examples of infrequent absences that would not adversely affect the beneficiary's homebound status. Furthermore, CMS notes that these events are "not all-inclusive and are meant to be illustrative of the kinds of infrequent or unique events a patient may attend." In a press release announcing this change (available at: [www.hhs.gov/news/press/2002pres/20020726d.html](http://www.hhs.gov/news/press/2002pres/20020726d.html)), CMS stated that in some instances, home health agencies and the insurance companies that administer home care benefits had terminated home health benefits after a beneficiary attended a special event, even though the beneficiary otherwise continued to qualify as homebound.

Generally, beneficiaries will be considered homebound if they have a condition due to an illness or injury that restricts their ability to leave their homes except with the aid of supportive devices such as crutches, canes, wheelchairs, the assistance of another person or if leaving the home is medically contraindicated. The current home health agency manual instructions list some examples of conditions that may indicate that beneficiaries

cannot leave their homes.

The new instructions add the late stages of amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) or other neurodegenerative disabilities to the list of examples and clarify that beneficiaries with psychiatric problems who refuse to leave their homes or for whom leaving home unattended would not be safe can be considered homebound *even if they have no physical limitations* (italicized language is new).

Lastly, the new instructions indicate that the determination of beneficiaries' inability to leave their homes should be made by looking at their condition over a period of time rather than for short periods within the home health stay. "For example, a patient may leave the home (under the conditions describe above, e.g[.], with severe and taxing effort, with the assistance of others) more frequently during a short period when, for example, the presence of visiting relatives provides a unique opportunity for such absences, than is normally the case. So long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home."

While the above changes do not alter the existing homebound eligibility criteria, they do make it easier for beneficiaries to leave their homes for reasonable non-medical absences without fear of jeopardizing their home health coverage. ☼

**Teleconference July 10, 2003**

**Handout #4**

## NEW MEDICARE NOTICES ISSUED FOR PHYSICIAN AND LABORATORY SERVICES

By Andrew Koski, M.S.W.

In June 2002, the federal Office of Management and Budget approved two forms that physicians or suppliers must give to Medicare beneficiaries **before** items or services are furnished when the physician or supplier believes that Medicare Part B will **not** pay for some or all of the services. Also, in July 2002, the Centers for Medicare and Medicaid Services issued a Program Memorandum (available at: [http://cms.hhs.gov/manuals/pm\\_trans/AB02114.pdf](http://cms.hhs.gov/manuals/pm_trans/AB02114.pdf)) containing instructions for use of these forms. The two forms (see pages 13 & 14 or download from <http://cms.hhs.gov/medicare/bni>), Advance Beneficiary Notices for General Use (CMS-R-131-G) and for Laboratory Tests (CMS-R-131-L), are to be given to beneficiaries in **advance** of receiving services that the provider believes will **not** be covered by Medicare because the care is not medically necessary, the services exceed certain frequency limits, certain Medicare requirements have not been met by the medical equipment supply company, a hospice patient is not considered terminally ill, or a level of care is considered inappropriate for a hospice patient. While both forms were approved for voluntary use in June 2001, providers were required to use them starting **October 1, 2002**.

Medicare protects beneficiaries from having to pay for some services that are denied because they are considered “not medically reasonable and necessary” or for other reasons stated in the previous paragraph. In such cases, if the

**beneficiary** could not have been expected to know that the services would not be covered, the beneficiary is **not** held liable, and the provider may **not** bill the beneficiary. To protect themselves from liability, providers are required to provide notices (Advance Beneficiary Notices) to Medicare beneficiaries before Medicare services are furnished if they believe that Medicare will not pay for all or part of the services because the services are not medically reasonable and necessary.

The purpose of the Advance

Beneficiary Notices (the Notices) is to advise the beneficiary that Medicare may not pay and that, by signing the Notice, the beneficiary agrees to be “personally and fully responsible for payment” either through other insurance coverage (e.g. an employer plan), Medicaid or private payment. Even if Medicare denies payment for the service, the beneficiary should be encouraged to file an appeal of Medicare’s denial.

If the beneficiary is **not** given a Notice or the Notice does not meet certain delivery and format requirements, the beneficiary is **not** responsible for paying the provider even if Medicare denies payment. Providers are **not** required, however, to give Notices to beneficiaries before providing services **excluded** by Medicare, which include routine physicals, cosmetic surgery, personal comfort items, routine eye and hearing exams and hearing aids (this is only a partial list of excluded services).

In addition, Notices are also **not** required when Medicare is expected to deny payment for an item or service which may be a Medicare benefit but for which coverage requirements are not met, such as when a service is covered only in a specific setting and the service in question was not provided in such a setting. Lastly, in some cases where beneficiaries were not given Notices, they may still be liable for payment if there is evidence that they knew payment would be denied. Such evidence could include previous receipt of a denial notice for a comparable service.

### Notice Requirements

Both Notices must explain in sufficient detail which items or services the provider believes Medicare will **not** cover so the beneficiary can understand which services are in question. The beneficiary can request that the provider estimate the cost of such services. The Notice for non-laboratory tests must explain in lay language why the provider believes Medicare will deny payment so the beneficiary can decide whether or not to receive the service and pay for it personally. “Simply stating ‘medically unnecessary’ or the equivalent is not an acceptable reason, insofar as it does not at all explain why the physician or supplier believes the items or services will be denied as not reasonable and necessary.” The provider can, however, use the following list of reasons found on the Laboratory Test Notice indicating why Medicare will not pay: (i) the items or services are not covered by Medicare for the beneficiary’s condition; (ii) the services exceed how often Medicare pays for such services; or (iii) the services are considered experimental or for “research use.”

(Continued on page 12)



(Continued from page 11)

Beneficiaries who receive either of the two Notices must select one of two options: (i) receive the services, ask that a claim be sent to Medicare and agree to be responsible for payment if Medicare denies payment; or (ii) not receive the services. Even in cases where the beneficiary requests that the provider sends a claim to Medicare, the provider may bill the beneficiary for services that the provider believes will not be covered **prior** to a decision by Medicare. Should Medicare or other insurance pay for the services, the provider must refund any payments made by the beneficiary.

#### Notice Delivery

The Notice must be hand-delivered to the beneficiary or an authorized representative, and the beneficiary or representative must be able to comprehend the Notice. The beneficiary must be notified “far enough in advance of receiving a medical service so that the patient can make a rational, informed consumer decision without undue pressure.” Generally, delivery should occur before a procedure is initiated and before physical preparation of the patient. Giving a Notice to a beneficiary

**“Notices should not be given to beneficiaries in a medical emergency . . . .”**

after that person has been connected to a test machine would be considered “last moment delivery” and not meet this requirement.

Notices should **not** be given to beneficiaries in a medical emergency (such as being transported by ambulance for an emergency) or under “great duress” because beneficiaries cannot be expected to make a “reasoned informed consumer decision.” Notices given to beneficiaries who are under great duress would be considered defective, and the beneficiary will be found not to have known that Medicare would not pay.

The Notice must be signed by the beneficiary or representative and

a copy given to the beneficiary or representative. Non-receipt of the Notice, an incomprehensible Notice or a Notice which the beneficiary or representative is incapable of understanding is not sufficient and probably will protect the beneficiary from having to pay for the service. In such cases, the provider may be held liable.

When a Notice meeting the above requirements is given to a beneficiary who agrees to pay if Medicare denies payment, and Medicare, in fact, does deny payment, the provider may bill and collect from that beneficiary.

Medicare does **not** limit the amount that may be charged for such a service. In these cases, however, the beneficiary can appeal Medicare’s denial. ☼

## BURIAL GUIDE AVAILABLE

*By Andrew Koski, M.S.W.*

Volunteers of Legal Service, Inc. (VOLS) has recently published “A Guide to Burial Assistance for New Yorkers in Need.” The Guide provides burial assistance information for friends and families of poor persons who have died and for professionals who work with poor elderly individuals. Some of the sources of assistance include government agencies, religious organizations and non-profit groups. The Guide is available at: [www.probono.net/areas/libraryfiles/Burial.pdf](http://www.probono.net/areas/libraryfiles/Burial.pdf) or can be obtained by sending a stamped (\$1.52), self-addressed 9 x 12 envelope to Volunteers of Legal Service, 54 Greene Street, New York, NY 10013.

VOLS works to increase the availability of pro bono civil legal services to New York City’s poor by identifying areas of legal need, developing programs to meet these needs and recruiting volunteer lawyers and law firms to provide the necessary legal services. ☼

**Teleconference July 10, 2003**

**Handout #5**

Patient's Name:

Medicare # (HICN):

## ADVANCE BENEFICIARY NOTICE (ABN)

**NOTE:** You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for —**

**Items or Services:**

**Because:**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$ \_\_\_\_\_**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN AND DATE** YOUR CHOICE.

**Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

**Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

\_\_\_\_\_ **Date**

\_\_\_\_\_ **Signature of patient or person acting on patient's behalf**

**NOTE: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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**Handout #6**

Patient's Name:

Medicare # (HICN):

## ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these laboratory tests.

We expect that Medicare will not pay for the laboratory test(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for the laboratory test(s) indicated below for the following reasons:**

Medicare does not pay for these tests for your condition	Medicare does not pay for these tests as often as this (denied as too frequent)	Medicare does not pay for experimental or research use tests

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these laboratory tests will cost you (**Estimated Cost: \$ \_\_\_\_\_**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN AND DATE** YOUR CHOICE.

**Option 1. YES. I want to receive these laboratory tests.**

I understand that Medicare will not decide whether to pay unless I receive these laboratory tests. Please submit my claim to Medicare. I understand that you may bill me for laboratory tests and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

**Option 2. NO. I have decided not to receive these laboratory tests.**

I will not receive these laboratory tests. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I will notify my doctor who ordered these laboratory tests that I did not receive them.

\_\_\_\_\_ **Date**

\_\_\_\_\_ **Signature of patient or person acting on patient's behalf**

**NOTE: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

**Teleconference July 10, 2003**

**Handout #7**

## LIMIT SET FOR OUTPATIENT REHABILITATION SERVICES

by Andrew Koski, M.S.W.

Starting **July 1, 2003**, there will be a limit of **\$1,590** on Medicare-covered outpatient physical therapy and speech-language pathology services combined and a separate \$1,590 limit on outpatient occupational therapy services. These annual limits do **not** apply to services furnished directly or under arrangement by a hospital to an outpatient Medicare beneficiary or to a hospitalized beneficiary for which Medicare Part A is not paying for the hospital stay. The limits also do **not** apply to Medicare beneficiaries who qualify for therapy services under the Medicare home care benefit.

*“Providers are expected to notify beneficiaries of the therapy financial limitations...”*

The limits were established by federal legislation in 1997, became effective in 1999 but were postponed for 2000 through 2002 by other legislation. The Centers for Medicare and Medicaid Services issued a program memorandum ([http://cms.hhs.gov/manuals/pm\\_trans/AB03018.pdf](http://cms.hhs.gov/manuals/pm_trans/AB03018.pdf)) in February 2003 to implement the therapy limitation.

### Skilled Nursing Facility Residents

The \$1,590 limitation applies to outpatient rehabilitation services furnished to skilled nursing facility (SNF) residents for whom Medicare Part A is **not** paying and applies to SNF outpatient

beneficiaries receiving these services at the SNF, regardless of whether the services are furnished by the SNF directly or under arrangement with an outside therapist. The limitation does **not** apply to SNF residents covered by Medicare Part A because rehabilitation services are included in the Part A payment that the SNF receives from Medicare. For SNF residents who have exhausted their Part A benefits (and are eligible for Medicare Part B), the limit does apply. The SNF must bill Medicare Part B for such services, and once these residents have reached the \$1,590 limitation (and still remain in the SNF), Medicare will not make additional payments.

The \$1,590 limitation is based on the Medicare physician fee schedule (MPFS) amount **prior** to the Medicare Part B deductible and the 20% coinsurance which beneficiaries face.

### EXAMPLE 1: Medicare Part B Deductible Not Met

Mrs. Smith receives outpatient occupational therapy from a non-hospital provider. The MPFS allowed amount is \$1,590; Medicare pays 80% of \$1,490 (\$1,590 - \$100 deductible) = \$1,192. She is responsible for the remaining \$398 (\$100 Medicare

deductible + \$298 coinsurance.) Medicare will not pay for any additional outpatient occupational therapy services for the rest of the year.

### EXAMPLE 2: Medicare Part B Deductible Previously Met

Mrs. Smith receives outpatient occupational therapy from a non-hospital provider. The MPFS allowed amount is \$1,590 and Medicare pays \$1,272 (80%). Mrs. Smith is responsible for \$318 (20%). Medicare will not pay for any additional services for the rest of the year.

### EXAMPLE 3: Medicare Part B Deductible Previously Met

Mrs. Smith receives outpatient physical therapy services from a non-hospital provider. The MPFS is \$800 and Medicare pays \$640 (80%). Mrs. Smith is responsible for \$160 (20%). The amount applied to the \$1,590 limitation in this example is \$800.

Providers are expected to notify beneficiaries of the therapy financial limitations and that the limits apply in all settings except hospital outpatient departments. Providers are also supposed to use the Notice of Exclusions from Medicare Benefits (NEMB) form (see page 14) to inform beneficiaries of the therapy financial limitation at their first therapy visit with the beneficiary. When using the NEMB form, the provider checks box #1 and writes above this section that Medicare will not pay for physical therapy and speech-language pathology services or occupational therapy services over \$1,590. ☼

**Teleconference July 10, 2003**

**Handout #8**

## NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

**Before you make a decision, you should read this entire notice carefully.**

Ask us to explain, if you don't understand why Medicare won't pay.

Ask us how much these items or services will cost you (**Estimated Cost: \$\_\_\_\_\_**).

**Medicare will not pay for:** \_\_\_\_\_  
\_\_\_\_\_;

**1. Because it does not meet the definition of any Medicare benefit.**

**2. Because of the following exclusion \* from Medicare benefits:**

- |  |   |
|--|---|
| " Personal comfort items.  | " Routine physicals and most tests for screening. |
| " Most shots (vaccinations).   | " Routine eye care, eyeglasses and examinations.  |
| " Hearing aids and hearing examinations.   | " Cosmetic surgery.                               |
| " Most outpatient prescription drugs.  | " Dental care and dentures (in most cases).       |
| " Orthopedic shoes and foot supports (orthotics).  | " Routine foot care and flat foot care.           |
| " Health care received outside of the USA.   | " Services by immediate relatives.                |
| " Services required as a result of war.  | " Services under a physician's private contract.  |
| " Services paid for by a governmental entity that is not Medicare.   |   |
| " Services for which the patient has no legal obligation to pay.   |   |
| " Home health services furnished under a plan of care, if the agency does not submit the claim.  |   |
| " Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.  |   |
| " Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).                  |   |
| " Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.            |   |
| " Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF. |   |
| " Services of an assistant at surgery without prior approval from the peer review organization.  |   |
| " Outpatient occupational and physical therapy services furnished incident to a physician's services.  |   |

**\* This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

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**Handout #9**

## **MEDICARE OUTPATIENT MENTAL HEALTH BENEFITS EXPLAINED**

*by Vicki Gottlich, J.D., L.L.M. & Andrew Koski, M.S.W.*

While Medicare spent almost \$800 million for outpatient mental health services in 1998, many professionals working with Medicare beneficiaries are not aware of the requirements for, or the types of, Medicare-covered outpatient mental health services.

Medicare covers needed diagnostic and treatment services provided by physicians, including psychiatrists, as well as clinical psychologists, clinical social workers, psychiatric nurse practitioners, clinical nurse specialists and physician assistants. The services can be provided at hospital outpatient departments, skilled nursing facilities, private offices, community mental health centers, comprehensive outpatient rehabilitation facilities and rural health clinics. In addition, some services can be covered at home. Similar to other Medicare Part B services, mental health services must be “reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.”

### **Covered Services**

Some of the services Medicare will cover include: psychiatric diagnostic interviews to assess a patient’s history, mental status and disposition in relation to a specific problem; psychological and neuropsychological testing; psychotherapy services, including individual, group and family therapy; therapeutic activity programs; pharmacotherapy for management of prescription drugs, observation of side effects and regulation of dosage; and other psychiatric and psychological services, including electroconvulsive therapy and the intravenous administration of sedatives or tranquilizers.

Medicare's coverage of psychotherapy procedures does **not** include teaching grooming skills, monitoring activities of daily living, recreational therapy or social interaction.

### **Expectation of Improvement**

The Centers for Medicare and Medicaid Services (CMS), in a March 2003 Program Memorandum ([www.cms.hhs.gov/manuals/pm\\_trans/AB03037.pdf](http://www.cms.hhs.gov/manuals/pm_trans/AB03037.pdf)) has indicated that services must be for diagnosis or be "reasonably expected to improve the patient's condition." CMS further states,

"The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain level of functioning. The goal of a course of therapy is not necessarily restoration of the patient to the level of functioning exhibited prior to the onset of illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. 'Improvement' . . . is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that a patient's condition would deteriorate, relapse further, or require hospitalization if treatment services are withdrawn, this criterion would be met."

The Medicare laws and regulations do **not** place limits, such as the need to show improvement, on mental health covered services as long as they are medically necessary. Nevertheless, many of the Medicare Part B carriers that administer the benefit have established local medical review policies that limit the number of services Medicare will cover for mental health needs. Although the new Program Memorandum defines "improvement" to include prevention of deterioration or relapses, the improvement standard may create additional barriers to care for some Medicare beneficiaries. Social workers are encouraged to assist their clients to appeal any denials of coverage based on such policies.

## Medicare Payment

Reimbursement for certain outpatient psychiatric services differs from most Medicare-covered services under which Medicare pays 80% of an “approved amount” and the beneficiary is responsible for the remaining 20%. For most psychiatric services, Medicare approves a certain amount and pays only 50% of that amount, leaving the beneficiary responsible for the other **50%**. (In actuality, Medicare approves a certain amount, subtracts 37½ % from that amount, and then pays 80% of the remaining amount, resulting in a payment of 50%.)

### Example

Mrs. Smith receives outpatient mental health services from a clinical psychologist. She has already met her \$100 Medicare Part B deductible. Medicare approves \$200 but, due to the outpatient limitation, reduces the \$200 by 37½ % (\$75). Medicare pays 80% of \$125 ( $\$200 - \$75$ ) = \$100. Mrs. Smith is responsible for the remaining 50% coinsurance of \$100.

This payment “limitation” applies to therapeutic services and testing services performed to evaluate the progress of a course of treatment for a diagnosed condition. The limitation does **not** apply to tests and evaluations performed to establish and confirm the patient’s diagnosis, including psychiatric or psychological tests and interpretations, diagnostic consultations and initial evaluations. The payment limitation also does **not** apply to brief office visits to monitor or change prescription drugs used in the treatment of mental, psychoneurotic and personality disorders. Lastly, for patients with Alzheimer’s Disease or senile dementia, the outpatient limitation applies only if the treatment is primarily psychotherapy; if the treatment is a non-psychotherapy service, such as medical

management or “evaluation and management” of the disease, the payment limitation does **not** apply.

Clinical psychologists, clinical social workers, psychiatric nurse practitioners, clinical nurse specialists and physician assistants must accept assignment for all their Medicare patients. Once Medicare pays 50% of the approved amount, they can only bill their Medicare patients for the remaining 50% coinsurance. Medicare supplement or Medigap policies are required to pay this 50% coinsurance and some employer retiree plans also may pay this expense.

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The Center for Medicare Advocacy, Inc., founded in 1986, is a private, non-profit organization that provides education, advocacy, and legal assistance to help elders and people with disabilities obtain necessary healthcare. The Center’s website is:

[www.medicareadvocacy.org](http://www.medicareadvocacy.org).

Medicare outpatient mental health, 6/4/03

**Teleconference July 10, 2003**

**Handout #10**

## NEW RULES ISSUED FOR MEDICARE COVERAGE OF AMBULANCE SERVICES

by Andrew Koski, M.S.W.

In late February 2002, the Centers for Medicare and Medicaid Services (CMS) issued a final rule with comment period which establishes a “fee [payment] schedule” for ambulance services, mandates that ambulance suppliers accept Medicare “assignment” and revises the certification requirements for coverage of nonemergency ambulance services.

### FEE SCHEDULE AND MANDATORY ASSIGNMENT

For dates of service on or after April 1, 2002, ambulance services will be paid a pre-established fee for each different service provided (a fee schedule) and ambulance suppliers will be required to accept assignment; that is, to accept the Medicare approved fee as their full payment. This means beneficiaries will only have to pay 20% of the Medicare approved amount after they have met their annual \$100 Medicare Part B deductible (unless they have other insurance that reimburses for the 20% coinsurance).

### COVERAGE RULES

Medicare pays for ambulance services when three requirements are met: “medical necessity,” “destination” rules and provision by an approved ambulance supplier. Generally, Medicare covers ambulance services only if they are furnished to a beneficiary “whose medical condition is such that other means of transportation would be contraindicated.” Some examples of conditions for which ambulance transportation is considered medically necessary include: an emergency situation (that is, an accident, injury or acute illness); unconsciousness; severe hemorrhage; or shock.

Medicare categorizes ambulance services as “emergency” or “nonemergency”. An emergency service is defined as “one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (i) placing the beneficiary’s health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.”



### NONEMERGENCY SERVICES

Nonemergency services refer to all ambulance trips that do not meet the emergency criteria. Under the new rule, nonemergency transportation will be covered if **either**: the beneficiary is “bed-confined” and it is documented that other means of transportation are contraindicated; **or** the beneficiary’s medical condition, regardless of bed confinement, requires ambulance transportation. (This change was made to clarify that bed confinement is not the sole criterion in determining medical necessity.) For a beneficiary to be considered bed-confined, **all** of the following must be met: (i) the beneficiary is unable to get up from bed without assistance; (ii) the beneficiary is unable to ambulate; **and** (iii) the beneficiary is unable to sit in a chair or wheelchair.

### PHYSICIAN CERTIFICATION RULES

In addition to the above criteria, additional rules apply to nonemergency services. For **scheduled**,

**repetitive** services, Medicare will only cover nonemergency services if the ambulance supplier, **before** furnishing the service, obtains a written order or certification from the beneficiary’s attending physician certifying that the trip is medically necessary. The physician’s certification must be dated no earlier than **60 days** prior to the date of the ambulance trip.

Under the new rule, **scheduled, nonrepetitive** ambulance services no longer require advance physician certification. Now, for **unscheduled** services or services that are scheduled on a nonrepetitive basis, Medicare only pays for nonemergency ambulance trips under the following circumstances:

- ▶ for residents of a facility who are under the care of a physician if the ambulance supplier obtains a written order from the beneficiary’s attending physician, within **48 hours after** the trip, certifying that the trip was medically necessary; or
- ▶ for a beneficiary residing at home or in a facility who is not under the care of a physician (without a requirement for physician certification of medical necessity).

If the ambulance supplier is unable to obtain the required certification from the beneficiary’s attending physician, a signed certification from certain staff who are employees of the attending physician will suffice. Previously, CMS required this person to be an employee of the facility in which the beneficiary was receiving treatment. In situations where the ambulance supplier is unable to obtain the required certification within **21 calendar days** following the date of

(Continued on page 10)

(Continued from page 7)

service, the supplier must document its attempts to obtain the certification and may then submit the claim.

**LEVELS OF SERVICE**

Medicare covers the following levels of ambulance service:

► Basic life support (BLS): transportation by ground ambulance vehicle, medically necessary supplies and services and provision of BLS ambulance services.

► Advanced Life Support, level 1 (ALS1): transportation by ground ambulance vehicle, medically necessary supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.

► Advanced Life Support, level 2 (ALS2): either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications intravenously or by continuous infusion; or transportation, medically necessary services

and supplies and the provision of at least one of the following ALS procedures: manual defibrillation/ cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway or intraosseous line.

► Paramedic ALS Intercept (PI): Emergency Medical Technician-Paramedic services furnished by an entity that does not furnish the ground ambulance transport.

► Specialty Care Transport (SCT): inter-facility transportation of a

(Continued on page 15)

**MEDICARE SUPPLEMENT (MEDIGAP) INSURANCE  
MONTHLY PREMIUMS FOR NEW YORK CITY – APRIL 2002**

INSURANCE COMPANY	BENEFIT PLAN									
	A	B	C	D	E	F	G	H	I	J
American Family Life Assurance Co. of New York (800) 366-3436	\$127.70	\$187.55	\$220.60	\$211.40	\$218.10	\$259.00	\$242.35			
American Progressive Life & Health Insurance Co. of New York (800) 332-3377	\$107.85	\$156.43	\$191.60	\$181.33		\$208.49	\$188.56			
Empire Blue Cross/Blue Shield (800) 261-5962	\$115.56	\$139.12						\$302.64		
First United American Life Insurance Company (315) 451-2544	\$96.00	\$148.00	\$176.00			\$181.00				
Group Health Incorporated (GHI) (800) 444-2333	\$98.47	\$114.25	\$135.21						\$231.86	
Mutual of Omaha Insurance Company (800) 775-6000	\$128.90	\$186.33				\$226.67				
State Farm Mutual Auto Insurance Company (800) 688-0895	\$92.19	\$123.51	\$137.11			\$157.52				
United HealthCare Insurance Company of New York (American Association of Retired Persons – AARP) (800) 523-5800	\$96.75	\$142.75	\$160.75	\$150.75	\$143.00	\$161.50	\$152.25	\$255.50	\$259.00	
Univera HealthCare – CNY (800) 659-1986	\$137.80	\$172.78								

**NOTE:** Some Medigap companies do not offer a monthly premium plan but require quarterly premiums. Also, premiums can change frequently; check the New York State Insurance Department's Website ([www.ins.state.ny.us/caremain.htm](http://www.ins.state.ny.us/caremain.htm)) for current premium amounts and premiums for policies offered in other parts of New York State. See pages 8 and 9 for a description of Medigap plan benefits.

*(Continued from page 10)*

critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level beyond the scope of the Emergency Medical Technician-Paramedic.

▶ Fixed Wing (FW) air transport: transportation by an aircraft that is certified as a fixed wing air ambulance and such services and supplies as may be medically necessary.

▶ Rotary Wing (RW) air transport: transportation by a helicopter that is certified as an ambulance and such services and supplies as may be medically necessary.

**DESTINATION REQUIREMENTS**

Ambulance transport is allowed to the nearest facility unless necessary services are not available locally. In cases where services are not available locally, transportation to the nearest facility furnishing those services is covered. Medicare pays for transportation:

▶ from any point to the nearest hospital, critical care access hospital (CAH) or skilled nursing facility (SNF) that is capable of furnishing the required level of care;

▶ from a hospital, CAH or SNF to the beneficiary’s home;

▶ from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and back to the SNF;

▶ from the home of a patient receiving renal dialysis to the nearest facility that furnishes renal dialysis, including the return trip;

▶ from a hospital or SNF to a physician’s office to obtain medically

necessary diagnostic or therapeutic services **not** available at the institution where the beneficiary is an inpatient (and which are less costly than bringing to the patient); or

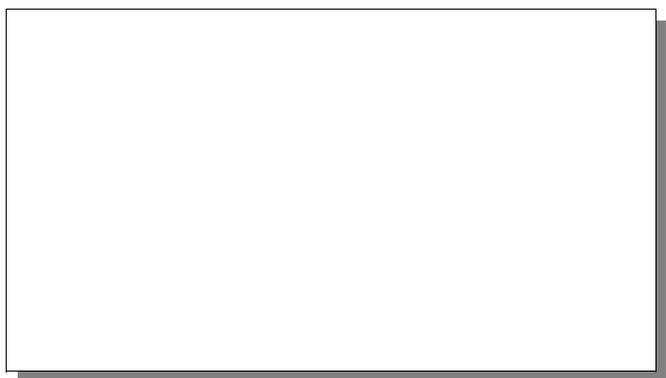
▶ to a physician’s office on the way to a hospital made because of the beneficiary’s dire need for professional attention, and immediately thereafter, the ambulance continues to the hospital.

Questions about specific claims for Medicare coverage of ambulance services should be directed to the Medicare carrier (insurance company) which covers a beneficiary’s county. In New York State, the Medicare carriers are:

▶ **Empire Medicare Services**, 800-442-8430, for New York City (except Queens) and counties of Columbia, Delaware, Dutchess, Greene, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster and Westchester;

▶ **Group Health Incorporated**, 800-632-5572, for Queens; and

▶ **Upstate Medicare Division**, 800-252-6550, for the rest of New York State. ☼



**Teleconference July 10, 2003**

**Handout #11**

# THE BROOKDALE SENIOR RIGHTS REPORT

SAMUEL SADIN INSTITUTE ON LAW / BROOKDALE CENTER ON AGING OF HUNTER COLLEGE / CITY UNIVERSITY OF NEW YORK / SEPT – OCT 2002

## MEDICAID MANDATES GENERIC DRUGS

By Sara Meyers, J.D.

As a result of State legislation passed in January 2002, the Medicaid Mandatory Generic Drug Program will go into effect on **November 17, 2002**. Under the new law, Medicaid will **prohibit** the use of brand name drugs when Federal Drug Administration-approved generic products are available (see: [www.health.state.ny.us/nysdoh/medicaid/ptcommittee/mandatorygen.htm](http://www.health.state.ny.us/nysdoh/medicaid/ptcommittee/mandatorygen.htm)). When a Medicaid recipient fills a prescription and a generic drug equivalent exists, the prescription will be filled with the generic, not the brand name drug. The State believes that the new law will play a significant role in containing drug costs.

### Prior Approval for Use of Brand Name Drugs

The Mandatory Generic Drug Program does allow for the use of brand name drugs when **prior authorization** is obtained from the State Commissioner of Health. Prior authorization to use brand name drugs is required unless the drug has been exempted from the program (see below). To obtain

*(Continued on page 10)*

## MEDICARE PART A & B APPEALS CHANGED

By Andrew Koski, M.S.W.

Effective **October 1, 2002**, the deadline for requesting a Medicare **Part A** reconsideration was **increased** from 60 days to **120 days** for both beneficiaries and providers. Also, starting **October 1, 2002**, **providers** will only have **120 days** to appeal **Medicare Part B** determinations. In addition, starting **January 1, 2003**, the time deadline for **beneficiaries** to request a Medicare **Part B** appeal will be **reduced** from 180 days to **120 days** (see charts on pages 8 and 9 for description of Medicare Part A and Part B appeals processes). Both beneficiaries and providers can request an extension of up to 60 days in the filing deadline

for Medicare Part B appeals if they need additional time to gather the necessary documentation.

These changes are the result of federal legislation, the “Benefit Improvement and Protection Act of 2000 (BIPA),” passed in December 2000. While BIPA mandated that both changes be effective October 1, 2002, the Centers for Medicare and Medicaid Services (CMS) has delayed the implementation date for beneficiaries who are appealing Medicare Part B determinations

until January 1, 2003 to give the Medicare carriers that administer Medicare Part B claims time to change the appeal information on their Medicare Summary Notices (MSNs). MSNs are statements sent to beneficiaries listing all Medicare services they received in a month, including the provider’s name, provider’s charge, Medicare’s approved amount, Medicare’s

*(Continued on page 7)*

*Newsflash!*

**See pages 8 and 9  
for new Medicare  
Part A & B  
appeals charts.**

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## RESOURCE LIMITS ELIMINATED FOR MEDICARE SAVINGS PROGRAMS

*By Andrew Koski, M.S.W.*

On September 2, 2002, the State Department of Health (SDOH) issued instructions (GIS 02 MA/025) informing local departments of social services (LDSS) that individuals who are income-eligible, but **not** resource-eligible, for the **Qualified Medicare Beneficiary (QMB)** program can have their Medicare Part B premiums paid through the **Qualifying Individual-1 (QI-1)** program. Previously, SDOH had instructed LDSS offices that individuals who are income-eligible, but not resource-eligible, for the **Specified Low Income Medicare Beneficiary (SLIMB)** program could have their Medicare Part B premiums paid through the QI-1 program (see the March-April 2002 issue of *The Brookdale Senior Rights Report*). These changes follow enactment of New York State legislation that eliminated the resource limit for the Qualifying Individuals programs (starting April 2002).

In addition to paying the Medicare Part B premium (\$54 per month), the QMB program also pays Medicare deductibles, coinsurance for doctors and copayments for hospitals and skilled nursing facilities, but only if they are Medicaid providers. Those individuals who qualify for QMB

based upon their income (\$759 for individuals; \$1,015 for couples), but who have excess resources will be eligible for payment of their Part B premiums **only** (under the QI-1 program). In order to qualify for payment of their Part B premium, they will have to complete the application for Medicaid benefits (LDSS-2921).

The SLIMB program pays the Medicare Part B premium **only** for individuals with income from \$760 to \$906 (\$1,016 to \$1,214 for couples) and requires individuals to complete a simple one-page application (LDSS-4592). This application is available at: [www.health.state.ny.us/nysdoh/mancare/omm/savingsprogram/mspapp.pdf](http://www.health.state.ny.us/nysdoh/mancare/omm/savingsprogram/mspapp.pdf).

SDOH staff have indicated that individuals who are income-eligible (\$654 for individuals; \$945 for couples), but not resource-eligible, for **Medicaid** can also have their Medicare Part B premiums paid through the QI-1 program. This information was **not** mentioned in SDOH's instructions and may require additional instructions before implementation by local departments of social services.

The resource limits for Medicaid are \$3,800 for individuals (\$5,550 for couples) and the resource limits for QMB and SLIMB are \$4,000 for individuals (\$6,000 for couples). In

addition, for all programs, individuals are allowed to set aside \$1,500 for burial expenses (\$3,000 for couples) or **any** amount in an irrevocable pre-need funeral agreement. ☀

*(Continued from page 1)*

payment and information about filing an appeal.

In addition, starting **October 1, 2002**, the "amount in controversy" required to request a Medicare **Part B** administrative law judge (ALJ) hearing was **reduced** from \$500 to **\$100**. The amount in controversy is determined by: (i) computing the difference between the provider's charge and Medicare's approved amount; (ii) subtracting any unmet deductible from the difference; and (iii) multiplying the remainder by 80% except for any services that are reimbursed at 100% of the allowed amount (such as laboratory tests, immunizations, etc.). For example, Mrs. Green had anesthesia services during an operation. Her provider charged \$1000 and Medicare approved \$400. Medicare paid 80% of \$400 or \$320 (she had previously met her \$100 annual Part B deductible).

*(Continued on page 8)*

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\* \* \* \* \*

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Thus, the amount in controversy is  $\$1000 - \$400 = \$600 \times 80\% = \$480$ . Medicare also allows beneficiaries to combine more than one claim from the same or different providers to meet the \$100 minimum amount required for an ALJ hearing.

As in the past for Medicare **Part B** services, beneficiaries must first have a hearing held by a

hearing officer appointed by the Medicare Part B carrier before they can have a hearing held by an ALJ appointed by the Social Security Administration.

BIPA also reduced the amount of time carriers and fiscal intermediaries have to make appeal determinations, imposed time limits on decisions made by ALJs and the Departmental Appeals Board, replaced the carrier hearing with a

reconsideration held by a new appeals entity, the Qualified Independent Contractor, and allowed for expedited determinations and expedited reconsiderations in some cases.

These changes, however, have not yet been implemented by CMS. Once these changes are effective, they will be outlined in a future issue of *The Brookdale Senior Rights Report*. ☀

## MEDICARE PART A APPEALS PROCESS

PROCEDURE STEPS	FORMS	TIME TO FILE	SCOPE OF REVIEW	CLAIMANT'S RIGHTS
RECONSIDERATION	CMS-2649	<b>120 days</b> after receipt of initial determination.	Review of claim by Fiscal Intermediary. Claimant is not present.	May appoint representative. May provide additional evidence. May file a brief in support of claim. Proceedings and decision become part of case file.
HEARING	CMS-5011A-U6	<b>60 days</b> after receipt of decision of reconsideration. Disputed amount must be \$100 or more.	Hearing before Administrative Law Judge of Social Security Administration. Claimant/Rep. may be present.	May appoint representative. May provide additional evidence. May file a brief in support of claim. May review case file. May present and cross-examine witnesses. May subpoena witnesses. Proceedings and decision become part of case file.
DEPARTMENTAL APPEALS BOARD	HA-520 U5	<b>60 days</b> after receipt of hearing decision.	Review of complete file by Departmental Appeals Board. Board may deny the request for review. Claimant is usually not present.	May appoint representative. May provide additional evidence. May file a brief in support of claim. May review case file. Proceedings and decision become part of case file.
JUDICIAL REVIEW	Not applicable	<b>60 days</b> after receipt of Departmental Appeals decision. Disputed amount must be \$1,000 or more.	Review by federal District Court of all materials in case file. Claimant needs to obtain an attorney.	All rights allowed in federal court.

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## MEDICARE PART B APPEALS PROCESS

PROCEDURE STEPS	FORMS	TIME TO FILE	SCOPE OF REVIEW	CLAIMANT'S RIGHTS
<b>REVIEW</b>	CMS-1964	<b>120 days</b> (starting January 1, 2003) after receipt of Medicare Summary Notice.	Review of claim by Carrier. Claimant is not present.	May appoint representative. May provide additional evidence. May file a brief in support of claim. Proceedings and decision become part of case file.
<b>HEARING BEFORE CARRIER HEARING OFFICER</b>	CMS-1965	<b>180 days</b> after receipt of review decision. Disputed amount must be \$100 or more.	Hearing before Hearing Officer appointed by Carrier: in-person, telephone or on-the-record hearing.* Claimant/Rep. may be present.	May appoint representative. May provide additional evidence. May review case file. May file a brief in support of claim. May present and cross-examine witnesses. Proceedings and decision become part of case file.
<b>HEARING BEFORE ADMINISTRATIVE LAW JUDGE</b>	CMS-5011B-U6	<b>60 days</b> after Carrier hearing decision. Disputed amount must be \$100 or more.	Hearing before Social Security Administrative Law Judge. Claimant/Rep. may be present.	May appoint representative. May provide additional evidence. May file a brief in support of claim. May review case file. May present and cross-examine witnesses. May subpoena witnesses. Proceedings and decision become part of case file.
<b>DEPARTMENTAL APPEALS BOARD</b>	HA-520 U5	<b>60 days</b> after hearing decision. Disputed amount must be \$500 or more.	Review of complete file by Departmental Appeals Board. Board may deny the request for review. Claimant is usually not present.	May appoint representative. May provide additional evidence. May file a brief in support of claim. May review case file. Proceedings and decision become part of case file.
<b>JUDICIAL REVIEW</b>	Not applicable	<b>60 days</b> after Departmental Appeals Board decision. Disputed amount must be \$1,000 or more.	Review of entire record by federal District Court. Claimant needs to obtain an attorney.	All rights allowed in federal court.

\* if an in-person or telephone hearing is requested, the Hearing Officer will first make a decision on the claim record; if claimant disagrees with this decision, a hearing will be held.

**Teleconference July 10, 2003**

**Handout #12**

## MEDICARE SUPPLEMENT INSURANCE BENEFIT PLANS, 2003

The chart below shows the benefits offered under ten Medigap plans -- known as plans 'A' through 'J'. To find out which benefits are contained in each plan: (1) select the desired benefit plan identified by the letters 'A' through 'J'; and (2) follow the appropriate column down to identify benefits (noted with a ✓).

MEDIGAP BENEFITS	BENEFIT PLAN									
	A	B	C	D	E	F	G	H	I	J
BASIC Coverage: 20% copayment for doctor bills, diagnostic tests and durable medical equipment; copayment for hospital days 61-90 (\$210/day); days 91-150 (\$420/day); plus 365 days over a lifetime; first three pints of blood.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospital Deductible (\$840).		✓	✓	✓	✓	✓	✓	✓	✓	✓
Skilled Nursing Facility copayment (\$105/day for days 21-100).			✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Deductible (\$100/year).			✓			✓				✓
Medicare Part B Charges in excess of Medicare's Approved Charge (subject to federal and state limits).						✓ 100%	✓ 80%		✓ 100%	✓ 100%

**CONTINUED ON PAGE 9** →

### MEDICARE SUPPLEMENT INSURANCE BENEFIT PLANS, 2003

*(continued from page 8)*

The chart below shows the benefits offered under ten Medigap plans -- known as plans 'A' through 'J'. To find out which benefits are contained in each plan: (1) select the desired benefit plan identified by the letters 'A' through 'J'; and (2) follow the appropriate column down to identify benefits (noted with a ✓).

MEDIGAP BENEFITS	BENEFIT PLAN									
	A	B	C	D	E	F	G	H	I	J
Treatment outside of United States: 80% of emergency medical costs; \$250 annual deductible and \$50,000 lifetime benefits; care must begin within first 60 days of trip.			✓	✓	✓	✓	✓	✓	✓	✓
Home Care: Assistance with activities of daily living: up to 7 visits/week; maximum payment of \$40/visit and \$1,600 each year; conditioned upon receipt of Medicare home care benefits.				✓			✓		✓	✓
Drugs: Basic -- 50% of drugs subject to \$250/year deductible and \$1,250 annual limit.								✓	✓	
Drugs: Extended -- 50% of drugs subject to \$250/year deductible and \$3,000 annual limit.										✓
Preventive Care: annual physical and preventive tests such as digital rectal exam, hearing and diabetes screenings, serum cholesterol screening, dipstick urinalysis, thyroid function test, tetanus and diptheria booster; limit of \$120/year.					✓					✓

**Teleconference July 10, 2003**

**Handout #13**

## MEDICARE SELECT POLICIES OFFERED

by Andrew Koski, M.S.W.

Since January 2003, Medicare beneficiaries in New York City, Nassau county and parts of Suffolk, Rockland and Westchester counties have been able to purchase Medicare Select policies from Mutual of Omaha Insurance Company to supplement their Medicare coverage. (Some Medicare Select policies were already available from Blue Cross/Blue Shield of Central New York in the Syracuse and Utica areas.)

Medicare Select is similar to Medicare Supplement (Medigap) health insurance in that companies can only offer plans 'A' through 'J' (see pages 8 and 9), but differs in that Medicare Select policies only pay full benefits if the services are furnished by "network providers" (i.e. hospitals) who have signed an agreement with the insurance company to provide benefits for Medicare Select insured individuals. If Medicare Select policyholders use non-network providers (for non-emergency services), Medicare will still pay its share of approved charges, but the Medicare Select company is allowed to provide **no benefits** or reduced benefits. In exchange for using network providers, individuals with Medicare Select policies may face

lower premium costs than those with Medigap insurance (see premium charts on pages 10 and 14 of this issue or visit the State Insurance Department's website at: [www.ins.state.ny.us/caremain.htm](http://www.ins.state.ny.us/caremain.htm)).

There are numerous protections for Medicare beneficiaries who are looking to purchase either a Medicare Select or a Medigap policy.

### OPEN ENROLLMENT

In New York State, insurance companies must accept any Medicare enrollee's application for Medicare Select or Medigap coverage at any time during the year. Insurers may not deny a policy nor vary the premium based on the individual's age, health status, claims experience, medical condition or whether the applicant is receiving health services. This applies to all Medicare beneficiaries who have Medicare Part A and Part B and includes those **under 65** who receive Medicare based upon being disabled. Eligibility for policies offered by a group, such as AARP, however, may be limited to those individuals who are members of the group. Also, premiums may vary based on the geographic region where the policies are offered.

### PREEXISTING CONDITION COVERAGE

Medicare Select and Medigap policies may contain up to a six-month waiting period before preexisting conditions are covered. A preexisting condition is a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the date that Medicare Select or Medigap coverage starts. Companies are required to reduce the waiting period by the number of days that individuals were covered under some form of "creditable" coverage so long as there were no breaks in coverage of more than **sixty-three days**. Creditable coverage includes an employer plan, Medicaid, another Select or Medigap plan, a Medicare+Choice managed care plan and some other plans. Coverage will, therefore, start immediately for preexisting conditions if the individuals had coverage under one of these plans for at least six months and their **immediately** prior health insurance coverage was not interrupted by more than sixty-three days.

### DUPLICATION OF COVERAGE

Individuals who have a Medicare Select or Medigap policy cannot be sold another such policy

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unless they intend to replace their existing policy. Medicare Select and Medigap policies also cannot be sold to individuals enrolled in a Medicare+Choice plan if such policies “would duplicate benefits to which the individual is entitled under a Medicare+Choice plan.” In addition, insurance companies are prohibited from selling Select or Medigap policies to Medicaid recipients unless: (i) Medicaid pays the premiums; (ii) the individuals are enrolled in the Specified Low Income Medicare Beneficiary or Qualifying Individual programs, in which the State pays only their Medicare Part B premium; or (iii) the individuals are enrolled in the Qualified Medicare Beneficiary program, in which the State pays their Part B premium, deductible and coinsurance and Part A coinsurance and copayments **and** they are sold a policy which provides prescription drug coverage.

Medicare Select or Medigap policyholders who become entitled to Medicaid can suspend their Select or Medigap policy for up to two years. During that period, the individual does not pay premiums and the policy will not pay any benefits. If the individual loses entitlement to Medicaid during that two-year period, the individual can start up the suspended policy again without filing a new application and will be covered immediately for coverage of preexisting conditions.

**RENEWABILITY**

Each Medicare Select or Medigap policy must be “guaranteed renewable.” Insurance companies cannot cancel or refuse to renew a policy unless the policyholder does not pay the premiums or has provided incorrect or incomplete information (such as omitting information about

past health problems) on the initial application. When the policy is provided by a group, the policy may contain written language stating that the group is allowed to terminate the policy. If the group decides to terminate the policy, however, the insured individual will be allowed to continue the policy with another group or to purchase an individual policy.

**SELECT COVERAGE FOR EMERGENCY CARE**

Medicare Select policies must pay benefits for covered services obtained from non-network providers if “the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and it is not reasonable to obtain services through a network provider.”

**GRIEVANCE PROCEDURES**

Insurance companies offering Medicare Select policies must establish procedures for hearing complaints and resolving written grievances from insured individuals. A complaint is an individual’s dissatisfaction with a Medicare Select company or its network providers. A grievance is defined as a “dissatisfaction expressed in writing . . . with the administration, claims practices, or provision of services . . .”

**ASSISTANCE**

Individuals can obtain information on

Medicare Select and Medigap insurance, as well as Medicare and HMOs, by calling their local office for the aging Health Insurance Information, Counseling and Assistance Program or HIICAP (in New York City, call the Department for the Aging at **212-333-5511**; outside New York City, call the Senior Citizens Hotline at **800-342-9871** and ask for the number of the local HIICAP or office for aging); the Medicare Rights Center-HIICAP Hotline (in New York City, **212-869-3850**; outside New York City, **800-333-4114**); the New York State Insurance Department Consumer Services Bureau (in New York City, **212-480-6400**; outside New York City, **800-342-3736**); or the federal government’s Medicare Helpline (**1-800-Medicare**). Medicare beneficiaries can also obtain helpful information on the internet at: [www.hiicap.state.ny.us](http://www.hiicap.state.ny.us), [www.medicarerights.org](http://www.medicarerights.org), or [www.medicare.gov](http://www.medicare.gov). ☀

**PAID ADVERTISEMENTS**

## PRESIDENT BUSH ANNOUNCES MEDICARE DRUG PROPOSALS

*by Andrew Koski, M.S.W.*

In March 2003, President Bush announced proposals to provide prescription drug coverage for Medicare beneficiaries (see: [www.whitehouse.gov/news/releases/2003/03/20030304-1.html](http://www.whitehouse.gov/news/releases/2003/03/20030304-1.html)). His proposals include three options for drug coverage.

### MEDICARE FEE-FOR-SERVICE

Starting 2004, beneficiaries in Medicare fee-for-service (FFS) would receive a drug discount card that the government estimates would provide savings of 10% to 25% on drug purchases. In addition, starting 2004, low-income Medicare beneficiaries would be provided a \$600 annual subsidy for drug coverage that could be used with their discount card or alternatively paid to existing Medicare+Choice health plans that enroll low-income seniors and provide prescription drug coverage. Also, FFS beneficiaries would be offered two new Medigap plans that provide drug coverage, protection against “high out-of-pocket

[hospital] costs” and reduction of deductibles and copayments. Lastly, starting 2006, FFS beneficiaries would receive “catastrophic” drug coverage that would take effect after beneficiaries spent a large amount of money on drugs in a given year (the amount is not defined but is expected to be between \$5,500 and \$7,000).

### ENHANCED MEDICARE

A second option for beneficiaries, starting 2006, would be to leave Medicare FFS and join a private “Enhanced Medicare” program. These private insurance plans would offer prescription drug benefits with a monthly premium, an annual deductible and protections against high drug costs; full coverage without a deductible for preventive services; lower out-of-pocket costs for long hospital stays; and a single deductible for Medicare Part A and Part B services. Medicare beneficiaries would be able to choose any provider but would pay more for providers who are not part of the

approved network. Low-income beneficiaries not eligible for Medicaid would receive financial assistance with out-of-pocket prescription drug expenses while “lowest income” beneficiaries would not have to pay any premiums or deductibles (but would have to make copayments) for drug coverage. All other beneficiaries would have to pay a premium equal to the Medicare Part B premium (\$58.70 per month in 2003) for these plans.

### MEDICARE ADVANTAGE

Medicare beneficiaries would have a third option to enroll in a “Medicare Advantage” plan that is similar to managed care plans currently available under the Medicare+Choice program. These plans can, but would **not** be required to, offer drug coverage.

In addition to the President’s Medicare proposals, members of Congress have also proposed legislation to provide prescription drug coverage. Future issues of *The Brookdale Senior Rights Report* will discuss any legislative changes that are made. ☀

## MEDICARE SELECT INSURANCE MONTHLY PREMIUMS FOR PART OF NEW YORK STATE – MAY 2003

INSURANCE COMPANY	BENEFIT PLAN									
	A	B	C	D	E	F	G	H	I	J
Mutual of Omaha Insurance Company <sup>1</sup> (800) 775-6000		173.57	204.40	181.39	208.90	207.18	183.55			
Blue Cross/Blue Shield of Central New York (Excellus Health Plan) <sup>2</sup> (800) 659-1986	69.01	89.04	106.85					182.53		

<sup>1</sup> includes all of New York and Nassau and parts of Suffolk, Rockland and Westchester counties

<sup>2</sup> Includes all of Onondaga and Cortland counties and parts of Oswego, Madison and Cayuga counties

**Teleconference July 10, 2003**

**Handout #14**

## MEDICARE OFFERS NEW PPO PLANS

By Andrew Koski, M.S.W.

In August, the Centers for Medicare and Medicaid Services (CMS) announced that new health care plans, called preferred provider organizations (PPOs), will be available to some Medicare beneficiaries in New York and twenty two other states starting **January 1, 2003**. They will be offered under the Medicare+Choice managed care program.

PPOs consist of networks of preferred providers (hospitals, physicians and other providers) who sign an agreement with an insurance company to provide services to Medicare beneficiaries. According to the CMS press release

(at: [www.hhs.gov/news/press/2002pres/20020827.html](http://www.hhs.gov/news/press/2002pres/20020827.html)), PPOs have to offer all of Medicare’s “required benefits,” but will also be able to offer additional benefits such as prescription drugs, disease management and preventive services. Unlike most Medicare health maintenance organizations (HMOs) which require members to utilize network providers only, PPO members will be allowed to visit “out of network” providers but will pay more than if they use “in-network” providers. In addition, some PPOs may set a cap on members’ copayments for covered services.

The premiums and benefits will vary among PPO plans, but CMS expects premium amounts to be higher than the premiums charged by HMOs and less than premiums for Medigap policies. (See the March-April 2002 issue of *The Brookdale Senior Rights Report* for information on Medigap.) Medicare beneficiaries will be able to enroll in the new PPOs during the Medicare+Choice annual election period from **November 15 to December 31, 2002**, with benefits starting January 1, 2003. The chart below lists the plans that will offer PPO benefits and the counties they will cover. ☀

### LIST OF PPOs IN NEW YORK STATE

HEALTH PLAN	SERVICE AREA
Group Health, Inc.	Bronx, Brooklyn, Manhattan, Queens, Staten Island, Rockland and Westchester
Managed Health/Health First	Bronx, Brooklyn, Manhattan, Queens and Staten Island
United Healthcare	Bronx, Brooklyn, Manhattan, Queens and Staten Island
Blue Cross Blue Shield of Western New York/HealthNow	Albany, Allegany, Cattaraugus, Chautauqua, Columbia, Erie, Fulton, Genesee, Greene, Montgomery, Niagara, Orleans, Rensselaer, Saratoga, Schenectady, Warren, Washington and Wyoming

**NOTE:** Additional information on the plans’ benefits and premiums will be covered in a future issue of *The Brookdale Senior Rights Report*.

**Teleconference July 10, 2003**

**Handout #15**

## **NEW APPEAL PROCEDURES SET FOR MEDICARE MANAGED CARE**

In April 2003, the Centers for Medicare and Medicaid Services (CMS) issued a “final rule with comment period” that established **new** notice and appeal procedures for Medicare+Choice (managed care) enrollees who face **termination** of services by home health agencies (HHAs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs) or hospitals. The rule did **not** change the appeals procedures for other types of Medicare managed care plan determinations. These determinations include the plan’s: (i) payment for emergency services, post-stabilization care or urgently needed services; (ii) payment for any other health services furnished by non-affiliated Medicare managed care providers that the enrollee believes are covered by Medicare, or, if not covered by Medicare, should have been furnished, arranged for or reimbursed by the managed care plan; (iii) refusal to provide or pay for services; or (iv) failure to approve, furnish, arrange for, or provide payment for health services in a timely manner and such delay would adversely affect the enrollee’s health.

The rule also made revisions to grievance procedures for Medicare managed care enrollees. Although the new rule became effective **May 5<sup>th</sup>**, some of the required notices (new or revised) will not be available until approval is obtained from the federal Office of Management and Budget. The rule is part of a negotiated settlement CMS reached with Medicare managed care enrollees after suit was brought against the federal government (*Grijalva v. Shalala*) for its failure to provide meaningful procedural protections when enrollees’ services were denied, reduced or terminated. Under this rule, CMS will contract with organizations, called independent review entities (the review entity), to handle appeals concerning termination of the services listed above.

## **Advance Notice of Service Terminations**

Under the new rule, when a Medicare managed care plan decides to **terminate** HHA, SNF or CORF services, their providers are required to give a brief written notice to the Medicare managed care enrollee no later than **two days before** services will end. In non-institutional cases where the amount of time between services is more than two days, the notice should be given no later than the next to last time services are furnished. The notice must include the following information: (i) the date that covered services will end; (ii) the date that the enrollee will start to be liable for continued services; (iii) a description of the enrollee's right to a "fast-track" appeal to the review entity, including information about how to contact the review entity, an enrollee's right to submit evidence showing that services should continue and the availability of other appeal procedures if the deadline for a fast-track appeal is not met; and (iv) the enrollee's right to receive detailed information (explained below).

## **Fast-Track Appeal**

Medicare managed care enrollees can request a fast-track appeal of a Medicare managed care plan's decision to **terminate** HHA, SNF or CORF services if they submit a request to the review entity by phone or in writing by **noon of the first day after the day** that the termination notice was delivered to them. On the date that the review entity receives an enrollee's request for a fast-track appeal, the review entity must immediately notify the Medicare managed care plan that the enrollee has filed such a request and that the plan is required to supply any information needed for the review entity to make a decision. This information must be given to the review entity by the **close of the**

**business day** that the review entity has notified the Medicare managed care plan of the appeal request.

When the review entity notifies a Medicare managed care plan that an enrollee has requested a fast-track appeal, the Medicare managed care plan must send a **detailed** notice to the enrollee by close of that business day. The notice must include an explanation why services are either no longer covered or “reasonable and necessary,” a description of any applicable Medicare coverage rule or other Medicare policy, and a statement of any applicable Medicare managed care plan policy, contract provision or rationale upon which the termination decision was based. The enrollee can also request any documentation sent by the plan to the review entity that holds the fast-track appeal.

The review entity must make a decision on the fast-track appeal and notify the enrollee, the Medicare managed care plan and the provider of services by **close of the business day after** it receives the information necessary to make a decision. If the review entity’s decision is delayed because the Medicare managed care plan does not timely supply necessary information or records, the managed care plan must pay for any additional coverage.

If the review entity reverses the Medicare managed care plan’s termination decision, the enrollee is entitled to continued services and the plan must issue a new notice before terminating services in the future. If the review entity upholds the Medicare managed care plan’s termination decision and the review entity’s decision was not delayed, the enrollee will be responsible for paying for any services received starting **three days after** receipt of the termination notice. CMS states in the comments section

of the rule that an enrollee may face a maximum of one day of financial liability if the review entity upholds the termination decision.

### **Reconsideration**

Enrollees whose appeals are denied by the review entity can request a reconsideration within **sixty days** of being notified of the review entity's decision. The review entity is responsible for issuing its reconsideration determination as "expeditiously as the enrollee's health condition requires," but no later than **fourteen days after** receiving the enrollee's reconsideration request. If the review entity reaffirms its decision, further appeals can be made to an Administrative Law Judge, the Departmental Appeals Board and to federal court.

### **Additional Appeal Option**

Enrollees who fail to make a timely request to the review entity for a fast-track appeal can still request an "expedited" reconsideration to the Medicare managed care plan. Under this procedure, the plan must make a determination as expeditiously as the enrollee's health requires but no later than **seventy-two hours after** receiving the request, with a possible fourteen-day extension. If the Medicare managed care plan issues an expedited reconsideration that is partially or wholly unfavorable to the enrollee, the plan must submit the case file to the Maximus Center for Health Dispute Resolution (the Maximus Center) as expeditiously as the enrollee's health condition requires, but not later than **twenty-four hours** from its determination. The Maximus Center is a private contractor that reviews reconsideration determinations that are not completely favorable to enrollees. The Maximus Center must make a decision as quickly as the enrollee's health condition requires but no later than **seventy-two hours** from receipt of the case.

Enrollees who do not request either a fast-track or an expedited appeal will have services terminated **two days after** they receive a termination notice. Enrollees may waive their right to two days of continued services and choose to be discharged sooner.

### **Hospital Discharge Notices**

CMS' rule also **eliminated** the current requirement that **hospitals** must provide a written notice of noncoverage to each Medicare managed care enrollee the day before discharge. Instead, the Medicare managed care plan or hospital will have to provide a notice of noncoverage **only when the enrollee disagrees** with the discharge decision. What is unclear is how the enrollee is expected to receive the written discharge decision, known as the Notice of Discharge and Medicare Appeal Rights (the discharge notice). Will hospital staff contact the Medicare managed care plan and request that a discharge notice be issued if the enrollee disagrees with the "verbal" discharge decision? Will Medicare managed care plans delegate the responsibility for issuing the discharge notice to hospitals in cases where enrollees express disagreement? Should enrollees be encouraged to call their Medicare managed care plan and request a discharge notice or should they call the Quality Improvement Organization --Island Peer Review Organization (IPRO) in New York State--that handles hospital appeals and request that IPRO contact the Medicare managed care plan for a discharge notice? These issues all need to be clarified before Medicare managed care enrollees can be expected to exercise their appeal rights.

What is clearer is that the discharge notice must be received by enrollees no later than **the day before** hospital coverage ends. The notice has to include the following information: (i) the reason why inpatient hospital care is no longer needed; (ii) the

effective date and time of the enrollee's liability for continued inpatient care; and (iii) the enrollee's appeal rights. All Medicare managed care plan enrollees who enter hospitals will still be given the "Important Message from Medicare" form that explains some of their rights as hospital patients.

### **Appeals of Hospital Notices of Noncoverage**

Those enrollees who receive a discharge notice will be entitled to continued hospital coverage until at least **noon of the day after** such notice is provided. If they don't agree with the discharge decision, they can request an **immediate review** by IPRO (which is listed on the notice). The appeal, in writing or by phone, must be made by noon of the **first working day after** receipt of the notice. If enrollees submit such a timely appeal and IPRO affirms the termination decision, they will not be liable until noon of the calendar day **following the day** of IPRO's determination. If IPRO determines that a further hospital stay is necessary, the enrollees will be able to stay until they are notified again by the Medicare managed care plan or hospital that they are being discharged.

### **Grievance Procedures**

CMS has decided **not** to establish time frames for Medicare managed care plans to respond to most grievances. Grievances are complaints or disputes that are not organization determinations (defined in first paragraph of this Article) and which involve "any aspect of a Medicare managed care organization's or provider's operations, activities, or behavior . . . ." This could include waiting times, attitude of health care staff, and cleanliness of facilities. Instead, CMS will require plans to respond to the following types of enrollee grievances within **twenty-four hours**: (i) complaints

involving a Medicare managed care plan's decision to extend the time frame for issuing an organization determination or reconsideration; or (ii) complaints involving a Medicare managed care plan's refusal to grant an enrollee's request for an expedited organization determination or an expedited reconsideration. CMS is also requiring Medicare managed care plans that receive a complaint to promptly determine and inform the enrollee whether the issue is subject to the grievance or appeal procedure.

Medicare+Choice appeals, 6/21/03

**Teleconference July 10, 2003**

**Handout #16**

# IMPORTANT MESSAGE FROM MEDICARE

## (CMS-R-193)

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### YOUR RIGHTS AS A HOSPITAL PATIENT

- You have the right to receive necessary hospital services covered by Medicare, or covered by your Medicare Health Plan ("your Plan") if you are a Plan enrollee.
  - You have the right to know about any decisions that the hospital, your doctor, your Plan, or anyone else makes about your hospital stay and who will pay for it.
  - Your doctor, your Plan, or the hospital should arrange for services you will need after you leave the hospital. Medicare or your Plan may cover some care in your home (home health care) and other kinds of care, if ordered by your doctor or by your Plan. You have the right to know about these services, who will pay for them, and where you can get them. If you have any questions, talk to your doctor or Plan, or talk to other hospital personnel.
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### YOUR HOSPITAL DISCHARGE & MEDICARE APPEAL RIGHTS

- **Date of Discharge:** When your doctor or Plan determines that you can be discharged from the hospital, you will be advised of your planned date of discharge. You may appeal if you think that you are being asked to leave the hospital too soon. If you stay in the hospital after your planned date of discharge, it is likely that your charges for additional days in the hospital will not be covered by Medicare or your Plan.
- **Your Right to an Immediate Appeal without Financial Risk:** When you are advised of your planned date of discharge, if you think you are being asked to leave the hospital too soon, you have the right to appeal to your Quality Improvement Organization (also known as a QIO). The QIO is authorized by Medicare to provide a second opinion about your readiness to leave. You may call Medicare toll-free, 24 hours a day, at 1-800 MEDICARE (1-800-633-4227), OR TTY/TTD: 1-877-486-2048, for more information on asking your QIO for a second opinion. If you appeal to the QIO by noon of the day after you receive a noncoverage notice, you are not responsible for paying for the days you stay in the hospital during the QIO review, even if the QIO disagrees with you.

The QIO will decide within one day after it receives the necessary information.

- **Other Appeal Rights:** If you miss the deadline for filing an immediate appeal, you may still request a review by the QIO (or by your Plan, if you are a Plan enrollee) before you leave the hospital. However, you will have to pay for the costs of your additional days in the hospital if the QIO (or your Plan) denies your appeal. You may file for this review at the address or telephone member of the QIO (or of your Plan).
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**Teleconference July 10, 2003**

**Handout #17**

## INCOME LEVELS AND RECERTIFICATION PROCESS CHANGED FOR MEDICARE SAVINGS PROGRAMS

*by Andrew Koski, M.S.W.*

In March 2003, the State Department of Health (SDOH) **reduced** the income levels for the Medicare Savings (Buy-In) Programs because the originally announced levels were based upon SDOH’s estimate of the federal poverty levels that were higher than the official poverty levels. SDOH had used the estimated levels for applications since January 1, 2003. The following chart outlines the new monthly income guidelines and **replaces** a similar chart in the January-February 2003 issue of *The Brookdale Senior Rights Report* as well as the amounts listed in the *Benefits Checklist for Older Adults* which was inserted into the November-December 2002 issue of *The Brookdale Senior Rights Report*.

SDOH has indicated in a General Information System notice (GIS 03MA/006) that the new levels are effective for all new applications and recertifications retroactive to **January 1, 2003**. Individuals found eligible under the previously estimated poverty levels, however, will not be “rebudgeted” until the next regularly scheduled recertification or client contact.

In addition, SDOH previously announced (in February 2003) the elimination of the requirement for a personal face-to-face interview for recertification of **Medicaid, Qualified Medicare Beneficiary (QMB), and Family Health Plus** recipients. Instead, starting **April 1, 2003**, recipients will receive a notice in the mail that indicates their current income and resource information. In

order to remain enrolled in either Medicaid or QMB, individuals will have to indicate any changes in their income or resources on the notice, supply documentation of the changes, sign the form and return it. A similar mail-in recertification process has been used for recipients of the two other Medicare Savings Programs—the Specified Low Income Medicare Beneficiary (SLIMB) and Qualifying Individual-1 (QI-1) programs. Both the SLIMB and QI-1 programs pay the Medicare Part B premium (\$58.70 per month), while QMB pays the Medicare Part B premium, the Medicare Part A premium (if the county determines that payment is “cost effective”), Medicare deductibles, coinsurance for doctors and copayments for hospitals and skilled nursing facilities, but only if they are Medicaid providers. ☼

### INCOME and RESOURCE LEVELS FOR MEDICARE SAVINGS (BUY-IN) PROGRAMS (Effective January 1, 2003)

PROGRAM	INCOME <sup>1</sup> GUIDELINES	BENEFITS	ELIGIBILITY
<b>QMB Qualified Medicare Beneficiary</b>	<ul style="list-style-type: none"> <li>• Individuals: \$749 (+\$20)<sup>2</sup></li> <li>• Couples: \$1,010 (+\$20)<sup>2</sup></li> </ul>	State pays Medicare Part A and Part B premiums, deductibles, coinsurance for doctors and co-payments for hospitals and skilled nursing facilities, but only if they are Medicaid providers	Eligibility starts the month after a determination is made
<b>SLIMB Specified Low Income Medicare Beneficiary</b>	<ul style="list-style-type: none"> <li>• Individuals: \$750 to \$898 (+\$20)<sup>2</sup></li> <li>• Couples: \$1,011 to \$1,212 (+\$20)<sup>2</sup></li> </ul>	State pays only the Medicare Part B premium (\$58.70 per month)	Eligibility may be retroactive for up to three months prior to the date of application
<b>QI-1 Qualifying Individual-1</b>	<ul style="list-style-type: none"> <li>• Individuals: \$898 to \$1,011 (+\$20)<sup>2</sup></li> <li>• Couples: \$1,212 to \$1,364 (+\$20)<sup>2</sup></li> </ul>	State pays only the Medicare Part B premium (\$58.70 per month)	Eligibility may be retroactive for up to three months prior to the date of application

**RESOURCE REQUIREMENTS FOR QMB & SLIMB:** \$4,000 plus \$1,500 for burial expenses (individuals) and \$6,000 plus \$3,000 for burial expenses (couples) or any amount in an irrevocable pre-need funeral agreement.  
**QI-1:** No Resource limit.

<sup>1</sup> In computing an individual’s income, include the gross amount of the Social Security check (the amount before the Medicare Part B premium is deducted)

<sup>2</sup> The first \$20 of monthly income per household is not counted when determining the eligibility of those applicants or recipients who are aged, blind or disabled

**Teleconference July 10, 2003**

**Handout #18**

## **SSA CONDUCTS OUTREACH ON MEDICARE SAVINGS PROGRAMS**

*by Andrew Koski, M.S.W.*

In May 2002, the Social Security Administration (SSA) started an outreach campaign to inform Social Security recipients about the various Medicare Savings Programs. This activity was mandated by the “Beneficiary Improvement and Protection Act of 2000.”

Under this campaign, SSA started sending letters to individuals whose Social Security benefits are below the levels for the Qualifying Individual-1 (QI-1) program (\$1,017 per month for individuals; \$1,364 per month for couples). The letters inform them that they may be eligible for payment of their Medicare Part B premium and other medical costs by the State and provide a phone number (New York State Department of Health) to call for more information. When they call the State Department of Health, they will be referred to their local Medicaid office.

From May to November, SSA plans to send letters to about 1.1 million Social Security recipients in New York State who may be eligible for the Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLIMB) or QI-1 programs. In the last week of November, SSA will send a separate mailing to about 3,700 recipients with information about the Qualified Disabled Working Individual (QDWI) program.

There are five Medicare Savings programs: QMB which pays Medicare Part B premiums (and, in some cases, Part A premiums) and Medicare coinsurance, deductibles and copayments; SLIMB and QI-1 which pay the Medicare Part B premium (\$54 per month) only; Qualifying Individual-2 (QI-2) which pays a portion of the Medicare Part

B premium (\$3.91 per month); and QDWI which pays the Medicare Part A premium for disabled working individuals under age 65 who lost Part A benefits because of their return to work, are **not** on Medicaid, have income less than \$3,039<sup>1</sup> per month (\$4,065<sup>1</sup> for couples) and resources less than \$4,000 (\$6,000 for couples).

The March-April 2002 issue of *The Brookdale Senior Rights Report* contains a chart that lists the income and resource guidelines for QMB, SLIMB, QI-1 and QI-2. Effective **April 1, 2002**, resource limits were **eliminated** from the QI-1 and QI-2 programs, individuals applying for SLIMB were allowed to attest to their resources rather than supply resource documentation and individuals income-eligible, but **not** resource-eligible, for SLIMB, can be determined eligible for QI-1.

The application for SLIMB, QI-1, QI-2 and QDWI is a one page two-sided form which can be downloaded from the State Department of Health Medicare Savings Program website at:  
[www.health.state.ny.us/nysdoh/manicare/omm/savingsprogram/medicaresavingsprogram.htm](http://www.health.state.ny.us/nysdoh/manicare/omm/savingsprogram/medicaresavingsprogram.htm). Applicants for QMB must use the Medicaid application.

Medicare Savings Program Outreach, 6/20/02

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<sup>1</sup> The first \$20 of income is not counted; in addition, the first \$65 of earned income and one-half of the remaining earned income are not counted.

**Teleconference July 10, 2003**

**Handout #19**



[QMB/SLMB/QI Letter]

### **Information from the Social Security Administration about the Medicare Savings Programs (Help From Your State to Pay Your Medicare Premiums)**

State programs help millions of people with Medicare save money each year. The names for these programs change from State-to-State, but they are usually called “Medicare Savings Programs,” “buy-in programs” or the “qualified Medicare beneficiary program.” These programs help people with limited income and resources pay their Medicare premiums. In some cases, the programs may also pay Medicare deductibles and coinsurance.

#### **You can apply for these programs if:**

- You have Medicare Part A, also known as Medicare Hospital Insurance. (If you pay for Medicare Part A or could purchase Part A but don't think you can afford it, there is a program that may pay the Medicare Part A premium for you.)

**and**

- You are an individual with resources of \$4,000 or less, or a couple with resources of \$6,000 or less. Resources include things like money in a checking or savings account, stocks, or bonds. When counting your resources, do **not** include certain items like the home where you live, your home furnishings, a car, burial plots, and \$1,500 in a burial account.

**and**

- You are an individual with a monthly income of less than **\$1,031\*** or a couple with a monthly income of less than **\$1,384.\***

**NOTE:** Individual States may have more generous income and/or resources requirements.

Call your State or local medical assistance (Medicaid) office, social service or welfare office listed in the blue (government) pages of your phone book and ask for information on the programs that help pay Medicare expenses. It's very important to call if you think you qualify for any of these Medicare Savings Programs, even if you aren't sure.

Jo Anne B. Barnhart  
Commissioner  
*Social Security Administration*

Thomas A. Scully  
Administrator  
*Centers for Medicare & Medicaid Services*

\*Income limits will change slightly in 2004. If you live in Alaska or Hawaii, income limits are slightly higher

**Teleconference July 10, 2003**

**Handout #20**

## PRESIDENT BUSH ANNOUNCES MEDICARE DRUG PROPOSALS

*by Andrew Koski, M.S.W.*

In March 2003, President Bush announced proposals to provide prescription drug coverage for Medicare beneficiaries (see: [www.whitehouse.gov/news/releases/2003/03/20030304-1.html](http://www.whitehouse.gov/news/releases/2003/03/20030304-1.html)). His proposals include three options for drug coverage.

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[hospital] costs” and reduction of deductibles and copayments. Lastly, starting 2006, FFS beneficiaries would receive “catastrophic” drug coverage that would take effect after beneficiaries spent a large amount of money on drugs in a given year (the amount is not defined but is expected to be between \$5,500 and \$7,000).

### ENHANCED MEDICARE

A second option for beneficiaries, starting 2006, would be to leave Medicare FFS and join a private “Enhanced Medicare” program. These private insurance plans would offer prescription drug benefits with a monthly premium, an annual deductible and protections against high drug costs; full coverage without a deductible for preventive services; lower out-of-pocket costs for long hospital stays; and a single deductible for Medicare Part A and Part B services. Medicare beneficiaries would be able to choose any provider but would pay more for providers who are not part of the

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## MEDICARE SELECT INSURANCE MONTHLY PREMIUMS FOR PART OF NEW YORK STATE – MAY 2003

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Mutual of Omaha Insurance Company <sup>1</sup> (800) 775-6000		173.57	204.40	181.39	208.90	207.18	183.55			
Blue Cross/Blue Shield of Central New York (Excellus Health Plan) <sup>2</sup> (800) 659-1986	69.01	89.04	106.85					182.53		

<sup>1</sup> includes all of New York and Nassau and parts of Suffolk, Rockland and Westchester counties

<sup>2</sup> Includes all of Onondaga and Cortland counties and parts of Oswego, Madison and Cayuga counties

**Teleconference July 10, 2003**

**Handout #21**



# INTERNET NEWS: Medicare Websites

by Andrew Koski, M.S.W.

Below is a list of helpful websites for locating information on Medicare.

DESCRIPTION OF WEBSITE	WEBSITE ADDRESS
<b>National Senior Citizens Law Center:</b> good articles on Medicare benefits, legislation, regulatory changes and court decisions.	<a href="http://www.nscclc.org">www.nscclc.org</a>
<b>National Health Law Program:</b> daily list of newspaper articles on Medicare and other health programs; announcements of Medicare studies and reports; and links to helpful organizations.	<a href="http://www.nhelp.org">www.nhelp.org</a>
<b>Medicare Rights Center:</b> excellent source for current information on Medicare fee-for-service, Medicare managed care and Medigap benefits and policy issues.	<a href="http://www.medicarerights.org">www.medicarerights.org</a>
<b>Center for Medicare Advocacy:</b> good source for information on Medicare benefits and proposed changes in legislation and regulations.	<a href="http://www.medicareadvocacy.org">www.medicareadvocacy.org</a>
<b>Health Insurance Information, Counseling and Assistance Program:</b> New York State Office for Aging's site for comprehensive information on Medicare, Medicare managed care and Medigap insurance.	<a href="http://www.hiicap.state.ny.us">www.hiicap.state.ny.us</a>
<b>New York State Insurance Department:</b> information on Medigap insurance policies, premiums and consumer protections and Medicare managed care.	<a href="http://www.ins.state.ny.us/caremain.htm">www.ins.state.ny.us/caremain.htm</a>
<b>Federal Register:</b> proposed and final rules on Medicare, Medicaid and income support programs and notices of funding opportunities.	<a href="http://www.access.gpo.gov/su_docs/fedreg/frcont03.html">www.access.gpo.gov/su_docs/fedreg/frcont03.html</a>
<b>General Accounting Office:</b> reports and testimony on Medicare, Medicaid and income support programs.	<a href="http://www.gao.gov">www.gao.gov</a>
<b>Department of Health and Human Services (DHHS) Press Releases:</b> press releases on Medicare and other health and income programs and information on DHHS-funded initiatives.	<a href="http://www.hhs.gov/news/press/2003.html">www.hhs.gov/news/press/2003.html</a>
<b>Centers for Medicare and Medicaid Services (CMS):</b> comprehensive site for basic information on Medicare fee-for-service; health issues; publications on Medicare; comparison of Medicare managed care plans by benefits, costs and quality data; comparison of Medigap plans; comparison of nursing homes; and prescription drug assistance programs.	<a href="http://www.medicare.gov">www.medicare.gov</a>
<b>CMS:</b> list of Operational Policy Letters for providers on Medicare managed care rules and procedures.	<a href="http://cms.hhs.gov/healthplans/opl">http://cms.hhs.gov/healthplans/opl</a>
<b>CMS:</b> program manuals, transmittals and memos for Medicare (and Medicaid).	<a href="http://www.cms.hhs.gov/manuals/default.asp">www.cms.hhs.gov/manuals/default.asp</a>
<b>CMS:</b> website for information on Medicare managed care.	<a href="http://cms.hhs.gov/healthplans">http://cms.hhs.gov/healthplans</a>
<b>CMS:</b> information on Medicare's prospective payment system for skilled nursing facilities.	<a href="http://cms.hhs.gov/providers/snfpps">http://cms.hhs.gov/providers/snfpps</a>
<b>CMS:</b> source for information on Medicare's home health prospective payment system.	<a href="http://cms.hhs.gov/medlearn/refhha.asp">http://cms.hhs.gov/medlearn/refhha.asp</a>
<b>CMS:</b> data on the Outcome and Assessment Information Set (OASIS), an assessment tool home health agencies must use for their Medicare patients.	<a href="http://cms.hhs.gov/providers/hha">http://cms.hhs.gov/providers/hha</a>
<b>CMS:</b> site for Medicare's hospital outpatient prospective payment system.	<a href="http://cms.hhs.gov/regulations/hopps">http://cms.hhs.gov/regulations/hopps</a>
<b>CMS:</b> site for information on Medicare and Medicaid hospice programs.	<a href="http://cms.hhs.gov/providers/hospiceps">http://cms.hhs.gov/providers/hospiceps</a>
<b>CMS:</b> information on a variety of Medicare topics and publications, satellite broadcast programs and web-based training.	<a href="http://cms.hhs.gov/medlearn/default.asp">http://cms.hhs.gov/medlearn/default.asp</a>
<b>CMS:</b> site for physicians, health plans and providers who need information on Medicare managed care, CMS publications and forms, quality of care and CMS program transmittals and memoranda.	<a href="http://cms.hhs.gov/professionals/default.asp">http://cms.hhs.gov/professionals/default.asp</a>
<b>CMS:</b> site for data on Medicare, Medicaid and managed care.	<a href="http://cms.hhs.gov/researchers">http://cms.hhs.gov/researchers</a>
<b>CMS:</b> site for information on fraud and abuse, including fraud schemes, manual instructions and links to other organizations.	<a href="http://cms.hhs.gov/providers/fraud/default.asp">http://cms.hhs.gov/providers/fraud/default.asp</a>
<b>CMS:</b> site for information on ambulance coverage and payment policies.	<a href="http://cms.hhs.gov/medlearn/refamb.asp">http://cms.hhs.gov/medlearn/refamb.asp</a>
<b>Empire Medicare Services:</b> information for consumers and professionals on Medicare, including Part A and Part B local medical policies, newsletters, list of participating providers and doctors who have "opted out" of Medicare and various brochures on Medicare benefits.	<a href="http://www.empiremedicare.com">www.empiremedicare.com</a>
<b>United Government Services:</b> information for providers and beneficiaries, including recent Medicare memos, CMS alerts, Medicare benefits and system updates from the insurance company which administers the Medicare home health benefit for New York State.	<a href="http://www.ugsmedicare.com">www.ugsmedicare.com</a>
<b>HealthNow NY:</b> information on Medicare Part B benefits and durable medical equipment (DME) from the insurance company which administers DME benefits for New York State and Part B benefits for part of New York.	<a href="http://www.umd.nycpic.com">www.umd.nycpic.com</a>
<b>Office of Inspector General:</b> reports on Medicare, Medicaid and other programs.	<a href="http://oig.hhs.gov/w-new.html">http://oig.hhs.gov/w-new.html</a>
<b>Center for Medicare Education:</b> Issue Briefs on Medicare and employer health insurance, beneficiary education and use of volunteers; and resources on a variety of issues.	<a href="http://www.medicareed.org">www.medicareed.org</a>

**Teleconference July 10, 2003**

**Handout #22**

## PRESIDENT BUSH PROPOSES MAJOR MEDICAID CHANGES

*by Andrew Koski, M.S.W.*

In January 2003, President Bush announced proposals to change Medicaid that would adversely affect elderly and disabled recipients. The Bush plan would offer states the choice to continue operating their Medicaid program under current rules with no additional fiscal relief or to accept an optional “block grant” for Medicaid with the promise of additional money in the early years of operation and less money in later years.

### BACKGROUND

Under current Medicaid rules, each state decides how to structure eligibility, benefits, service delivery and payment rates within guidelines established by federal law. In exchange for receiving federal Medicaid matching payments, states must cover certain “mandatory” groups of beneficiaries (see Chart 1 below). States also have broad flexibility to cover individuals in each of these categories at higher income

levels known as “optional groups” (Chart 1).

States participating in Medicaid must cover certain “mandatory” services (see Chart 2 on page 4), including physician services, laboratory tests, inpatient and outpatient hospital services, nursing home services for individuals 21 or older and home health aide services (not including personal care/home attendant services) for individuals entitled to skilled nursing or therapy at home. States are also allowed to cover certain “optional” services (Chart 2) which include prescription drugs, home health care services for those not in need of nursing home care, personal care and private duty nursing services. Currently, mandatory and optional recipients are entitled to Medicaid coverage for both mandatory and optional services covered by their individual state. New York State provides most Medicaid optional services.

President Bush’s proposal would eliminate the guarantee of Medicaid benefits for millions of recipients in states that opt for the block grant. The proposal requires states to provide an undefined level of “comprehensive” benefits to mandatory groups of Medicaid recipients, but allows states to change the rules for optional benefits provided to these groups. The proposal also would **not** require states that opt for the block grant to provide current services for optional recipients. States that choose the Medicaid block grant could eliminate optional services, such as personal care/home attendant services, impose high copayments for services or create different benefit packages for recipients living in different parts of a state. These proposed changes would adversely affect elderly and disabled recipients because they make up a large part of optional recipients and are heavy users of two optional services—long-term nursing home care for residents whose incomes exceed the Supplemental Security Income (SSI) levels and prescription drugs—that comprise more than two-thirds of the Medicaid money spent on optional benefits.

*(Continued on page 4)*

### CHART 1 – GROUPS OF MEDICAID RECIPIENTS\*

MANDATORY GROUPS	OPTIONAL GROUPS
Elderly SSI recipients	Nursing home residents whose income exceeds SSI levels
Disabled SSI recipients	Disabled and elderly individuals with high medical expenses (medically needy)
Medicare Buy-In <sup>1</sup> beneficiaries	Low-income disabled individuals who need home and community-based care
Certain working disabled individuals	Certain working disabled individuals whose income exceeds SSI levels
Children below federal minimum income levels	Certain disabled individuals whose income exceeds SSI levels
Adults with children whose family income is below certain amounts	Elderly individuals who receive only state, not federal, SSI benefits
Pregnant women with income below 133% of the federal poverty level	Children above federal minimum income levels
	Adults in families with children who meet certain income limits
	Pregnant women with income above 133% of the federal poverty level

\* Based on the Kaiser Commission on Medicaid and the Uninsured report, “Medicaid ‘Mandatory’ and ‘Optional’ Eligibility and Benefits”

<sup>1</sup> Includes Qualified Medicare Beneficiary, Specified Low Income Medicare Beneficiary and Qualifying Individual-1 programs

## CHART 2 – CATEGORIES OF MEDICAID BENEFITS\*

MANDATORY ACUTE SERVICES	OPTIONAL ACUTE SERVICES
Physician services	Prescription drugs
Laboratory and x-ray services	Dental services and dentures
Inpatient hospital services	Clinic services
Outpatient hospital services	Physical therapy and related services
Early and periodic screening, diagnostic, and treatment services for those under 21	Prosthetic devices and eyeglasses
Family planning services and supplies	Diagnostic, screening, preventive and rehabilitative services
Federally-qualified health center services	Medical or remedial care furnished by licensed practitioners under state law
Rural health clinic services	Tuberculosis-related services
Nurse midwife services	Primary care case management services
Certified nurse practitioner services	Other specified medical and remedial care
MANDATORY LONG-TERM CARE SERVICES	OPTIONAL LONG-TERM CARE SERVICES
Nursing home services for those 21 or older	Home health care services for those not in need of nursing home care
Home health care services for individuals entitled to nursing home care	Personal care services
	Private duty nursing services
	Home and community-based services under a “waiver” program
	Hospice care
	Case management services
	Programs for All-Inclusive Care for the Elderly (PACE) services
	Respiratory care services for ventilator-dependent individuals
	Inpatient and nursing home services for individuals 65 or over in an institution for mental diseases
	Intermediate care facility services for individuals with mental retardation
	Inpatient psychiatric hospital services for individuals under 21
* Based on the Kaiser Commission on Medicaid and the Uninsured report, “Medicaid ‘Mandatory’ and ‘Optional’ Eligibility and Benefits”	

(Continued from page 3)

### BLOCK GRANT

Currently, Medicaid is an entitlement program that allows anyone who meets the program’s requirements to be eligible for benefits. This assures that individuals found eligible are not denied services due to state funding shortfalls and that states receive federal matching funds for their Medicaid programs regardless of increases in their caseloads or in

the amount and cost of services. Bush’s proposal would allow states the option to change their Medicaid program into a block grant under which federal matching funds would be “capped.” States would receive two allotments—one for long-term care and one for acute care—from the federal government. States would not receive federal matching funds for any Medicaid costs that exceeded the allotted amounts. Those states that chose this option would receive more money for 2004 – 2010 than those

who did not opt for the block grant, but these “block grant” states would then receive reduced funds for 2011 – 2013. The proposal offers **no** fiscal relief to states that want to continue in the current Medicaid program.

Bush’s Medicaid proposal requires legislative approval and that is not certain at this time. If any Medicaid changes are enacted, such information will be included in a future issue of *The Brookdale Senior Rights Report*. ☀

**Teleconference July 10, 2003**

**Handout #23**

## LEGISLATURE PASSES STATE BUDGET

*by Andrew Koski, M.S.W.*

In May, the New York State Legislature passed a budget that restored most of the reductions proposed in Governor Pataki's budget (see the January-February 2003 issue of *The Brookdale Senior Rights Report*).

Some of the more prominent provisions **rejected** by the State Legislature were proposals to:

- eliminate the federal cost-of-living adjustment for Supplemental Security Income recipients;
- increase fees and deductibles for the State's EPIC (Elderly Pharmaceutical Insurance Coverage) program;
- increase Medicaid fee-for-service recipients' copayments for drugs and their annual copayment maximum;
- require Medicaid managed care recipients to pay the same copayments as Medicaid fee-for-service recipients;
- combine the Community Services for the Elderly program and EISEP (Expanded In-Home Services for the Elderly Program) into a new Community Services Program and reduce funding for those programs;
- reduce Family Health Plus eligibility from 150% to 133% of the federal poverty level; and
- cap STAR (New York State School Tax Relief) program benefits for non-seniors at 2002 – 2003 levels.

In addition, the Legislature **rejected** proposed reductions in spending for hospitals and nursing homes and most of the provisions targeting home care funding. The State Legislature did **not** reject the Governor's proposal for utilization review of certain high cost and/or high hours home health services because legislators believed that the Governor already has the authority to conduct such reviews. The final budget also provides the authority for New York State to participate in a Medicare home health maximization demonstration program, though New York has not yet entered into an agreement with the Centers for Medicare and Medicaid Services to start this program.

The Legislature **rejected** the Governor's proposal to allocate \$8 million to assess the needs of adult home residents, provide enhanced medication management, improve service coordination, and wellness, social and recreational activities. Instead, the Legislature approved \$6 million for the Quality Incentive Payment Program, which provides funding for capital improvements, service enrichment and increased staff wages and benefits, and approved an additional \$2 million for a new Adult Care Facility Quality Service and Advocacy Initiative which can be used to fund case management, advocacy and peer support services.

The Legislature agreed to reduce reimbursement to pharmacies by 2% for drugs provided to EPIC recipients and to reduce Medicaid reimbursement to certain providers who serve dually eligible Medicare and Medicaid or Medicare and Qualified Medicare Beneficiary patients. Such providers, including physicians, will receive only **4%**, rather than 20%, of Medicare's approved amount while other providers, including ambulance companies, psychologists, certain mental hygiene facilities, outpatient hospital

departments and clinics, will continue to receive Medicaid reimbursement equal to 20% of Medicare's approved amount.

For example, Mrs. Smith, a Medicare beneficiary and Medicaid recipient, visits her primary care physician who participates in both Medicare and Medicaid. Medicare approves \$100 for the visit and pays 80% of the approved amount or \$80 to the doctor. Under the State legislative change, Medicaid will pay only 4% of the Medicare approved amount or \$4 (instead of 20% or \$20). Thus, Mrs. Smith's doctor will receive a total of \$84 (\$80 from Medicare and \$4 from Medicaid) and **not** \$100 (\$80 from Medicare and \$20 from Medicaid) which the doctor would have received under prior rules. Her doctor will **not** be able to collect the \$16 difference from Mrs. Smith.

Lastly, the State Legislature postponed until **April 1, 2004** implementation of the Governor's proposal to eliminate the Alzheimer's Tax Check-off General Fund match under which the State matches taxpayers' contributions to the Alzheimer's Disease Assistance Fund for education and supportive services. The chart on page \_\_ shows how much money was approved for other programs that serve older persons in New York State.

final state budget, 6/5/03

**Teleconference July 10, 2003**

**Handout #24**

## FINAL NEW YORK STATE BUDGET FOR AGING PROGRAMS

PROGRAM	2002 FINAL BUDGET	GOVERNOR'S PROPOSED 2003 BUDGET	2003 FINAL BUDGET
Elderly Pharmaceutical Insurance Coverage (EPIC)	\$484,900,000 <sup>1</sup>	\$578,000,000 <sup>1</sup>	+\$590,400,000 <sup>1</sup>
Expanded In-Home Services for the Elderly (EISEP)	25,500,030	38,573,000*	25,500,030
Supplemental Nutrition Assistance Program (SNAP)	17,209,000	17,209,000	17,209,000
Community Services for the Elderly (CSE)	16,573,215	38,573,000*	16,573,215
Quality Incentive Payment Program (QUIP) <sup>2</sup>	4,000,000	-0-	6,000,000
Adult Care Facility Quality Services and Advocacy Initiative	-0-	8,000,000 <sup>3</sup>	2,000,000 <sup>4</sup>
Naturally Occurring Retirement Communities (NORCs)	1,200,000	-0-	1,200,000
Respite Care	1,024,000 <sup>5</sup>	479,000 <sup>5</sup>	562,000 <sup>5</sup>
Social Model Adult Day Program	946,276	805,000	946,300
Congregate Services Initiative (CSI)	980,000	-0-	866,000
Long Term Care Ombudsman Program	804,365	804,400	804,400
Alzheimer's Disease Assistance Centers	540,000	486,000	523,800
Retired and Senior Volunteer Program (RSVP)	500,000	-0-	442,000
Caregiver Resource Centers	360,000	360,000	360,000
Foster Grandparent Program	300,000	-0-	200,000
Alzheimer's Community Assistance Program	51,000	- 0 -	35,700

<sup>1</sup> doesn't include administrative expenses

<sup>2</sup> QUIP provides additional funding to adult homes for improving service delivery, such as capital improvements, service enrichment and increased staff wages and benefits

<sup>3</sup> Governor's budget included \$8 million for a different program to assess the needs of adult home residents, provide enhanced medication management, improve service coordination and enhance wellness, social and recreational activities

<sup>4</sup> this money is for case management, advocacy and peer support services in adult homes

<sup>5</sup> also includes \$175,000 for New York Foundation for Senior Citizens Home Sharing and Respite Program

\* Governor proposed to consolidate EISEP and CSE into a single program and reduce funding by \$3,500,245

**Teleconference July 10, 2003**

**Handout #25**

**MEDICAID INCOME  
AND RESOURCE LEVELS**  
Effective January 1, 2003

<b>MONTHLY INCOME:</b>	
<b>FAMILY SIZE</b>	<b>INCOME LEVEL</b>
1	\$642 (+ \$20*)
2	\$934 (+ \$20*)
<b>RESOURCES:</b>	
1	\$3,850 †
2	\$5,600 †
<b>2003 COST-OF-LIVING ADJUSTMENT FOR COMMUNITY SPOUSE ALLOWANCES</b>	
Monthly Income	\$2,267
Resource Allowance	\$74,820 or the spousal share (one-half of a married couple's resources) up to a maximum of \$90,660
<p>* The first \$20 of monthly income per household will not be counted when determining the eligibility of those Medicaid applicants who are aged, blind, or disabled. † There is an additional exclusion for a burial fund of \$1,500 per person or any amount in an irrevocable pre-need funeral agreement.</p>	

**MEDICAID RATES FOR CALCULATING  
NURSING HOME INELIGIBILITY  
AFTER TRANSFER OF ASSETS**

Use this chart to calculate the ineligibility period for **institutional** Medicaid services where resources have been transferred. These rates apply to applications filed on or after January 1, 2003.

<b>REGION</b>	<b>COUNTIES</b>	<b>RATES</b>
New York City	Bronx, Kings (Brooklyn), Queens, Manhattan, Richmond (Staten Island)	\$ 8,157
Long Island	Nassau and Suffolk	\$ 8,583
Northern Metropolitan	Westchester, Rockland, Putnam, Orange, Sullivan, Ulster, Dutchess	\$ 7,464
Western (Buffalo)	Allegany, Genesee, Cattaraugus, Niagara, Chautauqua, Orleans, Erie, Wyoming	\$ 5,614
Northeastern	Albany, Franklin, Otsego, Warren, Clinton, Fulton, Rensselaer, Washington, Columbia, Greene, Saratoga, Delaware, Hamilton, Schenectady, Essex, Montgomery, Schoharie	\$ 5,998
Rochester	Chemung, Seneca, Livingston, Steuben, Monroe, Wayne, Ontario, Yates, Schuyler	\$ 6,058
Central (Syracuse)	Broome, Jefferson, Oswego, Cayuga, Lewis, St. Lawrence, Chenango, Madison, Tioga, Cortland, Oneida, Tompkins, Herkimer, Onondaga	\$ 5,390

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**Handout #26**

# THE BROOKDALE SENIOR RIGHTS REPORT

SAMUEL SADIN INSTITUTE ON LAW / BROOKDALE CENTER ON AGING OF HUNTER COLLEGE / CITY UNIVERSITY OF NEW YORK / SEPT – OCT 2002

## MEDICAID MANDATES GENERIC DRUGS

By Sara Meyers, J.D.

As a result of State legislation passed in January 2002, the Medicaid Mandatory Generic Drug Program will go into effect on **November 17, 2002**. Under the new law, Medicaid will **prohibit** the use of brand name drugs when Federal Drug Administration-approved generic products are available (see: [www.health.state.ny.us/nysdoh/medicaid/ptcommittee/mandatorygen.htm](http://www.health.state.ny.us/nysdoh/medicaid/ptcommittee/mandatorygen.htm)). When a Medicaid recipient fills a prescription and a generic drug equivalent exists, the prescription will be filled with the generic, not the brand name drug. The State believes that the new law will play a significant role in containing drug costs.

### Prior Approval for Use of Brand Name Drugs

The Mandatory Generic Drug Program does allow for the use of brand name drugs when **prior authorization** is obtained from the State Commissioner of Health. Prior authorization to use brand name drugs is required unless the drug has been exempted from the program (see below). To obtain

*(Continued on page 10)*

## MEDICARE PART A & B APPEALS CHANGED

By Andrew Koski, M.S.W.

Effective **October 1, 2002**, the deadline for requesting a Medicare **Part A** reconsideration was **increased** from 60 days to **120 days** for both beneficiaries and providers. Also, starting **October 1, 2002**, **providers** will only have **120 days** to appeal **Medicare Part B** determinations. In addition, starting **January 1, 2003**, the time deadline for **beneficiaries** to request a Medicare **Part B** appeal will be **reduced** from 180 days to **120 days** (see charts on pages 8 and 9 for description of Medicare Part A and Part B appeals processes). Both beneficiaries and providers can request an extension of up to 60 days in the filing deadline

for Medicare Part B appeals if they need additional time to gather the necessary documentation.

These changes are the result of federal legislation, the “Benefit Improvement and Protection Act of 2000 (BIPA),” passed in December 2000. While BIPA mandated that both changes be effective October 1, 2002, the Centers for Medicare and Medicaid Services (CMS) has delayed the implementation date for beneficiaries who are appealing Medicare Part B determinations

until January 1, 2003 to give the Medicare carriers that administer Medicare Part B claims time to change the appeal information on their Medicare Summary Notices (MSNs). MSNs are statements sent to beneficiaries listing all Medicare services they received in a month, including the provider’s name, provider’s charge, Medicare’s approved amount, Medicare’s

*(Continued on page 7)*

*Newsflash!*

**See pages 8 and 9  
for new Medicare  
Part A & B  
appeals charts.**

### SEPTEMBER – OCTOBER 2002



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## WNYLC & GULP LAUNCH ONLINE RESOURCE CENTER

By Sara Meyers, J.D.

The Western New York Law Center (WNYLC) and the Greater Upstate Law Project (GULP) have jointly launched an online resource center (ORC). The ORC will serve as an entry point for the Fair Hearing Bank and a searchable Benefits Law Database. The Fair Hearing Bank contains over 1,500 decisions. (See the January/February 2001 issue of *The Brookdale Senior Rights Report* for further information.) The Benefits Law Database includes court filings, unreported court decisions, helpful briefs and other documents related to

public benefits in New York State. ORC plans to add housing and disability sections in the upcoming months. To access the ORC go to either [www.wnylc.net](http://www.wnylc.net) or [www.gulpny.org](http://www.gulpny.org).

There is no charge for using the ORC, but advocates must register before searching the databases. Everyone who registers is given access to the fair hearings decisions. The administrators from the databases, including benefits, disability and housing, will review applications for access. These databases will be

available exclusively to advocates representing poor and low income clients.

For further information, contact Susan Antos at the Greater Upstate Law Project, Inc., 119 Washington Avenue, Albany, NY 12210, telephone (518) 462-6831, fax (518) 462-6687, e-mail [santos@wnylc.com](mailto:santos@wnylc.com), or Joseph Kelemen at the Western New York Law Center, Inc, 295 Main Street, Suite 454, Buffalo, NY 14203, telephone (716) 855-0203, fax (716) 855-0203, e-mail [JKelemen@wnylc.com](mailto:JKelemen@wnylc.com). ☀

(Continued from page 1)

prior approval for prescribing a brand name drug, prescribers must call the Prior Authorization Call Line (1-877-309-9493) and answer a brief series of questions, including clinical justification for the patient receiving the brand name drug. If approval is granted, the prescriber will be given a prior authorization number to write on the prescription. Once the prescription is presented at the pharmacy, the pharmacist must also call the Authorization Call Line and answer a few questions. If approval is granted, the prior authorization is valid for the prescription and up to five refills for **six months**.

### Exemptions from the Mandatory Generic Program

The Commissioner of Health can exempt certain drugs from the Mandatory Generic Drug Program. The Commissioner has already recommended that certain brand name drugs be exempted from the new law without requiring prior approval. The nine drugs listed by brand name (generic in parenthesis) are:

- Clozaril (clozapine)
- Coumadin (warfarin)
- Neoral, Gengraf and Sandimmune (cyclosporine)
- Tegretol (carbamazepine)
- Zarontin (ethosuximide)
- Dilantin (phenytoin)
- Lanoxin (digoxin)

Refills on prescriptions which were already written and dispensed prior to November 17<sup>th</sup> will **not** require prior authorization. When the current prescription expires, however, a prior authorization will be required for that patient to continue to receive the brand name drug.

Medicaid has developed a process for practitioners, consumer advocacy groups, manufacturers and others to request an exemption for brand name drugs with generic equivalents. Exemption forms can be found at: [www.health.state.ny.us/nysdoh/medicaid/ptcommittee/mangenform.pdf](http://www.health.state.ny.us/nysdoh/medicaid/ptcommittee/mangenform.pdf). ☀

**Teleconference July 10, 2003**

**Handout #27**

# THE BROOKDALE SENIOR RIGHTS REPORT

SAMUEL SADIN INSTITUTE ON LAW / BROOKDALE CENTER ON AGING OF HUNTER COLLEGE / CITY UNIVERSITY OF NEW YORK / NOV – DEC 2002

## RETIREMENT ACCOUNTS AND MEDICAID

by Bernard A. Krooks JD, CPA, LL.M., CELA

For many clients, retirement accounts constitute a significant portion of their assets. Some clients plan to rely on distributions from retirement accounts to maintain their standard of living during retirement, while others wish to pass these assets on to their children or grandchildren. Learning that Medicaid considers their retirement accounts to be available income and resources is often surprising. This Article will discuss the availability of assets held in retirement accounts when individuals or their spouses apply for Medicaid. For purposes of this discussion, retirement accounts include IRAs, Roth IRAs, 401(k) plans, profit-sharing plans, Keogh plans and 403(b) plans, among others.

Medicaid's treatment of retirement accounts depends upon whether the plans are in "pay status." Although the Medicaid statute or regulations do not define pay status, it is generally thought to mean that Medicaid applicants are in receipt of periodic distributions from their retirement accounts.

Under the Internal Revenue Code, individuals must commence taking distributions from their retirement accounts on or before

April 1 of the year after the year in which they reach 70½ (the "Required Beginning Date"). Pursuant to recently revised tables promulgated by the Internal Revenue Service (IRS), individuals age 70½ are generally required to withdraw 1/27 of the amount in their retirement accounts each year. If individuals die before their

retirement funds are exhausted, the remaining funds are distributed to their designated beneficiaries.

Although individuals are required to start taking minimum distributions when they turn 70½, they may start to take distributions at any age. If distributions commence before individuals turn

59½, however, a 10% penalty for early withdrawal generally applies. If the distributions commence after individuals turn 59½, no penalty is assessed. Another IRS approved distribution option is for individuals to elect to receive distributions in substantially equal periodic payments (at least once a year) made over their lives or the joint lives of themselves and their designated beneficiaries. Also, income taxes must be paid on all distributions from retirement accounts.

## NOT IN PAY STATUS

If retirement accounts are **not** in pay status, one way to become Medicaid eligible is to liquidate the retirement account, pay the income taxes and penalties, and spend down or transfer the net proceeds using traditional Medicaid planning techniques. When closing retirement accounts that are not in

*(Continued on page 4)*

*Save the Date!*



March 6th, 2003

(Continued from page 1)

pay status, clients should request that income tax and penalties be withheld at the time of closure to avoid having Medicaid treat the portion of the proceeds that must be paid to the IRS as available income or resources.

### IN PAY STATUS

Retirement accounts that are in **pay status** are considered available to pay for the applicant's care **only** to the extent of the amount of the distributions. Thus, once an individual has started to receive distributions, Medicaid does **not** consider the retirement account a countable resource for eligibility purposes. Medicaid nevertheless does consider the distribution payments to be **income** of the individual on a monthly basis (regardless of whether the payments are received monthly, semi-annually, annually, etc.). For example, if an individual has \$27,000 in a retirement account and is receiving a required minimum distribution of \$1,000 a year, Medicaid considers \$1,000 (\$83.33/month) to be available income. Medicaid does **not** consider the remaining \$26,000 in the account to be an available resource.

A recent fair hearing decision (*Matter of Arnold S.*) confirmed this result. In the *Arnold S.* case, a 77-year-old Medicaid applicant was receiving required minimum distributions. The fair hearing decision concluded that the Medicaid applicant's retirement accounts were not available resources since they were in pay status. Would the result have been

the same if the Medicaid applicant had been under 70½? One could argue that it should not matter if Medicaid applicants are under 70½ as long as their retirement accounts are in pay status. The fair hearing decision based its conclusion on the fact that the retirement accounts were in pay status prior to the application for Medicaid and does not seem to focus on the age of the Medicaid applicant.

### SINGLE INDIVIDUALS

Single individuals are not eligible for Medicaid if they have more than \$3,850 (in 2003) in non-exempt resources. Medicaid considers a retirement account not in pay status a countable resource and, thus, individuals with such retirement accounts that, together with their other resources, exceed \$3,850 are not eligible for Medicaid. This is true even if an individual is under 59½ years old and any withdrawal of retirement funds would be subject to income tax and penalties for early withdrawal.

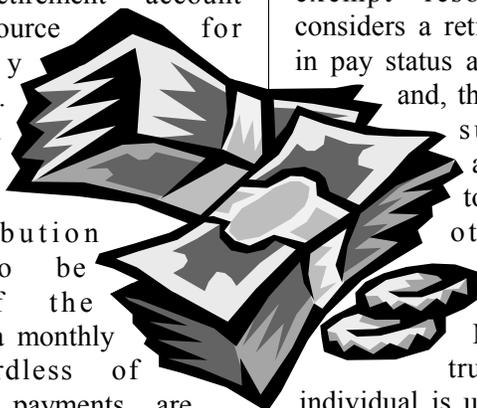
### MARRIED COUPLES

Married couples applying for Medicaid in the community are not eligible if they have more than \$5,600 (in 2003) in non-exempt resources. Since Medicaid considers retirement accounts not in pay status to be countable resources, couples with assets in such accounts that, together with their other resources, exceed \$5,600 are not eligible for Medicaid. If only one member of the couple needs community Medicaid, the ill spouse may apply as a single person if the non-

Medicaid spouse signs a "spousal refusal" form or letter. In spousal refusal community Medicaid cases, only the retirement accounts of the spouse who is applying will be counted.

In cases of married couples where one spouse lives in the community and the other spouse lives in a nursing home, one must look at who owns the retirement accounts to determine whether Medicaid will consider such accounts to be available for the cost of the institutionalized spouse's care in a nursing home. If the spouse residing in the nursing home owns the retirement funds, Medicaid will consider those funds available income or resources in accordance with the rules set forth above. Transfers of funds between spouses, however, do not affect the institutionalized spouse's eligibility for nursing home Medicaid because transfers to a spouse are **exempt** from the transfer penalty rules. A transfer of assets between spouses may protect a significant portion of the marital estate from the costs of

(Continued on page 12)



(Continued from page 4)

long-term care, although local departments of social services may sue community spouses who retain resources in excess of the community spouse resource allowance. A transfer of retirement assets between living spouses, however, generally results in income tax liability unless done pursuant to a divorce decree or separation agreement.

In New York State, Medicaid does not consider retirement accounts **not** in pay status that are owned by the **community** spouse to be available resources for the institutionalized spouse but does count such accounts first towards the community spouse's resource allowance. Retirement accounts of community spouses that are in **pay status** do **not** count towards a community spouse's resource allowance but the distributions do count towards the community spouse's income allowance.

### PLANNING CONSIDERATIONS

Whether particular clients are best served by either liquidating their retirement accounts, paying the income taxes and penalties and using Medicaid planning techniques for some or all of the net proceeds or electing to receive required minimum or substantially

equal periodic distributions depends upon the facts and circumstances of each case. These include factors that are outside of anyone's control, such as how long the client lives or how long the client remains in the institution.

Individuals who are going to be in a nursing home for a long time might be better off liquidating their accounts and receiving lump-sum distributions followed by traditional Medicaid planning. This approach provides more certainty to the plan because applicants and their families will know exactly how much money can be preserved through transfers or other planning techniques at the beginning of the period of institutionalization.

On the other hand, if applicants elect to receive periodic distributions from their retirement accounts, these distributions will have to be paid to the nursing home as excess or surplus income for as long as the recipient lives or the account is depleted, thus reducing the amount that ultimately passes to the Medicaid recipient's beneficiaries. Using this approach, the amount of the principal that will remain for the beneficiaries is less certain.

Prior to the *Arnold S.* decision, the treatment of retirement accounts in pay status by Medicaid was unclear. This decision confirms that when Medicaid applicants over 70½ choose to take required

minimum distributions, Medicaid will treat those distributions as countable **income** without having the principal of the account counted as a resource.

The rules pertaining to the availability of retirement funds for the costs of long-term care are complex. Advocates should advise clients that, although Medicaid considers their retirement accounts available income or resources, proper planning with a knowledgeable professional may allow them and their spouses to protect part or all of these important and, in many cases, substantial assets.☼

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**Handout #28**

<b>SSI INCOME &amp; RESOURCE LEVELS</b> Effective January 1, 2003		
<b>MONTHLY INCOME</b>		
<b>Living Arrangement</b>	<b>Individuals</b>	<b>Couples</b>
Living Alone	\$639.00 (+\$20.00*)	\$933.00 (+\$20.00*)
Living with Others	\$575.00 (+\$20.00*)	\$875.00 (+\$20.00*)
Living in the Household of Another	\$391.00 (+\$20.00*)	\$598.67 (+\$20.00*)
<b>LEVEL II – RESIDENTIAL CARE**</b>		
N.Y.C., L.I., West., & Rockland	\$987.00 (+\$20.00*)	\$1,974.00 (+\$20.00*)
Rest of the State	\$957.00 (+\$20.00*)	\$1,914.00 (+\$20.00*)
<b>RESOURCES</b>	\$2,000	\$3,000
<p>There is an additional exclusion for a bank burial fund of \$1,500 per person <b>or</b> any amount in an irrevocable pre-need funeral agreement.</p> <p>*The first \$20 of monthly income per household will not be counted when determining an applicant's or recipient's eligibility.</p> <p>**Includes adult homes and community residences; residents receive a personal needs allowance of \$124 per month.</p>		

<b>MEDICARE BENEFICIARY COSTS</b> Effective January 1, 2003	
Medicare beneficiaries are required to contribute the following amounts toward their cost of care:	
<b>MEDICARE PART A</b>	
<b>HOSPITAL:</b>	
Deductible	\$840/benefit period
Coinsurance Days 61-90 Days 91-150	\$210/day \$420/day
<b>SKILLED NURSING FACILITY:</b>	
Coinsurance Days 21-100	\$105/day
<b>MEDICARE PART A PREMIUM*</b>	
Individuals with 29 or fewer quarters of Social Security coverage	\$316/month
Individuals with 30-39 quarters of Social Security coverage	\$174/month
* most individuals qualify for Medicare Part A based upon eligibility for Social Security benefits and do <b>NOT</b> have to pay any premium.	
<b>MEDICARE PART B</b>	
Premium	\$58.70/month
Deductible	\$100/year

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**Handout #29**

## SOCIAL SECURITY RETIREMENT AGE INCREASES

Since January 2000, the age for receiving “full” Social Security benefits has started to gradually increase from 65 to 67 over a 22-year period. In addition, although 62 remains the earliest age at which individuals can retire and collect “reduced” Social Security benefits, those who retire at age 62 now face a greater reduction in their benefits. The following chart shows the effect of these two changes.

PEOPLE BORN IN:	AND REACHING AGE 62 IN:	CAN CLAIM UNREDUCED BENEFITS AT AGE:	AT AGE 62, BENEFITS WILL BE REDUCED BY:
1937 or earlier	1999 or earlier	65, 0 months	20.0 percent
1938	2000	65, 2 months	20.8 percent
1939	2001	65, 4 months	21.7 percent
1940	2002	65, 6 months	22.5 percent
1941	2003	65, 8 months	23.3 percent
1942	2004	65, 10 months	24.2 percent
1943 – 1954	2005 – 2016	66, 0 months	25.0 percent
1955	2017	66, 2 months	25.8 percent
1956	2018	66, 4 months	26.7 percent
1957	2019	66, 6 months	27.5 percent
1958	2020	66, 8 months	28.3 percent
1959	2021	66, 10 months	29.2 percent
1960 and later	2022	67, 0 months	30.0 percent

The early retirement reduction depends on the number of months the person actually receives benefits before the normal retirement age (NRA).

The benefit reduction for early retirement is permanent — it lasts for the rest of the worker’s lifetime. If, however, an early retiree does not receive a benefit for every month (because he or she goes back to work or has benefits withheld under the retirement earnings test), the permanent reduction in future benefits will be adjusted. That is, when an early retiree reaches the NRA, the reduction in benefits will be based on the number of early benefits actually received.

**National Academy of Social Insurance, based upon a table  
in the *Social Security Bulletin*, July 1983**

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**Handout #30**

## SOCIAL SECURITY CHANGES FOR 2003

<b>Estimated Average Social Security Benefits</b> Starting January 1, 2003, Social Security benefits will be increased 1.4% because of a cost-of-living adjustment.	
CATEGORY	AVERAGE 2003 BENEFIT
all retired workers	\$ 895
aged couple	1,483
aged widow(er) living alone	862
widowed mother with two children	1,838
all disabled workers	833
disabled worker and family	1,395

<b>Earnings Provisions</b> The amount that Social Security recipients can earn before their Social Security benefits are reduced has been increased.		
AGE	EXEMPT EARNINGS	REDUCTION LEVELS
Under full retirement age*	\$ 11,520	Social Security reduced \$1 for every \$2 earned above \$11,520
Year of full retirement age*: for months prior to full retirement age	\$30,720	Social Security reduced \$1 for every \$3 earned above \$30,720
Full retirement age* and older	ALL earnings	NO reduction in benefits

\* Full retirement age is 65 for individuals born in 1937 and earlier, and 65 and two months for those born in 1938.

**NOTE:** The amount of wages subject to Social Security taxes for old age, survivors and disability benefits is increased to \$87,000. The Medicare portion of the Social Security tax (1.45% of earnings) continues to apply to **all** earnings. The amount of wages needed to earn one quarter of coverage is increased to \$890.

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**Handout #31**

## FOOD STAMP CHANGES ENACTED

by Andrew Koski, M.S.W.

On May 13, 2002, President Bush signed the “Food Stamp Reauthorization Act of 2002.” The following summary of provisions is based on information provided by Barbara Weiner, Staff Attorney with the Greater Upstate Law Project (GULP), in GULP’s *Legal Services Journal* (June 2002). This legislation changes some of the food stamp information provided in the chart, “Non-Citizen Eligibility for Government Benefits in New York State,” from the May-June 2002 issue of *The Brookdale Senior Rights Report*.

### Partial Restoration of Benefits to Legal Immigrants

➤ Effective **April 1, 2003**, legal immigrants who have lived in the United States for **five years** as “qualified aliens”<sup>1</sup> can become eligible for food stamps (as long as they meet the other eligibility criteria). Federal welfare reform legislation in 1996 had eliminated food stamp benefits for most legal immigrants living in the United States except for certain qualified aliens who could only receive food stamps for the first five (later changed to seven) years they had been in the United States. Subsequent federal legislation restored food stamp eligibility for certain qualified aliens who were lawfully residing in the United States on August 22, 1996 **and** were 65 or older on August 22, 1996 **or**, at the time of application, disabled or under 18.

➤ Effective **October 1, 2002**, qualified aliens who meet the food stamp definition for **disability** will become eligible for food stamps, **regardless** of their date of entry. Currently, food stamp benefits are available only to disabled qualified

aliens who were lawfully residing in the United States on August 22, 1996 and were disabled at the time of application.

➤ Effective **October 1, 2003**, qualified aliens **under 18** will become eligible for food stamps without having to wait five years, regardless of their date of entry.

➤ Effective **October 1, 2003**, the counting of income and resources of the immigrant child’s sponsor (deeming requirements) will be **eliminated** when determining the eligibility and benefit amounts for children.

### Increased Resource Level

➤ Effective **October 1, 2002**, the resource level for households with a disabled member will be increased from \$2,000 to \$3,000. This is similar to the limit for households with an elderly member. The resource limit for households with neither elderly nor disabled members remains at \$2,000.

### Annual Increases to Standard Household Deduction

➤ Effective **October 1, 2002**, the current fixed standard deduction (\$134 per month) will be replaced with a deduction that varies according to household size and is adjusted annually for cost-of-living increases.

### Reduction of Household Reporting Requirements

➤ Effective **October 1, 2002**, states will have the option to adopt semi-annual income reporting requirements for all their food stamp households, not just those with earned income. Under semi-annual reporting, food stamp households would only be required to report changes in income and other circumstances at six-month intervals rather than within 10 days of such changes, unless their income exceeds the program’s gross income limit (130% of the federal poverty level). ☀

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<sup>1</sup> Qualified aliens include legal permanent residents, refugees, asylees, persons granted withholding of deportation, persons granted conditional entry, parolees who have been in the United States for at least one year, Cuban and Haitian entrants, Amerasians, and certain battered spouses or children.

## Medicare Eligibility

- 65 and older and eligible for Social Security
- Disabled and collecting Social Security Disability for 2 years

## Medicare Benefits

- Hospital
- Nursing home
- Home care
- Doctor services
- Laboratory services

## Out-of-Pocket Expenses

- Deductibles
- Copayments
- Coinsurance
- Premiums

## Changes in Medicare

- Homebound Criteria
  - those who go to a family reunion, funeral or graduation
  - determination made by looking at condition over period of time
  - those with ALS or psychiatric problems who refuse to leave home

## Changes in Medicare

- Medicare Part B Advance Beneficiary notices
  - given to patient when provider believes Medicare will not pay for a service

## Changes in Medicare

- Annual \$1590 limit on outpatient
  - physical and speech therapy
  - occupational therapy
  - no limit on hospital outpatient therapy
  - delayed until Sept. 1, 2003

## Changes in Medicare

- **Outpatient Mental Health**
  - coverage for diagnostic and treatment
  - copayment is 50% of Medicare approved amount
  - most providers must accept assignment

## Changes in Medicare

- **Ambulance Coverage**
  - must meet medical necessity, destination rules, and provision by an approved provider
  - provider must accept assignment

## Changes in Medicare

- **Appeals Procedures**
  - 120-day deadline for requesting a Medicare Part A or Part B reconsideration
  - Amount needed for Part B administrative law judge hearing is \$100

## Non-Covered Items

- Prescription drugs
- Hearing aids
- Dental work
- Eyeglasses
- Routine physicals
- Regular hearing and vision tests
- Custodial care

## Medigap Insurance

- 10 plans
- Open enrollment
- Community rating
- Limited waiting period for coverage of preexisting conditions
- Guaranteed renewable

## Medicare Select

- Similar to Medigap except beneficiary must use network providers
- Premiums should be lower than Medigap

## **Veterans Benefits Websites**

[www.va.gov](http://www.va.gov)

[www.veterans.state.ny.us](http://www.veterans.state.ny.us)

## **EPIC Website**

[www.health.state.ny.us/nysdoh/epic/faq.htm](http://www.health.state.ny.us/nysdoh/epic/faq.htm)

## **Medicare Managed Care Websites**

[www.hiicap.state.ny.us](http://www.hiicap.state.ny.us)

[www.medicarerights.org](http://www.medicarerights.org)

[www.medicare.gov](http://www.medicare.gov)

[www.ins.state.ny.us/caremain.htm](http://www.ins.state.ny.us/caremain.htm)

## **Medicare Managed Care Plans**

- Referrals required
- Lock-in requirement
- Emphasis on prevention and coordination of care
- May cover drugs, eyeglasses, hearing aids, well visits

## **Medicare Managed Care Plans**

- Lower premiums
- Restricted to service area
- Benefits can change annually
- Plan may decide to leave Medicare

## **Changes to Medicare Managed Care Plans**

- Preferred provider organizations
- New Appeal Procedures for Terminations

## **Medicare Savings Programs**

- QMB, SLIMB, QI-1 and QDWI
- Application Process
- Eligibility Criteria
- Mail Recertification
- Federal Outreach Efforts

## **Federal Medicare Proposals**

- Drug Discount Card
- Prescription drug coverage

## **Medicaid Eligibility**

- Aged, blind or disabled who meet income and resource limits
- Can be on Medicaid and Medicare
- TANF and other low-income individuals

## **Federal Medicaid Proposals**

- State block grant
- State option to reduce benefits for certain groups of individuals
- State option to discontinue coverage for certain categories of individuals

## **Status of State Proposed Changes**

- Increase drug copayments
- Increase annual copayments maximum
- Reduce Medicaid payments for individuals on Medicare and Medicaid
- Reduce payments for home care, hospitals and nursing homes

## **Changes to Medicaid**

- Revised income and resource levels
- New levels for calculating penalty period for transfers of assets
- Mandatory generic drug program
- Treatment of Individual retirement accounts
- Mail recertification process

## Medicaid Websites

[www.wnylc.net](http://www.wnylc.net)  
[www.nls.org](http://www.nls.org)  
[www.gulpny.org](http://www.gulpny.org)  
[www.seniorlaw.com](http://www.seniorlaw.com)  
[www.health.state.ny.us/nysdoh/medicaid/medicaid.htm](http://www.health.state.ny.us/nysdoh/medicaid/medicaid.htm)

## SSI Eligibility Criteria

- Aged, blind or disabled
- Meet income and resource requirements

## SSI Changes

- Benefit levels and living arrangements
- Photo ID

## SSI Problem Areas

- In-kind assistance
- Reporting of changes
- Overpayments

## SSI Websites

<http://policy.ssa.gov/poms.nsf>  
[www.nls.org](http://www.nls.org)

## Social Security

- Retirees
- Widow/widowers
- Survivors
- Disabled individuals

## **Social Security Changes**

- Increase in retirement age
- New levels

## **Food Stamps Changes**

- Changes in benefits for legal immigrants
- Increased resource limit for disabled households
- Standard deduction will vary and be adjusted annually

## **To Evaluate Online**

**From the Intranet:**

**<http://sdssnet5/>**

**From the Internet:**

**<http://ww.dfa.state.ny.us>**