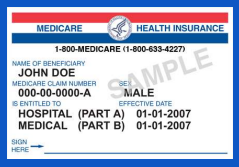
MEDICARE/HEALTH CARE/VA BENEFITS 2017

Linda R. Chamberlain, Board Certified Elder Law Attorney
Special Needs Lawyers, PA
www.SpecialNeedsLawyers.com

WHAT IS MEDICARE?

- The Red, White and Blue Card. Beginning in 2018 new Medicare Cards available with identifier number – no longer use your Social Security number.



WHO IS COUNTING?

There are **142** days till Medicare Open Enrollment, beginning October 15 – December 7, 2017.

WHAT IS MEDICARE?

- Medicare is health insurance for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (kidney failure requiring dialysis or kidney transplant).
- Title XVIII of the Social Security Act is administered by the Centers for Medicare and Medicaid Services. Title XVIII appears in the United States Code as §§1395-1395ccc, subchapter XVIII, chapter 7, Title 42.
- Regulations of the Secretary of Health and Human Services relating to Title XVIII are contained in chapter IV, Title 42, and in subtitle A, Title 45, Code of Federal Regulations.
- When researching you will want to utilize www.medicare.gov and www.ssa.gov. Each year Medicare publishes "Medicare and You."

MEDICARE PART A

- Hospital Benefits
- Home Health Care Benefits
- Hospice Benefits
- Skilled Nursing/Rehabilitation Benefits
- Mental Health Inpatient Stay

MEDICARE PART A- COST

- You usually don't pay a monthly premium for Medicare Part A coverage if you or your spouse paid Medicare taxes while working.
- If you buy Part A, you'll pay up to $413 each month in 2017. (If you paid Medicare taxes for less than 30 quarters the premium is $413, if you paid Medicare taxes for 30-39 quarters, the premium is $227).

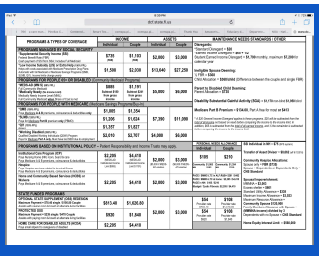
MEDICARE PART A – COSTS

- $1,316 deductible per benefit period (benefit period starts upon admission to hospital)
- $0 for the first 60 days of each benefit period
- $329 per day for days 61-90
- $658 per "lifetime reserve day" after day 90 (up to a maximum of 60 days over your lifetime).

MEDICARE PART A – PRACTICE TIP TO REVIEW WITH YOUR CLIENTS

- If Medicare beneficiary has income less than $1,005 per month and assets less than $7,390 – Can apply to Medicaid for Qualified Medicare Beneficiary (QMB) benefits (the benefit pays Part A & B premiums, coinsurance & deductibles).
- ***See SSI/Medicaid Grid for couple limits.

MEDICAID PROGRAMS AVAILABLE TO HELP PAY FOR MEDICARE PREMIUMS



MEDICARE PART B

- Physician Services
- Preventative Services
- Tele-Health covered IF patient lives within a Health Professional Shortage Area.
- Not covered:
  - Long-term care.
  - Routine Dental and Eye Exams
  - Dentures
  - Cosmetic Surgery
  - Acupuncture
  - Hearing aids and Exams
  - Concierge Care

MEDICARE PART B- COSTS

- Standard Part B premium is $134/month (or higher depending on your income). If your income is greater than $85,000/year as a single, or $170,000 married – your premium can be $187.50/month – up to $428.60/month.
- Part B deductible is $183/year.
- After deductible is met typically pay 20% of the Medicare-approved amount for doctor's services, outpatient therapy, and DME.

MEDICARE PART B – PRACTICE TIP

- If Medicare beneficiary has income less than $1,206/month and assets less than $7,390 – can apply to Medicaid for the Specified Low-Income Medicare Beneficiary (SLMB benefits) (pays Part B premium only).
- If Medicare beneficiary has income less than $1,357 and assets less than $7,390 – can apply to Medicaid for the Qualifying Individual (QI) to pay the Part B premium.
- ***QMB covers Part B premium, deductibles and co-pays. See Grid for Couple limits.

MEDICARE PART C

MEDICARE PART C

- Medicare Advantage Plans
  - Health Maintenance Organization Plans (HMO's).
  - Preferred Provider Organization (PPO).
  - Private Fee for Service Plan (PFFS).
  - Special Needs Plan (SNP).
  - Each plan has minimum coverage they must provide and can offer additional coverage if they wish.

MEDICARE PART C

- Medicare Advantage Plans
  - You can start your shopping online, plans are grouped by zip code and/or county.
  - Insurance websites have tools available for you to do comparisons as well as Medicare.gov.

MEDICARE PART D

- Prescription Drug Coverage
  - Creditable Prescription Drug Coverage
  - Covered Drugs (formulary)
  - Donut Hole ($3,700)
  - Catastrophic Coverage ($4,950)
  - Extra Help Program

MEDICARE PART D - COST

- Prescription Drug Coverage is whatever your plan premium states and the price they state.
- If your income is $85,000 or more, you will pay your premium + anywhere from $13.30/month - $76.20/month.

MEDICARE PART D – PRACTICE TIP

- Extra-Help Program
  - Medicare program to help beneficiaries with income less than $18,090 and assets up to $13, 820. ***Couple limits at Medicare.gov.
  - Costs are no more than $3.30 for each generic/ $8.25 for brand-name covered drugs.
  - Automatically on program if beneficiary receives full Medicaid, SSI, or QMB, SLMB, QI1.

MEDICARE SUPPLEMENT INSURANCE POLICIES (MEDIGAP)

- Can't purchase Medigap policy while enrolled in a Medicare Advantage Plan.
- Best time to buy is during your original Medigap open enrollment period.
- If you drop Medigap Insurance coverage to enroll in a Medicare Advantage program, most likely will not be able to get it back (outside the original 12 months of joining).

MEDICARE D TRANSITION RIGHTS

Sponsors of Part D prescription drug plans are required to provide beneficiaries with access to transition supplies of needed medications to protect them from disruption and must provide adequate time to move over to a drug that is on a plan's formulary (medication list), file a formulary exception requests or, or particularly for Low Income Subsidy recipients, enroll in a different plan.

TRANSITION RULES

Transition rules apply to:

- Stand-alone Medicare Prescription Plans
- Medicare Advantage Plans with Prescription Drug Coverage
- Medicare-Medicaid Managed Care Plans participating in a Dual Eligible Program
- Transition rules apply to low income beneficiaries automatically reassigned to new plans, which may or may not cover their medications.
- All plans change their drug formularies each year, so even people who remain in their same plan may find their plan no longer covers their medications or has newly imposed utilization management requirements.

TRANSITION POLICIES

Part D plans must establish transition policies to ensure beneficiaries who are stabilized on a medication are not left without coverage:

- When they first enroll in a Part D Plan.
- When they are moving to a new plan that does not cover their current drug.
- When, at the start of a new plan year, the current plan drops coverage of a drug they are taking or imposes new utilization management restrictions.
- When they experience a change in level of care (from hospital to nursing home, from a nursing home to home, hospice to standard Medicare)

WHAT ARE UTILIZATION MANAGEMENT RESTRICTIONS?

Quantity Limits - limiting the amount of a particular medication that you can receive in a given time. For example, only allowing Medicare plan members 30 tablets per 30 days and/or;

Prior Authorization - requiring plan members to get plan approval before filling a prescription and/or;

Step Therapy - requiring that plan members try lower-costing medications (such as generics) before using a more expensive drug (usually a brand-name drug).

TRANSITION POLICIES

For all enrollees plans must provide a one-time fill (30 day supply) unless a lesser amount is prescribed of an ongoing medication within the first 90 days of plan membership:

- Applies to drugs not on formulary and to those subject to utilization management controls.
- Applies to the first 90 days in the plan.
- Applies to both new members and continuing members when a plan has changed formulary.
- This does NOT cover non-Part D drugs or multiple prescriptions for the same medication.

NO MORE MEDICARE "IMPROVEMENT STANDARD"

On February 16, 2017 **Jimmo v. Sebelius** court approved a Corrective Statement to be used by CMS.

- The Medicare program covers skilled nursing and skilled therapy services under Medicare's SNF, HH, and out-patient therapy when a beneficiary needs skilled care in order to maintain or to prevent or slow decline or deterioration. ***Maintenance standard now recognized. Lack of restoration potential cannot serve as basis for denying coverage.

WHAT DIFFERENCE DOES JIMMO MAKE?

Jimmo change – in real life what does that mean?

- The documentation must justify the necessity of the skilled services provided. For example:
  - In the case of rehabilitative therapy: The patient's condition has the potential to improve or is improving in response to therapy. There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
  - In the case of maintenance therapy: The skills of a therapist are necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and the services cannot be safely carried out by the beneficiary or with assistance of non-therapists.

LOOK FOR THE MOON!

Moon – Medicare Outpatient Observation Notice

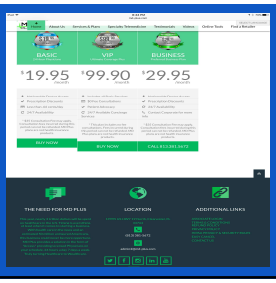
- Beginning March 8, 2017 hospitals are required to give written and oral notice to Medicare beneficiaries when they are placed in "outpatient" observation status for 24 hours and are not formally admitted to the hospital. Why do we care?
  - Hospital classification determines the costs the Medicare beneficiary has to pay for their care.

HEALTH CARE UPDATES - TELEHEALTH

All ages eligible to sign up for tele-health services and pay privately with their own money. For example, MD Plus (md-plus.com) is available 24 hours a day for a doctor in real-time for telephone consultations. Membership is $19.95/month and consult fee may be $35.

WHAT'S AVAILABLE IN TAMPA BAY?

WHAT'S AVAILABLE IN TAMPA BAY?



TELEHEALTH FOR MEDICARE BENEFICIARIES?

Telehealth Innovation and Improvement Act of 2017 introduced to the Senate March 30, 2017.

- Expands telehealth services to Medicare beneficiaries. Would provide coverage for remote monitoring technologies.
- Services to a Medicare beneficiary, i.e., remotely interrogating or programming a medical device such as a pacemaker or cardiac resynchronization therapy device outside of the Drs. office. May include Bi-directional audio/video technologies, physiologic and behavioral monitoring technologies, engagement prompt technologies, point-of-care testing technologies, other technologies as specified.

TELEHEALTH – IT'S COMING!

Telehealth Innovation and Improvement Act of 2017 introduced to the Senate March 30, 2017.

- The telehealth service shall likely do one or more of the following:
  - Assist physicians to coordinate care for patient.
  - Enhance collaboration among providers.
  - Improve quality of care to patients.
  - Reduce hospital admissions and readmissions.
  - Substitute for physician office visit.
  - Reduce utilization of skilled nursing facilities.
  - Facilitate return of patient to the community more quickly.

CHRONIC CARE ACT?

Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2017

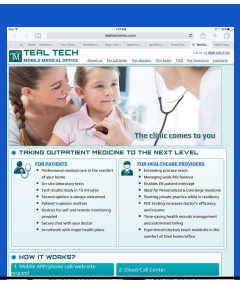
- The purpose is to implement Medicare payment policies designed to improve management of chronic disease, streamline care coordination, and improve quality outcomes without adding to the deficit.
- Funding to extend the Independence at Home Demonstration Program. Allows Health care providers to spend more time with their patients, perform assessments in a patient's home environment, and assume greater accountability for all aspects of the beneficiaries care.
- The focus is improved quality care and life for patients, while lowering health care costs.
- Year 2 study results show improved care and significant savings.

CHRONIC CARE ACT

Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2017

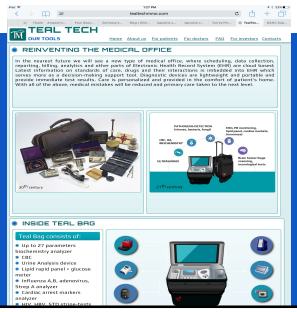
- Expand Access to Home Dialysis Therapy
- Continue Access to Medicare Advantage Special Needs Plans for Vulnerable Adults and Improve Care Management Requirements for Chronic Conditions
- Expanding Innovation and Technology and Telehealth in the Home.
- Improving Medication Synchronization – allows beneficiary to receive multiple prescriptions on same day to facilitate comprehensive counseling and promote medication adherence.
- Study Impact of Obesity Drugs on Patient Health and Spending (Medicare Part D has not covered drugs used for weight loss or gain.

SILICON VALLEY IS READY



WHAT'S THE PLAN?

PRIMARY CARE IN A WHEELY BAG!



CONTENTS IN THE BAG

AMERICAN HEALTH CARE ACT (ACA REPLACEMENT)

The American Health Care Act (replacement for ACA)

Kaiser Family Foundation Summary of the American Health Care Act

- Part D phased in coverage – not changed (no donut hole by 2019)
- Reductions to provider payments are not changed
- Increased Medicare premiums (based on income) not changed
- Repeals the HI payroll tax on high earners after 12/31/2022.

VETERANS CHOICE

Veterans Choice Program

- President signed law removing 8/7/2017 expiration date and allows the VA to utilize funding dedicated to the Veteran's Choice Program until it is exhausted.
- Program allows for authorization for Veterans to have access to care in their community (when not available at a VA Center in a timely manner (wait more than 30 days) or within a certain proximity (home is > 40 miles from VA facility).

VETERANS BENEFITS

Look back Status?

WHAT'S HAPPENING IN FLORIDA?

State of Florida update:

- SB 800 Medication Synchronization
  - The bill establishes coverage and payment requirements relating to medication synchronization. Medication synchronization is a process where a pharmacist coordinates or synchronizes refills for a patient who is taking multiple covered prescriptions, allowing them to be filled on the same day each month. Partial fills for less than the standard refill amount are often required in order to align all patient medications to the same refill date. Medication synchronization can be used to increase medication adherence.

SO WHAT MAY THE FUTURE LOOK LIKE?

- https://www.theverge.com/2017/5/19/15658614/amazon-echo-silver-elderly-sketch-watch

THANK YOU!

Linda R. Chamberlain
727.443.7898
Linda@specialneedslawyers.com