

# Chapter 1

## What is HICAP and the Importance of its Volunteer Network

**Scope of chapter.** This chapter addresses the legal authority for the Texas Benefits Counseling program known as the Health Information, Counseling and Advocacy Program, or HICAP. The attachments to this chapter include a Medicare law excerpt which currently is the main source of funding for the Benefits Counseling program. There is also a list of acronyms common to this program.

### **Overview of paragraphs**

- Paragraphs 1 - 3 identify federal and state provisions related to the Benefits Counseling program known as HICAP.
- Paragraph 4 describes the role of volunteers.
- Paragraph 5 – 6 discuss the role of Medicare as a source of referrals.
- Paragraph 7 discusses the role of the Council of Government as the umbrella agency for many area agencies on aging.
- Paragraphs 8 – 9 discuss the current grant cycle and funding stream for HICAP.
- Paragraphs 10 – 12 review certain roles of the Area Agencies on Aging.
- Paragraph 13 – 14 concern reporting and outreach.
- Paragraphs 15 – 16 describe certain resources available to HICAP, the Texas SHIP.
- Paragraph 17 discusses the Listserv maintained for HICAP.
- Paragraph 18 concerns building local partnerships.
- Paragraph 19 discusses reporting requirements for HICAP and Benefits Counselors.
- Attachments.
  - Appendix A: 42 United States Code §1395b-4 (part)
  - Appendix B: Acronyms.
  - Appendix C: Client Agreement.
  - Appendix D: Volunteer Job Agreement.
  - Appendix E: Changes in the Volunteer Profile.
  - Appendix F: Volunteer Survey.

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- Appendix G: Ways to Recognize Volunteers.
- Appendix H: Complaint Resolution Process re Volunteer Certified Benefits Counselors.
- Appendix I: Chapter One Questions and Answers.

**Chapter questions and answers.** After some of the paragraphs there are questions relating to the materials covered in the paragraphs. An answer key is at the end of the chapter.

1. **Sources of Law.** The Benefits Counseling program is authorized under provisions of the Medicare law, at [42 U.S.C. §1395b-4](#). That section of the Medicare law authorizes national funding for a program of health insurance information, counseling and advocacy grants. This program is often referred to as the “State Health Insurance Assistance Program” – the “SHIP.” The Administration for Community Living (ACL), which is part of the federal Department of Health and Human Services (DHHS), administers the SHIP program.

Thus, a Congressional appropriation to DHHS is the key funding source for HICAP under the federal State Health Insurance Assistance Program (SHIP). The above-referenced Medicare aspect of the program, 42 U.S.C. §1395b-4, was created under [Section 4360 of the Omnibus Budget Reconciliation Act \(OBRA\) of 1990 \(Public Law 101-508\)](#). This section of law authorized the Secretary of DHHS to use funds drawn from the Medicare trust fund to make grants to States. To receive a grant, the State must submit to DHHS “a plan for a State-wide health insurance information, counseling, and assistance program.” [42 U.S.C. §1395b-4\(b\)](#). There is a SHIP program in every state.

Question: What do the letters DHHS stand for?

Answer: \_\_\_\_\_

Question: What do the letters SHIP stand for?

Answer: \_\_\_\_\_

2. The Benefits Counseling program in Texas is a required component of an Area Agency on Aging System of Access and Assistance. This is provided for by [40 Texas Administrative Code \(TAC\) §83.3\(c\)\(2\)](#). There are 28 Area Agencies on Aging in Texas; together they serve all 254 counties in the State. The Area Agencies on Aging have contracts with the Texas Health and Human Services Commission (HHSC). HHSC heads up the health and human services agencies in Texas.

Question: How many Area Agencies on Aging are there in Texas?

Answer: \_\_\_\_\_

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Question: What do the letters HHSC stand for?

Answer: \_\_\_\_\_

True or False: It is optional whether an Area Agency on Aging will have a Benefits Counseling program as a component of an Area Agency on Aging System of Access and Assistance; it is not required.

True \_\_\_\_\_ (it is not required) False \_\_\_\_\_ (it is required)

3. The Benefits Counselors of the Area Agencies on Aging assist individuals to access a wide range of Medicare services. This includes application assistance relating to Hospital Insurance (Medicare Part A) and Medical Insurance (Medicare Part B). It includes assisting with Medicare Advantage enrollment and disenrollment. (Medicare Advantage is Medicare Part C). It includes assisting with Medicare Part D enrollment and disenrollment. (Medicare Part D is the Medicare Prescription Drug Program). The Benefits Counselors, staff and volunteer, are a fundamental part of the SHIP in Texas.

Questions:

What Part of Medicare is Hospital Insurance?

Answer: \_\_\_\_\_

What Part of Medicare is Medicare Advantage?

Answer: \_\_\_\_\_

What Part of Medicare is the Medicare Prescription Drug Program?

Answer: \_\_\_\_\_

4. Role of Volunteers: HICAP is made successful through volunteer counselors who use specific information or assistance to counsel individuals. Volunteers are an essential component of HICAP. Only through a statewide network of hundreds of dedicated and trained volunteers will HICAP be able to provide the services seniors require. The training sessions for staff and volunteers provide an objective approach to specific problems with claims and insurance policy review. The program combines federal, state, and local resources to serve clients. The volunteer base is essential to secure potentially eligible individuals appropriate free services. The task of recruiting, screening, training and placement of volunteers is a major component of HICAP for staff counselors. See the Age Well Live Well site at <https://hhs.texas.gov/about-hhs/community-engagement/age-well-live-well> for volunteer development resources.

5. Medicare law is now the main source of funding for HICAP. This funding is provided through an annual federal grant from the DHHS. The SHIP programs in each state are structured differently but in most other states the SHIP resides in only one state agency. Medicare publications and the Medicare national hotline will frequently refer beneficiaries to the SHIP in their state.

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6. Referrals from Medicare will be an opportunity for Benefits Counselors to assist older individuals in understanding their Medicare rights, exercising choice, benefiting from Medicare services and opportunities authorized by law and maintaining the rights of older persons, especially those with reduced capacity, and solving disputes. Assistance in applying for Medicare benefits and appropriate referrals are also a part of the counseling process.
7. The AAAs recognize HICAP as an important enhancement to their client services. Many (25) of these AAAs are under the umbrella of Councils of Government (COGs). One (Tarrant County) exists in the framework of a nonprofit group, the United Way. One is a part of city government (Harris County – under the City of Houston), and one is under a community council (Dallas).
8. **Grant Cycle for HICAP (SHIP) Funding.** The grant cycle begins April 1 and ends March 30 of the following year. Of course, DHHS' ability to make federal grants depends on Congress appropriating the funds for the SHIP.

Which branch of the federal government appropriates funds for federal grants for the SHIP?

Answer: \_\_\_\_\_

9. Grant funds are made available to support information, counseling and assistance activities relating to Medicare. The current HICAP grant establishes four objectives summarizing Benefits Counseling services as one-on-one counseling; targeted outreach that supports CMS initiatives and partnerships; proficiency and capacity to assist beneficiaries to understand health plan options and enrollment assistance; and participation in CMS education and communication activities to update individuals about Medicare changes. Additionally the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) is the basis for the appropriations by Congress of funds for SHIPs to conduct outreach related to the Low-Income Subsidy/Extra Help (LIS) that works with Medicare Part D and for application assistance for LIS and the Medicare Savings Programs.
10. **Role of the Area Agency on Aging.** Each AAA is responsible for maintaining a benefits counseling component with the AAA. For purposes of the HICAP grant, a lead counselor should be designated. The AAA is responsible for recruiting, screening, training, and placing volunteers throughout their assigned service area. Certified staff counselors and volunteers complete the same training course. Benefits Counselor training and oversight of volunteers can be completed in-house, at the sponsoring agency, as long as this in-house training is in coordination with the HICAP partnership. Volunteers may take calls and practice resolving problems with the guidance of staff counselor oversight. Benefits Counselors can supervise the volunteer's quality of work, record-keeping practices, ability to identify specific "profiles of need" issues and observe communication skills and interaction with clients.

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11. The AAA is responsible for maintaining training files for staff and volunteers and filing certification and re-certification documents. This is a requirement of HHSC. This subject is covered in more detail in the certification program requirements in Chapter 2 of this manual.
12. Building Capability and Capacity in Benefits Counseling. The AAA is responsible for assurance that the Benefits Counseling program is available to individuals residing in all of their service area.
13. The HICAP program is designed to function through staff benefits counselors and volunteer benefits counselors to provide older individuals and Medicare enrollees and pre-enrollees of any age with free, competent, and confidential counseling. Chapter Three of this manual discusses SHIP reporting and the filing of monthly reports. Again, these numbers become part of the national summary of how this state serves its seniors and persons on Medicare.
14. Increasingly, DHHS requires that SHIPs act as an integral partner on education and outreach campaigns. Performance guidelines expect not only promotion/outreach but measurable assistance to individuals. An example of this is the campaign on the Low Income Subsidy to Medicare Part D.
15. Key HICAP Resources - SHIPs are viewed as primary partners in CMS's effort to assist beneficiaries. Following are SHIP information and training resources from CMS.
  - A. The National Medicare Training Program hosts monthly audio conference calls and produces multimedia training aids, tool kits and partner publications. Their website is on the CMS versus public Medicare website. Outreach and Education information is located at <https://www.cms.gov/home/outreacheducation.asp>. The National Medicare Training Program website is at <http://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/>.
  - B. The SHIP Resource Center is a contracted entity that supports the state SHIPs, serving as a depository for SHIP-related communications from CMS. The Resource Center also issues a regular newsletter and offers a secure website at [www.SHIPTalk.org](http://www.SHIPTalk.org).
  - C. The SHIP Directors Conference has trained and supported state SHIP directors and state-level partners.
  - D. The CMS Regional SHIP Liaisons regularly communicate with SHIP Directors in their region. Texas is served by the Region VI CMS office in Dallas. The regional office has hosted annual Train-the-Trainer seminars each summer. This office also handles Medicare Advantage and Medicare Prescription Drug complaints after the client and/or their representative has exhausted the complaint process through the plans.
  - E. Other resources available to SHIP partners for use with beneficiaries include the following:
    - The *Medicare & You* handbook which is issued yearly.
    - The Medicare website [www.medicare.gov](http://www.medicare.gov), which includes plan comparison information for both Medicare Advantage plans and Medicare Prescription Drug plans.
    - The toll-free, 1-800-MEDICARE (1-800-633-4227) call center.

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16. Other SHIP Resources: At the national level there are other partners that work in conjunction with CMS. Among them are the National Council on Aging via My Medicare Matters at the Web site <https://www.mymedicarematters.org/>, and the Medicare Rights Center at <http://www.medicarerights.org/>.
17. [Texasadvocates@yahoo.com](mailto:Texasadvocates@yahoo.com) is a Listserv that allows Benefits Counselors to post questions or information of interest to the HICAP network. To register a Benefits Counselor to receive Texas Advocates notices, the AAA Director needs to send an e-mail to [bbower@tlsc.org](mailto:bbower@tlsc.org) or [mdeutsch@tlsc.org](mailto:mdeutsch@tlsc.org), requesting that the referenced counselor be allowed to join Texas Advocates. The listserv is used to issue timely information and notices to benefits counselors.
18. Building Local Partnerships. HICAP components at the state level are resources for building partnerships with federal, state, and community groups and organizations. Your partnerships can build capacity for services. A way to build capacity is to reach potentially eligible individuals through organizations such health providers as they are likely serving the target population HICAP needs to reach.
19. Reporting is a significant program requirement for counselors. Interest has grown relative to how all parts of the information infrastructure perform in the effort to serve the population targeted by HICAP. As a result, there is new government-wide emphasis on results and outcomes in all areas. This has brought about increased focus on accountability, including reporting of activity and performance assessments to determine the impact of these service programs. SHIP uses the National Performance Report (NPR) as a tool to measure outcomes of the grant partnerships with all states. HHSC uses the Social Assistance Management Software (SAMS) and other approved systems.

True or false:

The National Performance Report (NPR) as a tool to measure outcomes of the grant partnerships with all states.

True \_\_\_\_\_ False \_\_\_\_\_

## **Chapter 1 – Appendix A**

### *42 USCS § 1395b-4*

#### **§ 1395b-4. Health insurance information, counseling, and assistance grants**

(a) Grants. The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall make grants to States, with approved State regulatory programs under section 1882 of the Social Security Act [42 USCS § 1395ss], that submit applications to the Secretary that meet the requirements of this section for the purpose of providing information, counseling, and assistance relating to the procurement of adequate and appropriate health insurance coverage to individuals who are eligible to receive benefits under title XVIII of the Social Security Act [42 USCS §§ 1395 et seq.] (in this section referred to as "eligible individuals"). The Secretary shall prescribe regulations to establish a minimum level of funding for a grant issued under this section.



## **Chapter 1 – Appendix B**

### **ACRONYMS**

**Note:** There is a very thorough acronym search tool on the Web site of the Centers for Medicare and Medicaid Services, at <https://www.cms.gov/apps/acronyms/>.

<b>AAA</b>	<b>Area Agency on Aging</b>
<b>ACA</b>	<b>Affordable Care Act of 2010 (also referred to as the Patient Protection and Affordable Care Act of 2010) (May also be abbreviated PPACA)</b>
<b>ADL</b>	<b>Activities of Daily Living</b>
<b>ALF</b>	<b>Assisted Living Facility</b>
<b>ALJ</b>	<b>Administrative Law Judge</b>
<b>ALS</b>	<b>Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)</b>
<b>AoA</b>	<b>Administration on Aging</b>
<b>APS</b>	<b>Adult Protective Services</b>
<b>BBA</b>	<b>Balanced Budget Act</b>
<b>CAHPS</b>	<b>Consumer Assessment of Health Plans Study</b>
<b>CDC</b>	<b>Centers for Disease Control</b>
<b>CHAMPUS</b>	<b>Civilian Health and Medical Program of the Uniformed Services (now a managed care system known as TRICARE)</b>
<b>CHAMPVA</b>	<b>Civilian Health and Medical Program of the Department of Veterans Affairs</b>
<b>CHDR</b>	<b>Center for Health Dispute Resolution</b>
<b>CMS</b>	<b>Centers for Medicare and Medicaid Services</b>
<b>COBRA</b>	<b>Consolidated Omnibus Budget Reconciliation Act</b>
<b>COLA</b>	<b>Cost of Living Adjustment</b>
<b>CCAD</b>	<b>Community Care for the Aged and Disabled</b>
<b>DAB</b>	<b>Departmental Appeals Board</b>
<b>DHHS</b>	<b>Department of Health and Human Services</b>
<b>DME</b>	<b>Durable Medical Equipment</b>
<b>DRG</b>	<b>Diagnosis-Related Groups</b>
<b>ESRD</b>	<b>End-Stage Renal Disease</b>
<b>EOB</b>	<b>Explanation of Benefits</b>
<b>FOIA</b>	<b>Freedom of Information Act</b>
<b>FQHC</b>	<b>Federal Qualified Health Centers</b>
<b>GHP</b>	<b>(Employer) Group Health Program</b>
<b>HEDIS</b>	<b>Health Employer Data and Information Set</b>
<b>HHSC</b>	<b>Texas Health and Human Services Commission</b>
<b>HIPAA</b>	<b>Health Insurance Portability &amp; Accountability Act</b>
<b>HICAP</b>	<b>Health Information Counseling and Advocacy Program</b>
<b>HMO</b>	<b>Health Maintenance Organization</b>
<b>HMO-POS</b>	<b>Health Maintenance Organization – Point of Service option</b>
<b>IHFSP</b>	<b>In-Home Family Support Program (DADS)</b>
<b>LHT</b>	<b>Legal Hotline for Texans</b>



<b>LIS</b>	<b>Low-Income Subsidy</b>
<b>MA</b>	<b>Medicare Advantage</b>
<b>MEW</b>	<b>Medicaid Eligibility Worker</b>
<b>MIPPA</b>	<b>Medicare Improvements for Patients and Providers Act of 2008</b>
<b>MMA</b>	<b>Medicare Modernization Act of 2003</b>
<b>MQMB</b>	<b>Medicaid Qualified Medicare Beneficiary</b>
<b>MSA</b>	<b>Medical Savings Account</b>
<b>MSN</b>	<b>Medicare Summary Notice</b>
<b>NF</b>	<b>Nursing Facility</b>
<b>NMEP</b>	<b>National Medicare Education Program</b>
<b>OAA</b>	<b>Older Americans Act</b>
<b>OASDI</b>	<b>Old Age Survivors and Disability Insurance</b>
<b>PACE</b>	<b>Program of All-Inclusive Care for the Elderly</b>
<b>PCIP</b>	<b>Pre-Existing Condition Insurance Plan</b>
<b>PCP</b>	<b>Primary Care Physician</b>
<b>PFFS</b>	<b>Private Fee-for-Service</b>
<b>POMS</b>	<b>Program Operations Manual System (of Social Security)</b>
<b>POS</b>	<b>Point of Service Organization</b>
<b>PPACA</b>	<b>Patient Protection and Affordable Care Act of 2010 (also referred to as the Affordable Care Act of 2010)</b>
<b>PPO</b>	<b>Preferred Provider Organization</b>
<b>PRO</b>	<b>Peer Review Organization</b>
<b>PSO</b>	<b>Provider Sponsored Organization</b>
<b>QDWI</b>	<b>Qualified Disabled and Working Individual</b>
<b>QI</b>	<b>Qualified Individual</b>
<b>QMB</b>	<b>Qualified Medicare Beneficiary (Quimby)</b>
<b>REACH</b>	<b>Regional Education about Choices in Health</b>
<b>RFBS</b>	<b>Religious Fraternal Benefit Society Plan</b>
<b>RRB</b>	<b>Railroad Retirement Board</b>
<b>SEP</b>	<b>Special Election Period</b>
<b>SLMB</b>	<b>Specified Low-Income Medicare Beneficiary (Pronounced “Slimby”)</b>
<b>SHIP</b>	<b>State Health Insurance Assistance Program</b>
<b>SNAP</b>	<b>Supplemental Nutrition Assistance Program (formerly known as “food stamps”)</b>
<b>SNF</b>	<b>Skilled Nursing Facility</b>
<b>SSA</b>	<b>Social Security Administration</b>
<b>SSI</b>	<b>Supplemental Security Income</b>
<b>TANF</b>	<b>Temporary Assistance for Needy Families</b>
<b>TDD</b>	<b>Telecommunication Device for the Deaf (now, TTY is used – see below)</b>
<b>TDI</b>	<b>Texas Department of Insurance</b>
<b>TLSC</b>	<b>Texas Legal Services Center</b>
<b>TRS</b>	<b>Telecommunications Relay Service (for instance, Relay Texas)</b>
<b>TTY</b>	<b>Text Telephone</b>
<b>VA</b>	<b>Veterans Administration</b>

## **Chapter 1 – Appendix C – Client Agreement**

### **(AAA/BC LOGO) CLIENT AGREEMENT (EXAMPLE)**

**I understand that the Texas Health Information, Counseling and Advocacy Program is a state-sponsored, non-profit program for persons needing assistance with their public and/or private benefits. Counseling services are intended to help me understand public and private benefits in an objective manner that supports my independent decisions. I understand that counseling services are provided by Certified Counselors, acting in good faith to provide information about public/private benefits to me, the client.**

**I understand that Certified Counselors are not permitted to render legal advice or other legal services which would be construed as the unauthorized practice of law. I understand that Certified Counselors are neither affiliated with the insurance industry, nor are they financial planners. They do not sell, recommend or endorse any specific insurance product, agent, insurance company, or health plan.**

**Counseling is confidential and free of charge. I understand that I may make a donation to the program, if I desire.**

**Furthermore, I authorize the \_\_\_\_\_ (local program/agency), to receive information as necessary, from other agencies or provider of services from which I'm receiving services, to complete the course of action needed regarding my public/private benefits. Such authorization shall remain valid for a period of \_\_\_\_\_ days/months, from the date of signature.**

\_\_\_\_\_  
**CLIENT SIGNATURE**

\_\_\_\_\_  
**COUNSELOR SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**DATE**

**Note: You may be asked to fill out a HIPAA form for us to proceed on your behalf.**

## Chapter 1 – Appendix D – Volunteer Job Agreement

### **(EXAMPLE – VOLUNTEER JOB DESCRIPTION) (AAA/LOGO)**

**JOB TITLE:** VOLUNTEER BENEFITS COUNSELOR

**OBJECTIVE:** Complete 25-hour training program, attain level I certification, and provide HICAP services to individuals who are 60 years of age or older, or who are eligible for Medicare regardless of age.

**SCHEDULE:** Minimum of 2-4 hours of counseling services per week.

#### **GENERAL DUTIES:**

Provide counseling and advocacy for clients in the areas of benefits and entitlements. Provide confidential advocacy and counseling services. Assist clients in understanding and accessing public/private benefits. Respect and protect the privacy and confidentiality of client information. Be sensitive to client's social and emotional needs.

#### **SPECIFIC DUTIES:**

Provide 2-4 hours per week of outreach and counseling services. Practice effective communication techniques. Provide appropriate feedback to supervising staff through monthly reports. Reports are a program requirement. Attend in-services and mandatory meetings to share activity experiences, recruitment techniques and maintain updated resource materials.

#### **TRAINING:**

Training is a 25-hour course that will cover various topics. Please refer to the description of these topics in Chapter 2.

#### **CONFIDENTIALITY:**

All client information is confidential and not shared with anyone outside the volunteer program without client consent. Violation of confidentiality procedures will be grounds for dismissal.

#### **ABILITIES:**

Volunteers must be able to work independently and know when to ask for assistance. Volunteers will demonstrate qualities associated with problem solving, patience and persistence, and work well with

individuals, families and groups. Volunteers must demonstrate the ability to document and maintain accurate reports and submit reports in a timely manner.

CONFLICT OF INTEREST:

Volunteers with a conflict of interest are not potential candidates for this volunteer program.

## **Chapter 1 – Appendix E – Changes in the Volunteer Profile**

### **CHANGES IN THE VOLUNTEER PROFILE**

#### **TRADITIONAL VOLUNTEER**

- \_ FEMALE
- \_ HOUSEWIFE/MOTHER
- \_ WILLING TO TAKE DIRECTION
- \_ WILLING TO DO CLERICAL TASKS
- \_ DEFERRED TO STAFF OPINION, STYLES AND APPROACHES
- \_ VOLUNTEERING IS A DUTY/OBLIGATION

#### **TODAY'S VOLUNTEER**

- \_ WANTS FLEXIBLE HOURS
- \_ MAY BE AVAILABLE NIGHTS/WEEKENDS
- \_ HAS LIMITED TIME TO OFFER
- \_ BRINGS A WIDER VARIETY OF SKILLS
- \_ DOESN'T JUST WANT TO FILL A SLOT
- \_ MAY APPRECIATE CORPORATE SUPPORT FOR VOLUNTEERS
- \_ MAY ENGAGE IN GREATER QUESTIONING OF THE SYSTEM
- \_ ASKS HOW THIS WILL MAKE A DIFFERENCE
- \_ OFFERS SUGGESTIONS FOR PROGRAMMATIC CHANGES
- \_ QUESTIONS NEED FOR BACKGROUND CHECKS/INTERVIEWS

**Chapter 1 – Appendix F – Volunteer Survey – an example**

**Check one:**

1.    ☐ I have enough materials  
      ☐ I get materials fairly easily  
      ☐ I am usually waiting for materials

**Suggestions/Comments**

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2.    ☐ I feel very well trained in what I do  
      ☐ I usually have the right answer and feel comfortable that I'm giving the right advice  
      ☐ I wish I knew more about \_\_\_\_\_

3.    ☐ I know who to call when I have a question about my job  
      ☐ I am not always sure who to call but I manage somehow  
      ☐ I usually have to scramble to find out an answer

**Suggestions/Comments**

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4.    ☐ I am updated and have the most current information available  
      ☐ I mostly have the current material and feel informed  
      ☐ I wish I had more information about \_\_\_\_\_

5.    ☐ As a volunteer I feel supported and valued for the work I do  
      ☐ I mostly feel supported and valued  
      ☐ Sometimes I wonder if anyone knows what I do and I feel a little lost

## **Chapter 1 – Appendix G – Ways to Recognize Volunteers**

### **WAYS TO RECOGNIZE VOLUNTEERS**

#### **Substantive:**

- 1. Let them participate as program trainers**
- 2. Invite to staff meetings**
- 3. Keep them challenged**
- 4. Provide further training**
- 5. Provide enhanced service opportunities**

#### **Award Ideas**

- 1. Letter of Appreciation**
- 2. Refrigerator Magnets**
- 3. Pins**
- 4. Pens**
- 5. Certificates**
- 6. Ribbons**
- 7. T-Shirts**
- 8. Patches**
- 9. Flowers**
- 10. Thank You Photos**
- 11. Honor Roll**
- 12. Service Stripes**
- 13. Personalized Coffee Mug**

#### **Special Events**

##### **Ideas:**

**Special Volunteer Cake**

**Movie Tickets**

**Ice Cream Party**

**Coffee and Cake Party**

**Send Birthday/Holiday Cards**

**Volunteer Recognition Lunch**



**Chapter 1 – Appendix H – Complaint Resolution Process**  
**Regarding Volunteer Certified Benefits Counselors**

(AAA logo)  
(EXAMPLE)

**BENEFITS COUNSELING PROGRAM COMPLAINT RESOLUTION PROCEDURES**  
**BACKGROUND**

The following “Complaint Resolution Procedures” have been developed to comply with the requirements of the policy for Certified Benefits Counselor Dismissal Review. As the certification and re-certification of certified Benefits Counselor is at the agreement of the Texas Health and Human Services Commission, these procedures need to be consistent. Additionally, these procedures enable us to maintain a healthy atmosphere in which each certified volunteer can speak freely and have frank discussions with the Certified Staff Benefits Counselors.

**OVERSIGHT**

The Staff Benefits Counselor is responsible for overseeing the adherence to and timeliness of the complaint resolution process. These resolution procedures are available only to Certified Benefits Counselors.

**COMMUNICATION**

All certified volunteers can contact the Staff Benefits Counselor, in person, at any time by phone, fax, letter, or e-mail. The goal is always to have effective communication. The Staff Benefits Counselor will maintain effective communication with each certified volunteer to ensure knowledge of the philosophy regarding procedural changes from HICAP, its support agencies, and the AAA. Likewise, the Staff Benefits Counselor will communicate any concerns to the certified volunteer in respect to performance that may have a negative impact on the program. Acceptable performance includes, but is not limited to 1) reporting required monthly data to the Staff Benefits Counselor, and 2) conducting services in a confidential and professional manner. For example, inappropriate counseling, such as assistance with the drafting of a will or any other legal instrument, will bring dismissal as well as the potential for serious criminal penalties. Breach of confidentiality also has the consequences of dismissal also. Allegations of misconduct by a certified volunteer will be investigated by the Staff Benefits Counselor to determine the validity of the allegations. Amelioration of such allegations may be resolved through more training, increased supervision by the Staff Benefits Counselor, or other means. The discipline system to be utilized will be a graduated system: supervision assistance, written warning, suspension, and termination. However, should a certified volunteer wish to air any concern, make a complaint, or appeal a disciplinary action, they must follow the following procedures.

**CONTENT AND DELIVERY**

The appeal or complaint must be in writing and addressed to the attention of the Staff Benefits Counselor. The written record must contain the following: 1) the purpose of the record, 2) the date of the original action being addressed, and 3) a synopsis of efforts pursued to resolve the matter prior to the submission of the record. The written record should be delivered by hand or certified mail to the office of the Staff Benefits Counselor during the normal workweek.

**TIME LIMIT**

A written record must be submitted within thirty ( 30 ) days of the initial problem.

**VOLUNTEER STATUS**

The certified volunteer pursuing the resolution process will be placed on inactive status. No

**volunteer benefits counseling activities will be conducted by the certified volunteer.**

#### **REVIEW**

**The Staff Benefits Counselor will review all pertinent documentation and request clarification or additional information as necessary. Any new data must be received within ten (10) working days of the request. Once all data is available for review, a decision will be made within fourteen (14) working days. If immediate dismissal is the outcome, the certified volunteer will be notified immediately by certified letter with return receipt. Any certification badges or other agency identification will be returned within five (5) working days from the receipt of the letter. Duty stations will be notified of the volunteer's termination within five (5) working days of the final decision.**

#### **APPEAL PROCEDURES**

**An appeal of a decision by the Staff Benefits Counselor may be made to the Director of the Area Agency on Aging, in writing, within five (5) days of the decision. All documentation will be forwarded to the Director. That documentation, along with interviews with the Staff Benefits Counselor, the volunteer, duty station representatives, and other interested parties will be the record used to make a determination on behalf of the certified volunteer. The Director will issue a written decision to the volunteer with thirty (30) working days of receipt of the appeal notice. An appeal of the AAA Director's decision may be made to HICAP, through the Texas Health and Human Services Commission. Appeal notification must be made within seven (7) working days.**

## Chapter 1 – Appendix I – Questions and Answers

(Answers are on the third sheet down)

1. Question: What do the letters DHHS stand for?

Answer: \_\_\_\_\_

2. Question: What do the letters SHIP stand for?

Answer: \_\_\_\_\_

3. Question: How many Area Agencies on Aging are there in Texas?

Answer: \_\_\_\_\_

4. Question: What do the letters HHSC stand for?

Answer: \_\_\_\_\_

5. True or False: It is optional whether an Area Agency on Aging will have a Benefits Counseling program as a component of an Area Agency on Aging System of Access and Assistance; it is not required.

True \_\_\_\_\_ (it is not required) False \_\_\_\_\_ (it is required)

Questions:

6. What Part of Medicare is Hospital Insurance?

Answer: \_\_\_\_\_

7. What Part of Medicare is Medicare Advantage?

Answer: \_\_\_\_\_

8. What Part of Medicare is the Medicare Prescription Drug Program?

Answer: \_\_\_\_\_

9. Which branch of the federal government appropriates funds for federal grants for the SHIP?

Answer: \_\_\_\_\_

## **Chapter 1 -- Appendix I – Questions and Answers**

10 True or false:

The National Performance Report (NPR) is a tool to measure outcomes of the grant partnerships with all states.

True \_\_\_\_\_ False \_\_\_\_\_

## Chapter 1

### Appendix I – Questions and Answers

(Answers are on the third sheet down)

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Answer: \_\_\_\_\_

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## **Chapter 1**

### **Appendix I – Questions and Answers**

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True \_\_\_\_\_ False \_\_\_\_\_

## **Chapter 1**

### **Appendix I – Questions and Answers**

#### **Answers:**

1. Department of Health and Human Services
2. State Health Insurance Assistance Program
3. 28
4. Health and Human Services Commission
5. False (it is required)
6. D (Part D)
7. C (Part C)
8. D (Part D)
9. Congress
10. True



## **Chapter 2**

### **Counselor Skills/Qualifications**

Scope of chapter. This chapter sets forth the qualifications, skills, and abilities required for staff and volunteers working as Benefits Counselors I. The Benefits Counseling program, known as the Health Information, Counseling, and Advocacy Program (HICAP), is established as a basic program of the Area Agencies on Aging pursuant to funding received from the Texas Health and Human Services Commission, as described in Chapter 1 of this manual. Funding for all HICAP activities, except the HICAP Director's position, is pursuant to a State Health Insurance Assistance Program (SHIP) grant from the Administration for Community Living (ACL).

Chapter questions and answers. There are questions after some of the paragraph sections. An answer key is at the end of the chapter.

#### Overview of paragraphs.

- Paragraph 1 identifies the source of Medicare law regarding HICAP.
- Paragraph 2 identifies the allowable activities as defined by ACL for the SHIP (HICAP).
- Paragraph 3 discusses volunteers as Benefits Counselors I.
- Paragraph 4 explains the certification process available to Benefits Counselors I.
- Paragraph 5 describes the programs for which Benefits Counselors I receive training in accord with HICAP funding,
- Paragraph 6 describes other training requirements for Benefits Counselors I.
- Paragraph 7 discusses the role of outreach in the SHIP.
- Paragraph 8 addresses monitoring of HICAP.
- Paragraph 9 describes the increasing importance of quality assurance measures in the SHIP program.
- Paragraph 10 references training modules to promote assistance to beneficiaries with mental health conditions.
- Paragraph 11 addresses mystery shopping.
- Paragraph 12 addresses the requirement to safeguard personal client information.

- Attachments -- Appendices

- A – Chart of Allowable Activities
- B – Application for Certification
- C – Verification of Certification
- D – Home Visit Checklist
- E – Client Intake and Service Request Form
- F – Client Rights & Responsibilities
- G – Area Agency on Aging Client Information Release
- H – Medical Abbreviations – Most Frequently Used
- I – A-Z Medical Abbreviations – More Detailed List
- J – Chapter 2 Questions and Answers

1. Source of Medicare Law for the SHIP (HICAP)

The Medicare law at 42 United States Code § 1395b-4 provides in part:

Health insurance information, counseling, and assistance grants

- (a) Grants. The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall make grants to States, with approved State regulatory programs under section 1882 of the Social Security Act [42 USCS § 1395ss], that submit applications to the Secretary that meet the requirements of this section for the purpose of providing information, counseling, and assistance relating to the

procurement of adequate and appropriate health insurance coverage to individuals who are eligible to receive benefits under title XVIII of the Social Security Act [42 USCS §§ 1395 et seq.] (in this section referred to as "eligible individuals"). The Secretary shall prescribe regulations to establish a minimum level of funding for a grant issued under this section.

Thus, the individuals to be served by the SHIP are "individuals who are eligible to receive benefits under title XVIII of the Social Security Act" – which is to say, individuals eligible to receive Medicare benefits.

Question: (True or False): To receive SHIP services, an individual must be eligible to receive Medicare. \_\_\_\_\_ True \_\_\_\_\_ False

It should be noted that "an individual eligible to receive Medicare" includes persons on Medicare regardless of age. Certain individuals, such as those who have received 24 months of Social Security Disability Insurance Benefits ("DIB"), those who have end-stage renal disease, and those who have Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) and are receiving disability benefits from Social Security or the Railroad Retirement Board, can receive Medicare, even though they may be many years younger than age 65. Such individuals can be served by the Benefits Counseling program.

Question: (True or False): To receive Medicare, one must be at least 65 years of age; there is no basis on which a younger person can receive Medicare. \_\_\_\_\_ True \_\_\_\_\_ False

2. Allowable SHIP activities

Allowable SHIP activities include outreach, counseling and training regarding Medicare Part D (including Eligibility/Screening, Plan Comparison, Enrollment, Disenrollment, Plan Non-renewal, Low Income Subsidy/Extra Help Application Assistance); Medicare Parts A & B (including Application Assistance); Medicare Advantage (including Eligibility/Screening, Plan Comparison, Enrollment, Disenrollment); Medicare Supplement/Select (including Plan Non-Renewal, Eligibility/Screening, Plan Comparison); Medicaid (including Plan Non-renewal, Medicare Savings Program Screening, Medicare Savings Program Application, Medicaid Screening). Outreach and enrollment services regarding the Low Income Subsidy/Extra Help and regarding the Medicare Savings Program can also be provided with funding under the Medicare Improvements for Patients and Providers Act (MIPPA), and thus they are not exclusively available as SHIP services. MIPPA services also include outreach and enrollment services regarding Medicare Preventive services. Services regarding public benefits that are not listed as SHIP services are considered services under Title III B of the Older Americans Act; they cannot be provided as SHIP services. Other Title III B services (which thus are not allowable SHIP services) are services in regard to Advance Directives, Guardianship, Housing, Foreclosure/Eviction, Long-term Care, Economic Security, and Medicare Appeals.

Question (True or False): Medicare Part D Plan Comparison is an allowable SHIP activity.

\_\_\_\_\_ True \_\_\_\_\_ False

Question (True or False): Guardianship is an allowable SHIP activity.

\_\_\_\_\_ True \_\_\_\_\_ False

3. Volunteers as Benefits Counselors

Volunteers can be significant providers of Benefits Counseling. In SHIP (HICAP) volunteer Benefits Counselors I have the same training and reporting requirements as staff Benefits Counselors.

4. Benefits Counseling Certification.

The Texas HICAP program from its inception required the certification of Benefits Counselors. To gain certification, individuals are required to participate in training, work under supervision, and to pass a test. The certification period is for two years and also requires yearly participation in state HICAP training. Benefits Counselor Level I (SHIP Benefits Counseling) requires 25 hours of training, 20 hours of client counseling services under supervision, and passing a 100 question written test with a score of 70% or better.

Title III B – related certifications are:

Benefits Counselor Level II is based on a day of training on legal research, the appeals process and document preparation, in conjunction with a day during which the Benefits Counselor represents a client in a mock hearing, and also plays the role of the client in another hearing.

Long-Term Care Certification requires that a Benefits Counselor be certified as a Level II counselor, and then participate in a minimum of one and a half days of training ending with a written examination that must be passed with a score of 70% or better.

Advance Directive Preparer certification requires that a Benefits Counselor be certified as either a Level I or Level II Benefits Counselor, participate in a day of training, and pass a written test with a score of 70% or better.

Title III B certification is *not* a SHIP service.

Question: What one statement is true regarding Benefits Counselor I Certification?

(Circle the correct answer).

- A. It requires 70 hours of training.
- B. It requires 70 hours of supervised counseling.
- C. It requires 25 hours of training.
- D. It requires passing a test of no more than 20 questions.

Prior to embarking on certification of a Benefits Counselor, whether staff or volunteer, the AAA is required to have the individual complete an Application for Certification. See Appendix B – Application for Certification. The application alludes to other applicant screening requirements of the AAA and to policies and procedures of the AAA. The Application for Certification is maintained by the AAA and may be part of HHSC auditing for the Benefits Counseling program.

As noted, for Level I certification, the applicant, after completing training is required to take a 100 question test. The test changes from time to time. The most recent version of the test and answer key are made available to the AAA Director upon request. The test is administered locally and is based on information in the HICAP manual. The test is “open book” and must be completed within one 8-hour day. The passing score is 70. The AAA Director or their designee (in some cases the lead counselor) grades the test. The test should be kept as part of the counselor’s file. The Verification for Certification form is completed and signed by the AAA Director. A certificate and identification badge is prepared and the name of the counselor is entered into a data base. The certificate and badge is returned to the AAA. It is the responsibility of the AAA to give notice of the termination of any counselors. Benefits Counselors are required to maintain certification. Benefits Counselors must attend at minimum yearly training and are required to support Medicare outreach initiatives. CMS produces a Medicare calendar and expects SHIP programs to assist them in outreach. AAAs should encourage both staff and volunteer Benefits Counselors to improve their skills. Recertification for Level I does not require taking another test but it does require a minimum of 12 additional hours of training during each two-year recertification period.

Question: To maintain certification what is the minimum number of additional hours of training required during each two-year certification period? (Circle the correct answer)

24      36      12      48

5. HICAP (SHIP) Training Topics

The areas of knowledge necessary to the work of Benefits Counselors I are covered in Chapters 4 through 7 of the HICAP manual. Because adults learn differently, and individuals have varying experience, it is important to note that the HICAP manual is but one source for training. The National Medicare Education Program hosts periodic training seminars and develops multimedia training toolkits. Each AAA has access to training suites which include modules with PowerPoint presentations, exercises, games, tutorials and DVDs to use in training and presenting to beneficiaries.

CMS' Medicare Learning Network is another source of training. The Medicare program also produces numerous publications on Medicare Parts A, B, C, D, and related topics.

Question: (True or False) In regard to orientation and training for new counseling staff, the Medicare program itself has various training materials. \_\_\_\_\_ True \_\_\_\_\_ False

Following is a description of Chapters 3 through 7 of the HICAP Benefits Counselor Manual. Description of private insurance and public health programs are covered in Chapters 3, 4, 5, 6, and 7 the Manual. These chapters are aimed at building a counselor's skills and subject knowledge in regard to Medicare.

- 1) Chapter 3 provides a Benefits Counselor tools to gather the information that will be essential to helping a client obtain services they need. Intake forms and sample narratives help counselors who may not have experience in interviewing. This chapter also sets expectations for how to report the activities performed.
- 2) Chapter 4 addresses Medicare as a federal health program. It covers the health benefits available under Medicare Part A, Part B, and Part D known as the Medicare Prescription Drug Program. It also explains receiving benefits from the Traditional Medicare health plan versus Medicare Advantage, Part C, private health plan options. It includes information on eligibility and enrollment.



3) Chapter 5 introduces the fact that there are out of pocket costs associated with Medicare and identifies other insurance options to supplement Medicare. The chapter covers group insurance and Medicare Supplement policies. Also covered are rights and protections when someone loses health coverage through no fault of their own.

4) Chapter 6 presents information about the public government health programs available to help pay Medicare costs for persons with limited income and resources. This chapter explains Medicaid, the Medicare Savings Programs and the Low Income Subsidy for Medicare Part D.

5) Chapter 7 explains fraud and abuse in the Medicare program and other insurance fraud that falls under the authority of the Texas Department of Insurance.

6. Other training requirements. Benefits Counselors I are required to be proficient in problem solving beyond having a basic understanding of private and public programs. The expansion of Medicare health plans and the prescription drug plans, require specialized training to understand rules unique to each type of plan. Additionally, some problems presented by clients, may require special case work. An example of this includes using online Medicare plan comparison tools and reviewing a client's complaint to determine if there is a marketing violation or a right to a special enrollment. Some of this training is offered by CMS and other government and advocate organizations.

Question (True or False): Benefits Counselors I are required to be proficient in problem solving.

\_\_\_\_\_ True \_\_\_\_\_ False

7. Outreach Activities

a. Local Benefits Counseling programs are encouraged to maintain an overall awareness of, and work with, other existing service agencies. These include agencies such as health departments, clinics, and organizations seeking to help beneficiaries access Medicare. Benefits Counseling programs should maintain a referral process to appropriate programs and offices. Partnering with mental health and disability services providers can be especially useful to many beneficiaries.

d. In a screening process, a variety of individuals and agencies may assist individuals in exploring eligibility for benefits. This screening can be assisted by visiting [www.yourtexasbenefits.com](http://www.yourtexasbenefits.com) and [www.benefitscheckup.org](http://www.benefitscheckup.org).

e. Counseling programs are encouraged to assure that adequate services are available to clients in the entire AAA service area. Providing training to other aging and health providers helps to maximize the resources of local programs.

f. Local Benefits Counseling programs should take advantage of resource materials and consumer publications aimed to inform and educate individuals about the benefits to which they are entitled. Benefits Counseling programs have access to ordering bulk brochures from CMS.

g. Home visits to beneficiaries who are not able to leave their homes are an important outreach tool in some instances. A list of considerations regarding home visit issues is at Appendix D.

Question: In how much an AAA's service area are adequate counseling programs encouraged to be available? (Circle the correct percentage)

50%

75%

100%

90%

8. Monitoring. The Benefits Counseling program as a program of the AAA is subject to monitoring by HHSC. It is subject to ACL review, and performance reporting through the electronic National Performance Reporting (NPR) as well as quality assurance activities meant to evaluate the program.
9. Quality Assurance for SHIPs. Quality assurance activities are becoming of increasing importance in the SHIP program. Although states' Benefits Counseling programs are structured differently throughout the country and in U.S. territories, there are core SHIP services. For instance, all SHIP programs provide timely and accurate information. Additionally, programs must demonstrate a capacity to provide services to the areas they serve.
10. Training to serve Beneficiaries with Mental Illness. CMS provides training modules to promote outreach and assistance to beneficiaries with mental health conditions. The Medicare Learning Network has a module on mental services that are covered by Medicare.
11. Mystery Shopping. SHIPs have been requested to conduct mystery shopping to test Benefits Counselors' familiarity with terms such as "SHIP" and "Benefits Counseling." The survey also captured the willingness of counselors to serve individuals under the age of 65. Several states, including Texas, piloted a new Quality Assurance Toolkit for mystery shopping. The aim is to capture the accuracy of information given, measure customer service, monitor response time, and compliance with regards to privacy.

Question: What one answer describes a purpose of "mystery" shopping in the State Health Insurance Assistance Program (SHIP)? (Circle the letter of the correct answer).

- A. Mystery shopping is meant to test Benefits Counselors' awareness of the most recent trends in mystery novels.
- B. Mystery shopping is meant to test Benefits Counselors' familiarity with terms such as "SHIP" and "Benefits Counseling."
- C. Mystery shopping is meant to test Benefits Counselors' familiarity with the role of the Inspector of Hides and the Boll Weevil Commission.

D. Mystery shopping is meant to allow an individual to shop for durable medical equipment.

12. Safeguarding of Person Information of Clients. HHSC and ACL mandate that Benefits Counseling programs safeguard personal client information and disclose, per federal and state rules, privacy measures to their clients. The following forms are samples of documents aimed at documenting compliance.

i. Client Agreement forms used during intake and aimed at explaining Benefits Counseling services and use of personal information. See Appendix E – Client Rights and Responsibilities Form.

ii. Client intake form used to gather personal information needed to screen the applicant for services requested and other programs. See Appendix F- Client Intake and Service Request Form.

iii. HIPAA compliant release form necessary to obtain information from Medicare contractors and Medicare health and prescription plans. See Appendix G– Area Agency on Aging Client Information Release form.

## Appendix A – Chart of Allowable Activities

### Texas Health and Human Services Commission Allowable Activities Chart

State Health Insurance Assistance Program Outreach, Counseling And Training	Medicare Improvements for Patients and Providers Act Outreach and Enrollment	Legal Assistance Development
Medicare Part D:	Low Income Subsidy/Extra Help	Public Benefits
• Eligibility/Screening	Medicare Savings Program	Advance Directives
• Plan Comparison	Medicare Preventive	Guardianship
• Enrollment		Housing
• Disenrollment		Foreclosure/Eviction
• Plan Non-renewal		Long-term Care
• Low Income Subsidy/Extra Help Application Assistance		Economic Security
		Medicare Appeals
Medicare Parts A & B:		
• Application Assistance		
Medicare Advantage:		
• Eligibility/Screening		
• Plan Comparison		
• Enrollment		
• Disenrollment		
Medicare Supplement / Select:		
• Plan Non-renewal		
• Eligibility/Screening		
• Plan Comparison		
Medicaid:		
• Plan Non-renewal		
• Medicare Savings Program Screening		
• Medicare Savings Program Application		
• Medicaid Screening		

## Appendix B – Application for Certification

### THE TEXAS HEALTH INFORMATION, COUNSELING AND ADVOCACY PROGRAM

#### APPLICATION FOR CERTIFICATION

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
PHONE NO.: \_\_\_\_\_  
AREA AGENCY: \_\_\_\_\_

I request approval to become certified re-certified (circle one) as a Benefits Counselor I, Benefits Counselor II or Long Term Care Certification (circle one) for the Texas Health Information, Counseling and Advocacy Program (HICAP). I agree to abide by the rules, policies and procedures governing this program, including reporting requirements, as set forth by the Texas Health and Human Services Commission. I agree to accept supervision and direction from the area agency and its staff benefits counselor. I agree to perform my duties in a consistent and faithful manner and to maintain the need and rights of older people as a priority for my efforts.

I understand the need to maintain confidentiality of any and all personal information I receive in the course of my duties as benefits counselor.

I agree to notify the staff benefits counselor and area agency of any conflicts of interest that exist or may develop during the course of my duties.

I understand that I may be re-certified by showing evidence of my commitment to the required continued training and by mutual consent of the area agency. I further understand that this agreement may be terminated by either party by written notification.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
BENEFITS COUNSELOR APPLICANT SIGNATURE

## Appendix C -- HICAP VERIFICATION OF CERTIFICATION

I. The Area Agency on Aging of \_\_\_\_\_ verifies the application of

\_\_\_\_\_ (*name of applicant*) for:

\_\_\_\_\_ Benefits Counselor not certified \_\_\_\_\_ (check, if certification incomplete)

\_\_\_\_\_ Benefits Counselor I \_\_\_\_\_ (check, if for re-certification)

\_\_\_\_\_ Benefits Counselor II \_\_\_\_\_ (check, if for re-certification)

\_\_\_\_\_ Long Term Care Planning Certification

II. The area agency further verifies that the applicant has successfully completed and has adequate documentation, on the following:

\_\_\_\_\_ Certification pending

\_\_\_\_\_ 25 hours required training, topics covered

\_\_\_\_\_ 20 hours counseling, with oversight

\_\_\_\_\_ at least a minimum passing score on the self-assessment

**For Benefits Counselors II:**

\_\_\_\_\_ 5 additional hours administrative appeals training, topics covered

\_\_\_\_\_ served as advocate in at least one mock or real administrative appeals hearing

III. The applicant is seeking re-certification and has completed:

\_\_\_\_\_ 12 additional hours of training on public/private benefits and related legal issues

IV. The applicant is (check one):

\_\_\_\_\_ an employee of the area agency

\_\_\_\_\_ a volunteer of the area agency

**The area agency further verifies that the applicant does not present a conflict of interest with the HICAP program.**

---

DIRECTOR, AREA AGENCY ON AGING

DATE

---

Benefits Counseling Certification Program Chapter 2 -- 2017

## **Appendix D – Home Visit Considerations**

The question of whether a home visit should occur involves consideration of several factors. A home visit can sometimes be the most time-effective means of obtaining necessary information from the client or applicant, and of providing necessary information to clients and applicants. The following list is not all-inclusive, but rather it states some of the pertinent considerations.

1. Has the client or the applicant for services requested a home visit or is it rather the AAA staff member or volunteer who believes a home visit is the most time-effective form of visit?
2. Does the client or applicant, or the staff member or volunteer, have a disability that makes a home visit more, or less, appropriate?
3. Will a home visit meet the need for confidentiality?
4. Why is an in-office conference with the client or applicant, or gathering of information by telephone and by written correspondence, including questionnaire, checklist, fax (if available), or email (if available) not as time-effective as a home visit?
5. What information or “clues” would a home visit allow to be obtained, that an in-office conference or other means of information gathering will not allow?
6. Is photocopying likely to be necessary and does the client or applicant have a photocopy machine in their home or is there one in a nearby office or business that can be used, so as to speedily return to the client or applicant the important papers, or can the copying wait and be done in the office of the staff member or volunteer?
7. Does the client or applicant have a member of the household who cannot be left in the home without the client or applicant also being in the home?
8. Does the client or applicant have a member of the household or a family member or friend who can provide transportation for the client or applicant?
9. Is another means of transportation available for the client or applicant to come to the office?
10. Are there factors present in the location where the client or applicant stays that may require a home visit to involve more than one staff member or volunteer or that may rule out a home visit? Such factors to consider include, but are not limited to, dogs or other pets that may be dangerous, smoking, other occupants in the dwelling who have a criminal history or who have difficulty managing anger; whether an occupant of the dwelling has a communicable illness; and whether the dwelling is in good structural condition.
11. Does the staff member or volunteer have a communicable illness, which it would be best to not expose the client or applicant to?
12. Is the time-effectiveness of a home visit (which can sometimes be highly time-effective) outweighed by the loss of time in the office?

Remember, these are merely some considerations. A home visit can be a very time-effective means of gathering information from clients and applicants, and of providing information to clients and applicants. The experience of clients and applicants that you serve, and your own AAA’s experience may give rise to other considerations, and may cause some of the above to be eclipsed in importance by other considerations.





## Appendix E – Client Intake and Service Request Form

AREA AGENCY ON AGING OF \_\_\_\_\_

### CLIENT INTAKE AND SERVICE REQUEST FORM (Items in **BOLD** must be completed)

Client Rights & Responsibilities and Release of Information have been clearly explained to the client. ☐

Date: \_\_\_\_\_ Client ID Number: \_\_\_\_\_

Last Name: \_\_\_\_\_ MI: \_\_\_\_\_ First Name: \_\_\_\_\_

Gender: Male ☐ Female ☐ Birth Date: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Home Address: Street/Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

☐ Check if Mailing Address is Home Address

Mailing Address: Street/Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Home ☐ Cell ☐ Other ☐ (Check One)

#### Ethnicity (Check One):

- (1) Hispanic or Latino ☐
- (2) Not Hispanic or Latino ☐
- (3) Ethnicity Not Reported ☐

#### Race (Check all that apply):

- (1) White – Non Hispanic ☐
- (2) White – Hispanic ☐
- (3) American Indian/Alaska Native ☐
- (4) Asian ☐
- (5) Black or African American ☐
- (6) Native Hawaiian or Pacific Islander ☐
- (7) Persons Reporting Some Other Race ☐
- (8) Race Not Reported ☐

#### Marital Status (Check One):

- (1) Married ☐
- (2) Widowed ☐
- (3) Divorced ☐
- (4) Separated ☐
- (5) Never Married ☐
- (6) Not Reported ☐

Does client live alone? Yes ☐ No ☐

Total Number of Family Members in Household Including Client: \_\_\_\_\_

Client living in poverty (Low Income)? Yes ☐ No ☐

## Appendix F – Client Rights and Responsibilities



### Area Agency on Aging of \_\_\_\_\_ Client Rights & Responsibilities and Release of Information for Older Americans Act Programs

The Area Agency on Aging of \_\_\_\_\_ welcomes you to our programs, made available to you through the Older Americans Act of 1965. These programs and a variety of services are administered by the Area Agency on Aging with funding provided through the Texas Department of Aging and Disability Services, client contributions and local funding.

Programs and services are designed for people who age 60 or older, their family members, and other caregivers. Our goal is to help older people lead independent, meaningful and dignified lives in their own homes and communities as long as possible. Our program supports that goal by providing limited support services and by assisting you in finding answers when you want help. Your information will not be released to anyone, or any agency without your informed consent, with the exception of records subpoenaed by a court of law.

#### Release of Information:

Information we gather through an intake or through an assessment may be shared to plan, arrange and deliver services to meet your individual client needs. The information collected is required by your local service provider, the Area Agency on Aging (AAA), and the Texas Department of Aging and Disability Services. All of your information will be kept confidential and guarded against unofficial use.

#### Client rights and responsibilities:

1. You have the right to be treated with respect and consideration. You have the right to have your property treated with respect.
2. You may not be denied services on the basis of race, religion, color, national origin, sex, disability, marital status, or inability and/or unwillingness to contribute.
3. You have the right to make a complaint/grievance or recommend changes to policy or service, without restraint, interference, coercion, discrimination or reprisal. To make a complaint or grievance contact the Area Agency on Aging. Contact information is identified below:

Service Provider Information	Area Agency on Aging Information

4. You have the right to participate in the development of a care plan to address unmet needs (If Applicable).
5. You have the right to be informed in writing of available services and the applicable charges if the services are not covered or are unavailable by Medicare, Medicaid, health insurance, or Older Americans Act funding (If Applicable).
6. You have the right to make an independent choice of service providers from the list furnished by the Area Agency on Aging where multiple service providers are available, and change service providers when desired (If Applicable).
7. You have the right to be informed of any change in service(s).
8. You have the right to make a voluntary, confidential, contribution for services received through the Area Agency on Aging. Services will not be denied if you are unable or choose not to make a contribution. All contributions are confidential and are used only to expand or enhance the service(s) for which a contribution was provided.
9. You have the responsibility to inform the Area Agency on Aging or its service provider(s) of your intent to withdraw from the program or any known periods of absenteeism when you will not be using services.
10. You have the responsibility to provide the Area Agency on Aging or its services provider(s) with complete and accurate information.

I hold harmless this Area Agency on Aging program, its parent organization, funders, and the sponsoring state agencies for any liability arising out of the services provided in accordance with program guidelines.

---

Print Client Name

---

Date

---

Client Signature



## Appendix G – Client Information Release

### Area Agency on Aging of

### Client Information Release

<b>Client Name:</b>	<b>Client ID:</b>
By signing this authorization, you are giving the Area Agency on Aging (AAA) _____ permission to release all or part of your information provided, which includes health information. Failure to provide this authorization will result in limited service by the AAA. This release includes access to a continuum of service(s) available through the AAA or its providers.	

#### PARTS A, B & C TO BE COMPLETED BY CLIENT OR PERSONAL REPRESENTATIVE

I authorize the Area Agency on Aging to release my information to the following person or agency for the purpose(s) stated in Part A. My information will remain available to the person or agency indicated in accordance with the expiration event or date in Part B.

<b>PART A – Release of Information</b>
I understand that my information may contain protected health information. Release my information to the following person or agency: <input type="checkbox"/> Any person or agency necessary to meet my service needs.
<input type="checkbox"/> Only the persons or entities identified:
Check one of the following: <input type="checkbox"/> Release all of my information. <input type="checkbox"/> Release only the following information:

<b>PART B – Purpose of Release</b>
<input type="checkbox"/> General: To assist in assessing, arranging, and meeting individual service needs.
<input type="checkbox"/> Specific:
<input type="checkbox"/> Expiration: This authorization expires at point of reassessment, where applicable, or within three years of effective date.

<b>PART C – Signature</b>	
(Client or Personal Representative)	(Date)
<input type="checkbox"/> Check if you are signing for the client and please describe your authority to act for the client on the following line:	
Note: If the person requesting the release of information cannot sign his/her name, two witnesses to his/her mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason in the client file.	
Witness:	Date:
Witness:	Date:

#### Notice to Client:

- ✓ Once the authorization to release your information is granted, the AAA is not responsible for any redisclosure of the information by the recipient.
- ✓ You can withdraw permission you have given the AAA to use or disclose health information that identifies you, unless the AAA has already taken action based on your permission. You must withdraw your permission in writing.



## Agencia del Área para Adultos Mayores de Divulgación de información del cliente

<b>Nombre del cliente:</b>	<b>Identificación del cliente:</b>
Al firmar esta autorización, usted da a la Agencia del Área para Adultos Mayores (AAA) _____ permiso para divulgar toda o parte de su información provista, que incluye información médica. Si no firma esta autorización, la AAA limitará los servicios que le ofrece. Esta autorización de divulgación da acceso a una gama de servicios disponibles por medio de la AAA o de sus proveedores.	

EL CLIENTE O SU REPRESENTANTE PERSONAL DEBE LLENAR LAS PARTES A, B Y C

Yo autorizo a la Agencia del Área para Adultos Mayores para que divulgue mi información a las siguientes personas o departamentos con el propósito indicado en la Parte A. La información estará disponible para la persona o el departamento indicado hasta el evento o la fecha de vencimiento anotada en la Parte B.

<b>PARTE A. Divulgación de información</b>
Entiendo que la información puede contener información médica protegida. Divulguen mi información a la siguiente persona o departamento: <input type="checkbox"/> Cualquier persona o departamento, si se tiene que hacer para satisfacer mis necesidades de servicios.
<input type="checkbox"/> Sólo a las personas o entidades identificadas:
Marque una de las siguientes opciones: <input type="checkbox"/> Divulguen toda mi información. <input type="checkbox"/> Divulguen sólo la siguiente información:

<b>PARTE B. Propósito de la divulgación</b>
<input type="checkbox"/> General: asistir en evaluación, hacer arreglos, y a satisfacer las necesidades personales de servicios.
<input type="checkbox"/> Específico:
Expiración: Esta autorización expira en el punto de la reevaluación, donde esto se aplica, o tres años después de la fecha de vigencia.

<b>PARTE C. Firmas</b>	
(Cliente o Representante personal)	(Fecha)
<input type="checkbox"/> Marque este cuadro si firmó en nombre del cliente y describa en el siguiente renglón qué autoridad tiene para actuar por el cliente:	
Nota: si la persona que pide la divulgación de información no puede firmar su nombre, dos testigos de su marca (X) tienen que firmar a continuación. Acepte la firma de un solo testigo cuando no sea posible obtener la firma de dos testigos. Documente la razón en el archivo de cliente.	
Testigo:	Fecha:
Testigo:	Fecha:

Aviso al cliente:

- ✓ Una vez que se conceda la autorización para divulgar su información, la AAA no se hace responsable de ninguna divulgación de la información de parte del destinatario.
- ✓ Usted puede retirar el permiso que le haya dado a la AAA para usar o divulgar información de salud que lo identifique a usted, a menos que la AAA ya haya tomado alguna acción de acuerdo con su permiso. Si quiere retirar el permiso, tiene que hacerlo por escrito.

## Appendix H – Medical Abbreviations

### MEDICAL ABBREVIATIONS – MOST FREQUENTLY USED

<b>abd</b> -abdomen	<b>hs,H.S.</b> -hour of sleep, bedtime	<b>N+V</b> -nausea and vomiting
<b>a.c.</b> -before meals	<b>I&amp;O</b> -intake and output	<b>NPO</b> -nothing by mouth
<b>ad lib</b> -as desired	<b>IM</b> -intramuscular	<b>qnoc</b> -every night
<b>a.m.</b> -morning	<b>lab</b> -laboratory	<b>q2h</b> -every 2 hours
<b>bid</b> -twice daily	<b>MN</b> -midnight	<b>q4h</b> -every four hours
<b>BM</b> -bowel movement	<b>noc</b> -night	<b>qod</b> -every other day
<b>BP</b> -blood pressure	<b>O2</b> -oxygen	<b>r/o</b> -rule out
<b>BRP</b> -bathroom privileges	<b>O</b> -oral	<b>ROM</b> -range of motion
<b>c</b> -with	<b>O.D.</b> -right eye	<b>Rx</b> -treatment
<b>CA</b> -cancer	<b>O.S.</b> -left eye	<b>□</b> -without
<b>cant</b> -continuous	<b>O.U.</b> -both eyes	<b>ss</b> -half
<b>cap</b> -capsule	<b>os</b> -mouth	<b>spec</b> -specimen
<b>cath</b> -catheter	<b>oz</b> -ounce	<b>stat</b> -immediately
<b>cc,ml</b> -cubic centimeter	<b>p</b> -after	<b>ss-enema</b> -soap suds enema
<b>comp</b> -compound	<b>pc</b> -after meals	<b>sub q</b> -subcutaneous(injection)
<b>c/o</b> -complains of	<b>per</b> -as by	<b>supp</b> -suppository
<b>CVA</b> -cerebrovascular accident	<b>p.m.</b> -afternoon/evening	<b>T</b> -one
<b>CHF</b> -congestive heart failure	<b>po</b> -by mouth	<b>TT</b> -two
<b>EEG</b> -electroencephelogram	<b>prn</b> -as needed	<b>tab</b> -tablet
<b>EKG</b> -electrocardiogram	<b>p.t.</b> -physical therapy	<b>tid</b> -3 times daily
<b>En</b> -enema	<b>pt</b> -patient	<b>TPR</b> -temperature, pulse, respiration
<b>Fx</b> -fracture	<b>q</b> -every	<b>U.A.</b> -urinalysis
<b>Gr</b> -grain	<b>qd</b> -every day	<b>ung</b> -ointment
<b>(H)</b> -hypodermic	<b>qh</b> -every hour	<b>V.S.</b> -vital signs
<b>H2O</b> -water	<b>qid</b> -4 times a day	<b>w/c</b> -wheelchair

## **Appendix I – A-Z Medical Abbreviations – More Detailed List**

### **A**

<b>aa</b>	<b>of each</b>
<b>AAROM</b>	<b>active assistive range of motion</b>
<b>ABD</b>	<b>abduction</b>
<b>Abd pad</b>	<b>surgical pad</b>
<b>ADD</b>	<b>adduction</b>
<b>ADL</b>	<b>activities of daily living</b>
<b>A-fib</b>	<b>atrial fibrillation</b>
<b>AK</b>	<b>above knee</b>
<b>AKA</b>	<b>above knee amputation</b>
<b>A.M.</b>	<b>before noon</b>
<b>AMB</b>	<b>ambulation</b>
<b>AMI</b>	<b>acute myocardial infarction</b>
<b>AMP</b>	<b>amputee/amputation</b>
<b>ANT</b>	<b>anterior</b>
<b>Ap.</b>	<b>Apically</b>
<b>Approx.</b>	<b>approximately</b>
<b>A.P.</b>	<b>apical pulse</b>
<b>A/P</b>	<b>anterior/posterior</b>
<b>A/P &amp; Lat.</b>	<b>Anterior/posterior and lateral</b>
<b>AROM</b>	<b>Active Range of Motion</b>
<b>Art.</b>	<b>Arterial</b>
<b>ASA</b>	<b>aspirin, acetylsalicylic acid</b>
<b>ASHD</b>	<b>ateriosclerotic heart disease</b>
<b>aspir.</b>	<b>Aspiration</b>
<b>ax</b>	<b>axillary</b>

### **B**

<b>BE</b>	<b>barium enema</b>
<b>bilat.</b>	<b>Bilateral</b>
<b>bili</b>	<b>bilirubin</b>
<b>BIW</b>	<b>twice a week</b>
<b>BK</b>	<b>below knee</b>

**BKA**  
**bld.**  
**BLE**  
**BPM**  
**BS**  
**BSC**  
**BSD**  
**BUE**

**below knee amputation**  
**Blood**  
**bilateral lower extremities**  
**beats per minute**  
**bowel sounds**  
**bedside commode**  
**bedside drainage**  
**bilateral upper extremities**

## **C**

**C&S**  
**CAB**  
**CAD**  
**cal.**  
**CAT**  
**C, CI**  
**CBC**  
**CNS**  
**COPD**  
**COTA**  
**CPT**  
**CSF**  
**CT (scan)**  
**CVD**  
**CXR, c-xray**

**culture and sensitivity**  
**coronary artery bypass**  
**coronary artery disease**  
**Calorie**  
**computerized axial tomography**  
**cervical vertebrae**  
**complete blood count**  
**central nervous system**  
**chronic obstructive pulmonary disease**  
**certified occupational therapy assist.**  
**chest physiotherapy**  
**cerebrospinal fluid**  
**computerized tomography**  
**cardiovascular accident**  
**chest x-ray**

## **D**

**D/C**  
**Dig.**  
**DJD**  
**DM**  
**DNR**  
**DOE**  
**DON**  
**DVT**  
**DW**  
**DX**

**discharge**  
**Digoxin**  
**degenerative joint disease**  
**Diabetes Mellitus**  
**Do Not Resuscitate**  
**dyspnea on exertion**  
**Director of Nurses**  
**deep vein thrombus**  
**distilled water**  
**diagnosis**



**e.g.**  
**ENT**  
**ESRD**  
**Ext.**  
**EXTEN.**

**F**  
**F+**  
**F!**  
**FBS**  
**Fe**  
**Fld.**  
**FLEX.**  
**FS**  
**F/U**  
**FUO**

**G**  
**G+**  
**G!**  
**GI**  
**Gluc.**  
**GT**  
**GTT**  
**gtt.**  
**gtts.**

**H2O2**  
**HA**  
**HEENT**  
**HEMI**  
**Hg.**

## **E**

**example**  
**ear, nose, throat**  
**end stage renal disease**  
**external**  
**Extension**

## **F**

**fair (MMT grade) or female**  
**fair plus**  
**fair minus**  
**fasting blood sugar**  
**iron**  
**fluid**  
**Flexion**  
**finger stick**  
**follow-up**  
**fever of unknown origin**

## **G**

**Good (MMT grade)**  
**good plus**  
**good minus**  
**gastrointestinal**  
**Glucose**  
**gait training**  
**glucose tolerance test**  
**Drop**  
**Drops**

## **H**

**hydrogen peroxide**  
**headache**  
**head, eyes, ears, nose and throat**  
**hemiplegia**  
**Mercury**

**Hgb**  
**HHA**  
**H&H**  
**H&P**  
**HTN**  
**HX**

**hemoglobin**  
**home health aide/agency**  
**hematocrit and hemoglobin**  
**history and physical**  
**hypertension**  
**history**

## **I**

**ICU**  
**IDDM**  
**I&D**  
**IP**  
**IPPB**

**intensive care unit**  
**insulin dependent diabetes mellitus**  
**incision and drainage**  
**inpatient**  
**intermittent positive pressure breathing**

## **J**

**Jt.**  
**JVD**

**Joint**  
**jugular vein distension**

## **K**

**K, K+**  
**KUB**  
**KVO**

**potassium**  
**kidney, ureter, bladder**  
**keep vein open**

## **L**

**L**  
**LAT**  
**LB**  
**LE**  
**LLB**  
**LLE**  
**LLL**  
**LLQ**  
**LML**  
**loc**  
**LOC**  
**LPTA**

**left/liter**  
**left anterior thigh**  
**lower back**  
**lower extremity**  
**long leg brace**  
**left lower extremity**  
**left lower lung, lobe**  
**left lower quadrant-abdomen**  
**left middle lung, lobe**  
**laxative of choice**  
**level of consciousness/care**  
**licensed physical therapy assist.**

LUL  
LUE  
LUQ  
Lytes

left upper lung, lobe  
left upper extremity  
left upper quadrant  
electrolytes

## M

M  
mcg.  
MI  
MOD  
MOM  
MRI  
MRSA  
MSSW

male  
Microgram  
myocardial infarction  
moderate  
milk of magnesia  
magnetic resonance imaging  
methicillin resistant staph aureus  
medical social services worker

## N

Na  
NaCl  
N/C  
NS  
NIDDM  
NPH  
NSAID  
NTG  
NWB

sodium  
sodium chloride  
nasal cannula  
normal saline  
non-insulin dependent diabetes mellitus  
neutral protein hagedorn (insulin)  
non-steriod anti-inflammatory drug  
nitroglycerin  
non weight bearing

## O

O2 sat.  
OBS  
OOB  
OP  
O&P

oxygen saturation  
organic brain syndrome  
out of bed  
outpatient  
ova and parasites

## P

P  
P+

poor/pulse  
poor plus

**PI**  
**PCN**  
**PCO<sub>2</sub>**  
**PARA**  
**PERL**  
**PERRLA**  
**pH**  
**PKU**  
**PROM**  
**PVD**  
**PX**

**poor minus**  
**penicillin**  
**partial pressure of carbon monoxide**  
**paraplegia**  
**pupils equal and responsive to light**  
**pupils equal, round, react to light and accommodate**  
**hydrogen ion concentration**  
**phenylketonuria**  
**passive range of motion**  
**peripheral vascular disease**  
**prognosis**

**q.n.s.**  
**qs**  
**QS**  
**Quads**

**quantity not sufficient**  
**quantity sufficient**  
**quad sets**  
**quadriceps**

**R, Rt**  
**RA**  
**RAT**  
**RBc**  
**RDA**  
**RLE**  
**RLL**  
**RLQ**  
**RML**  
**ROM**  
**RR**  
**RUE**  
**RUL**  
**RUQ**

**right**  
**rheumatoid arthritis**  
**right anterior thigh**  
**red blood count**  
**recommended dietary allowance**  
**right lower extremity**  
**right lower lung, lobe**  
**right lower quadrant**  
**right middle lung, lobe**  
**range of motion**  
**respiratory rate**  
**right upper extremity**  
**right upper lung, lobe**  
**right upper quadrant**

## **S**

**SBA**  
**shld.**  
**S/I**  
**S/L**  
**SLR**  
**SOB**  
**SOC**  
**SW**  
**SX**

**stand by assistance**  
**Shoulder**  
**supervise and instruct**  
**sublingual**  
**straight leg raise**  
**shortness of breath**  
**start of care**  
**standard walker**  
**symptom**

## **T**

**TENS**  
**TIA**  
**Tinct.**  
**TIW**  
**TKO**  
**T.O.**  
**TTWB**

**transcutaneous electric nerve stimulation**  
**transient ischemic attack**  
**Tincture**  
**3 times a week**  
**to keep open**  
**telephone order**  
**toe touch weight bearing**

## **U**

**URI**  
**UTI**

**upper respiratory infection**  
**urinary tract infection**

## **V**

**Vd**  
**V.O.**  
**VS, V/s**  
**V-fib.**  
**V-tach**

**void**  
**verbal order**  
**vital signs**  
**Ventricular fibrillation**  
**ventricular tachycardia**

## **W**

**WBAT**  
**WBC**  
**WBS**  
**W/D**  
**WFL**

**weight bearing as tolerated**  
**white blood count**  
**weight bearing status**  
**warm and dry**  
**within functional limitations**

**WNL**

**within normal limits**

**X**

**X**

**times**

**XRT**

**radiation therapy**

## Appendix J – Chapter 2 Questions and Answers

Question: (True or False): To receive SHIP services, an individual must be eligible to receive Medicare. ☒ True ☐ False

Question: (True or False): To receive Medicare, one must be at least 65 years of age; there is no basis on which a younger person can receive Medicare. ☐ True ☒ False

Question (True or False): Medicare Part D Plan Comparison is an allowable SHIP activity.  
☒ True ☐ False

Question (True or False): Guardianship is an allowable SHIP activity.  
☐ True ☒ False

Question: What one statement is true regarding Benefits Counselor I Certification?

(Circle the correct answer).

- A. It requires 70 hours of training.
- B. It requires 70 hours of supervised counseling.
- © It requires 25 hours of training.
- D. It requires passing a test of no more than 20 questions

Question: To maintain certification what is the minimum number of additional hours of training required during each two-year certification period? (Circle the correct answer)

Question: (True or False) In regard to orientation and training for new counseling staff, the Medicare program itself has various training materials.   X   True        False

Question (True or False): Benefits Counselors I are required to be proficient in problem solving.

  X   True        False

Question: In how much of an AAA's service area are adequate counseling programs encouraged to be available? (Circle the correct percentage)

50%                      75%                      100%                      90%

Question: What one answer describes a purpose of "mystery" shopping in the State Health Insurance Assistance Program (SHIP)? (Circle the letter of the correct answer).

- A.     Mystery shopping is meant to test Benefits Counselors' awareness of the most recent trends in mystery novels.
- Ⓑ     Mystery shopping is meant to test Benefits Counselors' familiarity with terms such as "SHIP" and "Benefits Counseling."
- C.     Mystery shopping is meant to test Benefits Counselors' familiarity with the role of the Inspector of Hides and the Boll Weevil Commission.
- D.     Mystery shopping is meant to allow an individual to shop for durable medical equipment.



## Chapter Three

### Case Records and Reporting

1. **Reporting benefits counseling activities in an accurate and timely manner is both a program requirement and a training requirement.** The AAA staff track all legal awareness and legal assistance activities conducted by staff counselors and volunteers on a monthly basis. These reports are captured through software for both the TDoA monthly reports and on the CMS National Performance Report (NPR) monthly reports. The NPR reporting data becomes an integral part of the national aging network's mosaic and reflects how each state is serving its elderly and disabled population.

2. As discussed in the opening chapters of this textbook, legal assistance reports are individual and confidential sessions held between the counselor and the client. *Legal assistance* activities are advice, counseling, document preparation, and representation given to individuals on a one-to-one basis. When any or all of these activities are eight minutes or more, units are being generated and the total time spent on the case is counted and documented in the hard copy file. If the time spent is less than eight minutes, the time is not counted, however the contact is counted. This type of contact is a *legal awareness* activity and is captured in the appropriate data collection tool. Legal awareness will be covered in more detail later in this chapter.

### The Hard Copy File

3. Legal assistance case reports generally begin with a hard copy file that includes an intake page and one or more narrative pages. Using this file, data is collected and entries are made into the appropriate reporting tools. The hard copy file contains very sensitive information freely provided by a client and its contents are always treated in a confidential manner and as a legal document. The structure of the file is not unlike that of case-management. Entries are handwritten and are initialed by the counselor and the file is a confidential, legal document. The file documents are not difficult to complete, but do require close attention to accuracy. The hard copy file is the tool used by TDoA for monitoring accuracy of data reported.

4. Volunteers are supplied reporting forms and self-addressed stamped envelopes for mailing their monthly reports to the AAA. Volunteers may also fax or e-mail reports to the counselors. It is to the advantage of the counselor to require volunteers to file monthly reports within the first week of the new month. The volunteer report will consist of the intake and narrative pages for each new client who received legal assistance and a separate legal awareness form for each completed educational or outreach activity for the month. For cases that continue into the following month, the next legal assistance report for that client will consist of the narrative page(s) only. All narrative entries for a second month should be on a new page and not run together with entries from a previous month. This will prevent errors in calculation of time and contacts reported for the continued case.

5. The intake document for an initial client contact is titled “Benefits Counseling/Legal Assistance Case Report.” A copy of this form is in the resource section of this chapter and counselors are required to complete and maintain this one page intake for each individual counseled. The following entries are made on the top half of the legal assistance case report form:

- On line # 1, the date of the initial contact for individual assistance is recorded by the entry titled “Date”. The counselor’s AAA is identified and his/her initials (staff or volunteer) are entered at “Counselor/Legal Provider.”
- On line # 2, enter the client’s Social Security number.
- On line # 3, enter the client’s name and gender.
- Lines 4, 5, 6, 7 and 8 require the client’s address, city, state, zip code, county and phone number.
- Lines 9 and 10 address the client’s physician and phone number and these are completed if relevant to the case.
- On line 11, check the appropriate ethnicity.
- On line 12, check the appropriate marital status.
- On line 13, record the number in the household (include client), if relevant.
- On line 14, check the client’s income, if relevant.
- Line 15 is for the referral source, such as a relative or a home health agency representative.

- Line 16 is used to record the referral's telephone number.
- On line 17, indicate with a "yes" or "no" to indicate if the client is at least 60 years of age or eligible for Medicare.
- Line 18 records the client's date of birth. This is a required component of the TDOA software-reporting tool.
- Lines 19 through 22 are completed if relevant to the case.
- Check line 23, if the client has given consent for representation by the counselor.

6. The second section of the form is titled "ISSUE". In this section, the counselor identifies the issue(s) that were addressed for the client. To complete this section, consult the "Profiles of Need Categories" in the resource section of this chapter. This resource provides an in-depth clarification of the different categories of needs. The one-page "Short Version of Client Profile of Needs Categories" may be used as a quick reference for describing the need(s) of the client, under "ISSUE". These categories of need are more extensive than the categories recognized by CMS. TDoA recognizes that these other categories of need can directly and indirectly impact a beneficiary's Medicare, as well as his/her financial well-being.

7. On the "Short Version of Client Profile of Needs Categories," ADLs (activities of daily living) identify special assistance tasks that a client may require. This category includes general elderly assistance services that may be covered by a special city or county program, separate from a state program. Many of the tasks listed are provided to qualified candidates for the TDHS in-home service program CCAD (Community Care for the Aged and Disabled).

8. Transportation is often an unmet need. This service is not limited to medical transportation, but may be services for travel to and from a nutrition site, shopping and other needs. Escort is a service provided to eligible CCAD clients when the care plan indicates a need for this service.

9. Non-covered Health issues include dental, vision, hearing aids, assistance devices and other health needs not covered by Medicare. CMS has made medications a separate category on the National Performance Report. Medications or drugs are included by TDoA under N/C

Health for reporting purposes. Non-covered health issues can also include special diet needs, such as diet supplement drinks that generally are not covered by Medicare except under special medical necessity guidelines.

10. The Housing category is self-explanatory and covers almost every imaginable circumstance that could impact health and safety issues for a client. Unsafe living conditions can impact client Medicare utilization and the financial affairs of a client.

11. The remaining categories of need on the short version are self-explanatory and identify other issues that can impact a person with a disability or elderly person's chance of maintaining independence in the community. Many of the categories of need are money-related issues. Assistance with these issues can help the client keep more of their Social Security dollars to pay for health care costs as they age.

12. The next section identifies the type of counseling services provided to a client. A counselor may check off one or all of these options. Advice and counseling are the most routine services provided. Document preparation, for instance, can be assistance with completing a Medicaid form, disability form, or completing a simple form to access medical transportation. Representation is checked when the counselor acts as a client's advocate in resolving an issue the client cannot handle alone. The category "other" for this section may be advocacy efforts that connect the client with a resource or referral that would be more effective in addressing the client's needs.

13. The next to last section of the intake page addresses referrals and the counselor checks the appropriate box. These initial referrals would be included in the narrative for that specific month. Referrals made in the following month or several months later, would be captured in the narrative for that specific month.

14. Monetary Impact is completed when a course of action that could save money for the client is presented. This subjective calculation is not monitored or tracked by TDoA. CMS does

collect dollars saved in the current NPR. Future CMS reporting tools will assign a dollar value based on the appropriate information collected in its new NPR.

15. The narrative is the second part of the legal assistance form and provides for entries of the site (NAME OF AAA), the client's name, month and year, and number of pages (PAGE \_\_\_\_OF \_\_\_\_), used for daily entries in the course of a month. The initial or first contact date is recorded and initialed by the counselor. The time spent during the counseling activities is counted and recorded in the time block. Time spent on the phone, recording a written intake and narrative, providing advice, counseling, referrals, providing correspondence, research, and follow-up are a few examples of activities that are counted as time spent. At the end of the month, a counselor will count time spent on checking the hard file for correct entries, totals for contacts (count each entry as a contact for the NPR), and time spent (total number of minutes spent for that month), under the "maintenance of records". These additional minutes will be entered into the file on the last day of the month, when reports are finalized for that month. Time spent recording file data into appropriate reporting tools will also be added to the time spent on the case under the same code. Only staff will complete the unit calculation of time and contacts, as oversight by staff is part of record maintenance for staff generated files and volunteer client files. As part of the TDoA and CMS monitoring process, a second staff person will review all data for correctness and oversight.

16. In the chapter resource section, is a help sheet title "Guidelines for Determining Units of Service". The table converts the total minutes into units or total time spent on a case, for the month being reported. The first two columns represent minutes that are converted into hours. The remaining columns reflect units recorded based on the minutes and hours being reported. Note that total time contacts of less than 7 minutes generates zero units if that were the only contact recorded in the hard copy file.

17. Counting contacts would be accomplished by counting entries that reflect phone calls, direct contact with the client, relatives, faxes, e-mails, Internet queries, postal mailings and other resources that are instrumental in resolving the case. The codes at the bottom of the narrative are optional and are help codes for writing the narrative.

- Codes A and B are self-explanatory.

- Code C is used when you write a letter, send fax, Internet or e-mail to share information with a client.
- Code D is used to record in the file a date and time set by the client for a personal interview.
- Codes E and F are self-explanatory.
- Code H is the actual personal interview narrative.
- Code I designates completion of the intake page. The counselor may complete the intake or receive a partial intake from Information and Referral, Case-management, or the Ombudsman program. The time spent completing the intake is counted and the time can be shorter if the intake is from another source.
- Code L designates representation activity.
- Code M provides for the extra time spent at the end of the month on maintaining the file.
- Code N is used when staff makes contacts on behalf of a client.
- Code P designates document assistance.
- Code R is used when you provide referrals to the client and the client takes the initiative of making the contact his/herself.
- Code S designates mailing of a satisfaction survey. Surveys have been a TDoA program requirement in the past and this code is used if a client was sent an in-house survey.
- Code W identifies walk-in clients who may or may not have an appointment.

18. The last entry under the “Unit Calculation of Time” is “Verified by.” Another staff person checks the counselor’s entries and verifies that the time and contact totals calculated are correct. Upon verification, this staff person signs off on the calculations with his/her initials and the information is ready for entry into the appropriate reporting tool. This verification system provides TDoA with proof of efforts to ensure correct reporting of data and is also necessary to indicate to CMS that a system is in place for data oversight.

19. Remember that there is no limit on the amount of time spent on composing a narrative or counseling a client one-to-one. Write only facts that reflect efforts to resolve the case through advice, counseling, referrals, document preparation or representation. It is better to include great detail versus scant information that does not fully represent your work effort.

20. CMS requires designation of contacts by means such as telephone, home visit, office visit, e-mail, fax, and postal mail. TDoA does not require such designations of contacts with clients. This CMS designation is recorded on the NPR.

21. Companion cases or cases involving both spouses are addressed in the same manner for both CMS and TDoA. If the couple requires assistance with the same issues, make a hard copy file on the spouse that provided the bulk of the case information. If individual issues vary, make two hard copy files addressing the specific issues of each client. Count actual time spent for each individual client. Time spent will not necessarily be equal for the two clients, as one spouse may require more in-depth counseling.

22. The steps for entering data into TDoA and CMS reporting tools will be covered later in this chapter. CMS is still refining its newest version of the NPR and TDoA is also refining reporting tasks to capture appropriate data.

### **CMS New 2001 NPR**

23. The NPR is the reporting tool used by CMS as a performance measurement system to provide hard evidence of the type of SHIP customer service clients receive through the AAA aging network of integrated services. The objective of the NPR is to produce powerful and convincing client-level data about the people who have been served by SHIP's. The hard copy file achieves this HCFA grant objective.

24. The following instructions are for the newest NPR adopted by CMS. It has been recommended that utilization of the new form begin in October of 2001. The Client Contact form collects similar fields of data collected on the TDoA client intake form. The form addresses legal assistance activities but does not describe these activities as such. The form is a combination of issues collected by TDoA and CMS. The CMS contractor, ABT, generated the instructions.

# Instructions for Completing the Client Contact Form for the State Health Insurance Assistance Program (SHIP)

Aggregated data from Client Contact Forms to be submitted to HCFA every 6 months

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This document provides definitions and instructions for the information that is collected and reported on each contact with a client.

## Definition

**Client Contacts:** "Client Contacts" includes **all** contacts between counselors or staff and clients which include elders, Medicare or Medicaid beneficiaries, family members or others working on behalf of a



client. These contacts can be over the telephone, in person (site), in person (at home), or via postal mail, e-mail or fax.

**Do NOT use the Client Contact Form for:**

- persons reached at public events such as presentations or health fairs. Questions asked during or after a presentation are not considered individual client contacts unless one-on-one counseling occurs.
- contacts from agency staff persons not working on behalf of a beneficiary.
- unsuccessful attempts to reach a client (e.g., leaving messages on an answering machine), unless substantive information is provided in the message.

**Who Completes the Client Contact Form?**

The Client Contact Form is used by registered SHIP counselors only (i.e. individuals who have received counselor training and have signed some type of Counselor Agreement or Memorandum of Understanding). SHIP counselors can include volunteers, staff, toll-free helpline counselors, local coordinators/sponsors, etc.

**Client Contact Forms are considered confidential. They must be treated by counselors as confidential information. THE COUNSELOR MUST ASSURE THE CLIENT THAT ALL PERSONAL INFORMATION COLLECTED IS CONFIDENTIAL.**

## **Instructions for Completing the Client Contact Form**

### **Contact Information** (top section of page, before "**Section 1- Beneficiary Information**")

**Counselor Name:** Enter the name of the registered counselor who provided SHIP services to the client for this contact. If a team of two counselors helped the client, enter the name of the primary counselor (only complete one form). Include the agency name next to the counselor name.

**Zip Code of Counseling Location:** Enter the zip code of the location where counseling occurred. If the contact occurred in more than one location or more than once, enter the location where the first contact occurred.

**Type of Client/Assistance Requested by:** Check the box or boxes that best describes the type of client or clients who request information or assistance. Check "couple" only if both require SHIP services for the same issue.

**Quick telephone calls:** Check this box for calls lasting less than 10 minutes. If possible, counselors should make an attempt to complete the rest of the form. This contact is legal awareness for TDoA reporting purposes, if 7 minutes or less.

**Date of Initial Client Contact:** Enter the date on which the first counseling/assistance session occurred. Do not count contact with a client to merely set up an appointment for a later date. If discussion of other issues is made in conjunction with the appointment, count the contact.

**Total Client Contacts:** Enter the total number of additional contacts or counseling/assistance that occurred. Counseling sessions occurring on separate days should be entered as a separate contact date, in the narrative even if the counseling session is a follow-up session on the same topic. (The narrative page of the hard copy file will document these entries.)

**For clients who require monthly claims/billing assistance (for whom you may have multiple contacts on a regular basis), you need only complete one form each month for the client. Make sure to count all time spent during the month on the client's bills.**

**Type of Contact:** This section reports on the four ways in which counselors provide services to help the client resolve his/her insurance-related problem(s). Check whether the contact was made:

- over the telephone,
- in person (site),
- in person (home visit), or
- via postal mail, e-mail or fax.

*Note:* For in person contacts that occurred in other locations, such as a grocery store or church, check the box for in person (site).

**Time Spent:** Time spent represents the total minutes/hours a counselor spent counseling or working directly on behalf of the client for each contact.

This includes the total number of minutes/hours spent on the following activities to resolve the client's issue(s) related to each contact:

- counseling,
- researching,
- referring,
- advocating (calling agencies on the client's behalf),
- trying to reach the client
- waiting to meet with a client,
- traveling,
- preparing materials to send to the client, and
- completing paperwork/forms to report the client contact.

In the blank line(s) provided, write in the *total* number of minutes or hours spent on the case. Note that some of the time spent may take place on a day other than the contact date. For example, you may spend 1 hour with the client on the contact date, 1 hour the next day researching information on behalf of the client and another 20 minutes the following day completing paperwork. Two hours and 20 minutes should be entered as the total time spent next to the initial client contact date. (Total units generated are rounded up to the nearest hour for CMS and TDoA uses a unit's table.)

**Status of client contact:** Check "open" if contact with the client is likely to continue in order to resolve their issues/problems, or "closed" if no further contact is necessary.

## **Section 1- Beneficiary Information**

Enter the **name**, **zip code**, and **telephone number** of the Medicare beneficiary (or pre-Medicare beneficiary) who is the recipient of SHIP services. This information may be needed to contact the client with follow-up information and to assist with their particular issue or problem. This information also helps the Medicare program know how many unique beneficiaries the SHIPs are assisting. If the beneficiary is deceased, information on the beneficiary's representative should be entered instead.

*Note:* Please remember to include area code when recording the telephone number.

For couples needing assistance with the same issue(s), enter the name of the individual who the counselor spent more time speaking with. Exception: if both individuals need assistance with separate issues, please complete a separate form for each individual.

**Representative name:** If appropriate, enter the name of the person (spouse, relative, friend, agency staff) helping or representing the beneficiary.

## **Section 2- Beneficiary Demographics**

**Beneficiary Demographic information shall be completed only if a client is contacting SHIP for the first time since April 1, 2001. If the beneficiary is deceased, complete this section for the beneficiary's representative you are helping.**

### **Steps:**

1. First, ask the client if he/she has received SHIP services since April 1, 2001. If not, complete the Beneficiary Demographics Section. Take the word of the client; no check of past records is necessary. If a client is unsure whether they have received SHIP services since April 1, complete this section.
2. Assure the client that the data gathered in this section are confidential and are used for statistical analysis purposes only. Counselors may read the following statement to the client: "We need to collect as much of the following information about you as possible, but all information is optional. The program uses this information to get an idea of which clients we are reaching and which we aren't. We can also use this information to demonstrate how many people we reach so that we can continue to get funding to help Medicare beneficiaries. All information we collect is strictly confidential--no names will be attached when reported as totals."
3. The counselor should make his/her best attempt to collect as much of the demographic information as possible, but this information is optional.
  - The client often communicates beneficiary demographic information during the course of the counseling session. In these cases, the counselor does not need to ask for it directly.

- If the beneficiary demographic information is not shared during the course of the conversation and the counselor feels uncomfortable or is unable to collect this information from the client, an educated guess is acceptable or else “Not Collected” should be checked.

*Hint:* If the contact is in person, the counselor may ask the client to fill in the demographics him/herself. This can be accomplished easily by turning the form around to them and giving them a few minutes to complete it before the counselor continues.

**For couples, complete this section for only one individual. (Choose the one you spent more time talking with or who needs most assistance.)**

**Date of Birth or Age:** The counselor may collect either of these items. For the age categories, check the box that applies to the client. For date of birth, simply record this information in the allotted space.

*Hint:* If the client has not volunteered information about his/her age, it may be easier to ask for date of birth.

**Gender:** Check the appropriate one. If the gender is not obvious (over the telephone, for example), an educated guess is acceptable.

**Monthly income:** Check the appropriate box that applies to the client. Check “Not Collected” if the client is reluctant to reveal his/her income. While income is a sensitive topic, knowledge of a client’s income may help the counselor assess whether the client is eligible for Medicaid, QMB, SLMB, or any other needs-based programs.

*Note:* This category refers to the monthly "household" income of the client or the client and spouse only, not relatives with whom the client might be living.

*Hint:* If the counselor is feeling uncomfortable with this topic, the counselor might tell the client that there are different programs available for different income levels. The counselor can provide a list of the income levels and the programs that correspond with them and ask the client to report which programs sound appropriate to his/her income level. The counselor can then explain these specific programs to the client.

**Disabled:** Check “disabled” if the client is currently receiving or applying for Medicare, Social Security, SSI or Veterans benefits due to disability or End Stage Renal Disease (ESRD).

**Ethnicity/Race:** Check the ethnicity/race category that applies to the client. It is appropriate to ask the client what ethnicity/race category they declare.

*Hint:* It may be helpful to explain to the client that this information is being collected to ensure that SHIP services are accessible such that no group is under served.

### **Section 3- Topics Discussed**

**Discussed:** Many clients need assistance with more than one issue. Section 3 is designed to reflect all major topics discussed during the course of the client contact. For example, if a counselor discusses three topics with a client, then the boxes under the “discussed” heading for all three topics should be checked. Thus, this section provides a count of the specific issues that require counselor assistance to resolve or understand.

#### **Medicare:**

**Enrollment, eligibility, benefits:** includes helping someone understand what Medicare does and does not pay for, or answering eligibility and enrollment questions.

**Claims/billing:** includes any problems with Medicare covering a provider bill or with understanding the claims process that is not resulting in a review, reconsideration, or appeal. Helping a person sort bills and teaching them how to organize billings and claims papers fit into this category.

**Appeals/quality of care:** includes contacts associated with a review, reconsideration, or formal appeal regarding an original statement from Medicare.

**Medical Surrogate Decisions:** Advance directives such as directive to physician or living will, power of attorney for health care and out of hospital do not resuscitate order.

**Fraud/Scams:** this category identifies fraud as it relates to Medicare.

**Acute hospital/facility:** referrals to Medicare certified hospitals, acute care facilities, Medicaid nursing homes.

**Other:** issues related to Medicare not covered in the above categories.

**Medigap/Supplement/SELECT:**

**Enrollment, eligibility, comparisons:** includes contacts associated with explaining Medicare supplement coverage, answering questions about eligibility and enrollment, comparing policies, or providing information to help someone make a decision on the best policy to meet their financial needs.

**Change coverage:** includes discussion of the way a client can secure comparable or better insurance coverage, reduce coverage, cancel coverage, or not purchase unnecessary insurance. This also includes discussion of the Medicaid suspension option, which allows for the discontinuation of Medicare supplement premiums.



**Claims/appeals:** includes problems with Medigap covering a provider bill or with understanding the claims process. This section also includes contact associated with a review, reconsideration, or formal appeal regarding a Medigap decision or finding.

**Medicare+Choice (Health Maintenance Organizations (HMOs), Private Fee-For-Service (PFFS), managed care):**

**Enrollment/disenrollment, eligibility, comparisons etc.:** includes helping someone understand how Medicare+Choice plans work, answering eligibility and enrollment questions, reviewing similar insurance policies being considered by a client, and comparing different Medicare+Choice plans. It can include any mention of “Medicare+Choice” by the client or the need for assistance on any of the expanded health plan choices created as part of the Balanced Budget Act of 1997. These include Health Maintenance Organizations (HMOs), HMOs with Point of Service (POS) option, Preferred Provider Organizations (PPOs), Provider-Sponsored Organizations (PSOs), Private Fee-For-Service Plans (PFFS plans), or Medical Savings Accounts (MSAs).

**Plan or benefit changes/non-renewals:** includes any changes in a client’s coverage due to plan non-renewals/terminations, changes in provider participation, changes in premiums, or changes in covered benefits.

**Claims/billing:** includes any problems with a Medicare+Choice plan covering a provider bill or with understanding the claims process that is not resulting in a review, reconsideration, or appeal. Helping a person sort bills and teaching them how to organize billings and claims papers fit into this category.

**Appeals/quality of care/grievances:** includes contacts associated with an appeal, quality of care complaint or grievance related to HMOs or other choices authorized under Medicare+Choice.

**Medicaid:**

All of these categories include helping someone understand what services are covered under a particular Medicaid program, answering general eligibility and enrollment questions, such as income and resource limits, and possibly helping clients complete enrollment forms.

**Medicare Savings Programs - QMB:** includes discussion of eligibility for the Qualified Medicare Beneficiary program that pays for Medicare premiums, deductibles, and coinsurance. **SLMB/QI-1:** includes discussion of eligibility for the Specified Low-Income Medicare Beneficiary/Qualifying Individual-1 programs that pay for the Medicare Part B premium. **QI-2:** includes discussion of the Qualifying Individual-2 program that pays for a small part of the Medicare Part B premium.

**Nursing Home Medicaid:** assistance with document preparation, research, follow-ups, and all activities that assisted a client through the maze of access for Medicaid.

**Regular Medicaid:** includes access of special medical benefits for this Social Security entitlement for recipients with very limited income and resources.

**Other Medicaid** (some of these may not apply to all states): includes discussion of the Regular Medicaid program, Medicaid for Aged or Disabled, Medically Needy Medicaid, dual eligibility, LTC/home & community-based waivers, nursing home/spousal impoverishment, or Supplemental Security Income (SSI) and appeal rights.

### **Long-Term Care (LTC) Insurance/Other Insurance:**

May include explaining long-term care insurance; discussing eligibility; reviewing policies; providing someone with the information necessary to make a decision about whether or not to purchase a LTC policy; discussion of the way a client can secure comparable or better insurance coverage, reduce coverage, cancel coverage, or not purchase unnecessary insurance; and claims/appeals. Additional categories include COBRA, other health policies, individual and group policies, non-health policies, and other retirement plan policies.

**Social Security:** issues covered are eligibility, benefits, SSI, Food Stamps or TANF, Temporary Assistance for Needy Families (public benefits), disability, and appeals.

**N/C Covered Health:** includes medications, eyeglasses, dentures, hearing aids and assistive devices.

**Individual Rights:** includes abuse, neglect, exploitation, and discrimination (age, disability) immigration, civil rights, labor issues and other issues such as divorce, name change and other issues not provided.

**Veterans' Issues:** includes benefits, eligibility, service record issues, and VA nursing home eligibility.

**ADLS:** Activities of daily living covers meal prep/cooking, shopping, personal care, housekeeping, assistance with medications, communication assistance, chores, ERS (Emergency Response System), and general services from the community.

**Consumer Issues:** issues include bankruptcy, collections, financial counseling, bill reduction, and fraud.

**Other Issues:** issues include money management, guardianship, probate matters, other surrogate issues, and various retirement plans

**Housing:** covers disputes of landlord/tenant, repair/modification, utilities/weatherization, eviction/relocation, property tax, rent subsidy, and alternative housing.

### **Optional notes (attach separate page)**

This can include information from the hard copy file narrative page, helpful to the counselor or coordinator such as a summary of the question or problem that the client described to the counselor, the type of insurance coverage and policy numbers if needed for counseling purposes; what action was taken by the counselor and the outcome or resolution to the problem; referrals to other agencies; whether materials were mailed to the client; and status of the contact.

Furthermore, if a client specifies the exact dollar amount of savings associated with a particular issue checked in Section 3, then the counselor could use this space to provide the amount of dollar savings. Report this amount as given to you by the client (i.e. monthly or annually). No calculations are necessary.

### **Legal Awareness and the SHIP Public and Media Activity Form**

25. **Legal awareness** is the second part of benefits counseling service reports that are submitted monthly to TDoA and CMS and the same form will document activities for both agencies. A copy of this form, titled “ State Health Insurance Assistance Program (SHIP) Public and Media Activity Form,” is in the resource section of this chapter. Use this form to document presentations to groups or individuals. Counseling activities are not captured on this form. The top of the form provides space for inserting the AAA logo. Enter the AAA represented, presenters’ name, AAA address, business phone, fax number, counselor’s e-mail address, and date and length of time of presentation.

26. **Section One** addresses **Type of Activity**. Check A, **interactive presentation**, if substantive knowledge on Medicare or the SHIP program is transferred by oral and visual means from a SHIP presenter to those persons attending the presentation. Attach sign-in sheets or estimates provided to you by the promoter and signed by the promoter. The promoter may provide rough head counts. Check the box for in-person, if the program was provided on a face-to-face basis. Check video teleconferences or satellite broadcasts if the function was interactive with an audience. This activity includes presentations, video teleconferences or satellite broadcasts. Do NOT include SHIP counselor training events. Estimate the number of attendees and record in the space provided.

27. Check B if a presenter staffed a **booth** or exhibit and general information and /or simple printed fact sheets are shared with, or distributed, to the public to increase community awareness of services and the need for individual counseling. The purpose of the SHIP program participation at such events is to inform the public about the availability of SHIP services in their area. Estimate the number of people potentially reached by using a check mark, numbered ticket, or using handout kits counting the number of materials distributed. These examples are

acceptable means for head counting for both the TDoA and HCFA reports. Record the estimated number of people potentially reached in the appropriate space.

28. Part C of Section One addresses **media and print outreach**. Radio/TV and public service announcements (PSAs): cable/local network television programming; targeted informational mailings; and articles or PSAs in print media such as newspapers and newsletters, are reported under this heading. Media events can be live or taped. Report the date(s) you are aware the event was originally aired in Section 4. Estimate the number of people potentially reached such as estimated audience size or potential number of listeners.

29. Part D covers **web-site events**. This may be a one-time or limited time interactive event sponsored by the SHIP such as web conferences, forums, and interactive “chatrooms.” Visitors to other parts of your web-site should be reported on the Resource Report. Estimate the number of people potentially reached by estimating the number of visitors to these activities.

30. **Section Two** addresses **target audiences**. Check the appropriate box or boxes. If a special minority was served, please write in that ethnic group. Check the appropriate box or boxes for “Subject Areas Covered.”

31. Section 4, **activity information** is completed for interactive in-person presentations, booth/exhibit, or interactive radio/television broadcasts. It records the dates of the activity, length of time, location, presenters and the type of presenter.

# **Instructions for Completing the State Health Insurance Assistance Program (SHIP) Resource Report**

**Submitted every 12 months  
INDEX**

The following data elements are contained on the SHIP Resource Report form.

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a) # Volunteer Counselors	
b) # SHIP-Paid Counselors	
c) # In-kind Paid Counselors	
TOTAL # Counselors	
d) Volunteer Counselor Hours	
e) SHIP-Paid Counselor Hours	
f) In-kind Paid Counselor Hours	
<b>SECTION 2: Number of Local Coordinators/Sponsors and Hours</b>	<b>6</b>
a) # Volunteer (unpaid) Coordinators	
b) # SHIP-Paid Coordinators	
c) # In-kind Paid Coordinators	
TOTAL # Coordinators	
d) Volunteer (unpaid) Coordinator Hours	
e) SHIP-Paid Coordinator Hours	
f) In-kind Paid Coordinator Hours	
<b>SECTION 3: Number of Other Paid Staff and Hours</b>	<b>8</b>
a) # SHIP-Paid Other Staff	
b) # In-kind Paid Other Staff	

- c) SHIP-Paid Other Staff Hours
- d) In-kind Paid Other Staff Hours

**SECTION 4: Counselor Training's** **9**

- a) # Initial Training(s) for New SHIP Counselors
- b) # New SHIP Counselors Attending Initial Training(s)
- c) TOTAL # Counselor Hours in Initial Training(s)
- d) # Update Training(s) for SHIP Counselors
- e) # SHIP Counselors Attending Update Training(s)
- f) TOTAL # Counselor Hours in Update Training(s)

**SECTION 5: Number of Active Counselors with the Following Characteristics:** **10**

- a) Years of SHIP service
- b) Age
- c) Disability Status
- d) Gender
- e) Ethnicity/Race

**SECTION 6: Web Site Visitors** **10**

**SECTION 7: Case Summaries** **10**

**SECTION 8: Activities, Lessons Learned, Significant Events** **11**

**EXPLANATION OF DATA ITEMS**

**The following data items should be completed for the entire state for the 12-month report period indicated.**

**Definitions for Sections 1 and 3.**

**State Office:** The state SHIP office is the central office for the SHIP program, where the state SHIP project director, trainers, administrative staff, and/or state toll-free help-line counselors are usually based. These personnel provide counseling to clients from the entire state, not necessarily from only one area/region of the state. Counselors (volunteer or paid) and other personnel who are based in the state office should be counted in the “State Office” columns.

**Local and Field Sites:** Local and field sites refer to locations outside the state SHIP office where counselors, coordinators/sponsors, other SHIP staff, or volunteers may be based and/or provide counseling. Examples: A local/regional SHIP program may serve one or more cities/counties and may be located in a local hospital, RSVP (Retired Senior Volunteers Program), senior center, Area Agency on Aging, Senior Information and Referral program, a senior legal services program, or an independent non-profit agency. Counselors (volunteer or paid) and other personnel who are based in these local or field sites should be counted in the “All Other Local and Field Site” columns.

**Note:** The number of persons working or volunteering for a SHIP may be counted more than once since some coordinators or staff also provides counseling. If this is the case, then include them in both the counselor section (Section 1) and the coordinator section (Section 2). However, their number of hours for the reporting period should not be double-counted. Estimate the hours a person provides towards counseling separate from the hours spent on other tasks such as coordinating a program. Example: if a coordinator works 4 hours per week for the SHIP program, but spends half of this time counseling clients, then count her as providing 104 hours (2 hours per week X 52 weeks) coordinating and 104 hours (2 hours per week X 52 weeks) counseling.

## **SECTION 1 - NUMBER OF ACTIVE COUNSELORS AND HOURS**

**Active Counselor:** any person who provided counseling, information, or assistance related to Medicare or other health insurance for a SHIP during the reporting period. Do not count counselors, who did not provide any counseling during the reporting period, even if they were trained. The three most common types of counselors utilized by SHIP programs include:

1) volunteer, 2) SHIP-paid, and 3) in-kind paid. These include telephone helpline counselors.



# of Volunteer Counselors: the number of persons who:

- provided SHIP counseling hours during the reporting period; AND
- were registered volunteer counselors (they have signed some type of Counselor Agreement or Memorandum of Understanding (MOU)); AND
- did not receive paid compensation for their time or services (but may have received travel reimbursement).
- Volunteer counselors can also include local/area coordinators/sponsors if they also provided SHIP counseling AND were not paid by the SHIP program.

# of SHIP-Paid Counselors: the number of persons who:

- provided SHIP counseling hours during the reporting period; AND
- received any compensation for their time and services from the SHIP program, regardless of whether their salary was funded by CMS, the state, or some other funding agency.

Examples: state project directors, receptionists, telephone operators, and paid local/regional coordinators/sponsors, as long as they provided counseling during the reporting period as part of their normal duties.

# of In-kind Paid Counselors: the number of persons who:

- provided SHIP counseling during the reporting period; AND
- were registered SHIP counselors who have signed some type of Counselor Agreement or Memorandum of Understanding; AND
- received compensation for their time and services from a program other than SHIP.

Examples include: RSVP staff, hospital staff, senior center staff, Senior Information and Referral staff, Area Agency on Aging staff, and outreach social workers, who may or may also not be local/regional coordinators/sponsors.

**TOTAL # Counselors (a+b+c):** Add the numbers of the three types of counselors. This total should be the same as the totals in Section 5 of the Resource Report Form.

Note: The hours reported in the next data items should be from the same persons counted in a), b), and c).

**Volunteer Counselor Hours:** the total number of hours the volunteer SHIP counselors (counted in a) contributed to the SHIP program counseling or working directly on behalf of clients. This includes the total number of hours spent on the following activities to resolve clients' issues:

- counseling,
- researching,
- referring,
- advocating (calling agencies on the client's behalf),
- trying to reach the client,
- waiting to meet with a client,
- traveling,
- preparing materials to send to the client, and
- completing paperwork/forms to report the client contact.

**SHIP-Paid Counselor Hours:** the total number of hours the SHIP-paid counselors (counted in b.) spent in counseling activities described in d) above.

**In-kind Paid Counselor Hours:** the total number of hours the in-kind paid counselors (counted in c.), spent in counseling activities described in d) above.

## **SECTION 2 - NUMBER OF LOCAL COORDINATORS/SPONSORS AND HOURS**

**Coordinator/sponsor definition:** a person from a local or field SHIP site (see above definitions) who may do one or more of the following:

- supervises counselors,
- recruits counselors,
- trains counselors,
- meets with counselors,
- provides administrative support (schedules meetings, provides travel reimbursement),
- publicizes the SHIP program,
- oversees data reporting,
- distributes informational materials,
- conducts public and media activities such as presentations or health fairs.

Do NOT include persons/organizations that:

- only provide meeting or office space (these can be described in Section 8),
- contribute no time to the SHIP program,
- provide the same services, as a SHIP coordinator for another similar program that is not considered part of the SHIP program.

NOTE: Coordinators can also counsel clients, and thus may also be included both in the number of counselors in Section 1 a), b), or c) and in the number of coordinators in Section 2 a), b), or c). However, do not double count their hours by including total hours in both Section 1 d), e) or f) and Section 2 d), e) or f). Rather, separate counseling hours from coordinator hours if possible. For example, if a coordinator spends 8 hours per week counseling and the remaining 32 hours per week performing SHIP coordinator functions, you would indicate 8 hours X 52 weeks = 416 hours in Section 1 d), e), or f) and 32 X 52 weeks = 1,664 hours in Section 2 d), e), or f).

**a. # of Volunteer (unpaid) Coordinators:** the number of persons who:

- performed the SHIP coordinator functions defined above AND

- did not receive compensation for their time or services (but may have received travel reimbursement).

**b. # of SHIP-paid Coordinators:** the number of persons who:

- performed the SHIP coordinator functions defined above AND
- received compensation for their time from the SHIP program, regardless of whether their salary was funded by CMS, the state, or some other funding agency.

**c. # of In-kind Paid Coordinators:** the number of persons who:

- performed the SHIP coordinator functions defined above AND
- received compensation from a program other than SHIP.

Examples include: RSVP staff, hospital staff, senior center staff, Senior Information and Referral staff, Area Agency on Aging staff, and outreach social workers.

**TOTAL # Coordinators (a+b+c):** Add the numbers of the three types of coordinators.

**d. Volunteer (unpaid) Coordinator hours:** the total number of hours the volunteer (unpaid) coordinators (counted in a.) contributed to the SHIP program performing the functions of a coordinator, as defined above.

**e. SHIP-Paid Coordinator Hours:** the total number of hours the SHIP-Paid coordinators (counted in b.) contributed to the SHIP program performing the functions of a coordinator, as defined above.

**f. In-kind Paid Coordinator Hours:** the total number of hours that the In-kind paid coordinators (counted in c.) contributed to the SHIP program performing the functions of a coordinator, as defined above.

## SECTION 3 - NUMBER OF OTHER PAID STAFF AND HOURS

**Other paid staff definition:** persons who performed other functions for the SHIP aside from the counselor and coordinator functions described above. These persons can include state project directors, trainers, receptionists, administrative staff, etc. These types of paid staff can work in the state office or local/field sites.

**a. # SHIP-Paid Other Staff:** the number of persons who:

- performed the functions of other paid staff defined above AND
- received compensation for their time and services from the SHIP program, regardless of whether their salary was funded by CMS, the state, or some other funding agency.

**b. # In-kind Paid Other Staff:** the number of persons who:

- performed the functions of other paid staff defined above AND
- received compensation for their time and services by a program other than SHIP.

Examples include: RSVP staff, hospital staff, senior center staff, Senior Information and Referral staff, Area Agency on Aging staff, and outreach social workers.

**c. SHIP-Paid Other Staff Hours:** the total number of hours that the SHIP-Paid other staff (counted in a.) contributed to the SHIP program in activities defined above.

**d. In-kind Paid Other Staff Hours:** the total number of hours that the In-kind paid other staff (counted in b) contributed to the SHIP program in activities defined above.

## SECTION 4 - COUNSELOR TRAININGS

**a. # Initial Training(s) for New SHIP Counselors:** the total number of initial training sessions held throughout the state during the reporting period for new counselors, including volunteer or paid counselors. For example, if 20 local sites in the state conduct one initial training each

during the reporting period, report 20 initial trainings. If 4 local sites hold 2 initial trainings each, report 8 initial trainings. Initial trainings that last several days should be counted as one training.

- b. # New SHIP Counselors Attending Initial Training(s):** the total number of new counselors, including volunteer or paid counselors, who attended an initial training session for new counselors.
- c. TOTAL # Counselor Hours in Initial Training(s):** multiply the number of counselors who attended initial training (counted in b.) by the number of hours of the initial training session. For example, if ten counselors attended a two day (totaling 16 hours) initial training session, then report 160 total counselor hours in initial training.
- d. # Update Training(s) for SHIP Counselors:** the total number of update training sessions held throughout the state during the reporting period for counselors, including volunteer or paid counselors. An update training includes regular meetings or training sessions during which counselors are given updates on topics including but not limited to: Medicare changes, health insurance plan choices, counselor skills development, and SHIP program procedures. For example, if 20 local sites in the state conduct one update training each during the reporting period, report 20 update trainings. If 4 local sites hold 2 update trainings each, report 8 update trainings. Update trainings that last several days should be counted as one training.
- e. # SHIP Counselors Attending Update Training(s):** the total number of counselors, including volunteer or paid counselors, who attended an update training session.
- f. TOTAL # Counselor Hours in Update Training(s):** multiply the number of counselors who attended update training (counted in e.) by the number of hours of the update training session. For example, if ten counselors attend a two-hour update training session, then report 20 total counselor hours in update training. If three monthly meetings are held during which you spend 30 minutes on updates and ten counselors attend each meeting, then report  $3 \times 0.5 \text{ hours} \times 10 = 15$  counselor hours in update training.

## **SECTION 5 - NUMBER OF ACTIVE COUNSELORS WITH THE FOLLOWING CHARACTERISTICS (OPTIONAL)**

Note: Characteristics should be reported for all active counselors counted in Section 1.

**a. Years of SHIP service:** enter the number of counselors who (at the end of the reporting period) had participated in the SHIP program (regardless of which state) for less than 1 year, 1 up to 3 years, 3 up to 5 years, or over 5 years. Also enter the number of counselors for whom this information is not known (not collected).

**b. - e. Counselor demographic information (ethnicity/race, age, disability status, gender):**

The number of counselors with each characteristic plus the number for whom this information is not known (not collected) for each characteristic should equal the total number of counselors entered in Section 1. This includes any persons who provided counseling (volunteers, staff paid by SHIP, or in-kind staff), who may or may not have also performed other duties for the SHIP (coordinator, project director, trainer, receptionist, etc.).

## **SECTION 6 - WEB SITE VISITORS (if applicable)**

If your SHIP has its own web site, fill in the number of visitors. "Visitors" means the number of people who viewed any page of your web site, NOT the total number of pages viewed by that individual. Some duplication of people may occur if someone visits your web site several times during each quarter in the reporting period.

## **SECTION 7 - CASE SUMMARIES**

"Case Summaries" allow programs to record a brief summary of interesting and/or unusual cases handled by your counselors and staff. This is an extremely important part of the NPR. It "puts a face" on the cases and problem areas served by SHIP counselors. Also, narrative case summaries are one of the best ways to demonstrate the outcomes of your work because they show the depth and scope of beneficiary problems, the inter-disciplinary nature of benefits and

insurance problems, and prove the need for one-on-one assistance for a beneficiary who would not otherwise access the benefits and services she or he truly needs. Case summaries are also especially useful in testimony before Congress and other public presentations concerning the importance of the national SHIP program.

Please attach additional pages as needed. Programs should record at least three case summaries that have taken place within each reporting period. As always, do not include any client identifying information in the summaries.

## **SECTION 8 - ACTIVITIES, LESSONS LEARNED, SIGNIFICANT EVENTS**

In this section, SHIP directors are asked to describe activities, lessons learned (including challenges and problems encountered), significant events or developments that they want to share with other SHIP programs and CMS. Please organize the narrative by using the following headings: Outreach (including strategies for under-served populations), Information Access and Dissemination, Training of Staff and Volunteers, and Partnership and Networking (including relationship with carriers, HCFA regional offices, etc.) These headings correspond to those in the SHIP grant application and you are encouraged to include and update the information you prepared for the grant applications in these categories. Additional page(s) should be used for this section.

It is anticipated that Sections 7 and 8 together will demonstrate the varied and challenging program goals, the special outreach methods employed to serve diverse populations, the technical complexity of the SHIP subject matter, and the extensive skill that resides in the SHIP corps of competent and compassionate volunteer health insurance counselors.



## BENEFITS COUNSELING/LEGAL ASSISTANCE CASE REPORT

<p>1. Date: _____</p> <p>2. Client's SS#: _____ Medicare #: (if relevant) _____</p> <p>3. Name: _____ Client's Name (First, M.I., Last)</p> <p>Gender: _____</p> <p>4. Address: _____</p> <p>5. City: _____ State: _____</p> <p>6. Zip: _____</p> <p>7. County: _____</p> <p>8. Phone: ( ) _____</p> <p>9. Physician: _____</p> <p>10. Phone: _____</p> <p>11. Race (check one) : _____ Black _____ White          _____ Native American _____ Hispanic _____ Asian          _____ Other _____ Not Collected</p>	<p>Counselor/Legal Service Provider: <u>AAA/BC</u></p> <p>12. Marital status (check one) _____ married          _____ widowed _____ divorced          _____ separated _____ never married          _____ single _____ no information</p> <p>13. Total in household (include client): _____</p> <p>14. Income (check one) _____ low _____ medium          _____ high _____ SSI</p> <p>15. Referral person: _____</p> <p>16. Referral Phone: _____</p> <p>17. 60+ client? _____</p> <p>18. Date of Birth: _____</p> <p>19. TDHS CBA Client? _____</p> <p>20. DHS Waiting List? _____</p> <p>21. Has Guardianship? _____</p> <p>22. Representative Payee? _____</p> <p>23. Consent Given? _____</p>
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ISSUE: (Describe, using the "Client Profile of Need Categories"; if more than one, list each, or most prevailing issue)

TYPES OF SERVICE(S) NEEDED (check all that apply):

\_\_\_\_\_ advice /counseling      \_\_\_\_\_ document preparation      \_\_\_\_\_ representation      \_\_\_\_\_ other: (describe)

<p>CLIENT WAS REFERRED TO:</p> <p>_____ legal provider    _____ SSA    _____ Legal Hotline</p> <p>_____ Department of Insurance    _____ DHS    _____ Other(specify)</p>	<p>NOTES ABOUT REFERRAL(S):</p>
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MONETARY IMPACT (complete only if feasible, known, and accomplished with your assistance)

a. one time award: \$ \_\_\_\_\_      b. recurring benefits: \$ \_\_\_\_\_

TOTAL for year \$ \_\_\_\_\_



**Benefits Counseling Program**  
**2512 IH-35 South, Suite 340**  
**Austin, TX 78704-5798**  
**Telephone 512-916-6062**  
**Toll Free 1-888-622-9111**

Our records show that you contacted our Benefits Counseling Program for assistance in May 2000. Would you please assist us in our effort to maintain a high quality program by telling us about your experience with our agency? **Please complete the following Client Satisfaction Survey and return it at your earliest convenience in the enclosed postage paid envelope.** Your response is completely confidential. Thank you for your participation.

**Circle your response. 1= Not at all 2= Somewhat 3= Very much**

- |   |            |           |          |
|---|------------|-----------|----------|
| 1. Benefits Counselor was polite and helpful.   | <b>1</b>   | <b>2</b>  | <b>3</b> |
| 2. The Benefits Counselor provided useful and appropriate information for my case.  | <b>1</b>   | <b>2</b>  | <b>3</b> |
| 3. I understood the information the Benefits Counselor provided.  | <b>1</b>   | <b>2</b>  | <b>3</b> |
| 4. Please answer the following question if the Benefits Counselor made a visit to your home:<br>The interview was conducted in a private and confidential manner. | <b>1</b>   | <b>2</b>  | <b>3</b> |
| 5. The answers to my questions or information I sought was provided in a timely manner.   | <b>1</b>   | <b>2</b>  | <b>3</b> |
| 6. I am satisfied with the amount of involvement I had in the resolution of my case.  | <b>1</b>   | <b>2</b>  | <b>3</b> |
| 7. The Benefits Counselor provided me with enough information to make my own informed decision.   | <b>1</b>   | <b>2</b>  | <b>3</b> |
| 8. I felt the decisions made were my own, without undue influence from the Benefits Counselor.  | <b>1</b>   | <b>2</b>  | <b>3</b> |
| 9. I am satisfied with the outcome of my case.  | <b>1</b>   | <b>2</b>  | <b>3</b> |
| 10. I would recommend that my friends or family contact the Area Agency on Aging when seeking benefit information.  | <b>Yes</b> | <b>No</b> |          |

If you answered **No**, please comment on why you would not: \_\_\_\_\_

**\*\* If you would like to make additional comments or suggestions, please do so on the back side of this form. Again, thank you for your assistance.**

**AAA BENEFITS COUNSELING CASE NARRATIVE – NAME OF AAA**

**CLIENT NAME** \_\_\_\_\_

**MONTH/YEAR** \_\_\_\_\_

**PAGE** \_\_\_\_\_ **OF** \_\_\_\_\_

[illegible]

Codes		Unit Calculation of Time	
A – Advice/Counseling	P – Documentation	Total actual minutes for month	_____
B – Written Summary	Preparation/assistance		
C – Correspondence	R – Contact agencies for	Total actual minutes and hours	_____
D – Scheduled home visit	Client empowerment		
E – Research for case	S – Satisfaction survey	Total Contacts via phone, e-mail,	
Options/resolution	W – Walk-in	Fax, postal mail, home , office, or	
F - Case follow-up		Walk-in	_____
H - Home visit			
I – Intake		Verified by	_____
L – Legal assistance,			
Representation			
M – Maintenance of records		This section is <b><u>NOT COMPLETED</u></b> by	
N – Agency networking with		Volunteers. Staff will calculate time	
Other agencies for case		Spent on the case.	
Resolution			

### Guidelines for Determining Units of Service

Minutes	Hours	Units Recorded		Minutes	Hours	Units Recorded
1-7	0.02-0.12	0.00		413-427	6.88-7.12	7
8-22	0.13-0.37	0.25		428-442	7.13-7.37	7.25
23-37	0.38-0.62	0.50		443-457	7.38-7.62	7.50
38-52	0.63-0.87	0.75		458-472	7.63-7.87	7.75
53-67	0.88*1.12	1.00		473-487	7.88-8.12	8.00
68-82	1.13-1.37	1.25		488-502-	8.13-8.37	8.25
83-97	1.38-1.62	1.50		503-517	8.38-8.62	8.50
98-112	1.63-1.87	1.75		518-532	8.63-8.87	8.75
113-127	1.88-2.12	2.00		533-547	8.88-9.12	9.00
128-142	2.13-2.37	2.25		548-562	9.13-9.37	9.25
143-157	2.38-2.62	2.50		563-577	9.38-9.62	9.50
158-172	2.63-2.87	2.75		578-592	9.63-9.87	9.75
173-187	2.88-3.12	3.00		593-607	9.88-10.12	10.00
188-202	3.13-3.37	3.25		608-622	10.13-10.37	10.25
203-217	3.38-3.62	3.50		623-637	10.38-10.62	10.50
218-232	3.63-3.87	3.75		638-652	10.63-10.87	10.75
233-247	3.88-4.12	4.00		653-667	10.88-11.12	11.00
248-262	4.13-4.37	4.25		668-682	11.13-11.37	11.25
263-277	4.38-4.62	4.50		683-697	11.38-11.62	11.50
278-292	4.63-4.87	4.75		698-712	11.63-11.87	11.75
293-307	4.88-5.12	5.00		713-727	11.88-12.12	12.00
308-322	5.13-5.37	5.25		728-742	12.13-12.37	12.25
323-337	5.38-5.62	5.50		743-757	12.38-12.62	12.50
338-352	5.63-5.87	5.75		758-772	12.63-12.87	12.75
353-367	5.88-6.12	6.00		773-787	12.88-13.12	13.00
368-382	6.13-6.37	6.25		788-802	13.13-13.37	13.25
383-397	6.38-6.62	6.50		803-817	13.38-13.62	13.50
398-412	6.63-6.87	6.75		818-832	13.63-13.87	13.75

## PROFILE OF NEED

### DESCRIPTIONS OF CLIENT NEED CATEGORIES

The following is a list of descriptions of the items listed in the Profile of Need. These are the needs that have been determined by the case manager and/or benefits counselor through the assessment of the client's status.

Select all of the needs that describe the client's status including those which you will be able to address and for which you will refer the client to another service agency. Indicate those issues that you are unable to address or refer as unmet needs for the client.

### ADL/IADL IMPAIRMENT

Cooking/Meal Prep. - can include menu planning, preparing, cooking, and clean up at completion of tasks.

Shopping - going to the store and purchasing food and other items needed by the client. May include assistance in preparing a list.

Personal Care - hands-on assistance in activities such as eating, grooming, bathing, toileting, transferring, or ambulating. Most often these are referred to as personal care services.

Housecleaning - assistance with tasks such as vacuuming, mopping, sweeping, washing dishes, cleaning bathrooms, changing bed linens, and may include some laundry chores.

Assistance with Medication - the purchase of prescriptions, monitoring, screening, or periodic follow-up to assure that medications are being taken as prescribed.

Assistance with communication - hearing impairment, speech impairment, language barriers or assistance with using the telephone.

### OTHER IN-HOME SUPPORT

Chores - performing non-routine household chores, such as heavy cleaning (scrubbing floors, washing walls, washing outside windows), moving heavy furniture, yard and walk maintenance, which an individual is unable to handle on his or her own.

Care Giver Relief/Respite - any support options provided on a short-term basis for the purpose of relief to the primary caregiver in providing care to frail/disable individuals.

Visitation - regular personal contact provided to older persons for companionship.

Protective Supervision - standby assistance given to frail/disabled individuals because they are potentially vulnerable to physical harm. May include need for electronic monitoring services such as emergency response service.

## TRANSPORTATION

Medical Transportation - needing rides to the doctor, pharmacy, dentist, or other provider of medical services.

General Transportation - needing rides to all destinations

Escort - accompanying and personally assisting an individual in obtaining goods and services.

## NON-COVERED HEALTH SERVICES

Dental Care - oral health which includes prevention, treatment, and/or improved access to care. May include purchase of dentures.

Vision Care - eye health that includes prevention, treatment, and/or improved access to care. May include the purchase of eyeglasses.

Hearing Care - screening and care for the prevention, treatment, and/or improved access to hearing care services. May include the purchase of hearing aids.

Assistive Devices - any of a broad category of health-related support services and/or equipment such as wheelchairs, walkers, prostheses and other medical equipment.

## Housing

Landlord/Tenant - assistance with resolving issues and disputes between tenants and landlords or managers of rental property which could include information, referral, and/or counseling.

Repair/Modification - assistance in the form of consultation, labor, funding, and/or supplies for individuals who need to upgrade their homes to make them safe, accessible and energy efficient or maintain their property for health or safety reasons.

Utilities - assistance in the form of consultation, information and referral and/or funding for services related to water, gas, electric, or telephone.

Rent Subsidy - financial assistance for low-income individuals and families needing low rental housing.

Alternative Housing - any other living arrangement other than the client's own home. Some examples include: personal care homes, foster care, retirement apartments, congregate living, assisted living, board and care homes, half-way houses, emergency shelters, or group homes.

Weatherization - assistance with supplies and labor needed to upgrade an individual's home for energy efficiency.

Property Tax - a sum levied on persons by an authority for possession of land. A client may need assistance with the payment or counseling regarding exemptions of a local property tax.

Housing Relocation - assisting an individual in obtaining a suitable housing situation. Could include information, referral, assistance or funds.

## NUTRITION

Nourishment - the need for food provided during a meal period, including special diets such as diabetic, low-salt, high protein, etc. Does not include the need for meal preparation or shopping assistance and is not dependent on the client's kitchen facilities for preparing the meals.

Supplemental Nutrition - food or beverage which is fortified with calories and nutrients to meet the special dietary needs of participants with specific medical or nutritional needs.

Special Diet - special dietary needs which include cultural/religious preferences such as Kosher meals, and therapeutic medical diets such as meals that are altered to meet the specific requirement of a diagnosed disease or metabolic disorder, to correct nutritional deficiencies, and/or to support attainment of ideal body weight.

## INCOME MAINTENANCE

Food Stamps - establishing eligibility or providing advocacy to low income and indigent households to obtain stamps, vouchers, or electronic benefits which can be exchanged for food.

Social Security - establishing eligibility or providing advocacy for any of a category of income benefits administered by the Social Administration.

Social Security Disability - establishing eligibility or providing advocacy for cash benefits payments made to disabled, insured workers, certain of their dependents, their disabled widow(er)s, disabled divorced surviving spouses, and disabled adult children that are administered by the Social Security Administration.

Supplemental Security Income - establishing eligibility or providing advocacy for a federalized program that provides monthly cash benefits to poor persons who are aged, blind, and disabled. Administered by the Social Security Administration.

General Assistance - establishing eligibility or providing advocacy for cash or vouchers provided to eligible individuals and families to meet program-defined needs.

Veterans Benefits - establishing eligibility or providing advocacy for a wide range of cash and non-cash services, administered through the Department of Veteran's Affairs and available to former members of the active military, naval or air services.

Railroad Retirement - establishing eligibility for providing advocacy for benefits which provides payments to a worker equivalent to normal Social Security benefits, plus an additional pension based on actual railroad service.

Other Income Benefits - establishing eligibility or providing advocacy for any other benefits or income, or secondary income, provided on a regular basis to provide for basic material needs.

## MEDICAL ENTITLEMENTS

Medicare - establishing eligibility or providing advocacy for an array of programs provided by Title XVIII of the Social Security Act.

Medicaid - establishing eligibility or providing advocacy for an array of programs provided by Title XIX of the Social Security Act.

QMB/SLMB, QI 1 & 2 - Qualified Medicare Beneficiary Program, Specified Low Income Medicare Beneficiary Program and Qualified Individual 1 & 2 - establishing eligibility or providing advocacy for these special benefits which allows the Medicaid Program to pay for the Part B premiums and/or deductibles and co-payments, or premiums only under Medicare or a portion of the premium for low-income older persons.

VA Medical - establishing eligibility or providing advocacy for hospital and nursing facility benefits available to disabled veterans through the Department of Veteran's Affairs.



Indigent Health - establishing eligibility or providing advocacy for a local hospital/county-administered benefit, which pays for certain medical and hospital, services for low-income residents.

Other Medical Entitlement - establishing eligibility or providing advocacy for any other benefit or benefits which provide either partial or whole payment for medical and hospital services to qualifying recipients.

## INSURANCE

Medicare Supplement - establishing eligibility or providing advocacy for any of 10 standardized, private insurance policies designed to cover the gaps in expenses not covered by Medicare.

Medicare + Choice/Select - Medicare managed care organizations and Medicare Select - establishing eligibility or providing advocacy for services from a provider network of doctors and facilities who participate in a health care plan that covers services ranging from preventive care to hospitalization and surgery. Some plans contract with Medicare to provide comprehensive coverage to Medicare recipients. "Select" is a special type of Medicare Supplement which is typically sold by a managed care organization, but whose coverage is the same as a regular Medicare Supplemental.

Long-Term-Care Policy - establishing eligibility or providing advocacy for a health insurance policy designed to cover the costs of long-term-care at home, in a medical facility or nursing home setting.

Individual Health Policy - establishing eligibility or providing advocacy for an individually purchased insurance policy, which covers certain medical hospital, services.

Group Health Policy/COBRA - establishing eligibility or providing advocacy for an insurance policy, which covers certain medical and hospital services and which is available through an employer group plan, or other organizational plan. COBRA is a federal law requiring employers to extend the option to employees who are ending work to purchase health insurance under the employer's group plan at the full premium, and for a limited period of time past employment.

Other Health Policy - establishing eligibility or providing advocacy for any other type of insurance policy which covers certain medical and hospital services and which is not obtained through federal, state, or local government programs or through private and group plans. OR, a special type of health insurance policy usually purchased individually, which covers only a very limited scope of specialized medical and hospital services.

Non-Health (life, auto, etc.) - establishing eligibility or providing advocacy regarding insurance policies which provide compensation for goods and services other than health care, such as automobiles, home, fire, life, etc.

## SURROGATE DECISION MAKING

Advanced Directives - any of several legal actions, which can be taken by an individual to direct, in advance of need, certain person to carry out certain responsibilities in the event of his/her incapacitation or death. Examples of advance directive legal actions are: General Durable Power of Attorney, Special Durable Power of Attorney, Durable Power of Attorney for Health Care, Directive to Physician (Living Will), Designation of Guardian in Advance of Need and Wills.

Money Management - paying bills, budgeting and managing the financial affairs of individuals.

Guardianship - as a last resort measure, appointment of a person as guardian over the affairs of another person, his estate, or both. A court may limit the power of the guardian to only those things, which cannot be done by the person. A guardianship is indicated only in situations where a physician has diagnosed a person as being mentally incapacitated or incompetent.

Other Probate Matters - any other court process that involves, which a person dies, the establishment of validity regarding his will and its contents, relating to his estate, assets and heir-ship.

## INDIVIDUAL RIGHTS

Age Discrimination - instances when an older person has been prevented or denied access to goods, benefits, services, housing and employment because of his age. Discrimination in employment is prohibited under the Age Discrimination in Employment Act.

Abuse - intervention in and reporting to the Texas Department of Protective and Regulatory Services, the willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm or pain or mental anguish, or the willful deprivation by a caregiver or one's self of goods or services which are necessary to avoid physical harm, mental anguish or illness.

Neglect - intervention in and reporting to the Texas Department of Protective and Regulatory Services, the failure by a caregiver or one's self to provide the goods or services which are necessary to avoid harm, mental anguish or illness.

Exploitation - intervention in and reporting to the Texas Department of Protective and Regulatory Services, the illegal and improper act or process of an a caregiver, relative, company or agency using the resources of an elderly or disabled person for monetary or personal benefit, profit or gain.

## CONSUMER ISSUES

Bankruptcy - a petition filed for the liquidation or reorganization of assets in order to provide immediate relief to individuals facing foreclosure or repossession of property.

Collections - actions taken by companies, agencies, or providers of services which attempt to obtain payment from persons who are in arrears with credit payments. May often involve the agency making threat of dire consequences (such as lawsuit) if payment is not made.

Financial Counseling - advice, or counseling on a course of conduct provided to individuals regarding the paying of bills, budgeting or managing of personal financial affairs.

Unfair Sales/Fraud - the incidence of knowingly selling a person goods, services, or insurance which: do not actually provide the goods or services originally indicated to the buyer; do not suit the buyer's needs; exploits the person's mental, emotional or physical vulnerability; or, which are defective.

## INSTITUTIONAL CARE

Acute Care - inpatient and outpatient medical services which provide for the temporary care and treatment of individuals with physical illness or injury.

Nursing Facility Care - inpatient nursing and personal care given over an extended period to individuals who require convalescence care at a level less than that provided in an acute facility, to individuals with chronic illnesses, or those who are aged and have disabilities.

Mental Health Facility - facilities where services are provided to individuals who have mental illnesses or severe emotional and social disabilities and require extensive support and treatment.

## Short Version of

### Client Profile of Needs Categories: CMS NPR DATA ISSUES (Section 5 of the NPR) – Updated 8/00

1. **ADL**  
Meal prep/cooking, shopping, personal care, housekeeping, assist with meds. /communication, chores, ERS, general elderly services
2. **TRANSPORTATION**  
Medical, general, escort
3. **NON-COVERED HEALTH**  
Dental, vision, hearing, assistive devices
4. **HOUSING**  
Landlord/ tenant disputes, repair/modification, utilities, rent subsidy, alternative housing, weatherization, property tax, relocation, eviction, general property, neighbor disputes
5. **SOCIAL SECURITY**  
Eligibility, benefits food stamps, disability, Social Security income, SSI, income maintenance, general assistance, appeal
6. **MEDICARE**  
Eligibility, benefits of Part A & B, DME, DRGs, home health, hospice, limited care benefits, premium payments, preventive service coverage, SNF, lab services, MSNs, ambulance service, fraud, appeal/quality of care
7. **MEDICAID**  
Eligibility, regular Medicaid, QMB, SLMB, QI 1 & 2, nursing home Medicaid, CCAD, CBA, in-home family support services, other TDHS programs, MHMR programs, appeal
8. **MANAGED CARE PLANS/MEDICARE + CHOICE/PFFS/HMOs – enrollment, eligibility, dis-enrollment, plan comparisons/benefit change, claims/billing, appeal/quality of care/grievance**
9. **MEDIGAP/SUPPLEMENTAL INSURANCE/SELECT-enrollment, eligibility, billing/claims, plan comparisons/benefit change**
10. **LONG-TERM-CARE INSURANCE-providing advocacy in costs of such coverage, eligibility based on client's desire to protect resources, understanding terminology, and standards set for policy publication.**
11. **OTHER TYPES OF INSURANCE**  
Non health policies (such as auto, fire), individual and group health insurance, other health policies, COBRA, workers compensation, individual/group health policies
12. **SURROGATE DECISIONS**  
Advanced directives, money management, guardianship, probate matters, custody, divorce
13. **INDIVIDUAL RIGHTS**  
Age discrimination, disability discrimination, abuse, neglect, exploitation, dispute, immigration issues, civil rights, employment and labor issues
14. **CONSUMER ISSUES**  
Bankruptcy, collections, financial counseling, bill reduction, fraud
15. **INSTITUTIONAL/FACILITY CARE**  
Acute/hospital, nursing home care, mental health facility
16. **VETERANS ADMINISTRATION-eligibility, benefits, including medications, and referral resources**
17. **MEDICATIONS/INDIGENT DRUG PROGRAM-eligibility and manufacturer's guidelines.**
18. **FRAUD/SCAMS/UNFAIR SALES**
19. **OTHER RETIREMENT-Teacher, Railroad, state, county or city retirement plans, and private and corporate retirement plans.**
20. **CLIENT REPRESENTATION-APPEALS OR HEARINGS**

## STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP) RESOURCE REPORT

Name of Grantee Agency Reporting	State	6-month Report Period ____/____ to ____/____ month/year    month/year
Person Completing Report	Title	Telephone number

Section 1 - # of Active counselors and hours	State Staff	AAA Field Staff:	Total		Section 2 - # of AAA counselors/volunteers & hours	Total
a. # volunteer BC's					a. # volunteers BC's	
b. # SHIP paid BC's					b. # Ship paid BC's	
c. # in-kind pd. BC's					c. # in-kind BC's	
Total # BC's					Total # BC's	
d. Volunteer BC hours					d. Volunteer BC hours	
e. SHIP paid BC hours					e. Ship paid BC hours	
f. in-kind pd. BC hours					f. in-kind pd. BC hours	
Section 3 - # of other Paid Staff and Hours	State Staff	AAA Field Staff	Total		Section 4- Counselor Training	Total
a. # Ship pd. Other staff					a. # Initial Training(s) for New SHIP BC's	
b. # in-kind other staff					b. # New SHIP BC's attending Initial Training	
c. SHIP-pd. Other staff hours					c. Total # BC hours in Initial training	
d. in-kind pd. other staff hours					d. # updated training(s) for SHIP BC's	
					e. # active SHIP BC's attending Training(s)	
					f. Total # Counselor hours in update traing(s)	

### Section 5 – Number of Active Counselors with the following characteristics (Optional)

a. Years of SHIP Service		c. Ethnicity/Race		d. Ethnicity/Race	
Less than 1 year	—	Disabled	—	American Indian or Alaska Native	—
1 yr. up to 3 years	—	Not disabled	—	Asian	—
3 yrs. up to 5 years	—	Missing	—	Black/African American	—
Over 5 years	—			Hispanic/Latino	—
Missing				Native Hawaiian or other Pacific Islander	—
b. Age		d. Gender		White	—
Less than 65 years old	—	Female	—	Other	—
65 years or older	—	Male	—	Missing	—
Missing		Missing			

### Section 6 – WEB-SITE VISITORS (if applicable)      Total # of visitors during 2 quarters comprising the 6-month report period:

First Quarter \_\_\_\_\_ Second Quarter \_\_\_\_\_

### Section 7 – THREE CASE SUMMARIES (SEE ATTACHMENT)

### Section 8 – ACTIVITIES, LESSONS LEARNED, SIGNIFICANT EVENTS

This section should be tied into initiatives addressed in each SHIP grant application. This should include activities targeting the undeserved.

I state that to the best of my knowledge, this information is true.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>TEXAS STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP) CLIENT CONTACT FORM ( ) 5/01</b>				
<b>Counselor Name:</b> _____		<b>Agency:</b> _____		
<b>Zip Code of Counseling Location:</b> _____		<b>Type of Client/Assistance Requested by:</b> (Check all that apply: <input type="checkbox"/> Beneficiary (self) <input type="checkbox"/> Caregiver (family, other) <input type="checkbox"/> Couple <input type="checkbox"/> Agency		
<b>Check here for a quick telephone call (less that 10 minutes)</b>				
<b>Date of Initial Contact:</b> ____/____/____ <b>Total # of contacts with Client:</b> _____		<b>Type of Contact:</b> <input type="checkbox"/> Telephone <input type="checkbox"/> In-person (home) <input type="checkbox"/> In-person (site) <input type="checkbox"/> e-mail/fax/postal		<b>Time Spent:</b> _____ hours _____ minutes <b>Total units</b> _____
<b>Status of Client Contact(s):</b> <input type="checkbox"/> Open <input type="checkbox"/> Closed				
<b>Section 1 – Beneficiary Information</b>		<b>Client/Representative Name:</b> _____		<b>Zip Code:</b> _____ <b>Beneficiary Phone:</b> ( ) _____
<b>Section 2 - Beneficiary Demographics</b>				
<b>Is this his/her first contact with a SHIP since April 1, 2001?</b> <input type="checkbox"/> Yes (complete this section) <input type="checkbox"/> No (skip to Section 3)				
<b>DOB:</b> ____-____-____  <input type="checkbox"/> Under 65 <input type="checkbox"/> Not <input type="checkbox"/> 65-74      Collected <input type="checkbox"/> 75-84 <input type="checkbox"/> 85-older	<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Not Collected	<b>Disabled:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Collected	<b>Income:</b> <input type="checkbox"/> Less than/equal to SLMB <input type="checkbox"/> Greater than SLMB <input type="checkbox"/> Not Collected	<b>Ethnicity/Race:</b> <input type="checkbox"/> Asian <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Hawaiian, other Pacific Isl. <input type="checkbox"/> African Amer. <input type="checkbox"/> Not Collected <input type="checkbox"/> Other _____
<b>Section 3 – Topics Discussed (Check all that apply)</b>				
<b>Medicare:</b> <input type="checkbox"/> Enrollment, benefits, eligibility <input type="checkbox"/> Claims/billing <input type="checkbox"/> Appeal/quality care <input type="checkbox"/> Medical Surrogate Decisions <input type="checkbox"/> Fraud/Scams <input type="checkbox"/> Acute hosp/facility <input type="checkbox"/> Other _____	<b>Medigap/Supps/Select:</b> <input type="checkbox"/> Enrollment, eligible, comparisons <input type="checkbox"/> Change coverage <input type="checkbox"/> Claims/appeal	<b>M+C Plans:</b> <input type="checkbox"/> Enroll/disenroll eligibility, compare <input type="checkbox"/> Plan change/non renewal <input type="checkbox"/> Claims/appeals	<b>Medicaid:</b> <input type="checkbox"/> Medicare Savings Program <input type="checkbox"/> Nurse Home Medicaid <input type="checkbox"/> Regular Medicaid <input type="checkbox"/> Appeal <input type="checkbox"/> Other _____	<b>LTC/Other Ins:</b> <input type="checkbox"/> LTC Ins <input type="checkbox"/> COBRA <input type="checkbox"/> Other Health Policy <input type="checkbox"/> Ind/group health <input type="checkbox"/> Non health policy <input type="checkbox"/> Other retirement plan policy _____
<b>Social Security:</b> <input type="checkbox"/> SSI <input type="checkbox"/> Food Stamps- or general assistance <input type="checkbox"/> Disability <input type="checkbox"/> Benefit/eligibility <input type="checkbox"/> Appeal	<b>N/C Health:</b> <input type="checkbox"/> Medications <input type="checkbox"/> Eyeglasses <input type="checkbox"/> Dentures <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Assist. Device	<b>Individual Rights:</b> <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Exploitation <input type="checkbox"/> Disable discrimination/other _____	<b>Veterans Issues:</b> <input type="checkbox"/> Benefits <input type="checkbox"/> Eligibility <input type="checkbox"/> Service record issues <input type="checkbox"/> Nursing Home eligibility (VA)	<b>ADLs:</b> <input type="checkbox"/> Medical Transport. <input type="checkbox"/> Community Care for the Aged and Disabled <input type="checkbox"/> Other community services _____
<b>Consumer:</b> <input type="checkbox"/> Collections <input type="checkbox"/> Fraud/Scams <input type="checkbox"/> Bankruptcy <input type="checkbox"/> Financial counsel. <input type="checkbox"/> Bill reduction	<b>Other Issues:</b> <input type="checkbox"/> Money Management. <input type="checkbox"/> Federal, state, local county, city, rail-road, teacher, or cooperate retire-ment plans (circle one) <input type="checkbox"/> Guardianship <input type="checkbox"/> Probate matters <input type="checkbox"/> Other Surrogate issues		<b>Housing :</b> <input type="checkbox"/> Dispute/landlord/tenant <input type="checkbox"/> Alternative housing <input type="checkbox"/> Repair/modification <input type="checkbox"/> Utilities/weatherization <input type="checkbox"/> Eviction/relocation <input type="checkbox"/> Property tax <input type="checkbox"/> Rent Subsidy	

## **SHIP PUBLIC AND MEDIA ACTIVITY FORM**

### **Legal Awareness**

**Complete all blanks for the first third of the form. Use one form per activity.**

#### **➔Section 1 – Type of Activity**

- A. Interactive presentation to public – An interactive forum, speaking engagement, or seminar during which substantive knowledge on Medicare or the SHIP program is transferred by oral and visual means from a SHIP presenter to those persons attending the presentation. Includes In-person presentations, video teleconferences or satellite broadcasts. Do NOT include SHIP trainings, which should be reported on the second page of the client contact form.**

**Attach sign-in sheets or estimates provided to you by the promoter and signed by the promoter. The promoter may provide rough head counts.**

- B. Booth/exhibit – Any event where general/program information and/or simple printed fact sheets are shared with or distributed to the public. The purpose of SHIP program participation in such events is to inform the public about the availability of SHIP services in their area. For example, some SHIP programs attend health or senior fairs or set up information booths in shopping centers in order to increase that community's awareness of their services and the need for individual counseling.**

**Estimate the number of people potentially reached by using a tick-mark for each person that approaches your booth to take materials and /or speak with a SHIP representative or by counting the number of brochures/materials distributed.**

- C. Media/printed outreach – Includes radio/TV shows and public service announcements, Cable/local network television programming, targeted information mailings, and articles or PSA's in print media such as newspapers and newsletters. Media events can be live or taped. Report the dates you are aware the event was originally aired in Sections four.**

- D. Web site events – Includes one-time or limited time interactive events sponsored by your SHIP, such as web conferences or forums and interactive "chatrooms". Visitors to other parts of your web site should be reported for the SHIP 6-month report completed by TDOA and contractor.**

**Estimate the number of people potentially reached by estimating the number of visitors to these activities.**

#### **➔Section Two - Target Audience & Subject Areas Covered**

**Check the appropriate boxes and described other under "Subject Areas Covered" Lastly, sign the report. AAA staff verifies the information when completed by volunteers.**

## **Chapter 4**

### **Medicare Parts A, B, C, and D**

#### **INTRODUCTION**

In this chapter, we will discuss the federal Medicare program. Enacted in 1965, the Medicare program is Title XVIII of the Social Security Act. Medicare is a federal health program that provides both major medical coverage and coverage for medical expenses when an eligible person becomes ill.

This chapter outlines recent changes in the Medicare program and provides an overview of the current options available to eligible beneficiaries.

Paragraph 1 addresses the delivery of Medicare services.

Paragraph 2 addresses the sources of law.

Paragraph 3 is a brief overview of the Medicare program.

Paragraph 4 addresses Medicare eligibility.

Paragraph 5 addresses the four parts of Medicare.

Paragraph 6 addresses what Medicare does not cover.

Paragraph 7 addresses the deductibles, coinsurance, and copayments of Medicare.

Paragraph 8 addresses costs with Part A of Original Medicare.

Paragraph 9 addresses costs with Part B of Original Medicare.

Paragraph 10 addresses doctors and health care providers that accept assignment.

Paragraph 11 addresses enrolling in Original Medicare.

Paragraph 12 addresses how to know if employer insurance is primary.

Paragraph 13 lists the four ways to enroll in Medicare.

Paragraph 14 explains how to enroll in Medicare.



## **Chapter 4**

### **Medicare Parts A, B, C, and D**

Paragraph 15 discusses enrollment when a beneficiary automatically qualifies, or does not automatically qualify or must apply for Medicare.

Paragraph 16 addresses Medicare coverage options.

Paragraph 17 addresses ways to supplement Medicare.

Paragraph 18 addresses Part D of Medicare; prescription drug coverage.

Paragraph 19 addresses enrollment in Part D.

Paragraph 20 addresses Medicare private health plans (MA plans).

Paragraph 21 addresses concerns with Medicare Advantage plans.

Paragraph 22 addresses types of MA plans.

Paragraph 23 addresses employer sponsored and retirement Medicare Advantage plans.

Paragraph 24 addresses when to enroll in Medicare Advantage plans.

Paragraph 25 addresses how to enroll in a Medicare Advantage or drug plans.

Paragraph 26 discusses common problems with Medicare and tips to avoid them.

#### **1. Delivery of Medicare services**

Medicare is a federal health program for people aged 65 and older and individuals disabled or diagnosed with chronic illness as defined by law. The Medicare program is delivered through the Centers for Medicare and Medicaid Services (CMS) CMS operates under the supervision of the United States Department of Health and Human Services (HHS).

#### **2. Sources of law** Changes to the Medicare program were enacted through the following legislation that impacts the Social Security Act:

## Chapter 4

### Medicare Parts A, B, C, and D

- Patient Protection and Affordable Care Act (**PPACA**) of 2010
- Medicare Improvements for Patients and Providers Act (**MIPPA**) of 2008
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Medicare Modernization Act of 2000
- Balanced Budget Refinement Act of 1999
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Social Security Act of 1965 (Title XVIII)

These different laws have been “codified” in the United States Code. The United States Code brings together different enactments on the same subject. Medicare Part A is codified at 42 United States Code Sections 1395c to 1395i-5. Medicare Part B is codified at 42 United States Code Sections 1395j to 1395w-5. Medicare Part C is codified at 42 United States Code Sections 1395w-21 to 1395w-29. Medicare Part D is codified at 42 United States Code Sections 1395w-101 to 1395 w-154.

Medicare Part A may be referred to as hospital insurance. Medicare Part B may be referred to as medical insurance. Medicare Part C may be referred to as Medicare Advantage. Medicare Part D may be referred to as the Medicare Prescription Drug Program or the Medicare Prescription Drug Benefit. The words “United States Code” will often be abbreviated “U.S.C.” or simply “USC” without periods between the letters. The words “Section” or “Sections” will often be replaced by the symbols § or §§.

Although Medicare is under the general administration of CMS, rules resulting from these bills and amendments fall under the jurisdiction of various federal and state agencies and CMS subcontractors. CMS rules pertaining to Medicare are found in 42

## Chapter 4

### Medicare Parts A, B, C, and D

Code of Federal Regulations Parts 400 to 1008. The words “Code of Federal Regulations” are sometimes abbreviated “CFR.”

#### 3. Brief overview of Medicare

Medicare is a federally administered health insurance program for people age 65 or older, have earned entitlement to Social Security disability benefits for 24 months, individuals with ALS (Lou Gehrig

Disease) and most people with end-stage renal disease. Original Medicare has two parts - Part A (hospital insurance) and Part B (voluntary supplemental medical insurance). Enrollment is automatic for people 65 or older who have established eligibility to Social Security or Railroad Retirement Benefits, or are in the 25th month of disability benefits. Because no premium is paid for Medicare Part A for the beneficiaries mentioned above, it should be very rare for anyone to want to “opt out” of Medicare Part A. People with Medicare Part B will always have a premium and the premium cost depends on the person’s income. In 2019, the standard Medicare monthly premium is \$135.50 or higher depending on the beneficiary’s annual income. However, some people who get Social Security benefits may pay less than this amount. See <http://medicare.gov> under “Your Medicare Costs” tab for more information. It is typically not beneficial to “opt out” of Part B unless the person is still covered by an employment based group health plan (GHP) through their employer or a spouse. The premium is usually deducted from the monthly Social Security benefit.

#### 4. Medicare eligibility, people are eligible for Medicare if:

They are age 65 and above and eligible for Social Security or Railroad Retirement benefits;

## Chapter 4

### Medicare Parts A, B, C, and D

They are age 65 and above, are a current U.S. resident and are either a U.S. citizen or a permanent resident who has lived in the U.S. for five years in a row before applying for Medicare;

They have received Social Security Disability Insurance (SSDI) for at least 24 months;

They qualify for disability insurance due to being diagnosed with ALS (Lou Gehrig's disease);

They have been diagnosed with end-stage renal disease (ESRD) and they, their spouse, or parent have paid Medicare taxes for a sufficient amount of time.

Note: It is not necessary for people 65 years old or older to have a work history to get Medicare. However, people who have worked less than 10 years in the United States have to meet residency and citizenship requirements and may have to pay more for Medicare. Legal residents 65 and older that do not have 10 or more years of work history may be able to qualify for Medicaid and Medicare Savings Programs.

People younger than 65 with a disability must meet certain work history requirements to get Medicare.

In order to qualify for Part D an individual must have either Medicare Part A or Part B.

#### 5. The 4 parts of Medicare

**Medicare has 4 parts, 3 benefits, and Part C is an option.**

**Part A:** Hospital insurance covers most medically necessary hospital, skilled nursing facility, some home health and hospice care.

## **Chapter 4**

### **Medicare Parts A, B, C, and D**

Inpatient hospital care for up to 90 days each benefit period;

A benefit period starts the first day the beneficiary enters the hospital or skilled nursing facility;

The benefit period ends when the beneficiary has not gotten hospital care or skilled care in a skilled nursing facility for 60 days in a row;

Part A also pays for 60 more days, called lifetime reserve days, in a general hospital. These days can only be used once, and are not renewable.

Part A pays for more lifetime reserve days when someone receives inpatient care in a psychiatric hospital. It covers up to 190 lifetime reserve days in a Medicare-certified psychiatric hospital. These days aren't renewable and can only be used once.

However, people aren't allowed to use all of their lifetime reserve days at one time. Part A only covers 150 days of inpatient psychiatric hospital care in a benefit period.

Skilled nursing facility care is paid for up to 100 days each benefit period for beneficiaries that qualify for skilled nursing care.

Coverage for home health care for those who are homebound and need skilled care after a hospital stay. Part A of Medicare covers up to 100 days for those who qualify after being hospitalized. Part B covers home health care for people who haven't been hospitalized and for those who go beyond the 100-day Part A limit. The 100-day limit doesn't apply to you if you're only enrolled in Part A and there is no 100-day limit under Part B.

Hospice care is covered for the terminally ill if a provider certifies that life expectancy is 6 months or less.

## Chapter 4

### Medicare Parts A, B, C, and D

**Part B:** Medical insurance covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health services, home health and ambulance services.

Doctors' services;

Outpatient physical, speech and occupational therapy;

Outpatient mental health services;

Durable medical equipment, such as wheelchairs, walkers and oxygen tanks;

Some home health services for those who are homebound and need skilled care;

X-rays and lab tests;

Many preventive care services, such as annual wellness visits, diabetes screenings and flu shots;

The first three pints of blood needed each year;

Some prescription drugs that people get at their doctor's office that aren't usually self-administered.

**Part C:** Part of Medicare allows private insurance companies to provide Medicare benefits. These Medicare private health plans, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), are known as Medicare Advantage (MA) plans.

Part C is not a separate benefit. Part C gives the option of joining a Medicare private health plan.

Medicare private health plans include the health benefits of Parts A and B. Some Medicare private health plans also include Part D (MAPD) drug coverage.

## Chapter 4

### Medicare Parts A, B, C, and D

There are different coverage rules and costs with a Medicare private health plan than with Original Medicare.

**Part D:** Covers prescription drugs and is provided through private insurance companies that have contracts with the government. It is never offered directly by the government.

This coverage is optional for most people. Whether it is a good idea to sign up depends on current drug coverage and needs.

People must choose a Part D plan that works with their Medicare health benefits. With Original Medicare, choose a Part D plan. This is a plan that only covers prescription drugs.

**Question:** Which of the following are considered part of Medicare?

- \_\_\_\_\_ A. Medicare Part A
- \_\_\_\_\_ B. Medicare Part B
- \_\_\_\_\_ C. Medicare Preventive services
- \_\_\_\_\_ D. Medicare Part D
- \_\_\_\_\_ E. All of the above

#### 6. What Medicare does not cover

Medicare doesn't cover all health services. Health services that Medicare doesn't cover include, but are not limited to:

- Routine dental care
- Routine foot care

## Chapter 4

### Medicare Parts A, B, C, and D

- Hearing care, including hearing aids
- Personal care and custodial care except for people who need skilled care and qualify for skilled nursing facility or home health benefits
- Routine vision care
- Most care received outside the United States
- Most non-emergency transportation
- Trial treatments unless offered under approved demonstration programs.

Medicare private plans (Medicare Advantage) may include certain benefits that Original Medicare does not pay for, such as vision, dental or hearing.

Keep in mind that even if Medicare covers a service, Medicare does not usually pay 100 percent of the cost. Without supplemental insurance, people generally have premiums, deductibles, and coinsurances.

**Question:** What is not covered by Medicare?

- \_\_\_\_\_ A. Over the counter drug
- \_\_\_\_\_ B. Routine dental care
- \_\_\_\_\_ C. Non-emergency transportation
- \_\_\_\_\_ D. Hearing aid
- \_\_\_\_\_ E. All of the above

#### 7. Deductibles, coinsurance, and copayments in Medicare

There are deductibles and coinsurance amounts that beneficiaries must pay themselves or need supplemental insurance to cover. Out of pocket costs will occur in all four Parts A – D of Medicare. Each year, the amounts of deductibles and copayments typically change. Changes take place on January 1 of the following year.



## **Chapter 4**

### **Medicare Parts A, B, C, and D**

Those that enroll in Medicare Advantage health plans should compare the benefits in the plan versus Original Medicare to get a clear picture of how they are different.

#### **8. Out of Pocket costs with Medicare Part A**

Original Medicare Part A costs depend on the beneficiaries' work history and which Part A services are used.

There is no premium for Part A when a person qualifies for SSDI. There is also no premium for people who are 65 years or older and they or their spouse have worked at least 10 years in the United States.

People who have worked fewer than 10 years in the United States must pay a premium for Part A. In 2019, people 65 years old or older who have worked between 7.5 and 10 years in the United States must pay \$240 a month for Part A. Those who have worked less than 7.5 years in the United States must pay \$437 a month for Part A.

People with Medicare that need inpatient hospital care must pay a \$1,364 deductible in 2019, for each benefit period. Part A only covers hospital care after the deductible is met.

The benefit period starts on the first day a beneficiary is admitted to the hospital or skilled nursing facility. It ends when no skilled care has been received from the hospital or skilled nursing facility for 60 days in a row.

After paying the Part A deductible, the beneficiary pays nothing for inpatient hospital care for the first 60 days in the hospital. For days 61 to 90, there is a daily \$341 copayment in 2019.

## Chapter 4

### Medicare Parts A, B, C, and D

For hospital stays longer than 90 days, people have 60 lifetime reserve days. There is a daily \$682 copayment per lifetime reserve day in 2019. Lifetime reserve days can only be used once and are not renewable.

There is no deductible or a coinsurance for skilled nursing facility care until after the 20th day in the facility. There is a \$170.50 daily copayment for days 21 to 100 per benefit period.

The beneficiary pays the full cost of skilled nursing facility care after day 100 in a benefit period.

**Question:** How many years of work history are needed to qualify for Medicare benefits?

- \_\_\_\_\_ A. 0 years, just need to be a legal citizen of United States
- \_\_\_\_\_ B. 5 years
- \_\_\_\_\_ C. 7.5 years
- \_\_\_\_\_ D. 10 years

#### 9. Out of Pocket costs with Medicare Part B

In addition to the Part B premium, there is a \$185 deductible for Part B services in 2019 that must be paid before Medicare covers any outpatient care.

There is a coinsurance for most services Part B covers. In general, if a provider accepts assignment, Medicare pays 80 percent of the Medicare-approved amount. The Medicare-approved amount is the fee that Medicare sets as the amount a provider who accepts assignment should be paid for a particular service. The Medicare-approved amount includes what Medicare pays and what the beneficiary pays (deductibles, copays, and coinsurances).

## Chapter 4

### Medicare Parts A, B, C, and D

Patients no longer have to pay a higher coinsurance for outpatient mental health care. In 2019, there is a 80 percent coinsurance (you pay 20 percent) for outpatient mental health care that Medicare covers. If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital. This amount will vary depending on the service provided but will be between 20 percent and 40 percent of the Medicare approved amount.

Preventive services have been added to Original Medicare due to federal health reform. The list of services is on pages 30-49 in the 2019 *Medicare & You* booklet.

#### **10. Doctors and health care providers that accept assignment**

In order to keep health care costs as low as possible, people with Medicare should use doctors and other providers who take assignment.

Doctors who take assignment accept Medicare's approved amount as payment in full. Medicare pays the doctor 80 percent of its approved charge for most services and the patient must pay the remaining 20 percent coinsurance

For doctors who do not take assignment, the government limits how much they can charge. Doctors who do not take assignment generally can't charge more than 15 percent above Medicare's official amount for providers who do not accept assignment.

People can look at their Medicare Summary Notice (MSN) to find out how much they need to pay when they see a provider who doesn't take assignment. The MSN is a statement people get every three months that lists services they received and how much Medicare paid.

## Chapter 4

### Medicare Parts A, B, C, and D

Some doctors officially opt out of Medicare and do not have to follow Medicare rules that limit how much they can charge.

People who see doctors that have opted out of Medicare must pay the entire bill unless it's an emergency. Medicare will not pay for any of those services. Doctors must tell patients if they have opted out of Medicare before providing services. Patients will be asked to sign a contract saying they understand they are responsible for the full cost of the services.

For instance, say a doctor takes assignment and charges \$150 for an office visit. If Medicare only approves \$100 for the visit, then Medicare pays 80 percent or \$80 and the patient pays the 20 percent coinsurance, or \$20. A doctor who takes assignment cannot ask for the remaining balance of \$50.

A doctor who does not take assignment can charge the patient more than a doctor who does take assignment can charge. Doctors who do not accept assignment can charge an excess or limiting charge up to 15 percent over the amount that Medicare pays doctors who do not accept assignment.

Last, if the doctor charges \$150 for an office visit and opts out of Medicare, Medicare will not pay for the services. The patient must pay the entire \$150.

**Question:** How much more (as a percentage) can doctor's charge if they do not accept assignment?

- \_\_\_\_\_ A. 0 percent
- \_\_\_\_\_ B. 5 percent
- \_\_\_\_\_ C. 10 percent
- \_\_\_\_\_ D. 15 percent

## Chapter 4

### Medicare Parts A, B, C, and D

#### 11. Enrolling in Medicare

Whether people should enroll in Medicare depends on their situation.

Most people do not have to pay a premium for Part A. Part A coverage is free for people who qualify for Medicare because of a disability. It's also free for people 65 or older who qualify for Social Security or Railroad Retirement benefits and they or their spouse worked in the United States for at least 10 years. So, for the majority of people, it is a good idea to enroll in Medicare Part A.

Whether it is a good idea to take Part B depends on the kind of health insurance the beneficiary has upon becoming eligible for Medicare. **In some cases, there is a premium penalty for delaying Part B enrollment and a risk of losing other health insurance coverage, such as coverage from a former employer.**

The Part B premium penalty is a monthly charge added to the Part B premium. It is 10 percent of the annual standard premium for every 12 months someone delayed enrollment. In most cases, the penalty never goes away and increases when the Part B premium increases.

People who have insurance through a current job (either their own or their spouse's), may be able to delay enrolling in Part B without facing a premium penalty. Additionally, people who qualify for Medicare because of a disability may have insurance from a family member's current job that will enable them to delay Part B enrollment without facing a penalty.

The ability to delay Part B enrollment without penalty applies only to people who have insurance from a current employer, not insurance from a past employer, such as retiree insurance, unless it is long-term disability coverage that allows participation in the employer's benefit plan for current employees. The beneficiary should find out

## Chapter 4

### Medicare Parts A, B, C, and D

whether the employer insurance is primary or secondary for people who also have Medicare. Primary insurance pays first for covered health services. Secondary insurance then pays some or all the unpaid portion of covered health expenses.

If the current employer coverage is primary, the beneficiary can delay enrolling in Medicare Part B. People can enroll in Medicare at any time, without penalty, while they have current employer coverage and up to eight months after losing that coverage. It may be unnecessary to get Medicare Part B with employer coverage, unless the beneficiary is unhappy with the employer coverage.

If Medicare is primary, it is important to enroll in Medicare when first eligible. People who wait to enroll and lose employer coverage may have no health coverage at all until Medicare takes effect.

#### 12. How to know if employer coverage is primary

Employer insurance is primary in the following situations:

The beneficiary is 65 or older and has health coverage through a current job (theirs or their spouse's) with an employer that has 20 or more employees; **or**

The beneficiary is under 65 and has a disability or is diagnosed with ALS (Lou Gehrig Disease) and has health coverage through a current job (theirs or their spouse's) with an employer that has 100 or more employees.

Note that employer insurance is also primary with long-term disability coverage from a **former** employer that allows the beneficiary to continue to participate in the benefit plan for current employees, and the employer has 100 or more employees.

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For people who are not in one of the situations described above, and do not have End Stage Renal Disease (ESRD), Medicare is primary. They should enroll in Medicare when they first become eligible.

For people with ESRD, employer coverage from a current job is primary for the first two and a half years, or 30 months, after they are first eligible for Medicare Part A. Medicare usually becomes primary after that 30-month coordination period even if they have not applied for Medicare.

#### 13. The four ways to enroll in Medicare

There are several ways to enroll in Medicare, and each has different rules and different time frames. Sometimes there are penalties for late enrollment, so it is important to know how to enroll to avoid these penalties. The four ways to enroll are:

##### **Automatic enrollment**

People are **automatically enrolled** in Medicare Part A and Part B if one of the following is true:

They signed up for Social Security or railroad retirement benefits before they turned 65;

They are disabled and have been receiving Social Security Disability Insurance (SSDI) or railroad disability annuity checks for total disability for at least 24 months;

They have been diagnosed with ALS (Lou Gehrig's disease).

People who fall into one of those categories do not have to do anything—they will get a letter telling them they have been automatically enrolled into Medicare and will get a Medicare card for Part A and Part B in the mail.

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### **Medicare Parts A, B, C, and D**

Remember it is usually best to keep Medicare Part B unless the beneficiary or their spouse work for a company with at least 20 employees and has health insurance through that company. People who have Medicare because of a disability should keep Part B unless they, their spouse, or other family member work for a company with at least 100 employees and has health insurance through that company.

#### **Initial Enrollment**

People who are not automatically enrolled when first eligible for Medicare and want to enroll in Parts A and B must actively enroll during their Initial Enrollment Period.

The Initial Enrollment Period is the seven-month period that starts three months before the month the beneficiary becomes eligible for Medicare and continues for three months after.

The date Medicare coverage starts depends on the enrollment date. People should enroll one to three months before their first month of eligibility to get coverage as soon as they are eligible.

#### **General Enrollment (annual)**

People who do not enroll in Medicare or refused Medicare when they originally became eligible for it can sign up during the General Enrollment Period (GEP).

The General Enrollment Period is January 1 through March 31 each year. Coverage starts July 1 in the calendar year they sign up.

Keep in mind that without a Special Enrollment Period to sign up for Part B, people must pay a 10 percent Part B premium penalty for each 12-month period they delay enrolling.



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### Medicare Parts A, B, C, and D

#### **Special Enrollment Period for Part B**

There is a Special Enrollment Period (SEP) to enroll in Part B for people who delay signing up for Part B because they have health insurance from a current employer or their spouse's current employer.

A SEP allows a person with Medicare to enroll in Part B without penalty, at any time while they are still working or for up to eight months after they retire or lose their current employment status.

COBRA and retiree insurance coverage are not considered current employment or coverage and do not give a person a SEP (Special Enrollment Period).

Without this SEP, a person must wait until the General Enrollment Period (GEP) to enroll.

The General Enrollment Period is January 1 through March 31 of each year. If a person enrolls during the GEP, their Medicare coverage begins July 1<sup>st</sup> of the year they enroll.

**Question:** What are the four enrollment options for Medicare?

- \_\_\_\_\_ A. General, Automatic, Special, and Initial
- \_\_\_\_\_ B. General, Retroactive, Special, and Initial
- \_\_\_\_\_ C. General, Automatic, Special, and On-going
- \_\_\_\_\_ D. General, Automatic, Inclusionary, and Initial

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#### 14. How to enroll in Medicare

People who do not get Social Security or Railroad Retirement benefits must take action to enroll in Medicare. They should contact their local Social Security office, or, if they are railroad employees or retirees, their local Railroad Retirement Board field office by going in person, writing a letter, or calling.

People should keep proof of when they tried to enroll in Medicare to protect them from incurring a Part B premium penalty if the application is lost. If enrolling by mail, they should use certified mail or return receipt requested. If enrolling in person or on the phone, they should take down the name of the person who helped them and ask for a written receipt.

People getting Social Security benefits, railroad retirement benefits, Social Security Disability Insurance, or railroad disability annuities when they become eligible for Medicare do not need to do anything. They will get a Medicare card in the mail.

#### 15. Enrollment - when a beneficiary automatically qualifies or does not automatically qualify or must apply for Medicare

People **automatically qualify** for Medicare Part A and Part B if one of the following is true:

They signed up for Social Security or railroad retirement benefits before they turned 65;

They are disabled and have been receiving Social Security Disability Insurance (SSDI) or railroad disability annuity checks for total disability for at least 24 months;

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### Medicare Parts A, B, C, and D

They have been diagnosed with ALS (Lou Gehrig's disease);

They have been diagnosed with End Stage Renal Disease (ESRD).

People who fall into one of those categories do not have to do anything—they will get a letter telling them they have been automatically enrolled into Medicare and will get a Medicare card for Part A and Part B in the mail.

Remember, it is usually best to keep Medicare Part B unless the beneficiary or their spouse work for a company with at least 20 employees and has health insurance through that company. People who have Medicare because of a disability should keep Part B unless they, their spouse, or other family member work for a company with at least 100 employees and has health insurance through that company.

There are also people who will turn 65 and will not automatically qualify for Medicare Part A. These are people that have not accumulated the 40 credits of Social Security coverage needed for automatic Medicare entitlement. They may choose to enroll in Medicare Part A during specified enrollment periods. The first three calendar months of each year are always one of these periods. The other is the "Initial Enrollment Period (IEP)" which is the three calendar months before the month in which the person turns 65, the birth month and the three calendar months after the person turns 65. The people that choose to purchase Part A are enrolled in "Premium Medicare," meaning they will pay a premium for their coverage. The monthly premium is \$437 for Part A in 2019. The premium will be \$240 if they have accumulated 30 or more of the 40 credits needed to get Part A. More detailed information about Social Security credits can be found by visiting their website at [www.ssa.gov](http://www.ssa.gov). People can also choose to enroll in Part B. These people will pay the standard monthly Medicare Part B premium of \$135.50. If the person receives Social Security Benefits, it is possible that they can pay less than the \$135.50 Part B

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premium depending on the individual's income. And remember, people with higher incomes may have to pay more than \$135.50 a month.

Finally, in some instances, people must enroll in Medicare to receive certain benefits. For example, people who want a Medicare Supplemental Policy (Medigap) must enroll in Medicare Part A and B. Other programs that require Medicare enrollment include Medicare Advantage Plans, Medicare Part D, Tricare for Life, CHAMPVA or employer plans with less than 20 employees. For more information, please see <https://www.medicare.gov/Pubs/pdf/02179.pdf> Who Pays First. Also see <https://tricare.mil/mybenefit>.

#### 16. Medicare coverage options

People can start with Original Medicare when they first enroll in Medicare. Original Medicare does not pay for health care in full, so it is best to have a supplemental plan, such as retiree insurance or a Medigap plan, to help pay for care. Original Medicare pays directly for the care and supplemental insurance covers the out-of-pocket costs.

People can instead choose to get their Medicare benefits through a Medicare private health plan, also known as a Medicare Advantage (MA) plans. Medicare Advantage plans are usually HMOs, PPOs or PFFS plans. Medicare private health plans have a contract with the government to provide Medicare Part A and B benefits to their members. They often also include Part D coverage. If a beneficiary chooses to join a MA plan when they first become eligible for Medicare, the beneficiary may choose to leave the MA plan at any time during the first year and return to Original Medicare without penalty.

People who want Medicare prescription drug coverage, Part D, must make sure that the Part D coverage works with their other health coverage.

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People in Original Medicare should sign up for a stand-alone Medicare private drug plan (often referred to as a PDP). A PDP only covers prescription drugs.

People in a Medicare private health plan must usually get drug coverage as part of the health plan benefits package (often referred to as a MA-PD).

Those with a Private Fee-for-Service plan (PFFS) without drug coverage or a Medicare Medical Savings Account plan (MSA) can join a stand-alone Medicare private drug plan.

People with insurance from a current or former job should find out whether signing up for Part D will affect the benefits they get from their employer. Some employer plans don't let their members have Part D. People and their family members (dependents) could lose their employer-based insurance coverage if this is the case.

**Question:** What are common types of Medicare Advantage plans?

- A. \_\_\_\_\_ PPO, HMO, and SLMB.
- \_\_\_\_\_ B. PPO, HMO, and PFFS.
- \_\_\_\_\_ C. PPO, HMO, and MSP.
- \_\_\_\_\_ D. PPO, HMO and QE2.

#### 17. Ways to supplement Medicare coverage

For a full review of ways to supplement Original Medicare please see Chapter 6 of this manual.

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### **Medicare Parts A, B, C, and D**

Supplemental coverage with Original Medicare will help pay for Medicare out-of-pocket costs like deductibles and coinsurances. It may also fill other gaps, such as coverage while traveling or routine hearing or vision care.

There are different types of health coverage that can supplement Original Medicare, including:

- Employer insurance through a current job or union
- Retiree coverage through a former employer or union
- Medigap insurance from insurance companies such as Blue Cross Blue Shield or Mutual of Omaha, or from sponsoring organizations such as AARP. These policies were created to pay Medicare out-of-pocket costs.
- Medicaid or other state assistance programs, such as a Medicare Savings Programs, for people who have low incomes.

#### **18. Part D of Medicare - Prescription drug coverage**

People who are in Original Medicare and want the Medicare drug benefit (Part D) should enroll in a stand-alone private drug plan that only covers drugs. This is also known as a PDP. Original Medicare still covers all other medical services, such as doctor visits and hospital stays.

Before signing up for Part D, people who have employer-based insurance coverage should check with their employer to find out whether signing up for Part D will affect their benefits.

Each Part D plan has different costs, a different list of covered drugs (formulary), and its own pharmacy network. It is vital that people pick a plan that covers the drugs they

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### Medicare Parts A, B, C, and D

need and works at the pharmacies they use. To enroll, people can call the plan itself, call 800-MEDICARE, or go to Medicare's website, [Medicare.gov](https://www.medicare.gov).

People with low incomes may qualify for Extra Help, a federal program that helps pay some or most of the costs of Medicare prescription drug coverage. How much people pay for drugs with a Medicare drug plan depends on which drugs they need and how the plan structures its benefits.

Every Medicare drug plan charges a monthly premium that varies from plan to plan. The average national premium in 2019 is \$33.19, but premiums can range from less than \$15 a month to more than \$100 a month. The \$33.19 amount is important to know as benefits counselors because it is the "national base beneficiary premium."

There are usually four coverage phases under a Medicare drug plan. The beneficiary must pay the monthly premium through all four periods.

In the first phase there is an annual deductible to meet before the plan pays anything. In 2019, it cannot be more than \$415. Some plans do not charge a deductible before they start paying for drugs. Other plans may pay for some drugs (like generics) during the deductible phase.

The second phase starts after a person pays the deductible. During this time, the beneficiary pays some and the plan pays some, but only for drugs on the plan's formulary and from pharmacies in the plan's network. Some plans charge a flat copay for drugs (such as \$15); others charge a coinsurance (for example 25 percent of the cost of each drug). Most plans arrange drugs by tiers and beneficiaries pay less for drugs in lower tiers.

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### **Medicare Parts A, B, C, and D**

The third phase is a coverage gap, also called the doughnut hole, where the dollar amount someone pays for drugs suddenly increases. It begins each year once the beneficiary and the plan spend a certain amount. In 2019, this amount is \$3,820.00 in total drug costs in most plans. Realize that total drug costs are what the beneficiary pays plus what the plan pays. Once the beneficiary enters the coverage gap, they will pay 25 percent of the cost of most brand-name drugs and 37 percent of the cost of generic drugs. The doughnut hole is being phased out so that by 2020, people in Part D plans will pay no more than 25 percent of the cost of their drugs throughout the coverage gap. Some plans provide additional coverage during the coverage gap so people may pay even less, or zero, for drugs in the gap.

The fourth phase is after the beneficiary spends \$5,100.00 out of pocket. At that point, the beneficiary leaves the coverage gap. This \$5,100.00 limit is the true out-of-pocket (TrOOP) maximum in 2019. This true out-of-pocket cost does not include the Part D premium that the beneficiary continues to pay. Once they satisfy the coverage gap, their drug costs go down significantly. This last period is called catastrophic coverage. For the rest of the year, the beneficiary pays a small coinsurance amount or copayment while receiving catastrophic coverage.

If the beneficiary buys drugs that are not on the plan's formulary, those costs do not count toward the true out-of-pocket maximum. Payments made by other types of insurance also do not count toward the TrOOP maximum, but can help the person pay less up front. Payments made by beneficiaries, by other people on their behalf, by state prescription drug assistance programs, by Aids Drug Assistance Programs, by the Indian Health Services and by most charities count towards the TrOOP maximum. Remember the coverage gap begins after the Medicare beneficiary spends \$3,820 for covered drugs. Once they are in the coverage gap, they will pay 37 percent of the



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### Medicare Parts A, B, C, and D

plan's cost for generic drugs and 25 percent of the plan's cost for brand name drugs until they reach the end of the coverage gap.

Also, people with limited incomes can get Extra Help, a federal program that pays most of the costs of a Medicare private drug plan.

**Question:** What is the national base beneficiary premium in 2019?

- A. \$33.09
- B. \$33.19
- C. \$33.29
- D. \$33.39

#### 19. Part D enrollment.

The Medicare drug benefit (Part D) is optional. Whether a person should sign up depends on the quality of current drug coverage and their drug needs. People who have other drug coverage (like an employee or retiree plan) that is at least as good as the basic plan outlined in Medicare law, called **creditable coverage**, find it is usually beneficial to keep it. People can take Part D later without penalty as long as they have not been without creditable coverage for more than 63 days.

People can find out if their drug coverage is creditable from the company that provides their benefits. The company should send members a written notice every year stating if their coverage is creditable. People can also contact the company's Human Resources department directly if they have questions.

People without creditable coverage may have to pay a premium penalty if they wait to enroll. The penalty means the person must pay a higher monthly premium to get

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Medicare drug coverage. The premium penalty is 1 percent of the national average drug plan premium for every month the person did not have Medicare drug coverage but could have (\$33.19 in 2019).

People who get Extra Help do not have to pay a Part D premium penalty, even if they delayed enrolling in a Medicare private drug plan. People also do not have a premium penalty if they can show they got inadequate information about whether their drug coverage was creditable.

People can enroll in Part D at the following times:

- During their **Initial Enrollment Period**.
- During the **Fall Open Enrollment Period**, which is October 15 through December 7 each year
- During a **Special Enrollment Period** for people who qualify. Special Enrollment Periods let people enroll in or change Medicare drug plans outside of normal enrollment periods because of special circumstances. People who have Extra Help can change Part D plans during the following times, January-March; April-June; July-September. They can also still use the **Fall Open Enrollment Period** to make changes to their coverage.
- During **General Enrollment Period** for those who do not have Medicare Part A coverage, and enroll in Medicare Part B during the Part B General Enrollment Period (January 1–March 31), these people can sign up for a Medicare Part D plan April 1–June 30 and coverage will start July 1.
- During the **Disenrollment Period** from a MA Plan. For those people who want to switch from a MA Plan to Original Medicare, they can dis-enroll from the MA Plan starting January 1 – February 14 and select a Medicare drug plan to add drug coverage. Coverage starts the first day of the month after the plan gets the enrollment form.

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### Medicare Parts A, B, C, and D

- **5-Star Special Enrollment Period** for those people who have 5-Star Plans in their service area. Medicare rates Medicare Advantage and Medicare Prescription Drug Plans. Based on member satisfaction, it is possible for a plan to receive an excellent or 5-Star rating. If there is a plan in the beneficiary's service area with a 5-Star rating, and the Medicare beneficiary is not a member of that plan, then the person can use this benefit period to enroll in the 5-Star plan. They can enroll once per calendar year from December 8 – November 30.

#### 20. Medicare Advantage plans.

Most people with Medicare get health coverage from Original Medicare. However, people can choose to get their benefits from a Medicare private health plan, like an HMO or PPO. These are also called Medicare Advantage plans.

People still have Medicare if they join a Medicare private health plan. The private plan must provide all Part A and Part B services. Some plans provide extra benefits that Original Medicare does not cover, such as routine vision or dental care.

People who join a Medicare Medical Savings Account (MSA) or a Private Fee-For Service (PFFS) without drug coverage can join a separate stand-alone drug plan. Part D coverage from a Medicare private health plan works the same way as it does in a stand-alone private drug plan (PDP).

**Question: True or False?** A beneficiary may join an MA plan and a stand-alone Part D prescription drug plan?

\_\_\_\_\_ True

\_\_\_\_\_ False

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### Medicare Parts A, B, C, and D

#### 21. Addressing concerns about Medicare Advantage health plans

Before joining a Medicare private health plan, it is important to understand the plan's costs, rules, and restrictions. Medicare private health plans can cost less than Original Medicare for someone who does not need a lot of care. However, people in Medicare private plans have less ability to decide when they get care, what care they get, and which doctors they can use.

Before joining a Medicare private plan, people should make sure their doctors are in the plan's network and that they are accepting new patients from the plan. Many plans only cover services from doctors, hospitals and pharmacies in their network.

Private health plans must cover all health services that Original Medicare covers but can put other restrictions on care, such as requiring a referral from a primary doctor to see a specialist. They can also require the doctor to ask the plan for permission before providing certain services or drugs.

A private health plan may not be the best option for people who need a lot of specialized care.

**Keep in mind that doctors and hospitals may leave the plan at any time, but members can only leave a Medicare private health plan at certain times of the year. Plans may also withdraw or close, forcing members to find a new plan.**

**Question: True or False?** A Private health plan must cover all of the benefits that Original Medicare would provide?

\_\_\_\_\_ True

\_\_\_\_\_ False

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### **Medicare Parts A, B, C, and D**

#### **22. Types of Medicare Advantage (MA) plans**

A Medicare Advantage plan is an alternate health choice plan that may be available as a part of Medicare. These types of plans are also called “MA” plans and/or “Part C” of Medicare. These plans are offered by private companies which must be approved by Medicare. If you join a MA plan you still have Medicare. However, you will get Part A and Part B benefits from the Medicare Advantage plan and not from Original Medicare.

MA plans are required to follow Medicare’s rules for providing care, meaning they must cover all of the health services which would be covered in Original Medicare. However, MA plans can charge different out-of-pocket costs for services and may have different rules for how you get health services.

MA plans are required to send members an annual “Evidence of Coverage” (EOC) and an “Annual Notice of Change” (ANOC). These are important notices that inform the member of any changes in the plan each year. If a member does not get either of these notices every autumn, they should contact their plan directly.

Medicare private health plans are usually managed care plans. The most common types of Medicare Advantage plans are Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Private Fee-For-Service (PFFS) plans.

There are others, like Provider Sponsored Organizations (PSOs), and Medicare Medical Savings Accounts (MSAs), but they are not available in many parts of the country.

Special Needs Plans (SNPs) are Medicare private health plans that serve certain populations, such as people with low incomes or specific chronic conditions. All SNPs

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must include drug coverage. If you are eligible to join a SNP plan, you may do so at any time during the year. A SNP plan must limit membership in each plan to the following groups: 1.) people who live in certain institutions, such as a nursing home or who require nursing care at home 2.) people who are dual eligible 3.) people that have a certain specific chronic or disabling conditions, like end-stage renal disease (ESRD), dementia, or chronic heart failure.

No matter which type of Medicare private health plan a person decides to join, it is important to know the specific plan's network rules, restrictions, and costs. Even plans from the same company can vary greatly.

If you want to see the Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals procedures that CMS has established for Medicare Advantage health plans, use the following link: <http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/mc86c13.pdf>.

#### 23. Employer Sponsored and Retirement MA plans

It would always be a good idea to talk to the employer's administration or human resources department to find out exactly how an employer sponsored MA plan would work. If you drop your current employer or union coverage to join an employee sponsored MA, you may not be able to get your original coverage back. The same will be true for a spouse.

#### 24. When to enroll in a Medicare Advantage plan

People can only enroll in Medicare private health plans at certain times:

- During their **Initial Enrollment Period (IEP)**. This is the seven-month window surrounding the month people become eligible for Medicare. It starts

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three months before the month they become eligible for Medicare and ends three months after the month they become eligible. The eligibility month is either the month they turn 65 if they qualify for Medicare because of their age, or the month they get their 25<sup>th</sup> SSDI check if they qualify because of a disability.

- Remember that a person must have both Parts A and B to enroll in a Medicare private health plan.
- During the **Fall Open Enrollment Period** which is October 15 through December 7 each year.
- Some people with special circumstances can use a **Special Enrollment Period** to enroll in or change Medicare private health plans outside of normal

enrollment periods. For example, people who have Extra Help or enter a nursing home get a Special Enrollment Period.

#### **25. How to enroll in a Medicare health or drug plan.**

People who enroll in both Part A and Part B can choose to enroll in a Medicare Advantage plan instead of Original Medicare. People thinking about doing this should do their homework first. They should make sure there is a Medicare private health plan available in their area that meets their health care needs and that they can afford.

As a benefits counselor, you will be asked to help people make these decisions.

For people with Medicaid, Original Medicare may give the most benefits and choice at the lowest cost. Medicaid beneficiaries thinking about joining a Medicare private health plan should find out how it works with Medicaid.

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People who decide to join a Medicare private health plan can call 800-MEDICARE to enroll when they find one that meets their needs.

Generally, the new coverage starts the first day of the month after the month of enrollment. However, coverage starts January 1 for people who enroll during the Fall Open Enrollment Period, which runs October 15 through December 7 each year.

Once coverage starts, people should use the card from the Medicare private plan when they go to the doctor or hospital. Do not use the red, white, and blue Original Medicare card.

The same enrollment process applies for people who want to sign up for Medicare drug coverage from a stand-alone private drug plan. They should think about their options and do their homework before picking a plan. Then, they can call 800-MEDICARE to sign up.

**Question: True or False?** A beneficiary can join a Medicare Advantage health plan at any time?

\_\_\_\_\_ True

\_\_\_\_\_ False

#### 26. Common problems with Medicare and tips to avoid them

**Creditable Coverage:** People who have what is called “creditable coverage” for Medicare have insurance that is as good as or better than Medicare. People who do not have creditable health insurance or drug coverage should consider enrolling in Medicare Part B or D when they first qualify to avoid having to pay a premium penalty for coverage in the future.



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Penalties: People can incur penalties when they do not sign up for Medicare when they become eligible. Unless they have **creditable coverage** from a company where either they or their spouse still work, to avoid penalties, people should sign up for Medicare Part B and/ or Part D as soon as they are eligible;

Assignment: People can open themselves to unwanted costs if the doctor they choose does not take assignment. A doctor accepts assignment when the doctor takes the Medicare approved amount as payment in full. To save money in Original Medicare, people should make sure their doctors and other health service providers take assignment.

**Question: True or False?** People who have what is called “creditable coverage” for Medicare have insurance that is as good as or better than Medicare.

\_\_\_\_\_ True

\_\_\_\_\_ False

## **Chapter Five**

### **Other Medicare Options for Paying Health Care Costs Not Covered by Original Medicare**

#### **INTRODUCTION**

Chapter 4 described Medicare as a federal health program that provides both major medical coverage and coverage for medical expenses when an eligible person becomes ill. However, Medicare is not intended to pay for all of a Medicare beneficiary's medical expenses. When Medicare does not cover a medical expense, the beneficiary must pay for it. Medicare beneficiaries are also responsible for paying Medicare out-of-pocket costs for premiums, deductibles, coinsurance and/or copayments, and excess charges. People on Medicare usually need another health plan, policy, or program to pay for the things Medicare won't pay for. Individuals are encouraged to contact the Health Information, Counseling and Advocacy Program (HICAP) benefits counseling program for more information about alternatives to cover the gaps in Medicare.

This chapter outlines recent changes in the Medicare program and provides an overview of the current options available to supplement Medicare.

Paragraph 1 addresses delivery of Medicare services.

Paragraph 2 addresses sources of law.

Paragraph 3 addresses the Original Medicare plan.

Paragraph 4 addresses Medicare basics.

Paragraph 5 addresses identifying gaps in Original Medicare.

Paragraph 6 addresses premiums for Original Medicare and other insurance premiums.

Paragraph 7 addresses deductibles of Original Medicare.

Paragraph 8 addresses other deductibles of Original Medicare.

Paragraph 9 addresses coinsurance and copayments with Original Medicare and Medicare Advantage (Part C).

Paragraph 10 addresses excess charges with Original Medicare.

Paragraph 11 addresses services not covered by Original Medicare.

Paragraph 12 introduces options to cover gaps in Original Medicare.

Paragraph 13 addresses Medicare supplement policies.

Paragraph 14 addresses Medicare Select policies.

Paragraph 15 addresses regulation of companies selling Medicare supplement policies.

Paragraph 16 is a summary of Medicare supplement benefits.

Paragraph 17 addresses additional benefits in Medicare supplement policies B through N.

Paragraph 18 addresses new cost-sharing Medicare supplement policies.

Paragraph 19 addresses understanding the cost of Medicare supplement policies.

Paragraph 20 addresses consumer protections when buying Medicare supplement policies.

Paragraph 21 addresses other information about Medicare supplement insurance.

Paragraph 22 addresses unfair trade practices in the sale of Medicare supplement policies.

Paragraph 23 addresses money-saving tips for buying Medicare supplement policies.

Paragraph 24 addresses other resources for information about Medicare supplements.

Paragraph 25 addresses employer-related health plans.

Paragraph 26 addresses sources of law regarding employer-related health plans.

Paragraph 27 addresses when a person with an employer-related health plan does not need to enroll in Medicare.

Paragraph 28 addresses how employer-related plans work to cover the gaps in Medicare.

Paragraph 29 addresses understanding the cost of group plans.

Paragraph 30 addresses how employer-related plans work with Medicare.

Paragraph 31 addresses doctors and health care providers that work with Original Medicare.

Paragraph 32 addresses denial of services or complaints.

Paragraph 33 addresses more about how group plans work.

Paragraph 34 addresses consumer rights under employer-related plans.

Paragraph 35 addresses former federal employee retirement plans.

Paragraph 36 addresses Medicare health care options, Medicare Advantage health plans.

Paragraph 37 addresses regulatory authority and sources of law regarding Medicare Advantage health plans.

Paragraph 38 addresses how Medicare Advantage health plans cover the gaps in Medicare.

Paragraph 39 addresses types of Medicare Advantage health plans.

Paragraph 40 addresses how Medicare Advantage health plans work.

Paragraph 41 addresses out-of-pocket costs with Medicare Advantage health plans.

Paragraph 42 addresses identifying Medicare Advantage benefits.

Paragraph 43 addresses more about how Medicare Advantage health plans work.

Paragraph 44 addresses how to get the most from a Medicare Advantage health plan.

Paragraph 45 addresses other information and resources regarding Medicare Advantage health plans.

Paragraph 46 addresses Medicare Advantage private fee-for-service plans (PFFS).

Paragraph 47 addresses regulatory authority and sources of law regarding Medicare private fee-for-service plans (PFFS).

Paragraph 48 addresses how the Medicare private fee-for-service plans (PFFS) cover the gaps in Medicare.

Paragraph 49 addresses how the Medicare private fee-for-service plans (PFFS) work.

Paragraph 50 addresses identifying the out-of-pocket costs for the Medicare private fee-for-service (PFFS) options.

Paragraph 51 addresses identifying Medicare private fee-for-service (PFFS) benefits.

Paragraph 52 addresses how Medicare private fee-for-service plans (PFFS) work.

Paragraph 53 addresses how to get the most from Medicare private fee-for-service plans (PFFS).

Paragraph 54 provides more information and resources on the private fee-for-service plans (PFFS).

Paragraph 55 provides a list of CMS reading resources.

## **1. Delivery of Medicare services.**

Beginning in 1996, the U.S. Congress directed the U.S. Centers for Medicare & Medicaid Services (CMS) to phase in new initiatives to encourage contracts with insurance companies and other health plans for the delivery of Medicare benefits. Previously, Medicare beneficiaries would receive their

Medicare benefits through traditional Medicare, also known as Original or fee-for-service Medicare. However, the Balanced Budget Act of 1997 made changes to fee-for-service Medicare and also authorized the creation of new Medicare contracts now referred to as Medicare Advantage (MA) plans.

**2. Sources of law.** Changes to the Medicare program were enacted through the following legislation that impacts the Social Security Act:

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Patient Protection and Affordable Care Act (PPACA) of 2010
- Medicare Improvements for Patients and Providers Act (MIPPA) of 2008
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Medicare Modernization Act of 2000
- Balanced Budget Refinement Act of 1999
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Social Security Act of 1965 (Title XVIII)

Although Medicare is under the general administration of CMS, rules resulting from these bills and amendments fall under the jurisdiction of various federal and state agencies and CMS subcontractors. Each section in the chapter identifies entities responsible for implementation, regulation, and enforcement.

**3. Original Medicare plan.** The changes that impact Original Medicare include reimbursement of services and Medicare supplement insurance plan benefits. Medicare supplement plans are sold by private insurance companies, but the benefits are set by federal and state law. These are commonly called “Medigap” or “Medsup” plans, and these terms are used interchangeably throughout this chapter. These plans are designed to work with Original Medicare. Medicare beneficiaries have the option to choose from Plans A, B, C, D, F, G, K, L, M, and N. Plan F also has a high deductible option which can potentially mean a lower premium for the beneficiary. Plan J also used to be an option for Medicare beneficiaries but effective June 1, 2010 as part of federal health care reform, Medicare discontinued the option. But, if a beneficiary has a Plan J in force prior to that date, they would be allowed to keep it. And keep in mind, there may be other plans such as H, I and L that are no longer being sold but, Medicare beneficiaries may still have one. Finally, the Medicare Access

and CHIP Reauthorization Act of 2015 (“MACRA”) changed who can apply for Plans C and F. Accordingly, Section 401 of MACRA forbids the sale of Plans C and F to people who turn 65 on or after January 1, 2020 or to people who get free Part A due to ESRD or disability as of January 1, 2020 or later. Plans C and F are guaranteed renewable for those who already have effective plans in place. However, if the premiums are not paid, then the Medicare beneficiary will lose the plan and will not be able to re-enroll in the plan.

- 4. Medicare basics.** To understand the gaps in Medicare, it is important to understand what Medicare covers under Medicare Part A (inpatient hospital insurance) and Medicare Part B (medically necessary medical services). Note: For purposes of this chapter we will not discuss Medicare Part D in detail. Medicare benefits are covered in Chapter 4. The CMS publication *Medicare & You* provides useful information about Medicare benefits. This brochure is mailed to all Medicare beneficiaries in the fall and provides a consumer-friendly description of what Medicare covers and any changes to Medicare benefits for the coming year. There is also an electronic version of *Medicare & You* at <https://www.medicare.gov/medicare-and-you/medicare-and-you.html>.

- 5. Identifying the gaps in Original Medicare.** Generally, there are five categories of costs that Medicare beneficiaries have to pay out of their own pockets or paid for by other health coverage they have. These coverage gaps include premiums, deductibles, coinsurance/copayments, excess charges, and costs for services not covered by Medicare. The out-of-pocket costs in Original Medicare are different than those under Medicare Advantage plans and other coverages available to individuals vary depending on their situation. As an example, an individual might have Original Medicare, a retirement group plan, and be eligible for Veterans health benefits.
- 6. Premiums.** Both Medicare Part A and Part B have a premium. The premium amounts apply to both Original Medicare and Medicare Advantage plans. Most people eligible for Medicare are not required to pay the Part A premium if they have accrued 40 credits. In some cases, people may be eligible for Medicare, but not qualified for premium-free Part A.

An individual may earn up to four credits each year toward their goal of receiving 40 credits to qualify for Medicare coverage. The amount a person needs to make to earn one credit may change each year depending on cost-of-living adjustments. At the website [www.ssa.gov](http://www.ssa.gov), Social Security typically posts a press release during the last four months of the year, stating what the amounts will be for the

following year, to earn a credit, and other amounts pertinent to Social Security and Supplemental Security Income. Medicare posts its updated figures, also toward the end of the year, at [www.medicare.gov](http://www.medicare.gov).

People can purchase Medicare Part A by paying a premium. Anyone who chooses Medicare Part B pays a monthly premium. The Part B premium usually changes in January of each year. People who have health coverage through an employer and turn 65 or otherwise become eligible for Medicare should find out if they need to start their Medicare Part B coverage.

Most people have to pay Medicare premiums out of their own pockets because health plans that supplement Medicare do not pay the cost. However, people with limited income and resources may qualify for Medicaid by applying for and receiving Medicare Savings Programs (MSP) benefits to help pay these costs. MSPs, administered by the Texas Health and Human Services Commission, include the Qualified Medicare Beneficiary (QMB) Program, which pays the Part A premium, if there is one, and the Part B premium. The Specified Low-Income Medicare Beneficiary program (SLMB) and the Qualifying Individual (QI) program pay only the Medicare Part B premium, but allow individuals to have a higher income to qualify. The Qualified Disabled Working Individual (QDWI) program pays the Part A premium. See Chapter 6 for more information about MSPs.

**Other premiums.** In addition to Medicare premiums, Original Medicare beneficiaries may have to pay the premium for any supplemental health coverages they have or choose to buy. The cost of the added premium will be a factor in deciding how much additional coverage a person on Medicare will want to purchase. People who have a Medicare supplement policy for several years can expect significant increases in their premiums. Although these people may not have a special protection to buy a different Medicare supplement, it might be worthwhile to shop for another policy even if it means reducing their benefits.

7. **Deductibles.** Beneficiaries must also pay deductibles for both Medicare Part A and Part B before Medicare will pay. The amount of the deductible is usually a fixed amount. The amount can change annually in January. The Medicare Part A deductible is paid per benefit period. A benefit period begins when the person is hospitalized and ends when the person has been out of a facility for 60 consecutive days. Therefore, someone who has several hospitalizations in one year could pay more than one deductible in that year. The Medicare Part B deductible is paid annually. Some Medicare supplement policies and most group retirement plans cover Medicare deductibles. When selecting a

Medicare supplement plan, a person can choose a plan that covers only the more costly Medicare Part A deductible or a plan that covers both the Part A and Part B deductibles.

8. **Other deductibles.** Group retirement plans that supplement Original Medicare may also have deductibles. For example, a group plan might have an initial deductible that must be met before they cover the deductibles under Medicare Part A or Part B. Group plans may not be on the same calendar year as Medicare. Someone who sees the doctor infrequently may never reach their group plans annual deductible. On the other hand, someone who sees the doctor frequently will find that once the deductible has been met, the group plan will cover any other costs.
9. **Coinsurance and copayments.** Coinsurance is a percentage of the Medicare-approved costs that a beneficiary must pay. Both Medicare Part A and Part B require beneficiaries to pay coinsurance for covered services. Most Medicare Part B services require that the beneficiary pay 20 percent of the Medicare-approved amount. In Medicare Part A, the inpatient hospital copayment is a set daily rate for days 61 through 150 and for days 21 through 100 in skilled nursing home stays. These amounts can change in January each year. Since the change is not approved until after the printing of the annual *Medicare & You* publication, the coinsurance amounts for specific Medicare covered services will be out of date each January. Medicare coinsurance and copayments are a covered benefit if someone buys a Medicare supplement policy. By understanding how a Medigap policy covers these costs, it is easier to help someone review how their group retirement plan covers Medicare's coinsurance and copayments. Some Medicare supplement plans only pay the Medicare-approved coinsurance amount. This means that any excess charges beyond what Medicare approves would be the responsibility of the beneficiary. Medicare supplement plans F and G offer coverage for the excess charges, which is limited to 15 percent over the Medicare-approved charge.

Although most group retirement plans cover coinsurance amounts, people need to review their plans to know if there are any dollar limits or excluded services. In Original Medicare, someone could purchase a Medicare supplement policy even if they have a group retirement plan. Agents selling Medicare supplement policies are required to review an applicant's existing coverage to identify where there would be duplication of coverage.

Sometimes the term "copayment" is used in place of coinsurance. This term used to be more common to Medicare Advantage plans but now these plans also include coinsurance. Like coinsurance, a copayment is an amount that the beneficiary pays out-of-pocket when receiving a covered medical service. In Medicare Advantage plans, copayments are fixed amounts that are unique to each plan



and are usually not covered by any other insurance or health plan. Medicare rules do not allow someone in a Medicare Advantage plan to buy a Medicare supplement policy or to be in two Medicare Advantage plans at the same time. In certain situations, it might be possible for someone to have a Medicare Advantage plan and their own group retirement plan. A benefits counselor assisting someone in this situation would probably want to encourage the client to contact the group plan administrator to determine how the two plans will work together. An example would be an employer who only offers a Medicare Advantage option. In this case, the retiree would need to join the Medicare Advantage plan versus Original Medicare.

Although some Medicare Advantage plans do not require payment of a premium other than the Part B premium (or Part A if applicable) all Medicare Advantage plans charge copayments and in some cases, coinsurance. The amount of the copayment is approved by the individual plan. Federal health reform requires Medicare Advantage plans to set annual caps on out-of-pocket costs paid by members. Most plans also set benefit periods for hospital stays with lower deductibles or copayments than Original Medicare. But, if someone returned to the hospital repeatedly, they might have to pay more than they would with Original Medicare. Similarly, most Medicare health plans also require inpatient hospital copayments. Remember that there are very limited options, if any, to finding alternate coverage for Medicare Advantage plan copayments and coinsurance.

**10. Excess charges.** Health care providers who participate in Original Medicare can choose to accept Medicare “assignment.” These providers are listed in a directory maintained by the Medicare carrier in each state. Assignment means that the provider agrees to accept the Medicare-approved amount for a certain service or supply as payment in full. Doctors who do not accept assignment may charge up to 15 percent above the Medicare-approved amount when treating a person with Original Medicare. The charge above the Medicare-approved amount is called an excess charge. The beneficiary is responsible for paying the coinsurance amount and the excess charge. Medicare supplement plans F and G offer coverage for the excess charges. People with retirement group plans should check their policy to see if the plan will pay for the excess charge.

**11. Services not covered by Original Medicare.** In addition to Medicare premiums, deductibles and coinsurance/copayments, there are several services and medical costs that Medicare does not cover. A beneficiary is responsible for the full cost of those services. Some of the most common excluded services include emergency care while traveling out of the country, prescriptions, routine foot care, dental care, eye exams, and hearing aids. Some Medicare Advantage plans offer some coverage for

these excluded services. Since Medicare supplement policies are designed to coordinate with Medicare, Medicare supplement plans do not pay for most medical services that are not covered by Medicare. Some older Medicare supplement plans offer prescription benefits, emergency care while on foreign travel, and routine physicals. Medicare supplement plans that cover these services will cost more because the plan, not Medicare, is covering the benefit.

A benefits counselor can use the list of services not covered by Medicare to determine how an individual's retirement plan covers services Medicare doesn't cover. Some retirees complain that they can no longer afford the premiums for their group plan and have dropped their coverage knowing they might not get it back.

**12. Additional options to cover the gaps in Original Medicare.** Medicare premiums, deductibles, and coinsurance could cause financial hardship to people with Medicare, especially those with fixed incomes. Following is an overview of the available options that reduce the gaps in Medicare and provide additional benefits.

**13. Medicare supplement policies.** Medicare supplement insurance can help pay some of the gaps in health care costs that Original Medicare will not pay. Medicare supplement policies are sold through private insurance companies. To buy a Medicare supplement policy, a person must usually have both Medicare Part A and Part B.

There are 10 standardized Medicare supplement insurance plans, labeled A through N. Each plan offers different benefits. Companies must use the same identifying letters for their plans. All companies selling Medicare supplement insurance must offer at least Plan A but do not have to offer any of the nine other plans. Companies are also allowed to offer plan F with a high-deductible. The Texas Department of Insurance (TDI) publishes the *Medicare Supplement Insurance Handbook*. The guide includes general information about Medicare supplement policies and shopping tips. This, and other insurance publications for consumers, is available on the TDI website at <https://www.tdi.texas.gov/pubs/consumer/medsup.html>.

Centers for Medicare and Medicaid Services published a guide to help people choose a Medigap policy. If you go to <https://www.medicare.gov/Publications/> and type in Medigap in the Keyword or ID field, then several publications will appear including the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.

Medicare supplement policies help pay Medicare deductibles, coinsurance amounts, and excess charges. Medicare supplement policies only pay for services that Medicare deems medically necessary, and payments are generally based on the Medicare-approved amount. Medicare supplement policies will not cover either the Medicare Part A premium (if there is one) or the Part B premium.

Medicare supplement policies issued prior to 1992 were not standardized. Some pre-1992 policies offer better benefits for the premium charged. The second standardization of Medicare supplement policies took place on June 1, 2010, in accordance with federal health care reform. Someone with an older policy that they bought before either of these transitions does not need to switch plans.

**14. Medicare Select policies.** Medicare Select is a type of Medicare supplement policy that may provide a lower premium in exchange for using only providers on the insurance company's "network provider" list. An insurance company can issue Medicare Select coverage. If the beneficiary leaves a Medicare Select plan or the company stops offering the plan, the company must make available any non-Medicare Select policy it has on the market with comparable or lesser benefits.

**15. Regulation of companies.** Changes to standards for Medicare supplement policies may be issued as operation letters or as rules published in the *Federal Register*. TDI regulates companies selling Medicare supplement insurance in the state.

**16. Summary of Medicare supplement benefits.** Plans A, B, C, D, F, G, K, L, M, and N provide these basic benefits to cover gaps in Medicare:

- Daily coinsurance for hospitalization expenses from the 61st through the 90th day of any Medicare benefit period; Medicare Part A coinsurance for any hospital confinement beyond the 90th day in a benefit period; and up to an additional 60 days during a beneficiary's lifetime. These are called inpatient "reserve days." Beneficiaries may use these days when they require more than 90 days in the hospital during a benefit period. When a reserve day is used, it is subtracted from the lifetime total and cannot be used again.
- All Medicare-eligible hospital charges for a period of up to 365 additional days during the beneficiary's lifetime after all Medicare hospital benefit days are exhausted (benefits beyond what Medicare covers.)

- The reasonable cost of the first three pints of blood, or their equivalent, under Medicare Part A and Part B unless replaced. The covered period is the calendar year that runs January 1 through December 31.
- The 20 percent Part B coinsurance for Medicare-eligible expenses for medical services. This would include doctor bills, hospital or home health care, and outpatient hospital treatment, after the Part B annual deductible has been met.
- Hospice coinsurance for outpatient drugs and inpatient respite care.

**17. Additional benefits in Medicare supplement policies B through N.** Following is a brief description of the combinations of benefits that are added to the basic benefits in plans B through N:

- **Skilled nursing facility care:** Covers actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A. Available on plans C through G. This is not custodial care.
- **Part A deductible:** Pays the entire Medicare Part A inpatient hospital deductible amount per benefit period. Available on plans B through G and N.
- **Part B deductible:** Pays the Medicare Part B deductible amount per calendar year. Available on plans C and F.
- **Medicare Part B excess doctor charges:** Pays the entire medically necessary excess amount billed by providers who do not accept assignment. Plans F and G cover up to the 15 percent limit. Plan G covered 80 percent of the excess charge before the 2010 standardization; it is now 100 percent. If the doctor accepts Medicare assignment, this benefit is not needed.

**Question:**

Which of the following are considered Medicare out-of-pocket costs?

- A. \_\_\_\_\_ Medicare Part A and Part B premium
- B. \_\_\_\_\_ Copayments and coinsurance
- C. \_\_\_\_\_ Deductibles
- D. \_\_\_\_\_ Cost of services that Medicare does not cover

E. \_\_\_\_\_ All of the above

**Other Medicare supplement benefits:**

- **Foreign travel emergency:** Covers 80 percent of the billed charges for emergency care that Medicare would cover in the United States. Care must begin during the first 60 days outside the United States. There is a calendar year deductible of \$250. The lifetime maximum benefit is \$50,000. (Available on plans C, D, F, G, J, M, and N. Although plans E, H, I and J are no longer for sale, they still provide foreign travel emergency health care coverage.)
- **At-home recovery:** Covers doctor-approved, short-term, at-home assistance with activities of daily living while recovering from an illness, injury, or surgery. Limited to seven visits per week by a qualified care provider. Pays actual charges up to \$40 per visit, with a maximum of \$1,600 per year. (Available on pre-2010 plans D, G, I, and J.) This only applies to existing policies because these benefits have been dropped from plans available after the June 1, 2010 standardization of Medicare supplement policies.
- **Preventive medical care:** Includes an annual physical examination, certain lab tests, and other preventive measures deemed appropriate by a physician. Maximum benefit is \$120 per year. This only applies to in force policies because these benefits have been dropped from plans available after the June 1, 2010 standardization of Medicare supplement policies. Preventive medical care was only available on plans E and J.
- **Prescription drug benefits:** Existing policies will continue to offer prescription coverage to the policyholder. Medicare supplement policies sold after January 1, 2006, were not allowed to include this benefit.

**18. Plans K, L, M, and N:** These plans are cost-sharing Medicare supplement policies. All of them cover Medicare Part A hospital coinsurance and additional costs after the original 365 days have been used. Plans K and M cover 50 percent of the annual deductible of Medicare Part A. Plan L covers 75 percent of the Part A deductible, and Plan N covers 100 percent.

**19. Understanding the cost of Medicare supplement policies.** Medicare supplement plan benefits are identical but the premiums can still vary among companies. Medicare supplement policies in Texas are either issue-age rated or attained-age rated. Issue-age premiums are based on the person's age when they purchase a policy. Attained age premiums will automatically increase as the beneficiary gets older. The increase is in addition to any general annual premium increase. Companies sell

Medicare supplement insurance to qualified individuals or groups. A beneficiary must be a member of a particular group, association, or organization to get group insurance coverage.

Other factors that affect Medicare supplement rates include the person's gender, whether the person smokes or not, where the person lives, and whether the policy has an elimination period before it covers a preexisting condition.

**20. Consumer protections when buying Medicare supplement insurance.** A beneficiary does not need a Medicare supplement policy if the beneficiary has group health insurance through an employer or former employer; if the beneficiary receives Medicaid or qualify for the Qualified Medicare Beneficiary Medicaid or if the beneficiary belongs to a Medicare Advantage plan.

**Open enrollment rights to buy a Medicare supplement (persons 65 or older):** Insurance companies must sell a Medicare supplement policy to people who are at least 65 and who apply within six months after enrolling in Medicare Part B, even if they have preexisting conditions. These six months are called the "open enrollment" period. During open enrollment, an insurance company must allow the person to choose among all the Medicare supplement policies it offers. Open enrollment rights may be used more than once during this six-month period. For instance, people may change their minds about a policy, cancel it, and still have the right to buy any other Medicare supplement policy during the six months after the person first enrolled in Medicare Part B.

Questions:

Which is true of Medigap policies?

- A. \_\_\_\_\_ There are 10 standard plans.
- B. \_\_\_\_\_ There are high deductible versions of all 10 plans.
- C. \_\_\_\_\_ Medigap policies are sold and regulated by the federal government.
- D. \_\_\_\_\_ Medigap policies are guaranteed renewable which means the price can never increase.

Before buying a Medicare supplement policy, the beneficiary should:

- A. \_\_\_\_\_ Make sure that they have Medicare Part A and Part B.

- B. \_\_\_\_\_ Determine if they are entitled to group insurance through their employer or through a retirement plan from their former employer.
- C. \_\_\_\_\_ Find out if they might qualify for the Medicare savings programs.
- D. \_\_\_\_\_ Find out if there is a Medicare Advantage option available.
- E. \_\_\_\_\_ All of the above

**Texans with disabilities under age 65:** In Texas, people under 65 who become eligible for Medicare because of a disability also have a six-month open enrollment period beginning the day they enroll in Medicare Part B. This open enrollment right is applicable to Medicare supplement Plan A only, although there are companies that offer people who are under 65 and eligible for Medicare additional plans. When the beneficiary turns 65, the beneficiary will have a six-month open enrollment period during which any of the 10 plans may be purchased.

**Questions:**

The Medicare supplement high-deductible plan F requires that the beneficiary first pay the annual deductible before the plan pays any of the costs.

True \_\_\_\_\_ False \_\_\_\_\_

In Texas, a person with disabilities under age 65 may buy any Medicare supplement plan regardless of preexisting conditions during a six-month open enrollment period.

True \_\_\_\_\_ False \_\_\_\_\_

**Guaranteed issue protection:** A beneficiary may have a right to buy a Medicare supplement policy outside of the six-month open enrollment period due to the following situations:

- A Medicare Advantage health plan or private-fee-for-service plan ends its Medicare contract;
- The beneficiary moves outside a Medicare Advantage plan's area;
- The Medicare Advantage plan fails to meet its contractual obligations;
- An employer group plan that supplements Medicare ends its coverage;
- A plan ends through no fault of the beneficiary;
- The beneficiary buys a Medicare Select

plan for the first time or drops a Medicare supplement policy to join a Medicare Advantage plan, and then leaves the plan or policy within one year;

- A beneficiary joined a Medicare Advantage plan when they first became eligible for Medicare at age 65 and decides to leave the plan within one year of joining.

This right to buy a Medicare supplement policy requires companies to issue a policy without regard to the beneficiary's health or claim history. The protection allows a qualified beneficiary to purchase Medicare supplement plans A, B, C, or F (including high-deductible F), K and L within a 63-day period. The 63-day period begins the earliest of the day the beneficiary lost coverage or the date of notice that the coverage will end. Similar to the open enrollment period, this protection applies differently to Medicare beneficiaries under age 65. Beneficiaries under age 65 have the right to purchase Plan A, but may also purchase plans B, C, or F. Because the company cannot deny the plan or charge more because of health or claim history, a beneficiary could get better coverage than during their initial open enrollment period.

**Group Medicare supplement insurance rights.** The rights of group Medicare supplement policies and individual policies are essentially the same. Because the group might make decisions that are out of the person's control, members have the following protections:

- If the group changes insurance companies, the new company must offer coverage to everyone previously covered. The new policy must cover preexisting conditions that were covered by the old policy;
- If a person leaves the group, the insurance company must offer to provide unbroken Medicare supplement coverage with an individual policy or continuation of the group insurance;
- If the group cancels its coverage, the insurance company must offer the person either an individual policy continuing the benefits they had before or a different policy meeting Texas requirements.

**Free Look:** A policyholder can return a policy within 30 days from the date they purchased it and receive a full refund. Encourage a beneficiary to use this "free look" period to review the policy carefully.

**Renewability:** All Medicare supplement policies are guaranteed renewable. A company cannot cancel a policy or refuse to renew it, unless the beneficiary made material false statements on the application or failed to pay the premium. However, the amount of the premium is not guaranteed. An



insurance company may raise premiums, but may do so only once each year. If the person purchased an attained-age policy, a company may also raise the premium on the beneficiary's birthday.

## **21. Other information about Medicare supplement insurance:**

- **Medicare supplement claims.** Doctors and other health care providers must submit Medicare claims to the appropriate Texas Medicare contractor. Doctors and other health care providers generally know who the current contractor is. Medicare changes contractors from time to time. In most cases, these Medicare contractors send the Medicare claim directly to the Medicare supplement insurance company.
- **Coordination with Original Medicare, appeals, and complaints.** Medicare supplement policies won't pay for services that Medicare does not deem medically necessary. If the Medicare contractor denies the claim as medically unnecessary, the Medicare supplement company won't pay it. A beneficiary has the right to appeal a claim denial. The appeal process is described in the Medicare Summary Notice that is mailed to the beneficiary. If the Medicare supplement company refuses to pay a claim for a Medicare-approved charge or delays payment of a claim, the beneficiary can file a complaint with the Texas Department of Insurance.
- **Elimination period.** Even though a company must sell a policy during an open enrollment period, the company can require a waiting period of up to six months before covering a preexisting condition.

## **22. Unfair trade practice in the sale of Medicare supplement policies.** Agents and companies may not engage in any of the following illegal activities:

- Knowingly making any misleading statement that causes someone to drop a policy and buy a replacement from another company. This is called "twisting";
- Suggesting that a client replace or buy a new policy from the same company. Replacing or buying a new policy is not always a good idea because of preexisting conditions, costs, and other potentially negative outcome. This is called "churning";
- Using high-pressure tactics, including the use of force, fright, or threat to pressure someone into buying a policy;
- Obtaining sales leads by using advertising that doesn't say an agent or company is trying to sell insurance. This is called "cold lead advertising";

- Posing as a representative of Medicare or a government agency; ○ Selling a Medicare supplement policy that duplicates a person's existing Medicare benefits or health insurance coverage. An agent is required to ask if the person has other health policies;
- Suggesting that the beneficiary lie about something on the application. For example, telling an applicant not to mention a recent diagnosis;
- Using mail advertisements that appear to be from a government agency. These ads often have eagles or similar graphics and official-sounding government bureaus on the return address.

### **23. Money-saving tips:**

- Standardized benefit plans make price shopping easier. ○ Consider other factors. Price should not be the only consideration. Learn a company's complaint record by calling TDI's Consumer Help Line. Both are important indicators of the service a policyholder can expect from a company. Family and friends are other sources of information about a company's customer service. Consumers should get to know the independent agents in their area, and ask if they have any experience with the companies they're considering.
- Remind people to ask if their doctor accepts assignment. If the doctor accepts assignment, the person would not need the excess charge benefit offered by plans F and G.

**24. Other resources and Medicare supplement-related information.** Consumer publications that address Medicare supplement insurance include the CMS annual publication *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* and the TDI publication *Medicare Supplement Insurance Handbook*. CMS also has publications on its website that provide more details about Original Medicare. These publications can assist the member in appealing a claim or denial of services.

**25. Employer-related health plans and other health coverage that supplements Medicare.** Some people who are eligible for Medicare may also have the option to receive health coverage from a group health plan sponsored by an employer, union, or association. A group plan may cover employees, dependents, and retirees. People with employer-related coverage may not need to enroll in Medicare even though they are eligible for it. Additionally, a retiree who no longer works but is still eligible for group health coverage may not need to purchase other insurance coverage beyond Medicare.

**26. Sources of law.** Employer-related health insurance is not mandated by federal or state law. When an employer does offer it, there are Medicare rules that will determine which plan (Medicare or the employer plan) pays first. There are also federal laws that protect people from losing health coverage. This section relates to Medicare's secondary payer rules and also the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Depending on what type of insurance a person has there may be additional protections through other federal or state agencies.

An employer-related plan (sometimes referred to as private group insurance) may change how Medicare pays a claim and will affect when someone should enroll in Medicare Part B. Employer related plans may also coordinate coverage obtained either through a Medicare supplement policy or Medicare Advantage plan. As a benefits counselor, you will need to determine if there is a duplication of coverage and whether to suggest that someone consider additional coverage.

Each employer-related plan is unique and the benefits will vary from plan to plan. Before discussing how employer-related coverage coordinates to fill the gaps in Medicare, it is important that a benefits counselor understand certain aspects of this type of coverage. The benefits offered by an employer related plan are not standardized like Original Medicare or a Medicare supplement policy. To understand what protections a group plan offers, you will have to contact the plan sponsor or review the actual policy or contract.

**27. When does a person with employer-related coverage NOT need to enroll in Medicare?** If a person has coverage from a group plan – either because they are still working or covered as a dependent by a working spouse – the person needs to decide whether to enroll in Medicare Part B. The two sources for verifying this information are the Social Security Administration and the benefits coordinator for the group plan. Federal rules define the responsibility of a small versus large employer group. The importance of reviewing this information will affect the individual in two ways. First, if Medicare will not be the primary payer (group plan pays first), the individual could pay the annual premium for Medicare Part B and find that no benefits are paid by Medicare. Second, the person could face either a monetary penalty for delayed enrollment into Medicare, or could lose the open enrollment right protection for buying a Medicare supplement policy. For more information about these issues, refer to the CMS publications *Medicare and Other Health Benefits: Your Guide to Who Pays First* and *A Guide for Persons on Medicare*.

**28. How employer-related plans work to cover the gaps in Medicare.** Employer-related plans do not abide by Medicare supplement rules and are not required to coordinate with Medicare. Yet, in many

cases, a group plan will cover both the deductibles and coinsurance gaps in Medicare. Some plans also cover services that Medicare does not offer such as outpatient prescriptions, routine eye care, and dental care. Most group plans will not pick up the costs of the Medicare Part A and Part B premiums or offer coverage for long-term care. Be aware that some group plans completely cover the benefits available under Medicare Part B. The group might advise retirees that they do not need Medicare Part B since the group plan pays the coinsurance. Retirees need to be informed that should the group ever stop offering a health retirement plan, the retiree would be subject to the late penalty for each year that they delay enrollment.

**29. Understanding the cost of group plans.** Most people eligible for group coverage pay a premium for this coverage. The premium amount is set by the group, as are any increases. Traditionally, group insurance is a value when the group includes both active employees and retirees. The premium for the group will be based in part on the number of claims submitted. A key attraction to group plans is the fact that most plans offer coverage for dependents that are not yet eligible for Medicare. The person eligible for Medicare must pay both the Medicare premiums and the group plan premium.

Recent trends indicate employers are having difficulty covering the cost of health insurance for their employees. Many have had to pass on part of the increases to their covered members. Benefits counselors can help the client compare the cost of the group premium against the premium for a comparable Medicare supplement plan. In addition, the benefits counselor can review how many of the Medicare gaps the plan covers, the copayments (amount paid by the policyholder) and what added benefits the plan provides, including what it covers for dependents. If the person with the group plan ever has to drop it because of cost or because the plan ends, the person would have the guaranteed protection to buy Medicare supplement plans A, B, C, F, K or L.

**30. How employer-related plans work with Medicare.** The contractors that process Medicare claims and employer-related plans are able to communicate with each other. The Medicare guide “Who Pays First” also has pertinent information.

**31. Doctors and health care providers that work with Original Medicare** know who the Medicare administrative contractors (MAC) are for the type of claim to be submitted. The Medicare administrative contractors change from time to time due to rebidding of the contracts by Medicare.

**32. Denial of services or complaints.** If Medicare denies a claim, a beneficiary can appeal to Medicare as outlined in the MSN. If Medicare pays its portion of the claim and the group insurance plan denies or delays payment, a benefits counselor would need to suggest that the client review the group

member handbook or the policy for recourse. Depending on the type of plan, a complaint can be submitted by the client to the Texas Department of Insurance. The Texas Department of Insurance can advise the complainant of what other recourse is available.

**33. More about how group plans work.** The following is a list of information that a person should be familiar with regarding his or her group plan:

- How retirement or the death of the employee will affect coverage for dependents;
- Does the plan have a lifetime maximum? See the policy for a definition of lifetime benefit and find out what has been used to date;
- The policy's benefits coordination, limitations and exclusions. **Read the policy;**
- If it's possible to further supplement a group plan with a Medicare supplement policy or Medicare Advantage plan; □ Annual enrollment periods and whether it's possible to drop the group plan and get it back during the next enrollment;
- How frequently the employer changes plans or companies. This might require the policyholder to change doctors or to update his or her insurance information with Medicare.

**34. Consumer rights under an employer-related plan.** To assist a client who has a complaint or question about their employer-related plan the client and you will need to review the employer plan's benefit booklet. The following resources may offer further assistance related to state and federal monitoring of employer-related health plans.

**Question:**

A person who is still working when they become eligible for Medicare can delay enrollment in Medicare if their employer allows them to.

True \_\_\_\_\_ False \_\_\_\_\_

- **ERISA - U.S. Department of Labor**

Some employment-related benefit plans are subject to federal regulation under ERISA. ERISA has authority over how plans are administered and who is eligible.

Division of Technical Assistance and Inquiries  
2000 Constitution Ave. NW, Room N-5619

Washington, D.C. 20210 1 (866) 487-2365

[www.dol.gov/dol/pwba/public/pubs/mwguide.pdf](http://www.dol.gov/dol/pwba/public/pubs/mwguide.pdf)

- **COBRA - Consolidated Omnibus Budget Reconciliation Act**

COBRA is a federal law that requires employers with 20 or more employees to allow employees and their dependents to continue their group coverage under certain conditions. Some states extend the COBRA benefits beyond federal laws. COBRA interacts with Medicare secondary payer rules and also impacts eligibility between Medicare and COBRA coverage. See the CMS publication, *Guide to Health Insurance for People on Medicare* for more information about Medicare and COBRA coverage.

- **U.S. Department of Labor, Pensions and Welfare Benefits Regional Office**

525 S. Griffin St., Suite 900

Dallas, TX 75202

1-972-850-4500 (not a toll free number) [www.dol.gov/dol/pwba/public/health.htm](http://www.dol.gov/dol/pwba/public/health.htm)

- **Texas Department of Insurance**

TDI licenses agents and companies that sell health and life insurance. It also issues rules regarding payment of claims, and processes consumer and provider claims complaints. TDI also monitors insurance fraud and abuse.

Consumer Protection, Life, Accident and Health Complaints Resolution

P.O. Box 149091 M.C. 111-1A

Austin TX 78714-9091 1-800-252-

3439 [www.tdi.state.tx.us](http://www.tdi.state.tx.us)

- **Health Insurance Portability and Accountability Act (HIPAA)**

Contact TDI or CMS.

HIPAA Help Line: 410-786-1565 (not a toll-free number, second option on recording)

[www.hhs.gov/ocr/privacy](http://www.hhs.gov/ocr/privacy)

- **The Centers for Medicare and Medicaid Services Health Insurance Hotline**

The Centers for Medicare and Medicaid Services Health Insurance Hotline: 410-786-1565 (this is Not a toll-free number).

The Centers for Medicare and Medicaid Services Health Insurance Hotline is sponsored by an agency of the United States federal government. This hotline fields questions about: the Health Insurance Portability and Accountability Act (HIPPA Title 1), the Women's Health and Cancer Rights Act, the Mental Health Parity and Addition Equity Act, Newborns and Mothers Health Protection Act, the Genetic Information Nondiscrimination Act, and COBRA as it applies to public sector Employers. Calls are returned within five business days.

- **TRICARE (formerly CHAMPUS)**

TRICARE FOR LIFE (TFL)

Provides medical and prescription coverage for Medicare-eligible retirees and their qualified Medicare-eligible dependents. Must meet eligibility defined by the U.S. Department of Defense.

1-888-363-5433 [www.TRICARE.osd.mil](http://www.TRICARE.osd.mil)

**35. Former federal employee retirement plans.** Not all former federal employees are eligible for Medicare. Retirees should first contact their former employing office or retirement system. Information about current health plan options is also available from the U.S. Office of Personnel Management, Retirement and Insurance Services.

- **Other retirement plans**
- **Railroad Retirement Board (RRB)**

1-800-808-0772 for enrollment, lost RRB Medicare Card or address change.

**RRB Medicare Part A intermediary – TrailBlazers Health Enterprises**

1-800-442-2620

**RRB Medicare Part B carrier – Palmetto GBA**

1-800-833-4455 [www.opm.gov](http://www.opm.gov)

- **Employees Retirement System of Texas**

ERS administers retirement, health and other insurance benefits, TexFlex, a tax-savings flexible benefit program, and 401(k) and 457 investment accounts as part of the TexaSaver Program.

1-877-275-4377 or (512) 867-7711 in Austin [www.ers.state.tx.us/home/default.aspx](http://www.ers.state.tx.us/home/default.aspx)

- **Teacher Retirement System of Texas**

TRS-Care and TRS-Active Care. This is mainly for retirees who worked for independent school districts. State colleges and public universities should contact their former employer or the state retirement system.

1-800-223-8778 (for enrollment and eligibility) 1-800-367-3636

(for complaints and claims) [www.trs.state.tx.us/](http://www.trs.state.tx.us/)

### **Other health insurance options**

#### **Texas Health Options**

Texas Health Options maintains a website where consumers can obtain information pertinent to shopping for health insurance.

[www.TexasHealthOptions.com](http://www.TexasHealthOptions.com)

#### **□ TexCare Partnership**

Offers two health care coverage options for Texas children: Medicaid, and the Children's Health Insurance Program (CHIP). Both programs cover children from birth through age 18. Individuals can apply for both programs with a single application through TexCare Partnership.

1-800-647-6558

<https://www.dshs.texas.gov/region4-5/chips.shtm>

**36. Medicare health care options, Medicare Advantage health plans.** To give Medicare beneficiaries more options to receive their health benefits, the federal government may enter into contracts with health plans that sell insurance to large groups. Medicare Advantage (MA) health plans, also referred



to as coordinated care plans, contract with Medicare to serve a specific geographic area usually designated by ZIP code or county. MA health plans offer their members, people who are eligible and choose to join these plans, all of their Medicare benefits through a network of doctors, hospitals, and other related health care providers. A person who joins a MA health plan is no longer in Original Medicare and must follow the procedures and rules of the plan to receive their Medicare benefits.

When CMS contracts with a MA health plan, it agrees to pre-pay a monthly fee for each Medicare beneficiary that enrolls in the plan. Contracts are usually for one year, and each year CMS will approve the benefits and any fees that the plan passes on to its members. Most MA health plans charge their members a monthly premium (separate from the Medicare Part B premium) and copayments. The amount of these premiums is usually lower than what might be paid with a Medicare supplement policy.

Copayments in Medicare have usually been defined as a set amount that the beneficiary pays as a shared cost for an approved service. The term copayments is used mainly with Medicare Advantage health plans (MA) and the amounts have traditionally been low. In Original Medicare, this shared cost is called coinsurance and is a percentage of the approved amount for a service. Medicare now uses the term copayment in both Original Medicare and Medicare Advantage plans. Many people think that the copayments in MAs continue to be small amounts such as \$5 or \$10. In reality, most MAs have increased the amount of their copayments. In addition, new copayments for certain services needed as treatments for chronic illnesses such as radiation therapy are often higher than the coinsurance amount that a person would be responsible to pay under Original Medicare.

Each year these plans make a business decision of whether to continue their contracts or to terminate them.

To find out if a Medicare Advantage health plan is available in a specific area call Medicare's toll-free hotline available 24 hours a day at 1-800-633-4227 or visit the interactive Medicare website tool, Plan Finder at [www.medicare.gov](http://www.medicare.gov).

**37. Regulatory authority and sources of law.** Medicare Part C, or Medicare Advantage health plans, must meet the contracting requirements of 42 United States Code §1395w-27.

**Sources of law.** Changes to the Medicare program were enacted through the following legislation that impacts the Social Security Act:

- Patient Protection and Affordable Care Act (PPACA) of 2010
- Medicare Improvements for Patients and Providers Act (MIPPA) of 2008
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Medicare Modernization Act of 2000
- Balanced Budget Refinement Act of 1999
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act (HIPAA) of 1996

CMS is authorized to enter into contracts with federally qualified managed care plans to arrange or deliver services to Medicare beneficiaries. Legislation under the Balanced Budget Act of 1997 expanded the types of health plans that CMS could contract with as part of the federal campaign to expand Medicare choices.

The contract with CMS requires that a plan have sufficient administrative capacity to assure against fraud, provide adequate provider networks, and to develop processes for quality care improvement, appeals and grievances. They are also subject to external quality monitoring by independent CMS contractors called independent review organizations (IRO), state level contracts, and a national agent for reconsideration of managed care plan denials known as the Center for Health Dispute Resolution or CHDR. CMS regional offices are responsible for state monitoring of managed care plans and the review of marketing and advertising materials.

In addition to meeting federal requirements, managed health plans must meet state licensure requirements. However, state laws cannot conflict with or be more stringent than federal rules. TDI does not have a formal role in the application review process although federal law requires the plan to submit their application to TDI. As a state-licensed entity, the managed care plan is under the oversight of the insurance department related to solvency issues.

State laws regarding managed care patient protection rules and consumer complaints do not apply to a Medicare health plan. TDI does not track or maintain copies of Medicare health plan complaints. Since Medicare health plan coverage has a direct impact on Medicare supplement insurance policies, which are under the regulation of TDI, the agency frequently issues news releases and insurer directives as they relate to what is happening in the Medicare HMO market.

**38. How a Medicare Advantage health plan covers the gaps in Medicare.** Medicare plans referred to as Medicare Advantage plans (MA) agree to provide all Medicare-approved services to Medicare beneficiaries that join the MA. CMS pays the MA a monthly fee for each Medicare beneficiary

enrolled in the plan. People who join the plan, may or may not pay a plan premium and only pay copayments when they access a service or provider. The copayments have usually been less than what the beneficiary would pay as coinsurance under Original Medicare. In addition, Medicare Advantage plans usually cover benefits like preventive care and prescriptions. The added services may also have copayments. The beneficiary continues to pay the Medicare Part B monthly premium which is usually withheld from their Social Security check.

**39. Medicare Advantage (Part C) health plans.** CMS is authorized to contract with different health care plans including health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider sponsored organizations (PSOs), special needs plans (SNPs), and religious fraternal plans. The central and regional offices of CMS are responsible for MA subcontracts. CMS must approve annual benefit plans, premiums, and cost-sharing amounts.

- HMO – A type of health plan that is run by an insurance company or corporation that contracts with a network of doctors, hospitals, and other health care providers. The HMO contracts with Medicare to provide all Medicare services to Medicare beneficiaries that join the plan. The HMO receives a set amount of money from Medicare for each member of the plan.
- PSO – A group of doctors, hospitals, and other health care providers that agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. This type of health plan is run by the doctors and providers themselves, and not by an insurance company.
- PPO – You pay less if you use doctors, hospitals, and other health providers that belong to the plan's network. You pay more if you use similar services outside of the established network.
- SNP – SNP's provide focused and specialized health care for specific groups of people. Typically, those that have both Medicare and Medicaid, those who live in nursing homes, or have certain chronic medical conditions.

Medicare Advantage plans have become significantly more popular and there are generally more plans available to choose from. Additionally, any out of pocket costs will vary from plan to plan and can depend on a number of variables. For example, will the plan charge a premium or help with Medicare Part B premiums? Will the plan have a yearly deductible and / or how much will the copayment or coinsurance will be for each service visit in the plan? There are other variables to consider too such as the pan's yearly limit on out of pocket costs for all medical services. With that being said, benefits

counselors need to review how the MA plan defines terms and what the amounts are in order to better help a person compare costs between plans.

Question:

Medicare Advantage health plan refers to any Medicare plan option that is a contract between a private insurance company or corporation and the Medicare program. If a person joins a Medicare Advantage health plan, they are considered to be out of Original Medicare.

True \_\_\_\_\_ False \_\_\_\_\_

- 40. How Medicare Advantage health plans work.** To join a MA plan, the beneficiary must reside in the MA's service area (designated by county or ZIP code), must have both Medicare Part A and Part B, and must not have end stage renal disease (ESRD.) If a beneficiary develops ESRD after enrolling in the MA, coverage would continue and that person would have a right to continued coverage with another Medicare Advantage plan should their plan decide to end coverage. A Medicare Advantage plan cannot exclude an otherwise eligible applicant because of preexisting conditions other than

ESRD. To find out if a Medicare Advantage plan is available in a given area, contact TDI at 1-800252-3439, or Medicare at 1-800-633-4227 or [www.medicare.gov](http://www.medicare.gov).

To control costs, the MA plan contracts with health care providers to furnish all necessary services. These providers make up the MA's "network." Generally, members must obtain services from providers in their MA's network. Members choose a primary care physician (PCP) from the MA's network list of participating doctors. The PCP either delivers or authorizes all of the member's care. This means a member must have a referral from their PCP to see a specialist. In most cases, the specialist must also be in the MA's network. Members who obtain medical care from providers not in the MA's network or without a referral from their PCP may have to pay the full cost of the care they receive themselves. Exceptions are made for emergency care.

- 41. Out-of-pocket costs with Medicare Advantage health plans.** The beneficiary must continue paying the Medicare Part B premium, which usually is deducted from the beneficiary's Social Security check. Some Medicare Advantage plans then charge an additional monthly premium while others charge nothing. There is also a fixed copayment each time a medical service is provided.

Although assignment relates only to Original Medicare, some of the Medicare Advantage plans have additional excess fees that can be charged to the member. Similarly, there is a significant shared copayment for durable medical equipment for failure to pre-notify the plan. While most Medicare health plans do not charge excess fees, they can deny payment of a service if it was not medically necessary or if the service was a non-emergency and obtained from an out-of-network provider. Like the copayments in MA plans, members must pay for these excess charges out of their own pockets.

- 42. Identifying Medicare Advantage benefits.** The companies that contract with Medicare can change benefits and copayments each year. The Medicare website allows consumers to compare benefits amounts, copayments, and deductibles for Medicare Advantage plans in their area. To learn which providers are in a MA plan network, consumers must obtain an application packet from the plan or

may in some cases, visit the plan's website. The Medicare website provides a toll-free number for each MA plan option available and may list a web address if one is available.

- 43. More about how Medicare Advantage plans work.** When a Medicare beneficiary joins a MA, the beneficiary leaves Original Medicare. Medicare Advantage plans differ from Original Medicare in several ways, including:

- Medicare Advantage plan withdrawals - Medicare Advantage plans decide each year whether to stay in or withdraw from the Medicare market. If a plan withdraws from the market, its members are automatically returned to Original Medicare at the end of the fiscal year. Members may join another health plan, if one is available in their area. If another plan is not available, beneficiaries can consider purchasing a Medicare supplement policy to cover the gaps in Original Medicare. When a MA plan withdraws from the market, it must notify its members in writing about options available through remaining MA plans and their right to buy Medicare supplement insurance plans A, B, C, F, high deductible F, K or L. If a member has not moved into another Medicare Advantage plan by January 1, the beneficiary is automatically returned to Original Medicare. The right to buy Medicare supplement policy plans A, B, C, F, high deductible F, K or L, lasts for 63 days and requires that the companies sell the policy without regard to preexisting conditions or wait periods.
- Words like "assignment," "excess charge," and "Medicare-approved rate" that apply to Original Medicare do not apply to MA plans. The application packet for a MA plan and the member's

"evidence of coverage," sometimes referred to as the member handbook, will include definitions and terms that apply to the MA plan.

- When the beneficiary is outside of the service area, MA plans pay only for emergency care and urgently needed care. Be aware that there are review procedures in place for services that may be initially denied coverage. This could be a problem if the member travels frequently. A member can be dropped from the plan if they leave the service area for 90 consecutive days.
- Although a MA plan might offer prescription coverage, this does not mean that a member can get any brand name prescription they choose. MA plans have lists of prescriptions that they will cover. This list is called the plan's "drug formulary." Upon request, the plan must disclose whether a specific drug is on its formulary. The plan must pre-notify members about change to its formulary, which can take place during the year.
- Since health care in a MA plan must be provided or authorized by a member's PCP, the member cannot see a specialist without a referral from the PCP. If a specialist is not available in the network, the plan may refer the member to a specialist outside the network. The plan would be responsible for covering the costs of the specialist.
- Medicare Advantage plan members do not have to file claims when they receive care. The member is only responsible for paying the copayment amount. The provider, not the member, is responsible for collecting reimbursement from the plan for the services.
- Medicare Advantage plan members do not need other insurance to supplement their MA plan.
- **Additional benefits.** Some Medicare Advantage plans may provide more benefits than Original Medicare. These could include dental care, prescriptions, hearing aids, and eyeglasses. The MA plan may charge an additional premium for added benefits. Also, remember that MA plans can change their benefits each year when their contract with CMS is renewed. A MA plan that offers an added benefit, such as prescription drug coverage, can later drop that benefit.

**44. How to get the most from a Medicare Advantage health plan.** Members should:

- **Read the plan booklet.** Tell consumers to keep the HMO telephone numbers handy (usually located on the back of their member card) and to learn how regular appointments, referrals, and emergency care are handled.
- **Be clear about coverage for emergency care received at non-MA facilities ("out-of-plan facilities").** A MA must pay for emergency care wherever it is received. Members must make

sure they understand how the plan defines emergency care. Ultimately, however, the member is the judge of whether a situation is an emergency. The plan must approve or deny requests from a treating doctor within one hour for services following emergency treatment and stabilization. The plan should be notified as soon as possible that a member is receiving emergency care in an out-of-plan facility. Outside the service area, care for life-threatening conditions and other urgently needed care is covered. "Urgently needed care" will be defined in the member handbook.

- **Know how to file a complaint.** Members should first try to resolve any issues or concerns with their primary care physician. If the issue cannot be resolved at the doctor level, the member should file a written complaint with the MA plan administrator or customer service representative. Recent trends show that network provider problems have included limited access to doctors, greater travel distances for specialists or other services, and delayed appointments for referrals to specialists. While some of these issues can impact the quality of care, at times it may be necessary to address the issue from the perspective of access to care. MA plans are required to have adequate provider networks. Frequently, having the member or a benefits counselor question an action, or asking for a review, can change the response of the plan. A member also has the right to change their PCP. Inpatient hospital complaints regarding services would be processed through the IRO. Although TDI does not have authority over Medicare Advantage complaints, a HICAP representative may be able to assist the benefits counselors who have questions about complaints.
- **Know how to file an appeal.** Federal regulations require that Medicare Advantage plans provide appeals procedures for members. The member should ask the doctor to explain why a service was received or not received. If treatment was denied, find statements in the member handbook (evidence of coverage) that would lead the member to believe it should be covered. A denial of service outside the hospital setting would be filed directly with the plan.  
Benefits counselors can seek the assistance of the Legal Hotline for Texans to assist members with an appeal.
- **Know how to disenroll from a Medicare Advantage Plan.** To withdraw (disenroll) the member should notify the plan. It is important that alternate coverage be secured before leaving a Medicare Advantage plan. Additionally, health plans can close enrollment outside of the mandated annual open enrollment period under certain circumstances. There are special circumstances under which the above rules can be waived for a beneficiary. In addition to the new fall open enrollment dates, there is a new Medicare Advantage disenrollment period from January 1 through February 14.

- **Medicare Advantage plans must have procedures for continued coverage of "special circumstance" patients if the plan terminates its contract with a provider.** The plan must continue to pay the provider to treat the special circumstance patient for up to 90 days after the termination date. Special circumstances include acute or life-threatening conditions and terminal illness as determined by the treating physician.
- **Patient rights under a Medicare Advantage health plan.** Federal law requires that health plans inform their members about the grievance and appeals process. Specific information about grievances and appeals is contained in the member handbook.
- As advocates, benefits counselors can help members navigate getting services from their plans by helping them understand the importance of following the plan's rules for obtaining services. When a problem arises the first thing to do is to determine if the issue is a complaint/grievance (such as a fraudulent enrollment) or an appeal for denied services. The next step is to follow the process to address the problem.
- The Medicare Advantage appeal process is different from Original Medicare in that it allows for expedited appeals. Both grievances and appeals are most effective when in writing. Benefits counselors who establish contacts with MA plans operating in their area can frequently help resolve complaints or grievances on behalf of their clients without going through the written process. Health Law Program staff at Texas Legal Services Center will assist benefits counselors with difficult cases or will help elevate a complaint to the plan or CMS.
- There are various resources offered by CMS to address complaints. Besides calling 1-800MEDICARE, there is also an online complaint form that can be submitted to CMS.
- Once a complaint is submitted electronically, it is sent to the member's plan. The plan, not CMS, is supposed to follow-up with the member. Both consumers and benefits counselors get better responses from CMS if it is documented that the member followed the plans process and the plan did not address the problem in a timely manner or that the response was not adequate.

#### **45. Other information and resources regarding Medicare Advantage health plans.**

To find out if a MA health plan is available and to review benefits and costs use the Medicare website tool known as the Plan Finder. It will allow you to enter a ZIP code or county. You can also call 1800-MEDICARE, give them the ZIP code, and ask them for the toll-free telephone number for each plan available. You would then call each plan and ask for a prospective member packet.



## Questions

The Medicare website tool known as the Plan Finder can be used to find out if a MA health plan is available and to review benefits and costs. True \_\_\_\_\_ False \_\_\_\_\_

Which does not apply within a Medicare Advantage health plan?

- A. \_\_\_\_\_ A person must have Medicare Part A and Part B to enroll.
- B. \_\_\_\_\_ An enrollee must use the plan's network of providers and needs a referral to see a specialist.
- C. \_\_\_\_\_ A person needs to review their plan every year during the open enrollment period.
- D. \_\_\_\_\_ A person should use the Medicare Summary Notice to review if charges were correctly billed.
- E. \_\_\_\_\_ All of the above.

**46. Medicare private fee-for-service plans.** A private fee-for-service (PFFS) plan is another option for some Medicare beneficiaries. PFFS is different from Original Medicare or a Medicare Advantage health plan. With a PFFS plan, CMS contracts with a private insurance company that agrees to provide all Medicare approved services to Medicare beneficiaries who join the plan. The contract defines a geographic service area by county or ZIP code. PFFS plans are different from managed care plan options because they allow beneficiaries to go to any doctor, hospital, or provider, as long as the provider agrees to the terms and conditions for reimbursement outlined by the PFFS plan. A beneficiary who joins the PFFS plan is no longer in Original Medicare and must follow the procedures and rules of the plan to receive their Medicare benefits. Members don't have a primary care physician to oversee their care, so they don't need a referral to go to a specialist.

CMS enters into a one-year contract with the PFFS contractor and approves the plan's benefits, premiums, and any other out-of-pocket costs that will be passed on to beneficiaries. CMS pre-pays a monthly fee for each beneficiary that enrolls in the PFFS. The PFFS plan assumes all claims processing to health providers that agree to Medicare approved services to members of the plan. The

amount of reimbursement to providers may be different from the Medicare approved amounts under Original Medicare. Additionally, the rules allow for PFFS plans to balance bill members.

- 47. Regulatory authority and sources of law.** Medicare PFFS plans have as their source of law 42 United States Code §1395w-28(b)(2). The Balanced Budget Act of 1997 authorized HHS and CMS to enter into contracts with insurance companies. As a Medicare Advantage option, the PFFS must develop a process for quality care improvement, appeals, and grievances. The plan is subject to the external quality monitoring by the same independent CMS contractors and the national agent for reconsideration of denials that monitors the Medicare Advantage managed care plans. The CMS regional office is responsible for state monitoring of the PFFS plan and the review of marketing and advertising materials is approved at the CMS central office.

Similar to Medicare Advantage managed care plans, PFFS plans must meet federal contracting requirements and be state-licensed entities. TDI does not have a formal role in the review of the PFFS application process, although the company offering the plan must meet licensing requirements as a company selling insurance in Texas. Beneficiary complaints, grievances, or appeals regarding the PFFS plan must be submitted through the process outlined by the PFFS plan. Issues related to excessively delayed payment of claims can be directed to TDI as these might be indicators of solvency issues which are under the authority of TDI.

- 48. How the PFFS plans cover the gaps in Medicare.** The PFFS plans agree to provide all Medicare approved services to beneficiaries that join the plan. The member will pay a monthly premium to the PFFS plan. The premium is different from the Medicare Part B monthly premium which the beneficiary continues to pay directly to Medicare.

The beneficiary will pay Medicare Part A and Part B copayments (fixed amounts dependent on the service received) and coinsurance (a percentage of the cost for each service). These costs are applied differently in PFFS plans than in Original Medicare. For example, inpatient care in Original Medicare, a deductible applies to each benefit period. In the PFFS plan, the same inpatient care applies a per admission copayment without regard to benefit period. Additionally, the PFFS plan requires pre-notification of any inpatient admission. The coinsurance in Original Medicare is 20 percent of the Medicare-approved cost. In the PFFS plan, the coinsurance can range from 20 to 70 percent of the PFFS approved amount. As with the copayment, there is an increased amount that can be applied for failure to notify the plan in advance of receiving service.

- 49. How does the Medicare PFFS plan work?** To join the PFFS plan, a person must reside in the plan's service area, have both Medicare Part A and Part B, and cannot have ESRD. The PFFS plan's contract with CMS is for one year. Each year, the PFFS plan decides whether to stay in or leave Medicare. If the plan leaves Medicare, members must either return to Original Medicare or join another Medicare Advantage plan. The PFFS plan is available in rural areas that most Medicare health care plans would not traditionally serve. The monthly premium, copayments, and coinsurance change at the start of each year.

The PFFS plan cannot exclude an otherwise eligible applicant because of preexisting conditions other than ESRD.

Enrollees can obtain services from any provider that accepts the plan's terms and conditions. The PFFS plan is responsible for payment directly to the physician or provider. The beneficiary pays a set copayment to the provider. Providers are reimbursed at different rates dependent on whether they decide to work with the plan as a contracted provider, also referred to as a "deemed" provider or provide a service as a "non-contracted" provider. Responsibility to identify providers willing to accept the plan currently falls to the member. The member is also liable for paying any non-covered Medicare services received from providers. The PFFS plan uses prior notification rules as a way to control cost. The beneficiary will be charged a higher copayment or coinsurance if they fail to get prior approval before receiving certain services. In some instances, if the PFFS plan determines that a service received was not "medically necessary," they will deny payment. An enrollee may appeal the denial.

- 50. Identifying the out-of-pocket costs for the PFFS option.** The beneficiary pays a fixed monthly premium. In addition, there are different copayment amounts based on the service received. A member could pay a higher copayment amount if they do not comply with the prior notification rules.

The PFFS plan could be costlier than other Medicare options for certain beneficiaries. People who require frequent hospitalization or use durable medical equipment, outpatient mental health services or home health services (50 percent coinsurance) would pay significantly higher out-of-pocket cost than some of the other Medicare options. A screening questionnaire that identifies the beneficiary's insurance coverages and needed medical service would help a person decide if this option is appropriate for their situation.

In general, this plan may be a suitable option for someone who is fairly healthy and does not use the higher cost services such as hospitalization and durable equipment. The premium for the PFFS plan is now comparable to the premium for a Medicare supplement Plan A for someone who just turned 65. A more important aspect of this plan is assuring that the doctors and other health providers become familiar with how the plan reimburses providers and that those providers are willing to work with the PFFS plan.

- 51. Identifying Medicare PFFS benefits.** The PFFS plan will cover all required Medicare services that are provided as medically necessary. This includes new preventive health exams. The only benefit enhancements beyond what Medicare covers is reimbursement for emergency care outside the United States and increased inpatient hospital days beyond what Medicare covers.

The member must pay an annual deductible before the plan pays for emergency care. In addition, there is a coinsurance of 20 percent that the member must also pay. There is a maximum annual limit for emergency care while out of the United States. The PFFS plan's benefits and costs are also available on the Medicare Plan Finder website. If a person resides in a PFFS area, the PFFS plan will be included in the comparison of plans.

- 52. More about how Medicare PFFS plans works.** When a beneficiary joins the PFFS plan, they leave Original Medicare. Following are aspects of the PFFS plan that are different from Original Medicare:

- Eligibility, enrollment, and disenrollment guidelines in the PFFS plan are the same as those in Medicare Advantage managed care plans. New dates and rules concerning changing from a Medicare Advantage plan to Original Medicare were effective January 2011;
- Since doctors and other providers can choose not to accept the plan's terms of payment, members should tell their provider before a service is rendered that they are in the PFFS plan. If a particular physician or provider does not accept the plan, the member will have to find another provider;
- Like in Medicare health care plans, it is important that members become familiar with the plan's member handbook that defines terms unique to the plan and outlines procedures for accessing services. Some members could be liable for paying higher costs if they frequently need services that have higher copayments, if they fail to comply with prior notification rules or cannot find providers that accept the PFFS plan;

- People who require treatment from specialists or other providers should confirm that the specialist and facility they use is also willing to accept the PFFS plan;
- Members in a PFFS plan may not have to file claims when they receive care. The legislation that authorized the PFFS plan allows plans the option to require enrollees to pay providers in advance and then to submit claims to the plan for reimbursement back to the member. The member is responsible for paying the copayment amount. PFFS plans allow "balance billing," which means that the beneficiary can be asked to pay up to 15 percent more than the plan's payment for that service;
- PFFS plan members cannot be in another Medicare Advantage plan or have a Medicare supplement policy while they are in the PFFS plan. If the member has group insurance, they will want to review how their group plan will coordinate with the PFFS plan.

**53. Members should know how to get the most from the PFFS plan.** To get the most from the PFFS plan, members should:

- **As with any new program, members should do their homework.** Find out by talking to friends, physicians, and providers if the PFFS plan is accepted in your area. If no one is familiar with the plan, ask the plan representatives to tell you which providers in your area have agreed to accept the plan.
- **Members should be clear about coverage for emergency and inpatient hospital care.** The PFFS plan cannot restrict enrollees to use a provider network or require a referral to see a specialist. The plan does require prior notification defined as an "advance coverage decision" before certain services are accessed. The plan can charge a higher copayment for not receiving prior notification or could deny coverage as not "medically necessary."
- **Members should know how to file a quality of care, or access to care complaint.** PFFS enrollees have the same grievance and appeals rights as Medicare health care plans. The member handbook that the plan must provide each enrollee will outline and identify how to file a complaint. Medicare Advantage options do not follow procedures used in Original Medicare. Providers can file complaints directly to the PFFS plan for non-payment of claims. The provider cannot collect reimbursement from the member unless the member continues to see a provider that will not contract with the plan. Any undue delay in payment to providers for what would otherwise be an approved Medicare claim, may be filed with the Texas Department of Insurance as nonpayment and could be an indication of solvency problems.

- **Members should know how to appeal decisions.** The PFFS plan must follow the appeals process for all Medicare Advantage plans. This process has three components and is detailed in the member handbook. The categories of appeals are: regular appeal for denial of service or payment; expedited appeal, which requires a determination within 72 hours; and hospital-related appeal, which is handled by the state's IRO. Benefit counselors can seek the assistance of the Health Law Program at Texas Legal Services Center as well as the Legal Hotline for Texans to assist members with an appeal.
- **Members should know how to get out of the PFFS.** To withdraw (disenroll) from the PFFS plan the member must notify the plan or the local Social Security office in writing. Before leaving a MA plan, it is important that alternate coverage be secured. The insurance company that offers the PFFS plan also sells a Medicare supplement insurance policy. The company has promoted the option to begin in the PFFS plan with the understanding that if the beneficiary ever wanted to get out of the PFFS plan they would have an automatic right to buy a Medicare supplement policy from this company.

54. **Members can access more information and resources on the PFFS plan.** To find out if the PFFS plan is available and details about the costs and benefits a member can visit the Medicare Plan Finder website. More limited information can be obtained by calling the Medicare toll-free hotline (800) 633-4227.

**Question:**

Which of the following individuals would not be a good candidate for the PFFS plan?

- A. \_\_\_\_\_ Newly enrolled beneficiary who is very healthy, does not have access to employer or group insurance, and is budgeting because there is a spouse who is not yet Medicare eligible.
- B. \_\_\_\_\_ A beneficiary who has frequent hospitalizations and is beginning to have memory loss.

55. **CMS Reading Resources:**

- *Medicare & You* - Annual publication that outlines available Medicare Advantage plans and new changes to Medicare.
- *Choosing a Medicare Health Plan: A Guide for People with Medicare* – Worksheet-type brochure that describes different Medicare Advantage plans. The brochure is organized in a question

and answer format and requires the client to gather information that will help them make an informed choice about options. It is recommended as a training overview on how to assist client's to review their options. It is available at: <https://www.mymedicare.gov/>.

- *Medicare Health Plan Nonrenewal Fact Sheet* – General overview on the Medicare HMO termination process and steps to follow.
- *Your Medicare Rights & Protections* – This brochure outlines Medicare basic benefits and rights needed to better understand if an issue should be considered a justified denial, a complaint, or a grievance. This publication is recommended as a training overview to help benefits counselors research steps to follow to resolve a client's concern.

### **Other print resources and contacts**

- **Publications and periodicals from the Medicare Rights Center.** The MRC is a national nonprofit organization devoted to advocacy on behalf of Medicare beneficiaries. MRC has served as the state SHIP for the state of New York, making their information very timely on current issues related to Medicare. Learn more at their website: <http://www.medicarerights.org/> or call the toll- free number 1(800) 333-4114.

Chapter 5  
Questions

1. Which of the following are considered Medicare out-of-pocket costs?

- A. \_\_\_\_\_ Medicare Part A and Part B premiums.
- \_\_\_\_\_ B. Copayments and coinsurance.
- \_\_\_\_\_ C. Deductibles.
- \_\_\_\_\_ D. Cost of services that Medicare does not cover.
- \_\_\_\_\_ E. All of the above.

2. Which is true of Medigap policies?

- A. \_\_\_\_\_ There are 10 standard plans.
- \_\_\_\_\_ B. There are high deductible versions of all 10 plans.
- \_\_\_\_\_ C. Medigap policies are sold and regulated by the federal government?
- D. \_\_\_\_\_ Medigap policies are guaranteed renewable which means the price can never increase.

3. Before buying a Medicare supplement policy, the beneficiary should:

- A. \_\_\_\_\_ Make sure that they have Medicare Part A and Part B.
- B. \_\_\_\_\_ Review their entitlement to group insurance through their employer or to a retirement plan from their former employer.
- \_\_\_\_\_ C. Find out if they qualify for the Medicare Savings Programs.
- \_\_\_\_\_ D. Find out if there is a Medicare Advantage option available.
- \_\_\_\_\_ E. All of the above.



4. The Medicare supplement high deductible Plan F requires that the beneficiary first pay the annual deductible (\$2,300 in 2019) before the plan pays any of the costs.

True                      False

\_\_\_\_\_

5. In Texas, a person with disabilities under age 65 has a six-month open enrollment period, just like people over 65, and may buy any Medicare supplement plan regardless of any preexisting conditions.

True                      False

\_\_\_\_\_

6. A person, who is still working when they become eligible for Medicare, can delay enrollment in Medicare if their employer allows it.

True                      False

\_\_\_\_\_

7. A Medicare Advantage health plan refers to any Medicare plan option that is a contract between a private insurance company or corporation and the Medicare program. If a person joins a Medicare Advantage health plan, they are no longer in Original Medicare.

True                      False

\_\_\_\_\_

8. The Medicare Plan Finder can be used to find out if a MA health plan is available and to review benefits and costs

True                      False

\_\_\_\_\_

9. Which does not apply to a Medicare Advantage health plan?

A.                      A person must have Medicare Part A and Part B to enroll.

\_\_\_\_\_

An enrollee must use the plan's network of providers and needs a B. referral to see a specialist.

\_\_\_\_\_

C. \_\_\_\_\_ A person needs to review their plan every year during the open enrollment period.

\_\_\_\_\_

D. \_\_\_\_\_ A person should use the Medicare Summary Notice to review if charges were correctly billed

\_\_\_\_\_ E. All of the above.

10. Which of the following individuals would not be good candidates for the PFFS plan?

A newly enrolled beneficiary who is very healthy, does not have access to employer or group insurance, and is budgeting because their A. spouse is not eligible for Medicare.

\_\_\_\_\_

B. \_\_\_\_\_ A beneficiary who has frequent hospitalizations and is beginning to have memory loss.

#### Chapter Six Answers

1. E
2. A
3. E
4. True
5. False
6. True
7. True
8. True
9. D

10. B

## Chapter 6

### **“Medicare Savings Programs” (QMB, SLMB, QI), and QDWI**

Scope of chapter. This chapter deals with four programs. Three of them are sometimes referred to as the “Medicare Savings Programs.” These three are the Qualified Medicare Beneficiary Medicaid Program (QMB), the Specified Low-Income Medicare Beneficiary Medicaid Program (SLMB), and the Qualified Individual Program (QI). A fourth program that uses the same income exclusions and deductions is the Qualified Disabled Working Individual Program (QDWI). In addition to providing help with certain Medicare costs, the first three of these programs (QMB, SLMB, QI) have this feature: Eligibility for QMB, SLMB, and QI means the Medicare beneficiary has eligibility for the low-income subsidy – the “extra help” – in regard to Medicare Part D (the Medicare prescription drug program). Eligibility for QDWI may allow eligibility for the low-income subsidy, if the countable income of person eligible for QDWI is below 150% of the federal poverty income limit. Paragraph 12 contains a chart with income limits for the Medicare Savings Programs. This chapter contains several hyperlinks. Certain of the hyperlinks are necessarily to broader sections of background material (such as to a full statute section). This means that locating the exact point of reference (such as a sub-section or paragraph in a statute) may require scrolling once the hyperlink is accessed.

Chapter questions and answers. After some of the paragraphs there are questions relating to the materials covered in the paragraphs. An answer key is at the end of the chapter.

#### Overview of paragraphs.

- Paragraph 1 discusses the sources of law for the Medicare Savings Programs.
- Paragraph 2 provides a brief overview of the Medicare Savings Programs.
- Paragraph 3 discusses the role of the Social Security Administration’s Program Operations Manual System (POMS) in determining what resources and income count for eligibility in the Medicare Savings Programs.
- Paragraphs 4 and 5 discuss certain points regarding the Medicare Savings Programs.
- Paragraph 6 includes a discussion of what resources do and do not count, using the Qualified Medicare Beneficiary Medicaid Program as the context to describe the treatment of resources.
- Paragraphs 7 through 9 discuss the other two Medicare Savings Programs, and also the QDWI program, including the varying income limits for these programs.
- Paragraphs 10 through 15 discuss how countable income is determined, and what the income limits are for the different Medicare Savings Programs.
- Paragraphs 16 through 24 discuss the benefits under the Medicare Savings Programs, and QDWI.

- Paragraphs 25 and 26 discuss the application and appeals process.
- Paragraphs 27 through 32 address the relationship between the Medicare Savings Programs and Medicare Supplement Insurance (“Medigap”), including:
  - The right of Medicaid recipients to a 24-month suspension of a Medigap policy, and
  - The requirement that Medigap policies not duplicate Medicaid benefits.
- Paragraphs 33 and 34 provide information about some additional sources of assistance in serving clients. As with other programs administered by the State of Texas, [www.yourtexasbenefits.com](http://www.yourtexasbenefits.com) is a Web site to explore eligibility and through which an application can be submitted.

Back-up and support. Any Benefits Counselor who has questions about the information in this chapter can call the Legal Hotline for Texans at the Benefits Counselor support number for further information. In certain paragraphs, Web sites are identified. Once the reader has located the level of a Web site page or link that the reader will be using time and again, the reader can, of course, bookmark that Web location.

#### 1. **Sources of law.**

- a. The Medicaid law is Title XIX of the Social Security Act. It is sometimes called “Title Nineteen,” and when it is referred to in that manner, the reference is to Title XIX of the Social Security Act. The Medicaid law is *codified* at 42 United States Code Section 1396.
- b. When a Public Law is said to be “codified” that means it has been assigned a place in the United States Code. The United States Code may be abbreviated as “U.S.C.” The Medicaid law – codified at 42 U.S.C. §1396 – has *extensive* subparagraphs. For that reason, the particular part(s) of the federal Medicaid law that may bear on an individual’s case may have several lower and upper case letters, and several numbers. The definitions of individuals covered by the programs discussed in this chapter are located at these sections of the U.S. Code:

- QMB: [42 U.S.C. §1396d\(p\)\(1\)](#).
- SLMB: [42 U.S.C. §1396a\(a\)\(10\)\(E\)\(iii\)](#).
- QI: [42 U.S.C. §1396a\(a\)\(10\)\(E\)\(iv\)](#).
- QDWI: [42 U.S.C. §1396d\(s\)](#).

Note: Once at the links above, one scrolls to the particular subsection. The federal Medicaid law ([42 U.S.C. §1396 et seq.](#)) requires that states operate their Medicaid programs under a State Medicaid Plan, which is a very extensive document. The

- Texas State Medicaid Plan is available on the Internet at <https://hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/stateplan>
- c. Benefits Counselors who want assistance in obtaining the part(s) of the State Medicaid Plan or the parts of the federal Medicaid law that bear on a case, can call the Benefits Counselor support number at the Legal Hotline for Texans.
  - d. The Texas state statute which authorizes the Medicaid program is Chapter 32 of the Texas Human Resources Code. The state Medicaid administrative rules for the programs discussed in this chapter are found at [1 Texas Administrative Code Chapter 359](#). The Texas Administrative Code can be accessed directly through the Web site of the Texas Secretary of State, at <http://www.sos.texas.gov/tac/>.
  - e. The federal Medicaid law requires states to provide Medicaid for low-income families, for persons receiving SSI, and for persons qualifying for Title XIX long-term care (“Nursing Facility Medicaid”). The law also requires states to provide a limited type of Medicaid for certain low-income persons who are enrolled in Medicare. These persons are called “dual eligibles.” The programs they qualify for are now called “Medicare Savings Programs.” States are not required to participate in Medicaid, but if they do, they are required to follow the federal Medicaid law (42 U.S.C. §1396). All states were participating in the Medicaid program as of January 1, 2019.
  - f. The Medicare Improvements for Patients and Providers Act of 2008, which is Public Law 110-275, was enacted by the 110<sup>th</sup> Congress in July of 2008. It is sometimes abbreviated “MIPPA.” MIPPA included certain provisions regarding the Medicare Savings Programs. Most of these provisions took effect in 2010. One provision though, that had immediate effect in 2008, was the extension of the Qualifying Individual Program (“QI”). QI is the only one of the four programs discussed in this chapter that is not an entitlement, and so from time to time, Congress extended the QI program. However, that changed with the most recent extension in April of 2015, when Congress permanently extended the program with Section 211 of Public Law 114-10 (“Medicare Access and CHIP Reauthorization Act of 2015”). The most recent extension of the authorization of the QI program is codified at 42 U.S.C. §1305.
  - g. The state laws referred to in this chapter are accessible through the website <http://www.statutes.legis.state.tx.us/>. State administrative rules are codified by the Texas Secretary of State in the Texas Administrative Code, which is at <https://www.sos.state.tx.us/tac/>. Federal statutes are codified in the United States Code, which is at <http://www.gpo.gov/fdsys/browse/collectionUSCode.action?collectionCode=USC> [ODE](http://www.gpo.gov/fdsys/browse/collectionODE.action?collectionCode=ODE) and <http://uscode.house.gov/search/criteria.shtml>. Federal administrative rules are codified in the Code of Federal Regulations, which is at <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR>.

Questions regarding sources of law (circle the correct answer):

- i. The Medicaid law is Title XIX of which Act?
  1. The National Recovery Act
  2. The False Claims Act
  3. The Social Security Act
  4. The Data Quality Act
  
- ii. The federal Medicaid law requires that states operate their Medicaid program under (circle the correct answer).
  1. A State Medicaid Plan
  2. An Interstate Compact
  3. A State Sunset Law
  4. An Interstate Non-Compete Agreement
  
- iii. The Texas Administrative Code Sections pertaining to the Medicaid program can be accessed directly through the Web site of the (circle the correct answer).
  1. Texas Department of Agriculture
  2. Canadian River Municipal Water Authority
  3. Texas Drought Preparedness Council
  4. Texas Secretary of State
  
- iv. The law that was enacted by the 112<sup>th</sup> Congress, by the “American Taxpayer Relief Act of 2012,” extended the QI program to (circle the correct answer).
  1. December 31, 2023
  2. December 31, 2043
  3. December 31, 2013
  4. December 31, 2025

2. **Medicare Savings Programs.** There are three Medicare Savings Programs: Qualified Medicare Beneficiary Medicaid (QMB); Specified Low-Income Medicare Beneficiary Medicaid (SLMB); and Qualifying Individual (QI). The Qualified Disabled Working Individuals program (QDWI) is not a “Medicare Savings Program,” although it does use the same income exclusions and deductions as the Medicare Savings Programs. All four of the programs only assist persons who enroll or have already enrolled in Medicare. If a

person is eligible to enroll in Medicare but has not done so because of the cost-sharing expense (such as the premium expense), the person can enroll as part of the steps in achieving eligibility for one of the Medicare Savings Programs. This may require coordination between the state Medicaid program and the Social Security Administration. Persons who achieve eligibility for a Medicare Savings Program or for the Qualified Disabled Working Individuals Program are sometimes referred to by the abbreviation for their particular Medicare Savings Program. The Medicaid benefits that QMBs, SLMBs, QIs, and QDWIs receive are limited. The benefits are payment of some or all of the Medicare cost-sharing amounts (premiums, co-insurance, and deductibles). In Texas, all of the Medicare Savings Programs and QDWI have always been exempt from what is called “Medicaid Estate Recovery.” Persons who are eligible for QMB, SLMB, or QI are also considered to have met the eligibility requirements for the “extra help” (the low income subsidy) under Medicare Part D. Persons who qualify for QDWI and whose income is less than 150% of the federal poverty income limit can qualify on the basis of their income for extra help.

Questions regarding the Medicare Savings Programs (circle the correct answer):

i. To receive the help of the Medicare Savings Programs, a person needs to enroll or be enrolled in Medicare.

5. True

6. False

ii. In Texas, all of the Medicare Savings Programs are exempt from Medicaid Estate Recovery.

1. True

2. False

iii. Persons who are eligible for QMB, SLMB, or QI are eligible for “extra help” under Medicare Part D.

1. True

2. False

3. **The role of the Social Security Program Operations Manual System (“POMS”).** The provisions of the Social Security Program Operations Manual System (“POMS”) that relate to SSI’s treatment of income and resources can be useful in resolving intricate questions concerning how income and/or resources are treated under the Medicare Savings Programs in Texas. The POMS can be accessed at the Web site of the Social Security Administration – [www.ssa.gov](http://www.ssa.gov). The direct link to the POMS is <https://secure.ssa.gov/apps10/poms.nsf/partlist!OpenView>. (“SI” – the Supplemental Security Income area of the POMS – is the area that is most used in connection with



Medicaid program.) SI 011 is the area of the POMS that deals with what counts as a resource under SSI (and hence, under the Medicare Savings Programs and under other Medicaid programs). In addition to being useful for the Medicare Savings Programs and other Medicaid programs, the POMS' primary purpose is to provide detailed treatment of the SSI programs and of the Social Security benefit programs.

4. **Relationship between Supplemental Security Income (SSI) and regular Medicaid in Texas.** It is important to keep in mind that in Texas, every person who receives *any* amount of SSI – so little as one dollar – also receives regular Medicaid. A recipient of regular Medicaid who is a Medicare beneficiary receives the benefits of the Qualified Medicare Beneficiary Medicaid (QMB) program as part of the regular Medicaid program. Thus, knowledge of the POMS can help the advocate to represent persons seeking SSI. Qualifying for SSI means eligibility for regular Medicaid, in Texas. For a Medicare beneficiary, the benefits of regular Medicaid include the benefits of QMB.
5. **Two further points about the Medicare Savings Programs and the SSI program in regard to resources.** Unlike the SSI program, there is no penalty for giving away property to qualify for any of the Medicare Savings Programs. Also, under the Medicare Savings Programs, if only one spouse of a couple has Medicare, the couple general resource exclusion nonetheless is used, not the individual general resource exclusion.
6. **Qualified Medicare Beneficiaries (QMBs).**
  - a. A QMB is an aged or disabled Medicare beneficiary who has: (1) income at or below the Federal poverty line; and (2) resources not more than the maximum allowed under [42 U.S.C. §1395w-114\(a\)\(3\)\(D\)](#) (thus, effective March 1, 2019, \$7,730 for an individual and \$11,600 for a couple). Inasmuch as all the Medicare Savings Programs use the same resource exclusions, a review of the resource exclusions under QMB is pertinent. These resource exclusions also apply to SLMB, QI, and QDWI. There is a list of excluded resources at POMS SI 01110.210. The most frequently encountered excluded resources will be the homestead, a vehicle used for transportation regardless of year, make, model, or value, household goods and personal effects, separately identifiable burial funds up to \$1,500 and burial spaces. Under [42 U.S.C. §1395w-114\(a\)\(3\)\(G\)](#), no part of the value of any life insurance policy is to be taken into account in determining eligibility for QMB. Under the POMS, these resources are excluded:
    - i. The home serving as the principal place of residence, including the land on which the home stands and other buildings on that land. Thus, the homestead is excluded, regardless of value, number of rooms, size of dwelling, and regardless of acres (as long as the land is all contiguous with the land that the dwelling sits on);

- ii. Funds from the sale of a home, if reinvested timely in a replacement home (within three full calendar months of receipt of the funds (POMS SI 01130.110));
- iii. Jointly-owned real property which cannot be sold without undue hardship (due to loss of housing) to the other owner(s);
- iv. Real property for so long as the owner's reasonable efforts to sell it are unsuccessful;
- v. Restricted, allotted Indian land if the Indian/owner cannot dispose of the land without permission of other individuals, his/her tribe, or an agency of the Federal Government;
- vi. One vehicle used for transportation;
- vii. Burial space or plot held for an eligible individual, his/her spouse, or member of his/her immediate family (this is in addition to, and has no effect on, the burial funds exclusion (POMS SI 01130.400 A. 2.));
- viii. Separately identifiable burial funds of \$1,500 for the applicant and the applicant's spouse (POMS SI 01130.300 B. 4.);
- ix. Certain prepaid burial contracts;
- x. One vehicle used for transportation (regardless of year, make, model, or value);
- xi. Household goods and personal effects;
- xii. Property essential to self-support;
- xiii. Stock held by native Alaskans in Alaska regional or village corporations effective January 1, 1992 when the stock becomes a resource;
- xiv. Retained retroactive SSI or RSDI benefits;
- xv. Dedicated accounts;
- xvi. Restitution payments for misused Title II, Title VIII, and Title XVI benefits;
- xvii. Radiation Exposure Compensation Trust Fund payments;
- xviii. German reparations payments made to World War II Holocaust survivors;
- xix. Austrian social insurance payments;
- xx. Japanese-American and Aleutian restitution payments;
- xxi. Federal disaster assistance received on account of a Presidentially declared major disaster, including interest accumulated thereon;
- xxii. Cash (including accrued interest) and in-kind replacement received from any source at any time to replace or repair lost, damaged, or stolen excluded resources;
- xxiii. Certain items excluded from both income and resources by other Federal statutes;
- xxiv. Agent Orange settlement payments to qualifying veterans and survivors;
- xxv. Victim's compensation payments;
- xxvi. State and local relocation

assistance payments; xxvii. Tax refunds related to Earned Income Tax Credits; xxviii. Grants, Scholarships, Fellowships, and Gifts; xxix. Ricky Ray Hemophilia Relief Fund; xxx. Payments to Veterans' Children with Certain Birth Defects; xxxi. State Annuities for Certain Veterans.

- b. As mentioned above, the most frequently encountered excluded resources will be the homestead, a vehicle, household goods and personal effects, and separately identifiable burial funds up to \$1,500, and burial spaces. But as the list above shows, there are many additional resources which, from case to case, can be excluded. The chart at [POMS SI 01110.210](#) has links to more details regarding some of the more seldom encountered excluded resources. The Medicare Savings Programs' resource limits were affected by Sections 112 and 115 of the Medicare

Improvements for Patients and Providers Act of 2008 (Public Law 110-275) (MIPPA). Section 112 of MIPPA provided that, as of January 1, 2010, the resource limits for QMB will be the same as the resource limits for resources in the Low-Income Subsidy of the Medicare Prescription Drug Program ("Medicare Part D"). 42 U.S.C. §1396d(p)(1)(C). Thus, the resource limits for QMB will be the same as those for the Low-Income Subsidy (LIS) found at [42 U.S.C. §1395w114\(a\)\(3\)\(D\)](#), and they will be indexed for inflation. (Section 112 of MIPPA refers to 42 U.S.C. §1396(p)(1)(C), which is the resource limit for QMB. The sections of the U.S. Code that define SLMBs and QIs – 42 U.S.C. §§1396a(a)(10)(E)(iii) and (iv)(II) – appear to incorporate the QMB resource limits, so this MIPPA change also applies to SLMB and QI eligibility.) Section 115 of Public Law 110-275 amended 42 United States Code §1396p(b)(1)(B)(ii), so as to prohibit from January 1, 2010 onward, the use of estate recovery regarding benefits under the Medicare Savings Programs. (Texas never exercised the option to use estate recovery in regard to the Medicare Savings Programs.) It should be noted that the QDWI program does not use LIS resource limit, but rather uses twice the SSI resource limit of \$4,000 for an individual and \$6,000 for a couple, after using the exclusions available under SSI. This resource limit for QDWI is specified at [42 U.S.C. §1396d\(s\)\(3\)](#).

- c. To meet the QMB eligibility definition, the person must be entitled to Medicare Part A. Included is the relatively small group of aged persons who are not automatically entitled to Part A coverage, but who have bought (or could buy) Medicare Part A protection by paying a monthly premium. Not included in QMB are "Qualified Disabled Working Individuals" (QDWIs). Under 42 U.S.C. §1395i-2a, these individuals remain eligible for Medicare. They are individuals who have lost entitlement to Social Security Disability Benefits because they have earnings that exceed the "Substantial Gainful Activity" (SGA) threshold. (In 2019, this threshold is \$1,220 monthly income for a disabled person who is not blind, and \$2,040 monthly income for a person who meets the blindness criteria

of Social Security. See the Social Security Administration's Fact Sheet at <https://www.ssa.gov/oact/cola/sga.html>.) A person can be eligible for Medicare due to age (65); disability (receipt of 24 months of Social Security disability benefits which allows for Medicare eligibility with the 25<sup>th</sup> month), blindness, or due to end-stage kidney disease or amyotrophic lateral sclerosis (Lou Gehrig's disease).

- i. For QMBs, Medicaid is required to pay Medicare premiums and cost sharing charges as follows: (1) Part B monthly premiums; (2) Part A monthly premiums paid by the limited number of persons not automatically entitled to Part A protection; (3) coinsurance and deductibles under Part A and Part B including the Medicare hospital deductible, the Part B deductible, and the Parts A and B coinsurance; and (4) coinsurance and deductibles that Medicare Advantage plans charge their enrollees.

Questions regarding QMB (circle the correct answer):

- i. Only persons who are sixty-five (65) years of age can qualify for QMB, because there is no basis for qualifying for Medicare for persons who are not yet sixty-five (65).
  1. True
  2. False
- ii. If a person eligible for QMB has to pay a premium for Medicare Part A QMB will pay the Medicare Part A and Part B premiums.
  1. True
  2. False

**7. Specified low-income Medicare beneficiaries (SLMBs).**

- a. Medicaid is also required to pay Medicare Part B premiums for SLMBs. These are persons meeting the QMB criteria except that their income is slightly over the QMB limit. The resource limits for SLMB are the same as for QMB, detailed in paragraph 6 above. The SLMB resource limits, effective March 1, 2019, thus are \$7,730 for an individual and \$11,600 for a couple. The SLMB income limit is 120 percent of the Federal poverty line. SLMB is limited to payment of the Medicare Part B premiums.
- b. The benefit of SLMB is payment of the Medicare Part B premium. Although this is the same benefit as the Qualifying Individual (QI) program has, there is this difference: SLMB is an entitlement program. QI is not an entitlement program, and whether it will be available depends on Congress periodically reauthorizing

it (as Congress most recently did on December 31, 2012, by mean of Section 621 of Public Law 112-240).

Questions regarding SLMB (circle the correct answer):

- i. What one statement is true about the homestead exclusion under SLMB?
  1. The house cannot have more than one bathroom.
  2. The lot cannot be more than one typical city lot in size.
  3. If the applicant owns a lot in northeastern Louisiana as well as the house and lot in Texas, both lots can be considered part of the excluded homestead.
  4. There is no limit on the value, number of rooms, size of dwelling, nor number of acres, but the only land that can be excluded is land that is contiguous with the land on which the homestead dwelling sits can be excluded (along with the dwelling).
- ii. What one statement is true of the vehicle exclusion under SLMB?
  1. To be excluded, the vehicle must be made in America.
  2. To be excluded, the vehicle cannot have more than two doors.
  3. One vehicle used for transportation regardless of year, make, model, or value, is excluded.
  4. To be excluded, the vehicle cannot be newer than five years old.

8. **Qualifying individuals (QIs).** The Balanced Budget Act of 1997 required State Medicaid Programs, effective January 1, 1998 through December 31, 2002, to pay Part B premiums for beneficiaries with incomes of less than 135 percent of poverty. These persons are referred to as QIs. The resource limits for QI are the same as for QMB, detailed in paragraph 6 above. The QI resource limits, effective March 1, 2019, thus are \$7,730 for an individual and \$11,600 for a couple. The QI income limit is income less than 135 percent of the Federal poverty line. QI is limited to payment of the Medicare Part B premiums. The QI program is codified at [42 U.S.C. §1396a\(a\)\(10\)\(E\)\(iv\)](#). Unlike the other Medicare Savings Programs, QI is not an “entitlement” and hence Congress from time to time has extended it. The QI program’s benefit is the same as the benefit of the SLMB program – payment of the Medicare Part B premium. And historically, Congress, from time to time, had to extend the program because QI is a block grant funded program. This simply means that Congress approves limited amounts of funds (block grant) to each state to pay for QI beneficiaries. Once the states deplete the QI funding, financial support for eligible QI individuals ends. However, in 2015, Congress passed the Medicare Access and CHIP Reauthorization Act which permanently funds the QI program and therefore there is no further need for reauthorizations. Please see <https://www.gpo.gov/fdsys/pkg/PLAW-114publ10/pdf/PLAW-114publ10.pdf>. Just as

under QMB and SLMB, the QI general resource exclusion (after excluding those resources that do not count) is LIS general resource exclusion. QI excludes the same resources as QMB and SLMB.

Questions regarding QI (circle the correct answer):

- i. Under QI, there is no exclusion from resources for any value of life insurance.
  1. True
  2. False
- ii. Under QI, there is no exclusion from resources for any burial space for the applicant.
  1. True
  2. False

9. **Qualified Disabled Working Individuals (QDWIs).** As noted, Medicaid is authorized to provide protection against Medicare Part A premiums for QDWIs. QDWIs are persons who were previously entitled to Medicare on the basis of a disability, who lost their entitlement based on earnings from work, but who continue to have the disabling condition. The statutory basis for the QDWI program is [42 U.S.C. §1396d\(s\)](#). This occurs in the situation where a person became entitled to Medicare by virtue of having received 24 months of Social Security Disability Insurance (SSDI) benefits. Then, if the person begins to have earnings above the threshold at which earnings are considered evidence that the person is no longer disabled, the person usually becomes ineligible for SSDI. *Earned* income above the threshold is considered evidence that the SSDI recipient is now able to engage in “substantial gainful activity” (SGA). A person who is able to engage in SGA is not entitled to SSDI, since the ability to engage in SGA means that disability has ended or has been overcome. The SGA threshold increases each year. In calendar year 2019, the threshold is \$1,220 monthly for disabled persons who are not blind. For persons who meet the blindness standard under SSDI, the threshold in 2019 is \$2,040. *Unearned* income – such as interest or dividends – does not count toward the SGA threshold. Under the “Qualified Disabled Working Individual Program” (QDWI) Medicaid is required to pay the Medicare Part A premium for persons who lost eligibility for SSDI due to *earnings* above the threshold if their countable income does not exceed 200 percent of the Federal poverty line (FPIL), their resources are below 200 percent of the SSI limit, and they are not otherwise eligible for Medicaid. For QDWI eligibility, countable income includes *both* earned and unearned income. Because of the narrow income band – countable income (earned and unearned) cannot exceed 200% of FPIL, yet the Medicare enrollee has to have lost SSDI due to *earned* income above the SGA threshold – there are very few QDWIs. One study at the end of the 20<sup>th</sup> Century showed in the entire U.S. fewer than 50 QDWIs.

Note: The change in resource limits that MIPPA brought about for QMBs, SLMBs, and QIs, effective January 1, 2010 – see paragraph 6 b. above – does not appear in store for QDWIs. The statutory section that provides the resource limits for QDWIs – 42 U.S.C. §1396d(s)(3) – refers explicitly to the SSI resource limits, and Section 112 of MIPPA – 42 U.S.C. §1396d(p)(1)(C) – did not modify the QDWI resource limit provision. The QDWI countable resource limits are twice the SSI countable resource limits, hence \$4,000 for a single person and \$6,000 for a married person living with the spouse.

Questions about QDWI (circle the correct answer):

- i. Under QDWI, what is the importance of the Social Security Disability “SGA” threshold?
  1. It is the amount of earnings, at which point a person receiving Social Security Disability Insurance (SSDI) benefits will be considered to no longer be disabled.
  2. It is the amount of earnings that a person must exceed in order to be eligible for Social Security Disability Insurance (SSDI) benefits.
- ii. What is the benefit of the QDWI program?
  1. Payment of the Medicare Part A premium.
  2. Payment of the Medicare Part B premium.
  3. Payment of the personal needs allowance.
  4. Payment of the community spouse minimum monthly maintenance needs allowance.

10. **As noted, in the Medicare Savings Programs, SSI rules are used to determine what counts as income and what counts as resources.**

- a. These Medicare Savings Programs all have income and resource rules that follow the SSI methods for determining what counts as income and resources. The POMS section that has the excluded resources chart, [POMS SI 01110.210](#), has been addressed above.
- b. The POMS chart that lists exclusions of unearned income is at [POMS SI 00830.099](#). Commonly encountered excluded types of unearned income are food stamps (now called “Supplemental Nutrition Assistance” – SNAP), means-tested benefits (such as Temporary Assistance for Needy Families (TANF)), energy assistance, housing assistance, payments under the Foster Grandparents Program, payments under the Retired Senior Volunteer Program (RSVP), payments under the Senior Companion

Program, assistance under the Women, Infants, and Children (WIC) Program, victims' compensation payments, and Holocaust reparation payments. However, the list at POMS SI 00830.099 has additional entries, and links for details concerning each of the unearned income exclusions.

- c. One consequence of the use of SSI methods for determining income in the Medicare Savings Programs is that under POMS SI 00810.420, there is an exclusion of \$20 of monthly unearned income. An eligible couple does not receive double the \$20 exclusion; the \$20 exclusion is used once whether one spouse or both spouses will be or are applying. This means that, in calculating eligibility for a married couple in which each spouse is applying for a Medicare Savings Program, the unearned income of the spouses is totaled and then the \$20 exclusion of unearned income is taken against the combined unearned income of the spouses together.
- d. *Earned* income also is subject to certain exclusions under the POMS, and hence, under the Medicare Savings Programs. The POMS that treats the earned income exclusions is [POMS SI 00820.500](#). First, if there was little (or no) unearned income, whatever is unused of the \$20 exclusion of unearned income is used to reduce earned income. Under POMS SI 00820.500, there is also an exclusion of the first \$65 of monthly earned income and of one-half the rest of monthly earned income. As with the \$20 exclusion of unearned income, the earned income of both spouses – if both spouses are applying – is totaled and then the \$65 exclusion for earned income is taken against the total earned income of both spouses and then the exclusion of one-half the rest of the earned income is taken against the total earned income of both spouses.
- e. Social Security benefits are an example of unearned income, and thus \$20 is excluded from the gross Social Security benefits in calculating countable income. The gross Social Security benefit is the value of cash received from Social Security by direct deposit or by check, *plus* the amount of any Medicare premium(s) deducted from the gross Social Security benefit. Medicare premiums which are deducted from the gross Social Security benefit are added back in to determine the *gross* Social Security benefit, which is the amount against which the \$20 exclusion of unearned income is taken.



- f. Although the resource provisions of the POMS are useful for determining how resources will be treated under the Medicare Savings Programs, remember that one very important difference is this: There is *no* transfer of resources penalty under the Medicare Savings Programs. Under SSI, there may be a transfer of resources penalty if property is given away within 36 months of applying for SSI. The SSI transfer of resources penalty – which does not apply to the Medicare Savings Programs – is covered by [POMS SI 01150.000](#). Under the Medicare Savings Programs there is no penalty for giving away resources to become eligible.
- g. SSI income and resource provisions are also covered in Chapter Ten (Medicaid and Supplemental Security Income).
- h. If only one spouse of a couple is a Medicare beneficiary, the couple's combined countable income is first compared to the couple income limit. If that limit is not exceeded, then the individual's countable income is compared to the individual income limit. If that limit is not exceeded, income eligibility exists.
- i. A POMS section at [HI 03020.055](#) shows how to calculate the \$20 exclusion, the \$65 exclusion of earned income, and the exclusion of the remaining 50% of earned income. The chart also shows the declining percentage of Medicare Part D low-income subsidy (“extra help”), as countable income above 135% of the federal poverty income limit approaches closer and closer to 150% of the federal poverty income limit. Medicare beneficiaries with countable income at or above 150%, are ineligible for the low-income subsidy pertaining to Medicare Part D. Income at or below 135% of the federal poverty income limit qualifies individuals otherwise eligible, for full premium subsidy for Medicare Part D. A reason why a Medicare beneficiary, with income low enough to qualify for QMB, SLMB, or QI, may nonetheless may be ineligible for QMB, SLMB, or QI, is if countable resources are too high. Under QMB, SLMB, and QI, the countable resource limit for a single person is \$7,730, and for a married couple who live together (even if only one spouse is a Medicare beneficiary) is \$11,600. But for the low-income subsidy, the countable resource limits are \$14,390 (single person) and \$28,720 (married couple living together, even if only spouse is a Medicare beneficiary). Thus, there will be some Medicare beneficiaries, whose income is low enough for QMB, SLMB, or

QI, but whose countable resources are too high for QMB, SLMB, or QI. Nonetheless, their countable resources may be low enough for the low-income subsidy. See POMS [HI 03030.025](#) (“Resource Limits for Subsidy Eligibility”).

Questions regarding the applicability of SSI rules in determining income and resources under the Medicare Savings Programs (circle the correct answer):

- i. Non-attorneys are allowed to access the Social Security Administration’s Program Operations Manual System (POMS).
  - 1. True
  - 2. False
- ii. The transfer of resources penalty that is used in the SSI program is also used in the Medicare Savings Programs.
  - 1. True
  - 2. False

11. **The income limits for these programs change on or before April 1, and the value of the benefits changes every January.** The income limits for the Medicare Savings Programs are based on the federal poverty income limits (FPIL). Because the FPIL usually increases by each April 1, that is when the income limits for these programs usually will have increased, if not already in March. Since the vast majority of the beneficiaries of these programs receive Social Security, the annual Social Security cost-of-living increase (which occurs every January 1) is disregarded until the increase in the income limit takes effect. At that time, an automatic review of computer tape data occurs, to update the amount of countable Social Security. The value of the benefits under these programs increases each January 1, because that is when the Medicare premiums, deductibles, and cost-sharing amounts increase.

Questions about the income limits, resource limits, and value of benefits under the Medicare Savings Programs (circle the correct answer):

- i. The income limits are based on the federal poverty income limit.

1. True
2. False

ii. The income limits change by every April 1.

1. True
2. False

iii. The value of the benefits changes every January 1.

1. True
2. False

12. **Income limits effective until changed in 2019.** The income limits for QMB, SLMB, QI, and QDWI are different percentages of the federal poverty income limits. In recent years, the upcoming federal poverty income limits have been announced in late January. It is up to each federal agency to determine when they will become effective. For the past several years, the QMB, SLMB, QI, and QDWI have made use of the federal poverty income limits (announced in January), starting March 1 or April 1. The resulting income limits, starting March 1, 2019, are: QMB, individual: \$1,061, couple, \$1,430. SLMB, individual: \$1,269, couple, \$1,711. QI, individual, \$1,426, couple, \$1,923. QDWI, individual, \$4,249, couple, \$5,722. See <https://hhs.texas.gov/laws-regulations/handbooks/medicaid-elderly-people-disabilities-handbook/appendices/mepd-appendix-xxxi-budget-reference-chart>. These income limits have built into them the \$20 exclusion of unearned income. The following chart displays these income limits in a table:

Program	Monthly Income Limit as Stated by Texas HHSC	
	Single Person / + \$20	Couple / + \$20
QMB	\$ 1,041 / 1,061	\$ 1,410 / 1,430
SLMB	\$1,249 / \$1,269	\$1,691 / \$1,711
QI	\$1,406 / \$1,426	\$1,903 / \$1,923
QDWI	$(\$2,082 \times 2) + \$20$ *Also includes the \$65 earned income exclusion	$(\$2,819 \times 2) + \$20$ * Also includes the \$65 earned income exclusion

13. a. In calculating income, if a person is receiving Social Security and (as is typical) has the standard Medicare Part B premium deducted from the Social Security benefit, the actual countable Social Security benefit is the amount of Social Security direct deposited into the account of the beneficiary, or received by check plus the Medicare Part B premium.
- b. As noted above, because SSI rules are used to arrive at countable income, there is the general exclusion of \$20 of unearned income. The figures in paragraph 12 already have this \$20 factored in. Applicants for and recipients of QMB, SLMB, QI, and QDWI can exclude the first \$65 of earned income and one-half the remainder of earned income, since their income is calculated using SSI methods. Because QDWI by definition is for working individuals, those applying for or receiving QDWI very likely will be taking these deductions of the first \$65 of earned income and one-half the rest of earned income. But those applying for or receiving any of the Medicare Savings Programs can take those deductions against earned income, if they have earned income.

Question regarding the calculation of income under the Medicare Savings Programs:

Typically, the Social Security benefit of a Medicare beneficiary is higher than the amount that Social Security direct deposits or sends in the form of a check.

1. True
2. False

14. As noted above, because of the use of SSI methods for arriving at countable income, if the individual (or couple) has earned income, the first \$65 of monthly earned income is disregarded, and then one-half of the rest of the earned income is disregarded. (This exclusion is especially important for QDWI, but it is available under QMB, SLMB, and QI, for applicants or recipients who have earned income.) (If unearned income did not totally consume the \$20 disregard, whatever remains of that \$20 disregard is also deducted from earned income.) **Example:** Couple has monthly unearned income (all

Social Security) of \$1,100 (the gross benefit). This is the gross Social Security benefit. The couple has monthly combined earned income from a home business of \$445. Countable income is \$1,100 minus \$20 (thus, total countable unearned income of \$1,080) plus countable earned income (which is \$445 - \$65, minus ½ the remainder; resulting in \$380 (which is \$445 - \$65) minus one-half of \$380, which is \$190). Thus, countable income is \$1,270, which is below the \$1,354 income limit for a couple for QMB. Both spouses have end stage kidney disease and are enrolled in Medicare. Countable resources owned by the couple are \$10,000 (which is below the \$11,600 resource limit). The couple qualifies for QMB.

15. **Remember:**

- a. In calculating income for a couple under the Medicare Savings Programs, the \$20 exclusion for unearned income and the exclusion of the first \$65 of earned income and one-half the rest of earned income can only be taken once in the chain of calculations – not one time for each spouse, but rather one time for the spouses together. In the case of married persons living together, the \$20 is taken against total unearned income of the couple; they do not get to take the \$20 deduction twice.) If unearned income is so low that the \$20 exclusion is not fully used to off-set unearned income, then the remaining part of the \$20 is deducted from earned income, before the \$65 is deducted from earned income. In the case of a married couple living together, the deduction of \$65 and one-half the remaining earned income is taken against the total earned income of the couple; they do get to take these deductions twice.

Question regarding calculation of income, in the case of a married couple:

- i. Since a married couple living together involves two people, in calculating their income under the Medicare Savings Program, the \$20 exclusion for unearned income is taken fully (\$20) twice – it is taken against unearned income of one spouse and then fully again against the unearned income of the second spouse.

1. True

2. False

ii. Since a married couple living together involves two people, in calculating their income under the Medicare Savings Program, the \$65 and one-half rest exclusion for earned income is taken fully (\$65 and one-half the rest) twice – it is taken against unearned income of one spouse and then fully again against the unearned income of the second spouse.

1. True

2. False

16. **The value of the benefits in the year 2019.** Because the benefit of these programs is payment of all or some of the Medicare premiums, deductibles, and coinsurance amounts, when those amounts increase each January 1, the value of the benefit of these programs increases. Keep in mind that persons who are eligible for QMB, SLMB, or QI are also automatically eligible for the “extra help” – the low-income subsidy – under Medicare Part D. (QDWIs may qualify for the low-income subsidy depending on their income.) This link <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-atglance.html>, (“Medicare Costs at a Glance”) provides the cost information in paragraphs 17, 18, and 19 below, as well as further information regarding Medicare.

17. **QMB’s benefits.** QMB, for persons certified for it, pays all of the person’s Medicare Part A and Part B cost-sharing – premiums, co-payments, and deductibles. For most persons certified for QMB, the Medicare Part A premium is not a cost the person pays. Usually, Medicare beneficiaries have “paid” for Medicare Part A, through payroll taxes. But assume that a person certified for QMB has to pay the Medicare Part A premium. Assume it is the full, year 2019 Part A premium (\$437 monthly), and not just the Part A premium for those who have at least 30 credits of Social Security coverage (a \$240 monthly premium). For such a “QMB,” the value of the benefit would be at least the \$437 monthly Part A premium, the \$135.50 standard monthly Part B premium, each Part A hospital deductible incurred (\$1,364 per benefit period), all hospital co-insurance amounts (\$341 per day for days 61 – 90, and \$682 per day for days beyond the 90<sup>th</sup> day in a benefit period (up to the maximum

of 60 “lifetime reserve days”)), the skilled nursing facility copayment (\$170.50 per day for days 21 – 100), the 20% deductible for durable medical equipment, the \$5 co-pay for hospice prescriptions, the 5% co-pay for hospice inpatient respite care, the \$185.00 Part B annual deductible, the 20% Part B copay for most doctor services, the 20% co-pay for Part B outpatient physical, occupational, and speech-language therapy, the 20% to 40% co-pay for outpatient mental health services, and all other Medicare Part B co-pays. (Most QMBs do not have a premium for Medicare Part A, so for most “QMBs” the benefit eliminates payment of the other items listed. But, if a QMB does have a Medicare Part A premium (either the full \$437 monthly premium, or the reduced \$240 premium), the QMB program pays *that* as well.)

18. The Medicare website identified in paragraph 16, has this information about mental health services under Medicare Part A. Under Medicare Part A, in regard to a hospital inpatient stay for mental health hospital services, in 2019, for days 1 – 60, there is the same \$1,364 deductible per benefit period for the stay as under Medicare Part A anyway.

For days 61 – 90 of a mental health inpatient stay, there is a \$341 per day coinsurance as under Medicare Part A anyway. For days 91 and beyond of a mental health inpatient stay, when the beneficiary is in the Medicare Part A “lifetime reserve day” pool of days, there is a \$670 per day as under Medicare Part A anyway. Beyond the “lifetime reserve days” for inpatient mental health stays, as under Medicare Part A in general, the beneficiary is responsible for all costs of a mental health inpatient stay. The Medicare website identified in paragraph 16 further notes, “There’s no limit to the number of benefit periods you can have when you get mental health care in a general hospital. You can also have multiple benefit periods when you get care in a psychiatric hospital. Remember, there is a lifetime limit of 190 days.” [This 190-day lifetime limit on inpatient psychiatric hospital services under Medicare is codified in rule in the Code of Federal Regulations at [42 CFR §409.62](#).] Under Medicare Part A, in regard to mental health inpatient stays, there is a 20% copay of the Medicare-approved amount for mental health services which the beneficiary receives from doctors and other providers while the beneficiary is a hospital inpatient. See [“Medicare Costs at a Glance.”](#)

19. Mental health coverage under Medicare Part B, as described at [Medicare Costs at a Glance](#), has the following copays:

**“Outpatient mental health services** “You pay:

“20% of the Medicare-approved amount for visits to a doctor or other health care provider to diagnose your condition or to monitor or change your prescriptions. The Part B deductible applies.

“If you get treatment in a hospital outpatient clinic or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount of the hospital bill. This amount will vary depending on the service provided, but will be between 20-40% of the Medicare-approved amount.

“35% of the Medicare-approved amount for outpatient treatment of your condition (like individual or group psychotherapy) in a doctor or other health provider's office or hospital outpatient department.

**“Partial hospitalization mental health services**

“You pay a percentage of the Medicare-approved amount for each service you get from a doctor or certain other mental health qualified professional. You also pay a copayment for each day of partial hospitalization services provided in a hospital outpatient setting or community mental health center, and the Part B deductible applies.”

Source: [Medicare Costs at a Glance](#).

20. Because the Qualified Medicare Beneficiary Medicaid (QMB) program pays all Medicare Part A and B copays, as well as premiums and deductibles, the Medicare cost-sharing amounts set forth in paragraphs 17 – 19, above, are covered by QMB, for those Medicare beneficiaries with low enough countable income and low enough countable resources to qualify for QMB.
21. **SLMB’s benefits, and QI-s.** Both the SLMB program and the QI program have the same benefit: Payment of the standard monthly Part B premium. In the year 2019, this is \$135.50 monthly. (Although Medicare beneficiaries who file an income tax return and who have income greater than \$85,000 (single) or \$170,000 (married) pay a higher



Medicare Part B premium, such persons, by virtue of that income, would be ineligible for any of the Medicare Savings Programs.)

22. **QDWI's benefit.** The benefit of QDWI is payment of the Medicare Part A premium. Thus, whichever premium the "QDWI" would have to pay – the full \$437 monthly premium or the reduced \$240 monthly premium – that is the value of the QDWI benefit.
23. Once a person is certified for QMB, SLMB, QI, or QDWI, the Medicare premium that the person was paying and which is a benefit of the Medicare Savings Program for which the person qualifies, will be paid by the program. That means, for instance, that QMBs, SLMBs, and "QIs" will no longer see the \$135.50 reduction in their Social Security benefit, which occurs due to the standard monthly Medicare Part B premium being taken out of the Social Security benefit.
24. Benefits under the SLMB and QI programs can be paid retroactive for three months, if the person would have been eligible in those earlier three months before the person applied. This is provided for at 1 Texas Administrative Code §§[359.105\(e\)](#) and [359.107\(e\)](#). QMB and QDWI do not have this "three-month prior" coverage. 1 Texas Administrative Code §§ [359.103\(e\)](#); [359.109\(c\)](#) (referring to [42 U.S.C. §1395i-2a\(c\)](#), which is the federal statute regarding when QDWI Medicare coverage begins).
25. **The application form.** Applicants for these programs can use form [H-1200 EZ](#). The application normally can be handled entirely by mail and phone; no face-to-face interview is required. *As with all applications for medical benefits, all information supplied must be truthful, and is subject to verification.* Any of the Medicare Savings Programs can also be applied for through the Web site [Your Texas Benefits](#) for which the Web address is [www.yourtexasbenefits.com](http://www.yourtexasbenefits.com).
26. **Appeals.** The appeals process for these programs is governed by the same rules, as for regular Medicaid and long-term care Medicaid. Benefits counselors can refer clients who need to handle these appeals to the Legal Hotline for Texans.

27. **A few words about Medigap policies and the Medicare Savings Programs.** The Medicare law is Title XVIII of the Social Security Act. It is codified at 42 United States Code §§1395. As noted at the outset, the Medicaid law is Title XIX of the Social Security Act. It is codified at 42 United States Code §§1396. Medigap policies (formally called “Medicare supplemental health insurance policies”) are regulated by a part of the Medicare law, namely [42 U.S.C. §1395ss](#).
28. At [42 U.S.C. §1395ss\(q\)\(5\)\(A\)](#), one finds a requirement that Medigap policies be capable of suspension without penalty for a 24 month period, if a person becomes eligible for a Medicare Savings Program. This section of the Medicare law states, “Each Medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to medical assistance under subchapter XIX [the Medicaid program].” Because the Medicare Savings Programs are actually Medicaid programs, this right to suspend a Medigap policy covers people who enroll in a Medicare Savings Program.
29. In order to benefit from this right to suspend a Medigap policy, the person must notify the issuer of the policy within 90 days after the date that the person becomes entitled to Medicaid (within 90 days after the person becomes entitled to a Medicare Savings Program). If the person ceases to be entitled to a Medicare Savings Program (or to other Medicaid) the person has a right to be reinstated to the Medigap policy, if the person notifies the issuer of the policy within 90 days after the end of Medicaid entitlement. As noted, these concepts are set forth in [42 U.S.C. §1395ss\(q\)\(5\)\(A\)](#).
30. The terms of the Medigap policy to which a person has a right to reinstatement must not require any waiting period for pre-existing conditions, must provide for coverage which is substantially equivalent to the coverage the person had before the person suspended the Medigap policy, and must provide for premiums which are at least as favorable as the person had before the Medigap policy was suspended.

31. Another aspect of the relationship between Medigap policies and the Medicare Savings Programs concerns the prohibition against selling a Medigap policy that duplicates Medicaid benefits. Under [42 U.S.C. §1395ss\(d\)\(3\)\(A\)\(i\)](#), it is unlawful to sell a Medigap policy that duplicates coverage that a person would have under Medicare or Medicaid. However, this prohibition is not violated if the State Medicaid program pays the premiums for the Medigap policy, or if the person is entitled to QMB and the Medigap policy provides for coverage of outpatient prescription drugs, or the person is only entitled to payment of Medicare Part B premiums. Thus, it is lawful to sell a Medigap policy to a person entitled to QMB if the Medigap policy covers outpatient prescription drugs. However, with the arrival of the Medicare Prescription Drug Benefit under Medicare Part D, and given that eligibility for QMB means eligibility for premium-free access to the standard drug plan, the purchase of a Medigap policy will seldom if ever make sense for a person eligible for QMB. The Texas Department of Insurance, in its booklet “[Medicare Supplement Insurance Handbook and Rate Guide](#)” states, “You might not need Medigap insurance if you are in the QMB program.” It is lawful to sell a Medigap policy to persons entitled to SLMB or QI, whether or not the policy provides for coverage of outpatient prescription drugs.

Question about Medigap insurance and the QMB program (circle the correct answer):

What does the Texas Department of Insurance state concerning Medigap insurance in regard to persons who have QMB?

- ii. Such persons do not need a Medigap policy.
  - iii. Such persons definitely should purchase a Medigap policy.
32. Of course, the decision of whether a Medigap policy should be bought is one that a person entitled to the SLMB, QI, and QDWI Program would have to evaluate, based on individual circumstances.

33. **Medicare Part D.** Under Medicare Part D, all recipients of QMB, SLMB, and QI will qualify as “full-premium low-income subsidy eligible individuals.” They will not have to pay a premium for the standard Part D plan, nor a deductible.
34. **The Legal Hotline for Texans provides back-up and support.** Any benefits counselor of a Texas area agency on aging who needs back-up and support can call the Legal Hotline for Texans at special number for Benefits Counselor back-up and support.

Answer Key to Questions:

**Paragraph 1:**

The Social Security Act, State Medicaid Plan, Texas Secretary of State, December 31, 2013.

(3, 1, 4, 3)

**Paragraph 2:**

To receive the help of the Medicare Savings Programs, a person does need to enroll or be enrolled in Medicare.

In Texas, all of the Medicare Savings Programs are exempt from Medicaid Estate Recovery.

Persons who are eligible for QMB, SLMB, or QI are eligible for “extra help” under Medicare Part D.

(True, True, True)

**Paragraph 6:**

It is not true that only persons who are sixty-five (65) years of age can qualify for QMB, because there are bases for qualifying for Medicare for persons who are not yet sixty-five (65) – disability, end stage renal disease, Lou Gehrig’s disease. If a person has to pay a premium for Medicare Part A and the person is eligible for QMB, QMB will pay the Medicare Part A and Part B premiums.

(False, True)

**Paragraph 7:**

The homestead exclusion under SLMB has no limit on the value, number of rooms, size of dwelling, nor number of acres, but the only land that can be excluded is land that is contiguous with the land on which the homestead dwelling sits.

In regard to the vehicle exclusion under SLMB, one vehicle regardless of year, make, model, or value, is excluded.

(4,3)

**Paragraph 8:**

Under QI, there is an exclusion of \$1,500 face value of life insurance. There is also a burial space exclusion.

(False, False)

**Paragraph 9:**

Under QDWI, the SGA threshold is the amount of earnings, at which point a person receiving Social Security Disability Benefits (SSDI) will be considered to no longer be disabled.

The benefit of the QDWI program is payment of the Medicare Part A premium.

(1,1)

**Paragraph 10:**

Non-attorneys *are* allowed to access the Social Security Administration's Program Operations Manual System (POMS).

The transfer of resources penalty that is used in the SSI program is *not* used in the Medicare Savings Programs.

(True, False)

**Paragraph 11:**

Medicare Savings Programs' income limits are based on the federal poverty income limit.

The income limits change by every April 1.

The value of the benefits changes every January 1.

(True, True, True)

**Paragraph 13:**

Typically, the Social Security benefit of a Medicare beneficiary is higher than the amount that Social Security direct deposits or sends in the form of a check.

(True)

**Paragraph 15:**

Even in the case of a married couple, both of whom are applying for a Medicare Savings Program, the \$20 exclusion for unearned income and the \$65 and one-half rest exclusion for earned income (\$65 and one-half the rest) are each taken fully only once. (“True” is correct for both questions)

**Paragraph 31:**

What does the Texas Department of Insurance state regarding Medigap insurance in regard to persons who have QMB?

Such persons do not need a Medigap policy.

## Chapter Seven

### Medicare and Insurance Fraud

1.      Fraud Prevention and Benefits Counseling. The federal government is committed to protecting the integrity of the Medicare program from fraud and abuse. In an effort to reduce fraud, the Centers for Medicare & Medicaid Services (CMS) partners with other federal agencies, Medicare contractors and providers, and various state agencies. As a Benefits Counselor, your knowledge of Medicare's fraud prevention activities will help protect clients against Medicare fraud and thereby help safeguard the program.
2.      Benefit Counseling activities related to fraud include legal assistance (one-on-one counseling) and legal awareness. An example of legal assistance might be reviewing a monthly "Medicare Summary Notice" with a client who is concerned that the items listed do not reflect actual care or services provided. An example of legal awareness might be monitoring local events for the aged and/or disabled and then disseminating information about any that seem misleading or fraudulent to clients.
3.      Source of the Law. The Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act in 1996 strengthened efforts to monitor and prevent fraud and abuse in the Medicare and Medicaid programs. The Medicare Integrity Program was created with different authorities for contracting fraud prevention activities under CMS, the Office of Inspector General, the U.S. Department of Health and Human Services (DHHS), the Administration on Aging, and the Social Security Administration. Some of the Area Agencies on Aging have programs that include a fraud component beyond the State Health Insurance Assistance Program (SHIP) subcontract. The Texas SHIP is the partnership known as the Health Information, Counseling and Assistance Program (HICAP). Coordination with other program areas in your agency will assure that you reach a greater number of persons.
4.      The Older Americans Act amendments of 2006 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Senior Medicare Patrol. The Senior Medicare Patrol is codified at 42 U.S.C. § 3032. Senior Medicare Patrol is abbreviated SMP. SMP conducts group education sessions to educate audience members on spotting Medicare error, fraud and abuse. SMP also conducts one-on-one counseling sessions with Medicare beneficiaries or their authorized representative. SMP also conducts community education events. Media outreach is also used by

SMP. These and other SMP activities and additional resources to combat fraud are described at [http://www.aoa.gov/AoA\\_programs/Elder\\_Rights/SMP/index.aspx](http://www.aoa.gov/AoA_programs/Elder_Rights/SMP/index.aspx). A visit to that site allows one to click on the “SMP locator.” The SMP locator shows that the SMP in Texas is operated by the Better Business Bureau Education Foundation. Their SMP contact information is at <http://www.smpresource.org//AM/Template.cfm?Section=Home>. The Texas contact information for the SMP is:

Barbara McGinity, LMSW  
SMP Program Director  
BBB Education Foundation  
1333 W. Loop S., Suite 1200  
Houston, TX 77027  
Direct: 713-341-6184  
Toll Free: 1-888-341-6187  
Fax: 713-341-6192  
<http://texassmp.org>  
[bmcginity@bbbhou.org](mailto:bmcginity@bbbhou.org)

And

Rachanna Rodriguez  
SMP Coordinator  
The National Hispanic SMP  
National Hispanic Council on Aging  
840 W. Austin Ave.  
Alamo, TX 78516  
Direct: 956-782-7831  
Toll Free: 866-943-7289  
Fax: 956-783-0262  
[www.nhcoa.org](http://www.nhcoa.org)  
[Rachanna1@sbcglobal.net](mailto:Rachanna1@sbcglobal.net)

4. In the drop-down menu at the SMP website for Health Care, under “Report Fraud,” the SMP states,

“Here are the steps you should take to report your concerns and abuse:

- If you have questions about information on your Medicare Summary Notice or Part D Explanation of Benefits, call your provider or plan first.
- If you are not comfortable calling your provider or plan or you are not satisfied with the response you get, call your [local SMP](#).”



5. In 2010, the SMP program was granted \$9 million by CMS, to increase prevention of health care fraud, spotting of health care fraud, and reporting of it. Texas, California, New York, and Florida SMP programs received the largest shares of this funding -- \$430,000 each.
6. At the SMP website one can see that the SMP's partners include the National Association of Area Agencies on Aging, the National Association of Insurance Commissioners, and the National Association of Attorneys General, among other partners.
7. In addition to addressing fraud prevention in Medicare, this chapter will focus on identifying how the state level HICAP partners, including the Texas Department of Aging and Disability Services (DADS), the Texas Department of Insurance (TDI), and Texas Legal Services Center (TLSC), act as resources in fraud and abuse prevention.
8. Definition of Medicare Fraud and Abuse. Medicare consumer publications define fraud as "intentional deception" or a misrepresentation that an individual knows to be false and knows could result in some benefit to himself or herself or to some other person. The consumer website for Medicare includes fraud-related publications that can be downloaded or ordered in quantities. The website address is [www.medicare.gov](http://www.medicare.gov).
9. Medicare antifraud activities also focus on abuse, defined as incidents or practices that are inconsistent with sound and accepted medical, business, or fiscal procedures. Medicare fraud/abuse may be committed by health providers; home health agencies, durable equipment suppliers, nursing homes or hospice care centers, or Medicare beneficiaries. Medicare contractors are similarly charged with educating beneficiaries and providers to review medical bills with intent to detect possible fraud. While part of the focus is to correct errors in billing, certain activities are routinely monitored to identify patterns of fraud.
10. New fraud prevention efforts include identifying examples of situations where fraud may occur relative to specific Medicare benefits. Efforts are aimed at informing consumers how services sometimes are intentionally billed by providers to receive higher reimbursement. An example might be a provider billing for inpatient services when the care was provided on an outpatient basis. To help prevent Medicare abuse, consumers should be encouraged to learn what Medicare pays and does not pay.
11. The impact of fraud in Medicare or Medicare-related insurance products. At the highest level, the U.S. General Accounting Office has reported that billions of Medicare dollars are lost each year to fraud and abuse. To taxpayers it means higher costs, and to persons on Medicare it

can often mean both financial hardship and loss of needed services. The scope and nature of health care fraud can be seen by viewing the information at <http://oig.hhs.gov/fraud/fugitives/index.asp>.

12. Medicare Initiatives to Reduce Fraud and Abuse. CMS has at least four general methods of fighting Medicare fraud/abuse. These include prevention, investigation, coordination, and prosecution. Following are brief summaries of these CMS efforts and programs. CMS is also a partner with the SMP, of course.

13. Prevention – CMS efforts directed at consumers include:

- A. Each fall CMS distributes the publication, *Medicare & You*, to all Medicare enrollees as a tool to educate consumers. The publication encourages reporting fraud/abuse and cross-references each Medicare subcontracting agency. The publication includes
  - (1) a statement indicating that errors occur and urging review of the monthly Medicare Summary Notice (MSN),
  - (2) a description of the beneficiary's right to request an itemized statement from the provider,
  - (3) promotion of the Medicare incentive program, and
  - (4) the toll-free hotline number to the DHHS Inspector General to report complaints and information about fraud, waste, and abuse.
- B. CMS also promotes the toll-free number to report fraud to the DHHS Inspector General. The number is 1-800-HHS-TIPS (1-800-447-8477).
- C. An incentive program allows clients monetary awards of up to \$1,000 for reporting fraud that results in a recoupment of Medicare funds.
- D. People with Original Medicare are urged to use the MSN (previously called the Explanation of Medicare Benefits, or EOMB) to review services provided to them by Medicare contractors during the three-month period to which the MSN relates. The MSN details any supplies or services that were provided to the individual and billed to Medicare. The MSN shows the beneficiary what Medicare services have been billed to Medicare, in regard to the beneficiary, during the three-month period. Beneficiaries can also view Medicare claims that providers and suppliers have submitted, by visiting [www.MyMedicare.gov](http://www.MyMedicare.gov).
- E. Although the MSN is used solely with Original Medicare, Medicare Advantage (MA) plans as subcontractors with Medicare are also required to help educate consumers about fraud and how to report it.

The above Medicare information for enrollees on combatting fraud can be found in pages 116-120 of the 2012 edition of *Medicare & You*. That booklet can be accessed (and downloaded) at <http://www.medicare.gov/publications/pubs/pdf/10050.pdf>. The information at page 116 of *Medicare & You* includes pointers on guarding against identity theft. The Federal Trade Commission operates an ID Theft Hotline, at 1-877-438-4338. TTY users can call 1-866-653-4261.

14. CMS offers numerous additional consumer publications that address fraud patterns related to Medicare benefits, such as ambulance or home health services. Sample titles include *Fraud and Abuse; How to Report Fraud & Abuse; and Fraud and Abuse, Detection and Prevention Tips*. These can be accessed (and downloaded) at [www.medicare.gov](http://www.medicare.gov).

15. Investigation – CMS enforcement efforts have targeted home health agencies, durable medical equipment suppliers, nursing homes, and hospice care centers. CMS estimates that 40 percent of Medicare and Medicaid claims fraud is related to these services. Consumers and Benefits Counselors are urged to know whom to call regarding specific medical bills and Medicare coverage. CMS fraud publications identify the state SHIP as a source for consumers to get help with questions about their medical bills. A quick review of the publication *Medicare & You 2012*, Section 7, Pages 128-137, numerous resources with information about Medicare benefits. The *Medicare & You* booklet and the resources mentioned in it can be very helpful to beneficiaries in understanding the Medicare Summary Notice (MSN).

16. A blank MSN and guidance on how to read it, can be found at <http://www.medicare.gov/navigation/medicare-basics/understanding-claims/medicare-summary-notice.aspx>. Even more detail on what entries are required and appropriate in an MSN is at <https://www.cms.gov/manuals/downloads/clm104c21.pdf>. That is the Medicare Claims Processing Manual, Chapter 21 – Medicare Summary Notices. Providers and contractors must be mindful of the requirements of the Medicare Claims Processing Manual.

17. The contractors that pay Medicare claims are also responsible for fraud prevention activities. As a result of Section 911 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173), CMS has revised the allocation of contractor territories in the U.S. Section 911 of P.L. 108-173 became Section 1874A of the Social Security Act. Following enactment of P.L. 108-173 by the 108<sup>th</sup> Congress, Section 911 was codified (put into the United States Code) at 42 U.S.C. §1395kk-1. Under this provision, CMS has entered into contracts with “Medicare Administrative Contractors.” The MACs carry out functions that “Medicare carriers” AND

“Medicare intermediaries” used to carry out. Some businesses that had been carriers and intermediaries now have contracts as Medicare Administrative Contractors (MACs). In Texas, TrailBlazerHealth is the Part A and Part B MAC. See

<https://www.cms.gov/MedicareContractingReform/downloads/J4AwardQsAs.pdf>. The MAC for durable medical equipment (DME) for Texas is CIGNA Government Services, LLP. See <https://www.cms.gov/MedicareContractingReform/Downloads/DMEMACJurisdictionFactSheets.pdf>. The MAC for Home Health and Hospice for Texas is Palmetto Government Benefits Administrator. See <https://www.cms.gov/MedicareContractingReform/Downloads/HHMACMAP.pdf>.

18. A further result of Section 911 of P.L. 108-173 is the increased role of the Beneficiary Contact Center (BCC). In its “Functional Contractors Overview,” CMS described the role of the BCC thusly:

**Beneficiary Contact Center (BCC)**

The BCC is assuming the duties traditionally held by fiscal intermediaries and carriers. In the BCC environment, beneficiaries have a single Medicare point-of-contact, a 1-800-MEDICARE call center operated by CMS that that will connect them to a seamless network of customer service entities that can answer Medicare and related questions and resolve problems.

See <https://www.cms.gov/MedicareContractingReform/Downloads/FunctionalEnvironment.pdf>.

19. Although the BCC can answers many questions about Medicare, CMS has a separate fraud hotline (1-800-HHS-TIPS). CMS states this about using 1-800-HHDS-TIPS:

“You, as the Medicare beneficiary, are the most important link in finding Medicare fraud. You know better than anyone what healthcare services you have received. Review your Medicare Summary Notice when you receive it, and make sure you understand all of the items listed.

If you don’t remember a procedure that is listed, you should first call your physician, provider, or supplier that is listed on the Medicare Summary Notice. Many times a simple mistake has been made and can be corrected by your physician, provider, or supplier’s office when you call.

If your physician, provider, or supplier’s office does not help you with the questions or concerns about items listed on your Medicare Summary Notice and you still suspect Medicare fraud or if you cannot call them, you should call or write the Medicare company that paid the claim. The name, address, and telephone number are on the [Medicare Summary Notice \(MSN\)](#) you receive, which shows what Medicare paid.

Before contacting the Medicare claims processing company, carefully review the facts as you know them and as shown on the Medicare Summary Notice. Write down:

- The provider's name and any identifying number you may have.
- The item or service you are questioning.
- The date on which the item or service was supposedly furnished.
- The amount approved and paid by Medicare.
- The date of the Medicare Summary Notice.
- The name and Medicare number of the person who supposedly received the item or service.
- The reason you believe Medicare should not have paid.
- Any other information you may have showing that the claim for the item or service should not have been paid by Medicare.

If you plan to write rather than call, clearly state at the beginning of your letter that you are filing a fraud complaint. This will help to ensure that your complaint is forwarded to the fraud unit.

#### Office of Inspector General Hotline

To further assist you, the Office of the Inspector General maintains a hotline, which offers a confidential means for reporting vital information. The Hotline can be contacted:

By Phone: 1-800-HHS-TIPS (1-800-447-8477)

By Fax: 1-800-223-2164  
(no more than 10 pages please)

By E-Mail: [HHSTips@oig.hhs.gov](mailto:HHSTips@oig.hhs.gov)

By Mail: Office of the Inspector General  
HHS TIPS Hotline  
P.O. Box 23489  
Washington, DC 20026

Please note that it is current Hotline policy not to respond directly to written communications.”

See <http://www.medicare.gov/fraudabuse/howtoreport.asp>. A further website to visit is

<http://www.stopmedicarefraud.gov/>.

20. On the website [www.cms.gov](http://www.cms.gov), Benefits Counselors can find additional fraud-related information, including a Fraud Prevention Toolkit, an Overview How to Report Fraud, and State By State Fraud and Abuse Reporting Contacts. For Texas the listed contacts are: Health and Human Services Commission, 800-436-6184, <https://oighhsc.state.tx.us>, and Office of the Attorney General, 512-463-2011, <http://www.oag.state.tx.us/forms/mfcu/>. Although the MCFU stands for Medicaid Fraud Control Unit, some instances of fraud harm both Medicare and Medicaid. CMS coordinates with the U.S. Office of Inspector General, in the federal Department of Health and Human Services (DHHS), and with the Administration on Aging, the Office of the Attorney General, and the FBI.

21. The Administration on Aging also coordinates related fraud activities to programs that address issues of elder abuse and outreach to vulnerable populations. Making presentations on elder abuse and providing information via posters, conferences, and culturally relevant programs reach target populations. Oftentimes these local programs are an opportunity for networking. A Benefits Counselor might increase their outreach on fraud by conducting presentations on how Medicare works for staff and volunteers of the local programs. Such outreach will likely result in greater legal assistance requests as clients begin to understand the importance of reviewing their MSNs.

22. Prosecution can result from timely and accurate reports of fraud, although criminal liability in the United States requires proof beyond a reasonable doubt. Reporting fraud can also (or instead) result in administrative recoupment of Medicare/Medicaid dollars, provider penalties, disqualification as a provider in these programs, or license revocation. As noted, criminal actions and fines can also be imposed. As mentioned above, criminal prosecution, to be successful, must result in proof beyond a reasonable doubt – the highest burden of proof. Civil fraud claims and administrative penalties do not require that high a level of proof. Prosecution of Medicare/Medicaid fraud falls to federal and state agencies such as the federal DHHS, Office of Inspector General, FBI, and at state-level agencies like the Texas Attorney General’s Office and the Texas Department of Insurance.

23. The Office of the Attorney General (OAG) has a Civil Medicaid Fraud Unit. The unit is described thusly at the OAG’s website:

The group protects taxpayers by enforcing the Texas Medicaid Fraud Prevention Act (TMFPA), chapter 36 of the Texas Human Resources Code. The TMFPA permits private citizens to file lawsuits on behalf of the state against those who violate the TMFPA. These

private citizens are referred to as "relators" and they assist the state in identifying and pursuing fraudulent activity committed against the Medicaid program. Relators in successful matters receive a portion of the recovery. The OAG may also pursue cases on its own on behalf of the Medicaid program.

In addition to actively litigating in state and federal courts, CMF works with relators, the criminal Medicaid Fraud Control Unit, the federal government, other state governments, and law enforcement to effectively conduct nationwide fraud recovery efforts. Through these efforts, the OAG has recovered over a quarter of a Billion dollars on behalf of the Texas Medicaid system.

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See <https://www.oag.state.tx.us/consumer/civilmedicaid.shtml>. At that website, one also sees the contact information for the Civil Medicaid Fraud Unit – (800) 252-8011, or [mfcu@oag.state.tx.us](mailto:mfcu@oag.state.tx.us).

24. The Consumer Protection Division of the Office of the Texas Attorney General (OAG) has as a charge to prosecute those who cheat or deceive the elderly. OAG can file lawsuits under the Deceptive Trade Practices Act and also take legal action in cases referred by other state agencies such as the Texas Department of Aging and Disability Services, the Texas Department of Protective and Regulatory Services, and the Texas Department of Insurance.

25. OAG participates in crime prevention programs like the national TRIAD program. This program works in conjunction with a community-policing program that invites the involvement of the National Sheriffs' Association, the International Association of Chiefs of Police and the American Association for Retired Persons (AARP). Through these national sponsors, local programs unite seniors, their providers, and local police and sheriff's departments to combat fraud. The OAG takes legal action in cases referred by the Texas Department of Aging and Disability Services, the state agency that inspects nursing homes and investigates alleged violations of state



and federal nursing home standards.

26. OAG also focuses efforts on investigation of advertising and sale of retirement-oriented investments, and financial and estate planning services. It also files lawsuits under the Deceptive Trade Practices Act for consumer fraud that targets Texas seniors or other vulnerable victims in telemarketing scams, mail fraud, and home and personal services or products.

27. The Texas Department of Insurance (TDI) is involved in Medicare fraud efforts because many persons on Medicare look to other health insurance to cover costs not paid by Medicare.

There are several activities that TDI deems as practices that contribute to insurance fraud.

Mirroring the federal partnerships, TDI coordinates enforcement of fraud practices with OAG, other state agencies, and law enforcement entities. TDI also investigates workers' compensation fraud.

Reports of insurance fraud, including fraud against the workers' compensation program, can be made to TDI's toll-free insurance fraud hotline at 888-327-8818. Forms for reporting insurance fraud to TDI can be downloaded from <http://www.tdi.texas.gov/forms/form6.html>. The completed report can be emailed to [FraudReport@tdi.state.tx.us](mailto:FraudReport@tdi.state.tx.us). Or, the printed report can be mailed to Texas Department of Insurance, Fraud Unit, P.O. Box 149336, Mail Code 109-3A, Austin, TX 78714-9336. The overall website of the Texas Department of Insurance is at [www.tdi.texas.gov](http://www.tdi.texas.gov).

28. Three TDI divisions play an active role in reducing insurance fraud. The Consumer Protection Division reviews consumer complaints about insurance companies or agents; reviews insurance ads; and educates consumers, the industry, and the general public. Consumer Protection also refers potential fraud cases to the Legal and Compliance Division and to the Fraud Unit. The Legal and Compliance Division is responsible for enforcement and disciplinary action against insurance companies and agents. The Fraud Unit investigates claim fraud committed by consumers and health care providers against insurance companies. It also has authority to investigate insurance agents converting premium payments to their own use, insurance company officials embezzling funds, and persons who are doing the business of insurance in Texas without the appropriate license are also subject to investigation and prosecution.

29. The TDI Fraud Unit is a law enforcement agency employing both commissioned and non-commissioned investigators. The unit employs peace officers pursuant to Article 1.10D, Texas Insurance Code and Article 2.12(28), Texas Code of Criminal Procedure. TDI received the authority to commission peace officers from the Texas Legislature in 1995. The Fraud Unit



currently employs peace officers, investigators and criminal analysts.

30. TDI Fraud Unit investigators work on a variety of cases. TDI investigators cooperate with other law enforcement agencies and regularly conduct joint investigations with local police, sheriffs' departments, Texas district and county attorneys, the Texas Department of Public Safety (DPS), FBI, Internal Revenue Service, U.S. Postal Inspectors, and the U.S. Department of Labor. Upon completing an investigation, the investigator refers the case for indictment and prosecution directly to state or federal prosecuting attorneys. After the referral has been made, investigators continue to assist prosecutors and often serve as witnesses before grand juries and during trials. When asked, TDI will furnish attorneys as special prosecutors.

31. TDI has authority to punish fraud through license revocations, and cease-and-desist orders. The Fraud Unit and Legal and Compliance issue monthly reports on disciplinary actions taken against agents and individuals. This list is regularly issued as a press release by TDI and is available on the TDI website for downloading. The list identifies the name or company disciplined dollar amount of any penalties assessed, and the location in Texas where the crime was committed.

32. Fraudulent Insurance Practices – TDI defines any of the following activities as unfair practices in the sale of insurance products. Complaints can be referred to TDI using the consumer complaint form or by calling the Fraud toll-free number at TDI:

\_\_\_ Knowingly making any misleading statement that causes someone to drop a policy and buy a replacement from another company. This is called “twisting.”

\_\_\_ Using high-pressure tactics, including the use of force, fright, or threat to pressure someone into buying a policy.

\_\_\_ Obtaining sales leads through advertising that hides the fact that an agent or company may try to sell insurance. This is called “cold lead advertising.”

\_\_\_ Posing as a representative of Medicare or a government agency.

\_\_\_ Selling a Medigap policy that duplicates benefits or health insurance coverage someone already has. An agent is required to ask if the person has other health policies.

\_\_\_ Suggesting that someone falsify an application.

\_\_\_ Using misleading advertisements made to look like government mail by including eagles or similar graphics and official-sounding government bureaus on the return address.

33. Further protections relevant to specific insurance products. Both Medicare supplement

policies (also known as Medigap policies) and long-term care policies have requirements that offer further protection against fraud. These requirements include “30-day free-look” for both Medigap and long-term care policies. This protection allows a client to review the actual policy once it is received and to return it for a complete premium refund if the buyer determines that the policy is not what was discussed or requested. TDI publications suggest that consumers verify the license and complaint history of both the company they are considering and the agent assisting them in purchasing a policy.

34. TDI has a publication and a video on insurance fraud. These resources offer examples of fraud related to various insurance products. They also include tips for individuals to guard against fraud.

35. How To Report Fraud to TDI. Although there is a fraud insurance complaint telephone, Benefit Counselors, who believe that there is possible insurance fraud, should first call the toll-free Consumer Help Line at 1-800-252-3439. The caller will be able to review what next steps to take. Usually a recommendation will be made to file a written complaint with TDI. Once the case has been reviewed, if intentional fraud is suspected, the client will be advised on next steps to take or the case may be referred to the Fraud Division. It is through the review by Fraud and Legal & Compliance that patterns of fraud are identified and prepared for prosecution.

36. Benefits Counselors are encouraged to review print or electronic ads and refer misleading ads to TDI. TDI’s review might determine that an ad does not violate insurance rules but may be a violation of consumer deceptive trade practices and will make the appropriate referral to OAG.

37. The Texas Department of Aging and Disability Services is a regular funding source for national outreach activities aimed at reducing fraud and abuse. For Benefits Counselor it is suggested that part of networking include review of existing and ongoing projects that contribute to fraud prevention. The overall website of the Texas Department of Aging and Disability Services is at [www.dads.texas.gov](http://www.dads.texas.gov).

38. The Texas Legal Hotline for Texans provides Benefits Counselors with expertise to also review whether a client’s complaint is more appropriate as abuse, exploitation, or fraud related to public assistance programs. The Texas Legal Services Center (TLSC), which administers the Legal Hotline, is also a referral source for legal awareness activities related to fraud prevention. TLSC staff works in partnership with local Legal Aid Offices, Pro Bono programs and the State Bar of Texas. TLSC offers a separate toll-free line for use by Benefits Counselors. The

TLSC also collaborates with the State Long-Term Care Ombudsman Program related to nursing facility cases and training of staff and volunteers. TLSC is on the Web at [www.tlsc.org](http://www.tlsc.org).

39. Other state agencies that interact with fraud prevention and reporting. The following additional agencies are available and have a role in fraud reporting and investigation: The State Long-Term Care Ombudsman, on the Web at [http://www.dads.texas.gov/news\\_info/ombudsman/](http://www.dads.texas.gov/news_info/ombudsman/), The Long-Term Care Ombudsman protects the rights interests of recipients of long-term care.

40. The Texas Department of Family and Protective Services investigates reports of abuse or exploitation of vulnerable persons including children, the elderly and individuals with disabilities. It is on the Web at <http://www.dfps.state.tx.us/About/About/>.

41. Reporting fraud assistance and or awareness in the National Performance Report. Increasingly, the CMS is asking for reports related to fraud and abuse. It is important to document instances and remedies taken to reduce fraud. Congress has placed greater emphasis on fraud prevention and looks to benefits counseling to support efforts that safeguard the integrity of the Medicare and Medicaid programs.

### Chapter Seven Questions

1. Medicare fraud prevention is the responsibility of which agency?
  - A. \_\_\_\_\_ Centers for Medicare and Medicaid Services
  - B. \_\_\_\_\_ Medicare contractors (carriers and fiscal intermediaries) and subcontractors (providers, including the State SHIP).
  - C. \_\_\_\_\_ Office of Inspector General, U.S. Department of Health & Human Services
  - D. \_\_\_\_\_ Social Security Administration
  - E. \_\_\_\_\_ A & C only.
  - F. \_\_\_\_\_ All of the above.
2. A purpose of the Medicare Summary Notice is to directly involve Medicare beneficiaries in the prevention of Medicare fraud and abuse.  
True \_\_\_\_\_ False \_\_\_\_\_
3. An example of fraud is when a provider knowingly bills for services provided that were not medically necessary.  
True \_\_\_\_\_ False \_\_\_\_\_
4. A provider that routinely miscodes a service could be committing Medicare abuse without intentional fraud.  
True \_\_\_\_\_ False \_\_\_\_\_
5. List the four items that must be contained in the annual handbook, "Medicare and You."
  - A. \_\_\_\_\_
  - B. \_\_\_\_\_
  - C. \_\_\_\_\_
  - D. \_\_\_\_\_

6. It is Medicare abuse when a provider changes medical records to justify a higher payment unintentionally.
- True \_\_\_\_\_ False \_\_\_\_\_
7. It is Medicare fraud to knowingly falsify costs on Medicare cost reports.
- True \_\_\_\_\_ False \_\_\_\_\_
8. It is Medicare fraud when someone by mistake bills Medicare for psychological services, not furnished.
- True \_\_\_\_\_ False \_\_\_\_\_
9. A client that calls HICAP, saying that they were asked for their Medicare card and charged a \$10 fee for getting a flu shot, should be instructed to:
- A. \_\_\_\_\_ call the Medicare fraud hotline.
- B. \_\_\_\_\_ review their next Medicare Summary Notice to see what was billed and why.
- C. \_\_\_\_\_ turn in the name of the provider to the Medicare Administrative Contractor.
10. The Medicare Summary Notice is a replacement of what previous form?
- A. \_\_\_\_\_ the doctor or providers office receipts.
- B. \_\_\_\_\_ the billing statement to Medicare.
- C. \_\_\_\_\_ the Explanation of Medicare Benefits (EOMB) that was previously used by the Medicare.
11. The Medicare Incentive program rewards consumers with monetary awards for reporting fraud and abuse.
- True \_\_\_\_\_ False \_\_\_\_\_
12. Medicare publications that focus on fraud, identify the state SHIP as a resource to help persons with questions about their Medicare bills.
- True \_\_\_\_\_ False \_\_\_\_\_
13. Based on the definition of fraud and abuse, indicate whether the following would be fraud or abuse.
- A. \_\_\_\_\_ exceeding the Medicare limiting charge.

- B. \_\_\_\_\_ offering a discount or monthly award for referring Medicare patients to a supplier of durable equipment.
- C. \_\_\_\_\_ using another person's Medicare card to obtain medical services.
- D. \_\_\_\_\_ excessive charges for services or supplies.
- E. \_\_\_\_\_ submitting bills to Medicare when Medicare is not the primary insurer.
- F. \_\_\_\_\_ repeatedly violating the assignment agreement by balance billing clients for services.
14. Whom would you first contact to resolve a question about a Medicare billing?
- A. \_\_\_\_\_ The provider.
- B. \_\_\_\_\_ FEMA.
- C. \_\_\_\_\_ The U.S.D.A.
- D. \_\_\_\_\_ EPA.
15. Number the order of steps from first to last, to resolve a complaint from a client that their doctor is committing fraud by repeated lab tests.
- A. \_\_\_\_\_ Call the Medicare Administrative Contractor
- B. \_\_\_\_\_ Ask the client to bring the Medicare Summary Notice(s) that reflect the tests.
- C. \_\_\_\_\_ Ask the client to ask the provider, why it is necessary to repeat the lab test with such frequency?
16. Many complaints referred to the SHIP may not be fraud, but simple misunderstanding or billing errors that can be resolved by reviewing the Medicare Summary Notice with a client.
- True \_\_\_\_\_ False \_\_\_\_\_
17. The Office of the Texas Attorney General would be a referral source of which of the following situations:
- A. \_\_\_\_\_ Telemarketing fraud.
- B. \_\_\_\_\_ A new miracle drug that claims to heal arthritis.
- C. \_\_\_\_\_ Raising the cost of cooling fans during a heat wave.

- E. \_\_\_\_\_ Documented cases of nursing facility abuse.
- F. \_\_\_\_\_ A and B only.
- G. \_\_\_\_\_ All of the Above.
18. If the Texas Attorney General's Office investigated and verified Medicaid fraud, it would not have the authority to prosecute but would instead refer the case to the federal level.
- True \_\_\_\_\_ False \_\_\_\_\_
19. The Texas Attorney General's Office works with which local entities to educate older Texans and other vulnerable groups about criminal and deceptive trade practices.
- A. \_\_\_\_\_ Local chapters of the American Association for Retired Persons (AARP).
- B. \_\_\_\_\_ Enforcement groups including the police department, and sheriff offices.
- C. \_\_\_\_\_ Local Better Business Bureau offices
- E. \_\_\_\_\_ All of the Above.
- F. \_\_\_\_\_ A and B only.
20. The Texas Department of Insurance investigates suspected fraud cases related to Insurance.
- True \_\_\_\_\_ False \_\_\_\_\_
21. An insurance company can be held liable for the fraudulent actions of agents selling their product.
- True \_\_\_\_\_ False \_\_\_\_\_
22. The Texas Department of Insurance has the authority to impose which of the following:
- A. \_\_\_\_\_ To revoke the license of an agent or insurance company.
- B. \_\_\_\_\_ To halt the sale of insurance products that are being sold in Texas without a license (cease and desist orders.)
- C. \_\_\_\_\_ To levy fines for non-compliance with state insurance rules and regulations.
- D. \_\_\_\_\_ All of the Above.

23. Complaints about insurance benefits that are due to be paid by private insurance would be directed to the Texas Department of Insurance.

True \_\_\_\_\_ False \_\_\_\_\_

24. “Twisting” is an insurance term that refers to fraud by obtaining sales leads through advertising that hides the fact that an agent or company may be selling insurance.

True \_\_\_\_\_ False \_\_\_\_\_



Chapter Seven  
Answer Key

1. F
2. T
3. T
4. T
5. A. a statement indicating that errors occur and urging review of the Medicare Summary Notice (MSN),  
  
B. a description of the beneficiary's right to request an itemized statement from the provider,  
  
C. promotion of the Medicare incentive program, and  
  
D. the toll-free hotline number to the DHHS Inspector General to report complaints and information about fraud, waste, and abuse.
6. T
7. T
8. F
9. B
10. C
11. T
12. T
13. A. Abuse  
  
B. Fraud  
  
C. Fraud  
  
D. Abuse

E. Abuse

F. Fraud

14. A. The provider

15. A. 3

B. 2

C. 1

16. T

17. G

18. F

19. E

20. T

21. T

22. D

23. T

24. F