

Chapter Four

Medicare

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Chapter Four: Medicare

Introduction

What is Medicare?

Medicare is a federal health insurance program that is a primary source of coverage for adults 65 and over as well as certain individuals with disabilities. Eligibility is usually based on the work history of an individual or the individual's spouse. Some individuals may qualify even without a work history: if they are low income, they may get premium assistance, and if not, they may pay privately. Individuals must be either U.S. citizens or legal permanent residents.

Medicare does not cover all medical needs, and most beneficiaries have additional insurance (Medi-Cal, a private supplement, etc.). There are four "Parts" to Medicare: A, B, C & D.

Medicare Parts A, B, C, & D

There are four "Parts" to Medicare. Part A and Part B are referred to as "original fee-for-service" Medicare, or sometimes as "traditional" Medicare. Part C is a version of Medicare called "Medicare Advantage" - which is offered through private health care insurers. Part D is prescription drug coverage, and is discussed in Chapter 5.

Low income individuals may qualify for special programs to assist with Parts A/B/C (see 4-31), and/or for the Low Income Subsidy for Part D (see Chapter 5).

Medicare Part A is commonly known as "hospital insurance." Under certain conditions, Medicare Part A pays for a stay in a hospital or nursing home, or pays for certain expenses of home health care. In addition, Medicare Part A pays for certain expenses of hospice care provided to a terminally ill person.

Medicare Part B is commonly known as "medical insurance." Medicare Part B pays for certain expenses of physician services, therapies, tests, x-rays, and medical equipment. Under some circumstances, Medicare Part B will pay for particular services provided in a nursing home or for home health care.

Medicare Part C is Medicare Advantage, an alternative to fee-for-service Medicare. It is a system where Medicare pays a private plan to manage a beneficiary's health care. Medicare Part C coverage can include health maintenance organizations (HMOs); preferred provider organizations (PPOs); private fee-for-service plans (PFFs); special needs plans (SNPs); and medical savings accounts (MSAs).

Medicare Part D is the Medicare Prescription Drug program. Each year, prescription drug plans participating in the program are announced for the following year. Enrollment runs from October 15 to December 7 each year. A low income subsidy is available for those who qualify; applications for the subsidy are processed by Social Security. You can read more about Medicare Part D in Chapter 5.

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Eligibility

Most individuals are eligible for free Medicare Part A based on their work history. However, some individuals may be eligible without this history.

Part A Eligibility Without Premium

In general, eligibility for Medicare Part A is based on the work history of an individual or that of his or her spouse. In the most common type of eligibility, someone is at least 65 years old, and either the individual or spouse has a work history that creates an entitlement to Social Security retirement benefits (usually 40 quarters, or the equivalent of 10 years of work history). Married individuals, including those in same-sex marriages, can qualify for Medicare Part A coverage based on a spouse's work history. Certain divorced individuals, widows, and widowers can also rely on their spouse's earnings record. Eligibility does not extend to those in civil unions or domestic partnerships.

Part A eligibility is also available to persons who have been receiving Social Security disability benefits or railroad retirement disability benefits for at least 24 months. For people with end-stage renal disease (kidney failure) or ALS ("Lou Gehrig's Disease"), the 24-month waiting period is waived.

Part A Eligibility With Premium

If, due to an insufficient work history, an individual is not eligible automatically for Part A coverage, he nonetheless may be able to purchase Part A coverage. To purchase Part A coverage, he must be:

1. At least 65 years old;
2. Either a U.S. citizen or a permanent resident; and
3. Enrolled in Medicare Part B (by paying a further premium).

The 2018 premium for Medicare Part A is either \$232 or \$422 monthly, depending on work history.

***Note:** Low income individuals may be eligible for premium assistance and will not have to pay these premiums.*

Those who do not qualify automatically for Part A may choose to purchase only Part B coverage. However, as explained above, an individual wanting to purchase Part A coverage must also enroll in Part B.

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Part B Eligibility

Medicare Part B coverage is available to anyone who is eligible for Part A benefits, and/or is at least 65 years old and either a U.S. citizen or a permanent resident who has resided in the United States for the five years prior to enrollment for Part B.

Those receiving Medicare Part B coverage must pay a monthly premium—\$134 for 2018. The premium is deducted from the enrollee's Social Security, Railroad Retirement or Civil Service Retirement, or disability payment. Medicare will send a bill every three months to enrollees who do not receive any of these retirement benefits.

People who do not qualify for automatic Part A eligibility may choose to purchase only Part B coverage. However, as explained in the discussion of “Part A Eligibility With Premium,” to purchase Part A coverage, they must also purchase Part B coverage.

NOTE: *People with incomes above \$85,000 for an individual or \$170,000 for a couple will be required to pay a monthly surcharge to their Part B and Part D premiums called the Income-Related Monthly Adjustment Amount, (IRMAA).*

Part B Deductible

The beneficiary is responsible for a yearly deductible of \$183 in 2017.

Part B Co-Payment: 20 Percent

Medicare Part B payments can be made either to the beneficiary or the health care provider (physician, hospital, etc.). In general, if a provider accepts the Medicare approved amount as payment in full, Medicare will pay 80% of the cost to the provider, and the beneficiary is responsible for the other 20%. If the provider does not limit the costs of the services to the Medicare approved amount, Medicare will pay the claim to the beneficiary and the beneficiary will be responsible for the full payment to the provider, unless a limiting charge applies. Limiting charges apply only to physician and therapist services.

A more detailed explanation of the Part B co-payment, including an explanation of the Part B “limiting charge,” is set forth later in this chapter.

Medicare Part B enrollment is not automatic for many people turning 65. *Those who haven't started receiving Social Security or other federal retirement benefits need to contact the Social Security Administration to start their Part B coverage.*

Alert: *For a limited time, CMS is offering “equitable relief” to some people who were enrolled in Covered California plans with subsidies and then became eligible for Medicare. Many did not sign up for Part B when they should have because they thought, incorrectly, that their subsidies for Covered California plans would continue. As a result, they incurred late enrollment penalties. They can now file a request with the Social Security Administration to remove the Part B penalty. Details are available at www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/SHIP-and-Navigators-Fact-Sheet-Limited-Equitable-Relief.pdf. The deadline is September 30, 2018.*

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Enrollment in Medicare

Part A Enrollment

Enrollment is automatic for individuals who, at age 65, have started receiving benefits from either Social Security or the Railroad Retirement Board. For people who became disabled prior to age 65, enrollment is effective two years after the start of Social Security disability benefit eligibility, although the two-year waiting period is waived if the disability resulted from kidney failure or ALS.

An individual who does not begin receiving retirement benefits until after age 65 must apply for Medicare benefits when he turns 65. He may apply during the seven-month “Initial Enrollment Period,” which begins three months before the month of his 65th birthday and ends three months after the month of his 65th birthday.

***NOTE:** Most people enrolled in Covered California plans will lose their subsidies when they turn 65. They should promptly enroll in Medicare to avoid high premiums or coverage gaps.*

Part B Enrollment

There are three enrollment periods for Medicare Part B.

Initial Enrollment Period: If an individual is turning 65 and has not yet applied for Social Security or Railroad Retirement benefits, or Medicare Part A, he can enroll in Part B during the seven-month Initial Enrollment Period, which begins three months before the month of his 65th birthday and ends three months after that month.

General Enrollment Period: If the Initial Enrollment Period has passed, an individual may sign up during the General Enrollment Period.

- The General Enrollment Period runs from January 1 to March 31 each year.
- Coverage starts on July 1 of the year enrolled.

Penalty for Late Enrollment

- The cost of the premium will rise by 10 percent for each 12-month period in which someone who was eligible for Part B coverage did not enroll, except in special cases. This increase will apply as long as the individual receives Part B coverage.

Special Enrollment Period: This period is available to an individual who waited to enroll in Part B because he and/or his spouse was working and had group health plan coverage through an employer or union. He can sign up any time while still covered by the group health plan, or during the eight months following the date that the group health plan coverage ends or employment is terminated, whichever comes first. People who qualify for this special enrollment period are not assessed a penalty for late Medicare enrollment.

Note: This special enrollment period is available to same-sex spouses. It is not available to people with employer coverage based on a civil union or registered domestic partnership.

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Covered Services

Inpatient Hospital Care Under Medicare Part A

Medicare covers up to 90 days of hospital services in each benefit period, including a semi-private room, meals, general nursing, and other hospital services and supplies. Medicare does not cover private duty nursing, a television or telephone in the room, or a private room (unless the private room is medically necessary). Medicare also will cover an additional 60 “lifetime reserve” days, each of which can only be used once.

A “benefit period” (or “spell of illness”) begins when the beneficiary is admitted to the hospital and ends when the beneficiary has been out of the hospital for 60 consecutive days and has not received Medicare-covered care in a nursing home.

For each benefit period, the beneficiary pays:

- A deductible of \$1,340 per hospital stay.
- After the deductible has been met, a zero co-pay for days 1-60;
- \$329 per day for days 61-90 of a hospital stay; and
- \$658 per day for days 91-150 of a hospital stay.

Specialized Facilities Under Medicare Part A

Medicare covers care in a specialized facility- such as a rehabilitation hospital or a psychiatric facility- for up to 190 days during a beneficiary’s life.

Nursing Home Care Under Medicare Part A¹

Introduction

Many clients (and some advocates) are surprised by the very limited availability of Medicare Part A reimbursement for nursing home expenses. It is important to keep in mind that the Medicare program was never intended to be a comprehensive health insurance plan. For example, a general exclusion in the Medicare law forbids Medicare payment for any service or item deemed “custodial” in nature.

Maximum Duration of Payments

At most, Part A of the Medicare program pays for 100 days of nursing home care per benefit period, and only the first 20 days are paid in full. During days 21 through 100, the beneficiary must pay a daily co-payment of \$164.50 in 2017.

¹ This guide’s discussion of Medicare payment for nursing home care is taken in part from the Nursing Home Companion (Bet Tzedek Legal Services) and Chapter Eight of Eric M. Carlson, Long- Term Care Advocacy (Matthew Bender & Co.).

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Qualifying Hospital Stay

Medicare Part A may pay for a beneficiary's nursing home stay only if he has entered the nursing home within 30 days after being hospitalized in a hospital for at least three nights. Generally, the resident must begin receiving the Medicare-qualifying level of care (see below) within this 30-day period, although there is an exception if that level of care was not "medically appropriate" until after the expiration of the 30-day period.

Advocates should also be aware that sometimes, although an individual has spent three nights in a hospital, part or all of that time may not count for a qualifying hospital stay because the individual was in "observation status" and not considered to be an admitted patient. Hospital expenses for patients in observation status are treated as outpatient expenses and covered under Medicare Part B, which usually means that the individual pays more than if she were admitted as an inpatient.

Starting in March 2017, hospitals now must give a notice, called a MOON Notice, to patients in observation status for more than 24 hours. The notice includes an explanation of why the patient is in observation status and how it affects Medicare benefits.

Level of Care

Medicare Part A pays nursing home charges only for residents who need "skilled nursing or skilled rehabilitation services." For example, "skilled" nursing services (as defined by the Medicare program) include intravenous feeding, the treatment of widespread skin disorders, and the monitoring of residents who require relatively sophisticated evaluations. "Skilled" rehabilitation services include, for example, "range of motion" exercises, services provided by a speech pathologist, and physical, occupational, and speech therapy.

Note that a resident may qualify for Medicare Part A payment of his nursing home charges if he requires only one "skilled" service. Note also that the "skilled" services mentioned in the preceding paragraph are examples only. The Medicare regulations clearly state that a variety of conditions may qualify a resident for Medicare Part A payment of nursing home charges.

For residents receiving therapy, nursing homes frequently – but falsely– claim that Medicare Part A cannot pay unless a resident's condition is improving. Actually, prescribed therapy can justify Medicare Part A reimbursement even without current progress, if progress can be reasonably expected in the foreseeable future, or if therapy is necessary to maintain a resident's condition.

It should be noted, however, that most long- term residents of nursing homes are not receiving "skilled" services as defined by Medicare. The Medicare regulations state that the need for routine personal care services such as administration of medications, the maintenance of catheters, and the turning of residents do not qualify an individual for Medicare Part A payment of nursing home charges.

Remember: *Reimbursement can continue for therapy even if the resident is not "improving," if the therapy is medically justified.*

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Determining Level of Care

The nursing home makes the initial decision on whether a resident is qualified for Medicare Part A payment of nursing home charges. Consequently, a resident or family member immediately and consistently should emphasize the “skilled” services required by the resident.

If at any time (including the time of admission) the nursing home decides that the resident is not qualified for Medicare Part A payment of nursing home charges, the nursing home must give the resident written notice of the nursing home’s decision. If the resident or family member feels that the resident is qualified medically for Medicare Part A payment of nursing home charges, and thus disagrees with the nursing home’s decision, the resident or family member may appeal the nursing home’s decision. The resident or family member begins the appeal by returning the written notice to the nursing home after checking a box that states:

“Yes. I want to receive these items or services. I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicaid makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare’s decision.”

While the Medicare program considers an appeal of a nursing home’s decision, the nursing home cannot bill the resident for the nursing home charges in dispute. If the Medicare program eventually agrees with the nursing home and concludes that the resident was not qualified medically for Medicare Part A payment of nursing home charges, the resident or family member can appeal the Medicare program’s decision as well. During this second appeal, however, the nursing home can bill the resident for the charges in dispute.

If a nursing home fails to provide a resident or the resident’s family members with the required notice, a resident or family member should request in writing that the nursing home submit a bill to Medicare Part A, even if the resident’s medical condition may not meet the requirements described earlier in this chapter. Under Medicare law, a nursing home’s failure to give adequate notice may excuse the resident from paying the charges incurred during certain weeks or months, if the Medicare program finds that the resident could not have known that Medicare Part A would not be covering the charges incurred during that time period.

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Home Health Care Under Medicare Part A

The Basics of Home Health Care

Home health care is skilled care that is provided at the beneficiary's home, rather than in a nursing home. The home may be a residential care facility for the elderly or a similar facility.

If skilled care is required, other non-skilled services may be provided as well.

The Medicare home health benefit may include the following services or supplies:

- Skilled nursing care on a part-time or intermittent basis;
- Physical, speech and/or occupational therapy;
- Home health aide services on a part-time or intermittent basis;
- Medical social services;
- Medical supplies (not including drugs); and
- Medical equipment.

The Medicare home health benefit does not pay for:

- Around-the-clock care at the home;
- Prescription drugs;
- Home-delivered meals;
- Shopping, cleaning or laundry service; or
- Transportation.

Beneficiary Must Be Homebound

Home health care can be provided only to those beneficiaries considered "homebound," based on the reasoning that those who are not homebound can travel to a hospital or clinic for routine health care. A beneficiary is considered "homebound" if leaving the home is a very difficult process. In determining whether a beneficiary qualifies as "homebound," the beneficiary is not penalized for leaving home to receive health care treatment or to attend an adult day care program. Also, attending religious services does not limit a beneficiary's ability to be considered homebound.

Note: A beneficiary can be considered "homebound" even if he leaves the house on occasion.

Part-Time or Intermittent Care

Medicare will provide home health care only if the need for skilled nursing care is part-time or intermittent. This means that care is given less than seven days a week, or less than eight hours a day, with no more than 28 hours per week (although this may be increased to 35 hours on a case-by-case basis).

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Skilled Services

The nursing care or therapy services must be “skilled.”

Nursing care is considered “skilled” if a nursing service requires the expertise of a licensed nurse. For example, treatment of a wound and administration of an injection are skilled nursing services that qualify for Medicare reimbursement. On the other hand, bathing and helping with dressing are services that do not qualify as “skilled” services. For therapy services to be considered “skilled,” the expertise of a licensed physical therapist or certified speech therapist must be required.

Note: *If “skilled” care is required, the skilled care can be accompanied by “unskilled” personal care assistance.*

Home Health Aide

If a beneficiary requires skilled nursing services or skilled therapy, the Medicare home health benefit may also be able to provide the part-time assistance of a home health aide, as appropriate given the beneficiary’s care plan.

A home health aide is a health care worker who doesn’t have a nursing license. At least 75 hours of training is required. Home health aides help with non-medical care such as bathing, dressing, or exercising.

Authorization of Services

A physician must order home health care, and a care plan must be developed. Care must be provided by a Medicare-certified home health agency.

No Deductibles or Copayments

Medicare pays the full amount of all covered services, with a very limited exception: for durable medical equipment only, the beneficiary is responsible for 20% of the approved amount.

If a Home Health Agency Believes that Medicare Will Not Pay

If a home health agency believes that Medicare will not pay for services, and as a result decides to deny or cut back care, the home health agency first must give the beneficiary a Home Health Advance Beneficiary Notice (ABN). This notice must explain why the home health agency believes that Medicare won’t pay for the services, and must describe how the beneficiary can contest the agency’s decision.

Forcing a Home Health Agency To Bill Medicare

If a beneficiary is given a notice of non-coverage, the beneficiary may require that the home health agency bill the Medicare program. The bill submitted by the agency is called a “demand bill.”

When a demand bill has been submitted, the home health agency still can require the beneficiary to pay in advance for the services for which Medicare has been billed.

If the Medicare program subsequently pays for those services, the home health agency must reimburse the beneficiary.

Appeal

When the Medicare program denies payment of a bill (including a demand bill), the notice will contain instructions for filing an appeal. The appeals process is described later in this chapter, starting on page 4-19.

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Hospice Care Under Medicare Part A

What is Hospice?

Hospice care is specialty care for terminally-ill individuals and their families. Hospice care includes both medical care and counseling services. Hospice care focuses on keeping the resident comfortable – physically and emotionally – and does not attempt to cure the illness that is expected to cause the beneficiary's death. For example, a hospice program might put extra emphasis on pain reduction, supportive services, and/or respite care.

Eligibility for Hospice Care

A Medicare recipient who is terminally ill – i.e., certified by a physician as likely having a life expectancy of no more than six months – may elect to receive hospice care under Medicare Part A, in exchange for waiving his right to receive treatment under Part A for the terminal condition. The beneficiary retains his right to Medicare funding for medical conditions other than the terminal condition. At any time, the beneficiary may elect to leave hospice and return to original Medicare.

A beneficiary is entitled to two 90-day periods of hospice care, and an unlimited number of subsequent periods of 60 days each. For each period, he must be certified by a physician as being terminally ill.

Very Limited Cost to Beneficiary

Hospice care has no deductibles and very limited co-payments. A beneficiary pays a five percent co-payment for outpatient drugs and inpatient respite care.

What Services Are Provided?

The Medicare hospice benefit is similar to the home health benefit, and covers the following services:

- Physician services;
- Nursing services;
- Medical equipment;
- Medical supplies;
- Medication for symptom control and pain relief;
- Short-term hospital care;
- Home health aide and homemaker services;
- Physical, speech and occupational therapy;
- Social worker services;
- Dietary counseling; and
- Grief and loss counseling for the patient and the family.

The inpatient care is used for pain control, chronic symptom management, and/or providing a respite to regular caregivers.

Note: *Hospice care can continue indefinitely, as long as a physician continues to certify that the beneficiary is expected to die within the next six months.*

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Care Plans and Services

The hospice works with the beneficiary and the physician to form an individualized plan of care. Hospice care may be provided by a physician, a nurse, counselors and clergy members, social workers, home health aides, and trained volunteers.

Where Is Care Provided?

Hospice services mostly are provided where the beneficiary is living, whether the beneficiary is living in a house, apartment, assisted living facility, or nursing home.

Inpatient care is available for pain control and chronic symptom management. Also, for periods of no more than five days at a time, the Medicare hospice benefit may cover inpatient care to give at-home caregivers a respite from the rigors of caregiving.

Services Under Medicare Part B

Part B covers a wide range of medical services and supplies, including (but not limited to) the following:

- Annual wellness visit with no deductible or co-pay;
- Physician services;
- Outpatient hospital services;
- Home health care;
- Outpatient physical therapy, speech therapy, and occupational therapy;
- Psychologist and clinical social worker services;
- Durable medical equipment (wheelchairs, walkers, braces, oxygen equipment, etc.);*
- Medical supplies (ostomy bags, surgical dressings, splints, etc.);*
- Artificial limbs*;
- Ambulance services;
- X-rays;
- Laboratory and other diagnostic tests;
- Immunosuppressive drugs;
- Pneumonia and Hepatitis B vaccine (no co-pays);
- Flu vaccine (no co-pays);
- Diabetes self-management training and supplies;
- Glucose monitors and testing strips;
- Annual glaucoma screening for beneficiaries at a high risk for glaucoma;
- Pap smears and pelvic exams once every two years, or annually for high-risk women;
- Yearly mammograms for women age 40 and above (for those 35-39, one baseline mammogram);
- Annual prostate cancer screening test for men age 50 and above; and
- Colorectal cancer screening for beneficiaries age 50 and above.

* Special rules apply in the Competitive Bidding program for durable medical equipment, prosthetics, orthotics, and supplies in all or parts of many California counties. These rules also apply to those who travel to other areas in the U.S. covered by the Competitive Bidding Program. See www.medicare.gov/supplier for a list of suppliers searchable by zip code.

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No Co-Payment for Some Services

No co-payment is required for clinical laboratory services such as blood tests and urinalysis. Also, no co-payment is required for home health care, with the exception of the 20% co-payment that a beneficiary is required to pay for durable medical equipment provided as a part of the home health care. Also, there are no out-of-pocket costs for a wide range of preventive services, such as screenings for various cancers (including breast, colon, prostate, cervical), as well as heart disease, osteoporosis, glaucoma, and diabetes.

Services Not Covered Under Medicare Part B

Medicare Part B does not offer comprehensive coverage of health care services. Among those services and items not included in the Part B benefit are the following:

- Dental services;
- Eye glasses or contact lenses (except as a follow-up to cataract surgery); and
- Hearing aids

Note: Medicare allows a provider to charge a beneficiary for a missed appointment as long as the provider has the same policy for all patients, not just those with Medicare.

Submission of Medicare Part B Claims

Part B claims must be submitted by a Medicare Part B provider. The beneficiary generally does not submit these claims directly to the Medicare carrier. The time limit for submitting a claim to Medicare generally is the close of the calendar year after the year the services were provided.

Refusing to Accept Assignment

When a provider does not accept an assignment, the beneficiary is liable for the 20% co-payment plus the amount by which the provider's charge exceeds the Medicare-approved amount. The beneficiary pays the provider directly and Medicare will pay the beneficiary rather than the provider.

To protect beneficiaries from exorbitant charges, Medicare imposes a "limiting charge" of 115% of the Medicare-approved amount on physician services, and the charges of independent occupational, speech or physical therapists. Providers bound by the charge limit must accept 115% of the Medicare-approved amount as payment in full.

EXAMPLE

The Medicare-approved amount for a physician's visit is \$100. Even if a physician charges \$150, the Medicare program will impose a limiting charge of \$115. Of that \$115, Medicare will pay \$80 (80% of the approved amount), and the beneficiary will pay \$35 (20% of the approved amount, plus the \$15 difference between the approved amount and the limiting charge).

- Office Visit- \$150
- Approved Charge- \$100
- Medicare Payment (80% of what is approved) - \$80
- Medicare Charge Limit (115% of the approved amount)- \$115

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Hospital Discharge Planning

Federal Medicare law requires hospitals to provide Medicare-covered patients with discharge plans. A discharge plan should be prepared by the hospital staff in conjunction with the beneficiary and his family.

A discharge plan describes the care and services a beneficiary may need after leaving the hospital, and explains how such services may be provided. Also, a discharge plan gives the beneficiary guidance on how to improve or maintain his health after leaving the hospital.

Challenging Hospital Discharges

Expedited Appeals of Part A Hospital Discharge Decisions - Notice of Non-Coverage

A Medicare beneficiary must be provided with notice of discharge rights twice during the course of the hospital stay (this occurs when a beneficiary is given a notice called “An Important Message from Medicare” (IM) within two days after admission and again two days to four hours before discharge; if the stay is three days or less, once is sufficient). The information provided must include a description of the beneficiary’s hospital discharge appeal rights.

The IM notice must contain explicit information about 1) the process for requesting appeals of discharge decisions, 2) the right to remain in the hospital without charge if an expedited decision is requested, and 3) the right to receive a detailed notice of the reasons for discharge.

BFCC-QIO Expedited Review

If the beneficiary believes that he is not medically ready to be discharged from the hospital, he has the right to appeal the discharge in an expedited appeal process. The appeal is made to Livanta, the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for California. Contact Livanta online or by phone at 1-877- 588-1123 or 1-855-887-6668 (TDD for the hearing impaired). The patient may remain in the hospital at least until noon of the day after the BFCC-QIO decision.

If the beneficiary’s physician agreed with the discharge decision, the beneficiary has the right to appeal the decision by requesting an expedited review. The beneficiary should contact the BFCC-QIO before noon of the first working day after the date the Notice of Non-Coverage was received and ask the BFCC-QIO to review the case. This request may be verbal or written.

Note: A beneficiary should not be shy in requesting an appeal if he believes that further hospital care is appropriate.

If the BFCC-QIO issues a favorable decision, Medicare will continue to pay for the care.

If the BFCC-QIO is contacted within the above time limit and decides against the beneficiary, the hospital may charge the beneficiary for any costs incurred starting at noon of the day after the day the BFCC-QIO decision is received.
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EXAMPLE

On Monday, March 19, Maria received a written Notice of Non-Coverage from her hospital, notifying her that hospital care was no longer required for her condition, and that Medicare Part A would no longer pay for hospital care. Maria's physician agreed with this determination. Maria appealed to Livanta the following morning (March 20). Livanta denied her appeal on March 22. Accordingly, the hospital could not begin charging Maria until noon of Friday, March 23.

QIC Expedited Reconsideration

If the BFCC-QIO decision is unfavorable, the beneficiary has the right to request a reconsideration by the Quality Independent Contractor (QIC). The QIC for California is Maximus Federal Services. The request for a reconsideration must be made by no later than noon of the calendar day following the receipt of the BFCC-QIO decision. If the beneficiary requests the reconsideration within this timeframe, the hospital may not bill the beneficiary until the QIC makes a decision.

If the QIC is not contacted in a timely manner, the beneficiary will be liable for all costs of hospitalization starting at noon of the day after the receipt of the Notice of Non-Coverage.

If the beneficiary does not file a request for reconsideration within this specified timeframe, he must use the standard appeal process.

Expedited appeal rights around hospital discharge decisions are equally available to beneficiaries in fee-for-services Medicare and to those who are members of Medicare managed care plans.

Additional Appeal Rights for Hospital Discharge Cases

Following the expedited reconsideration, the beneficiary can appeal a hospital discharge using the same appeal rights available for standard Medicare Part A appeals.

Expedited Appeals of Skilled Nursing Facility, Home Health, Hospice and Comprehensive Outpatient Rehabilitation Facility Services

A beneficiary has the right to an expedited appeal when services are terminated by a skilled nursing facility, home health agency, hospice or comprehensive outpatient rehabilitation facility. The provider must provide written notice to the beneficiary at least two days or two visits before the services are to be terminated.

Expedited Determination

If the beneficiary wants to appeal the decision to terminate services, he must request an expedited determination by Livanta, the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for California. Contact Livanta online or by phone at 1-877-588-1123 or 1-855-887-6668 (TDD for the hearing impaired). Contact Livanta by noon of the day prior to the termination of services.

The beneficiary can make this request online, in writing, or by phoning. The provider must provide a second notice that includes detailed information regarding why the services were terminated. The provider must also continue to provide services until two days after the first notice was given or until the service termination date (whichever is later).

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Once the request for an expedited appeal is made, Livanta has 72 hours to make a determination. The decision is communicated by telephone, and a written decision is also provided. The determination must provide an explanation of the decision, the beneficiary's liability for services, and information on the beneficiary's appeal rights.

Expedited Reconsideration

A beneficiary has the right to appeal the expedited determination. To do so, he requests an expedited reconsideration by Maximus, the Quality Independent Contractor (QIC). The request can be made by phone or in writing and must be submitted by noon of the calendar day following the decision by Livanta. The QIC must make a decision within 72 hours of receiving the expedited reconsideration request. The QIC decision may be communicated by phone with a written notice that follows. The notice must provide the same type of information that is given in the determination decision.

If the reconsideration is unfavorable, the beneficiary has the right to continue using the standard fee for service appeals process.

Note: *Medicare Advantage enrollees have the same expedited discharge review and appeal rights for hospital, skilled nursing facility, home health, hospice and comprehensive outpatient rehabilitation facility services as beneficiaries who use fee-for-service Medicare.*

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Medicare Managed Care Organizations

Introduction

Medicare managed care plans provide hospital, outpatient and other health care services to Medicare beneficiaries who have assigned their Medicare benefits to these health plans. Medicare managed care plans are called Medicare Advantage (MA) plans in federal Medicare law. Most Medicare MA plans include prescription drug coverage and are referred to as MA-PD plans.

Many Medicare beneficiaries join Medicare MA plans in order to reduce their out-of-pocket medical expenses and to obtain benefits not covered by fee-for-service Medicare, such as the dental care and vision care offered by some plans.

The Medicare program pays a Medicare MA plan a monthly capitation payment for each Medicare enrollee.

Medicare MA plan members must use the plan for all their medical care needs except in certain circumstances such as emergency and urgent care situations. If they use a provider outside the plan's network without plan authorization, they will have to pay a higher co-payment or, in many cases, the full cost of the service. Because the Medicare program pays the plan a flat fee in advance, the Medicare claims process does not exist in MA plans.

A Medicare beneficiary must have Medicare Parts A and B in order to join a Medicare MA plan. Medicare beneficiaries who have end-stage renal (kidney) disease cannot join most Medicare MA plans. However, persons who are diagnosed with end-stage renal disease while in a Medicare MA plan cannot be forced to disenroll. Medicare beneficiaries receiving hospice care may enroll in a Medicare Advantage plan. Their hospice benefit will be covered under original Medicare.

With the exception of beneficiaries with end-stage renal disease, all Medicare beneficiaries are eligible to enroll in a Medicare MA plan. A Medicare MA plan cannot screen out applicants based on health history or disability.

Some Medicare Advantage Plans, called Special Needs Plans (SNPs) can limit enrollment to particular groups of individuals. SNPs are required to show that they are designed to meet the particular needs of the population they serve. There are three types of SNPs: those for people dually eligible for Medicare and Medicaid (D-SNPs), those for people with certain chronic conditions (C-SNPs) and those needing institutional care (I-SNPs). Most SNPs are D-SNPs.

Note: Medicare MA plans have limited provider networks. A beneficiary should check carefully to see whether her providers are part of the network of any Medicare MA plan she is thinking of joining. **MA plans cannot impose cost-sharing that exceeds that of original Medicare for the following: chemotherapy administration, renal dialysis services, and skilled nursing facility care.**

Cal MediConnect

California is one of several states participating in a demonstration project that combines Medicare benefits with Medicaid benefits through enrollment in a managed care plan. Cal MediConnect plans are available in Los Angeles, Orange, Riverside, San Bernadino, San Diego, San Mateo, and Santa Clara counties. Cal MediConnect is part of a broader program in California called the Coordinated Care Initiative (CCI). For more about the CCI, go to Chapter 6.

Chapter Four: Medicare

PACE

Programs for All-Inclusive Care for the Elderly (PACE) are available in many California counties, including Los Angeles, and provide comprehensive community-based care for older adults who have high care needs. To qualify for PACE, a Medicare beneficiary must be 55 or older, live in the service area of a PACE organization, be certified by the state as needing a nursing home-level of care and, at the time of enrollment, be able to live safely in the community with the help of PACE services. A large majority of PACE participants are dual eligible and they receive both their Medicare services and their Medi-Cal services through PACE. Medicare beneficiaries who do not qualify for Medi-Cal can also enroll in PACE but will be required to pay a monthly premium for the long-term services portion of the PACE benefit and a premium for Medicare Part D drugs.

Enrollment in Medicare Advantage Plans

Enrollment Process and Effective Enrollment Date

Beneficiaries enroll in a Medicare Advantage plan by filling out and signing a Medicare Advantage enrollment form and submitting it to the Medicare Advantage plan. Beneficiaries also can enroll online at the Enrollment Center section of the Medicare website, www.Medicare.gov. Beneficiaries also can contact the Medicare Advantage plans to enroll by phone.

The effective date of the Medicare Advantage enrollment depends on when the beneficiary has applied for enrollment. If the enrollment occurs during an open enrollment period, October 15 through December 7, the enrollment is effective on January 1.

A beneficiary may also disenroll from a Medicare Advantage Plan from January 1 to March 31, and return to original fee-for-service Medicare and a Part D plan or change to another Medicare Advantage plan.

Enrollment Periods

There are four enrollment periods during which a Medicare beneficiary can enroll in a Medicare Advantage plan. Some of these enrollment periods overlap, and the enrollment rules are complicated.

Initial Coverage Election Period (ICEP)

The initial coverage election period is the time period during which a person becomes newly eligible for Medicare A and B. The ICEP is the same as the initial enrollment period in Medicare Part B; it begins three months before an individual is eligible, including the month she is eligible, and ends three months later.

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Open Enrollment Period (OEP)

The open enrollment period is the time period during which a beneficiary can change from one Medicare Advantage plan to another or enroll in and disenroll from a Medicare Advantage plan. The OEP extends from October 15 to December 7 of each year. Enrollment changes made during the OEP are effective January 1 of the following year.

Medicare Advantage Open Enrollment Period (MA OEP)

An individual who enrolls in an MA plan may switch to another Medicare Advantage plan or return to original Medicare and a Part D plan during the first three months of a year, January 1 - March 31. If she is new to Medicare and her Medicare eligibility begins mid-year, the three month period begins the first month of her MA plan enrollment.

Note that the MA OEP, which starts in 2019, replaces the Medicare Advantage Disenrollment Period, which used to provide more limited opportunities to change and which had extended from January 1 to February 14 each year.

Special Enrollment Period (SEP)

Medicare provides for special enrollment periods for Medicare Advantage enrollees. They can enroll at any time in a plan that receives a five-star quality rating from Medicare. Enrollees who receive the Low Income Subsidy or live in nursing homes also can change plans at any time. Special Enrollment Periods also are available in a variety of circumstances including:

- the enrollee no longer lives in the Medicare Advantage plan service area
- the Medicare Advantage plan no longer contracts with Medicare or no longer provides services in the service area
- the beneficiary disenrolls from the Medicare Advantage plan during the first year he is in a Medicare Advantage plan
- the enrollee has enrolled in or disenrolled from a Medicare Advantage plan due to bad information or action by a federal employee
- the beneficiary has lost creditable retiree drug coverage or the coverage has been reduced so that it is no longer creditable
- other situations that are approved by CMS (Medicare)

See the Supplemental Materials at the end of Chapter 5 for a full list of Special Enrollment Periods.

Disenrollment from Medicare Advantage Plans

Medicare beneficiaries can disenroll from a Medicare Advantage plan only during one of the prescribed enrollment periods. Signing up for another plan automatically causes disenrollment from the old plan. A beneficiary also can disenroll by completing, signing and submitting a disenrollment form to the Medicare Advantage plan or by calling 1-800-MEDICARE. The effective date of the disenrollment depends upon the enrollment period. If the beneficiary disenrolls during the annual open enrollment period, it will be effective January 1.

Note: *Beneficiaries with the Medicare Part D Low Income Subsidy (Extra Help) can change plans at any time. The change will be effective starting the first day of the following month.*

This unlimited opportunity to change plans will change next year. *Starting January 1, 2019, people with Extra Help will be limited to one change per quarter unless they also qualify for another Special Enrollment Period.*

Chapter Four: Medicare

Medicare Part A & B Appeals

Introduction

As discussed in earlier sections of this manual, Medicare Part A and B claims are processed by Medicare contracting carriers and intermediaries. These Medicare contractors are responsible for processing the initial claim determination on Medicare claims and for some of the earlier stages of the Part A and B appeals process.

In this section of the manual, we will discuss the Medicare Part A and B appeals process in detail.

Detailed descriptions of the Medicare Advantage and Part D appeals processes are outlined in the respective sections on Medicare Advantage plans and the Part D program.

Overview of the Part A and B Appeals Process

Medicare Part A and B fee-for-service appeals follow a standard pattern of steps:

1. Initial determination made by a Medicare carrier or intermediary;
2. Redetermination made by the same Medicare carrier or intermediary;
3. Reconsideration, an external review that is made by an independent entity that contracts with Medicare;
4. Administrative Law Judge hearing;
5. Medicare Appeals Council review;
6. Federal District Court.

Initial Determination

When a Medicare carrier or intermediary processes a claim, a Medicare Summary Notice (MSN) is sent to the Medicare beneficiary. MSNs are mailed once each quarter unless the beneficiary is due a payment from Medicare. The notice informs the beneficiary whether Medicare has approved payment of the claim for services and the amount of that payment. If Medicare has not approved payment, the notice provides information on why the claim was denied or partially paid. The notice informs the beneficiary of his appeal rights.

Redetermination

The first level of the fee-for-service appeal process is called redetermination. A beneficiary who wants to appeal an initial determination must file a written, signed request for redetermination to the Medicare carrier/intermediary within 120 days of the initial determination. Medicare providers and suppliers can also file a request for redetermination. The Medicare carrier/ intermediary must issue a redetermination decision in 60 days.

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Reconsideration

A beneficiary can appeal a redetermination decision by filing a request for reconsideration. Beneficiaries have 180 days to request a reconsideration of a redetermination. Providers and suppliers also can file reconsideration requests. Reconsiderations are conducted by Medicare Qualified Independent Contractors (QICs). The QICs are responsible for conducting an external, independent review of redeterminations. The QIC for California is Maximus.

QICs must issue a reconsideration decision within 60 days. Beneficiaries can request a 14-day extension if needed to provide more evidence. If a QIC does not issue a decision within the required timeframe, the beneficiary can request an administrative law judge hearing. This is called a request for “escalation.” The QIC then has five days to issue a decision or send the case to the ALJ level. If an appeal is escalated to the ALJ level, the ALJ has 180 days, rather than the standard 90-day timeframe to make a decision.

Administrative Law Judge (ALJ) Hearing

Beneficiaries who want to appeal a reconsideration decision have the right to request an administrative law judge hearing. Beneficiaries have the right to an ALJ hearing only if the amount of money at issue is at least \$160. The request for an ALJ hearing must be filed within 60 days of receiving an unfavorable reconsideration decision. An ALJ has 90 days to issue a decision, but the timeframe can be extended to review additional evidence, to permit an in-person hearing or because of an escalated request from a QIC.

ALJ hearings are conducted by the Department of Health and Human Services (HHS). In most cases, the hearings are conducted by telephone or video teleconference. In-person ALJ hearings are conducted only if the beneficiary can show “good cause” for an in-person hearing. When a request for an in-person hearing is granted, the 90-day decision deadline is waived.

Medicare Appeals Council (MAC)

The Medicare Appeals Council review is conducted by the Departmental Appeals Board of HHS. A beneficiary who wants to appeal an unfavorable ALJ decision has 60 days to request a MAC review. This review is generally a paper review where a decision is made without a hearing. The time frame for a MAC decision is 90 days, but can be extended.

Federal District Court

A beneficiary can appeal a MAC decision by filing a lawsuit in federal district court. The suit must be filed within 60 days of receiving an unfavorable MAC decision. To appeal at this level, a beneficiary must show that at least \$1,600 is at issue.

Expedited Appeals of Hospital, Skilled Nursing Facility, Home Health, Hospice and Comprehensive Outpatient Rehabilitation Facility Services- The Medicare appeals process provides for an expedited or “fast track” independent review when hospital, skilled nursing facility, home, health, hospice and comprehensive outpatient rehabilitation facility services are terminated.

Chapter Four: Medicare

Medicare Advantage Managed Care Appeals

Medicare provides an appeals process for Medicare Advantage managed care plan members who have disputes with their Medicare MA plans. Medicare beneficiaries may use the appeals process to:

- Obtain payment for emergency or out-of-area urgently needed services;
- Seek payment for health services furnished by a provider not in the MA plan's network, that the MA plan member believes are covered by Medicare and should have been furnished, arranged or paid for by the MA plan; or
- Challenge the MA plan's refusal to provide services or the MA plan's termination of services.

There are five steps in the appeals process:

1. Organization Determination

Requests for claim payment for non-MA plan services or requests for medical services from the MA plan should be considered requests for an organization determination.

There are different time frames for service and claim payment requests. Claim payment requests must be reviewed in 60 days. Service requests must be reviewed in 14 calendar days. All of the following situations should be treated as an organization determination that is a denial:

- The plan has denied the level of care requested, but approved another level of care. For example, the request for skilled nursing care was not authorized, but home health services were approved;
- The plan has denied the request for service or has not approved the amount of service requested;
- The plan has reduced or discontinued services;
- The plan has failed to approve, provide or arrange the requested health care services in the time frame required;
- The plan has denied payment of the claim submitted or only partially paid the claim.

If the organization determination is a denial, it must be in writing and must provide the following information:

- The reason for the denial; and
- Information on how to appeal the denial and on the expedited appeal process.

2. Reconsideration

If the organization determination results in a partial or total denial, or the MA plan fails to issue a written determination within the specified time frames, the member may request reconsideration. The reconsideration review is performed by the MA plan. The member must file the reconsideration request with the MA plan within 60 days of the date of the organization determination. The beneficiary or his representative is entitled to present evidence, either in person or in writing.

The MA plan has 60 days to reconsider a claim payment denial. On service request denials, however, the MA plan has 30 days, but it may extend this 30-day period by an additional 14 days if the member requests an extension, or if the MA plan can show that additional information is needed and that the extension will benefit the member's reconsideration request.

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3. Outside Review by Independent Review Entity

If the MA plan decides to uphold the organization determination, in whole or in part, it must forward the case to Maximus/Center for Health Care Dispute Resolution, the Independent Review Entity that is contracted to review reconsideration cases for the federal government. Thus, the MA plan must inform the member, in writing, either that the claim has been approved in full, or that the case has been forwarded to the Independent Review Entity for further review. Depending on the case, the Independent Review Entity has up to 60 days to make a decision.

4. Administrative Law Judge Review

The beneficiary has 60 days from the date of an unfavorable determination from the Independent Review Entity to request a hearing before an Administrative Law Judge. At least \$160 must be at issue.

5. Medicare Appeals Council

If the decision from the Administrative Law Judge is unfavorable, the beneficiary has 60 days to request review by the Medicare Appeals Council.

Federal Review

If the Medicare Appeals Council decision is unfavorable, further review may be sought in federal District Court. The amount in controversy must be at least \$1,600.

Note: *When an MA plan denies an appeal on reconsideration, the appeal is automatically sent to the Independent Review Entity.*

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Expedited Appeals Process For Medicare Advantage Managed Care Enrollees

A Medicare Advantage (MA) plan member has the right to request an expedited review if the timeframe for a standard appeal could seriously jeopardize the member's health or ability to gain maximum function. This faster appeal process can be used to request medical care from the MA plan, and to appeal an MA plan denial of service or termination of care. An expedited appeal must be completed within 72 hours.

A request for expedited review by the MA plan can be made in person, by phone, or in writing. If the member requests the expedited review, the plan has the option to deny expedited processing. If, however, a physician requests expedited treatment, the MA plan must review the case within the 72-hour timeframe. An MA plan member who wants an expedited review should contact the MA plan's member services department.

Medicare Advantage plan members also have the right to a special fast track appeal directly to the BFCC-QIO when hospital, skilled nursing facility or home health services are terminated. In the case of skilled nursing facility or home health services, the provider must give the member a written notice at least two days before the services are terminated. To request a fast track appeal, a member must contact Livanta (1-877-588-1123) by noon of the day before coverage ends.

Chapter Four: Medicare

Claims Processing

Role of Medicare Administrative Contractors

Payment for fee-for-service Medicare Part A and Part B services are administered by private companies known as Medicare Administrative Contractors (MACs).

Medicare contracting providers are required to submit Medicare claims to the MAC for the region where the service was provided. After the claim is processed, a Medicare Summary Notice is generated and sent to the beneficiary each quarter. The Medicare Summary Notice informs the beneficiary that a claim has been processed for a particular provider and date of service. The notice includes information on the status of Medicare payment, along with the beneficiary's appeal rights.

Coordination with Medigap Policies

After a beneficiary receives a Medicare Summary Notice (MSN), there are three ways to make a claim with a supplemental insurance policy (Medigap) or retiree plan:

1. Medicare may have an electronic claims processing arrangement called "crossover" with the insurance company or retiree plan.
2. If the provider accepts Medicare assignment, the provider may submit the claim to the insurance company or retiree plan.
3. If neither Medicare nor the provider submits the claim, the beneficiary will need to take the following steps:
 - a. If required, fill out the claim form provided by the insurance company.
 - b. If required, attach copies of the bills being submitted for payment. Attach copies of the MSN related to those bills.
 - c. Make copies of everything for personal records. Mail the claim packet to the insurance company.

The beneficiary subsequently will receive an Explanation of Benefits (EOB) from the insurance company or retiree plan.

***Note:** Starting in July 2018, the MSN for QMBs will show that the QMB has zero payment liability for each covered service. The provider remittance that the doctor or other provider receives will also show that the QMB owes nothing. This new process should help both providers and their QMB patients to better understand when a QMB billing protection applies.*

Chapter Four: Medicare

Private Medicare Supplemental Insurance

Introduction

“Medicare Supplemental Insurance” is insurance that supplements fee-for-service Medicare coverage and meets specified coverage standards. It is usually paid for out-of-pocket, or may be offered by an employer or former employer.

***Note:** Most low-income individuals do not need such coverage, because they may qualify for other ways to supplement Medicare and/or may qualify for Medi-Cal coverage. See page 4-27 for more information on Medicare Savings Programs, and Chapter 6 for information on Medi-Cal.*

A Medicare Supplemental Insurance policy, often referred to as a “Medigap” policy, is designed to cover part or all of Medicare’s co-payments and deductibles. Medigap policies are available primarily to persons 65 and over who have both Medicare Part A and Part B. Policies are available to under-65 beneficiaries with disabilities on a more limited basis. Because Medigap policies are designed to go along with, or track, Medicare, most of the services excluded or denied by Medicare are also excluded or denied by Medigap policies.

***Note:** Individuals who choose Medicare Part C (“Medicare Advantage”) coverage do not need Medigap policies. Insurance companies and their agents are prohibited from selling Medigap policies to Medicare Advantage members.*

When evaluating any Medigap policy, beneficiaries and their advocates should remember that Medigap policies won’t cover all health care expenses not paid for by Medicare. Medigap insurance pays for only a portion of the remaining costs.

Basic Benefits

Insurance companies may offer standardized Medigap policies, labeled A, B, C, D, F, G, K, L, M, and N. Insurers may no longer offer plans labeled E, H, I, & J, which were available through 2010. Because all plans are standardized, consumers will receive the same benefits within a category regardless of which insurer they choose.

Part A Hospital Benefits

All new policies must offer:

- All coinsurance for hospital days 61-90 in a benefit period;
- Coinsurance for the 60 hospital lifetime reserve days; and
- 100% of the cost for hospital care beyond the 150 Medicare-covered days in a benefit period, up to a maximum of 365 days.

***Note:** A Medigap policy is not comprehensive coverage. Medigap policies are limited in the same ways that Medicare coverage in general is limited.*

Chapter Four: Medicare

Other Benefits

- All plans provide coverage for Part B coinsurance and copayments, the first three pints of blood, and hospice co-insurance. Coverage is at 100% except for plans K and L, which provide coverage at the 50% and 75% level respectively.
- Coverage for skilled nursing coinsurance, Part A deductibles, Part B deductibles, and emergency health care during foreign travel varies among plan types.
- Part B annual deductible (\$183 in 2018).
- 80% or 100% of Part B Excess Charges. Depending on the policy chosen, this benefit pays 80% or 100% of the Part B physician charges that exceed the Medicare-approved amount up to the physician charge limit of 115% of the approved amount. For example, if Medicare approves \$100 of a \$115 physician bill, this benefit will pay either an additional \$12 (if the 80% benefit is chosen) or the full \$15 (if the 100% benefit is chosen). ***Plans sold after June 1, 2010 have the 100% benefit.***

Note: Plans E, H, I & J are no longer sold but some people still have these plans.

For a good source on Medicare supplements go to:

www.cms.gov/Medicare/Health-Plans/Medigap/index.html.

Chapter Four: Medicare

Programs To Help Low-Income Medicare Beneficiaries With Medicare Costs

Low-income Medicare beneficiaries may be eligible for Medi-Cal in addition to Medicare (see Chapter 6). In addition, they may be eligible for one of the following Medicare Savings Programs (MSP): QMB, SLMB, or QI (see below for MSP descriptions). Persons who may qualify for any of these programs should apply at the county (in Los Angeles, at the Department of Public Social Services).

Qualified Medicare Beneficiary (QMB)

The QMB program is for individuals and couples with low incomes but with resources up to \$7,560 for individuals, and \$11,340 for couples. In 2018, the QMB income limit for a single person is \$1,032 per month and \$1,392 per month for a couple (these include a \$20 disregard that applies to all income). These figures change early each calendar year when the annual income poverty guidelines are issued.

See the Supplemental Material for a California QMB/SLMB/QI application.

The QMB program will pay the Medicare Part A premium (if not already free), the Medicare Part B premium, and all Medicare cost-sharing (deductibles and co-payments), and also automatically entitles the individual to the Medicare Part D Low-Income Subsidy (see Chapter 5).

Note: *QMB applicants who do not already have Medicare Part A must also apply at the Social Security office. Unless they are in their Medicare Initial Enrollment Period, they must do so during the January 1 - March 31 period of a given year, with benefits to start July 1. They must file a “conditional” Part A application with the Social Security office during the filing window and include a copy of the Part A application with their QMB application at the county or DPSS office. QMB coverage, including coverage of Part A premiums, will start on July 1 of the same year.*

For more information on QMB enrollment, see: www.medicareadvocacy.org/medicare-general-enrollment-begins-january-1st-limited-opportunity-for-some-states-to-expand-cmb-coverage/.

Providers may not bill any QMB (most dual eligibles are also QMBs) for Medicare deductibles, co-pays or co-insurance. This protection applies both to beneficiaries in fee-for-service Medicare and to those in Medicare Advantage plans.

Chapter Four: Medicare

Specified Low-Income Beneficiary (SLMB)

SLMB is a program similar to QMB, for individuals and couples with monthly incomes too high for QMB, but no more than \$1,234 for an individual, or \$1,666 for a couple (these include a \$20 disregard that applies to all income). These figures change early each calendar year when the annual income poverty guidelines are issued.

The resource requirements are the same as for QMB (\$7,560 for individuals, and \$11,340 for couples).

The SLMB program pays the Medicare Part B premium only. It does not cover deductibles and co-pays.

Qualified Individual (QI)

Again (as is the case for QMB and SLMB), the resource limit is \$7,560 for an individual, or \$11,340 for a couple. The income limits for the QI program are \$1,386 for an individual and \$1,872 for a couple. These figures change early each calendar year when the annual income poverty guidelines are issued.

Like SLMB, the QI program pays the Medicare Part B premium.

***Note:** Medicare Savings Programs assist Medicare beneficiaries with Medicare premiums, deductibles, and co-payments. All MSP recipients automatically receive the Medicare Part D Low Income Subsidy (LIS).*

Supplemental Materials

Sample Medicare Summary Notice Part A.....	4-29
www.medicare.gov/pubs/pdf/SummaryNoticeA.pdf	
Sample Medicare Summary Notice Part B.....	4-33
www.medicare.gov/pubs/pdf/SummaryNoticeB.pdf	
QMB/SLMB/QI Application	4-37
www.dhcs.ca.gov/formsandpubs/forms/Forms/MCED/MC_Forms/MC14A_ENG.pdf . Note that the income and asset limits have not been updated on the state's form	

Chapter Four: Medicare

Page 1 – Your Dashboard

1 DHHS Logo

The redesigned MSN has the official Department of Health & Human Services (DHHS) logo.

2 Your Information

Check your name and the last 4 numbers of your Medicare number, as well as the date your MSN was printed and the dates of the claims listed.

3 Your Deductible Info

You pay a Part A deductible for services before Medicare pays. You can check your deductible information right on page 1 of your notice!

Page 1 of 4

Medicare Summary Notice
for Part A (Hospital Insurance)

The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

JENNIFER WASHINGTON
TEMPORARY ADDRESS NAME
STREET ADDRESS
CITY, ST 12345-6789

THIS IS NOT A BILL

2 Notice for Jennifer Washington

Medicare Number	XXX-XX-1234A
Date of This Notice	September 15, 2013
Claims Processed Between	June 15 – September 15, 2013

3 Your Deductible Status

Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.

Part A Deductible: You have now met your **\$1,184.00** deductible for **inpatient hospital** services for the benefit period that began May 27, 2013.

Be Informed!

Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

4 Title of your MSN

The title at the top of the page is larger and bold.

5 Total You May Be Billed

A new feature on page 1, this summary shows your approved and denied claims, as well as the total you may be billed.

6 Facilities You Went To

Check the list of dates for services you received during this claim period.

7 Help in Your Language

For help in a language other than English or Spanish, call 1-800-MEDICARE and say "Agent." Tell them the language you need for free translation services.

5 Your Claims & Costs This Period

Did Medicare Approve All Claims?	YES
See page 2 for how to double-check this notice.	
Total You May Be Billed	\$2,062.50

6 Facilities with Claims This Period

June 18 – June 21, 2013
Otero Hospital

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
如果需要国语帮助, 请致电联邦医疗保险, 请先说“agent”, 然后说“Mandarin”. 1-800-MEDICARE (1-800-633-4227)

Chapter Four: Medicare

Page 2 – Making the Most of Your Medicare

1 Section Title

This helps you navigate and find where you are in the notice. The section titles are on the top of each page.

2 How to Check

Medicare offers helpful tips on what to check when you review your notice.

3 How to Report

Help Medicare save money by reporting fraud!

4 How to Get Help

This section gives you phone numbers for where to get your Medicare questions answered.

Jennifer Washington THIS IS NOT A BILL | Page 2 of 4

1 Making the Most of Your Medicare

1 How to Check This Notice

Do you recognize the name of each facility? Check the dates.

Did you get the claims listed? Do they match those listed on your receipts and bills?

If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

2 How to Report Fraud

If you think a facility or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633-4227).

Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

You can make a difference! Last year, Medicare saved tax-payers **\$4.2 billion**—the largest sum ever recovered in a single year—thanks to people who reported suspicious activity to Medicare.

3 How to Get Help with Your Questions

1-800-MEDICARE (1-800-633-4227)
Ask for "hospital services." Your customer-service code is 05535.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call **1-555-555-5555**.

5 Your Benefit Periods

Your hospital and skilled nursing facility (SNF) stays are measured in **benefit days** and **benefit periods**. Every day that you spend in a hospital or SNF counts toward the benefit days in that benefit period. A benefit period begins the day you first receive inpatient hospital services or, in certain circumstances, SNF services, and ends when you haven't received any inpatient care in a hospital or inpatient skilled care in a SNF for 60 days in a row.

Inpatient Hospital: You have **56 out of 90 covered benefit days** remaining for the benefit period that began May 27, 2013.

Skilled Nursing Facility: You have **63 out of 100 covered benefit days** remaining for the benefit period that began May 27, 2013.

See your "Medicare & You" handbook for more information on benefit periods.

6 Your Messages from Medicare

Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment.

To report a change of address, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

Want to see your claims right away? Access your Original Medicare claims at www.MyMedicare.gov, usually within 24 hours after Medicare processes the claim. You can use the "Blue Button" feature to help keep track of your personal health records.

5 Your Benefit Period

This section explains benefit periods.

6 General Messages

These messages get updated regularly, so make sure to check them!

Chapter Four: Medicare

Page 3 – Your Claims for Part A (Hospital Insurance)

1 Type of Claim

Claims can either be inpatient or outpatient.

2 Definitions

Don't know what some of the words on your MSN mean? Read the definitions to find out more.

3 Your Visit

This is the date you went to the hospital or facility. Keep your bills and compare them to your notice to be sure you got all the services listed.

4 Benefit Period

This shows when your current benefit period began.

Jennifer Washington THIS IS NOT A BILL | Page 3 of 4

1 Your Inpatient Claims for Part A (Hospital Insurance)

Part A Inpatient Hospital Insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care, and hospice care.

Non-Covered Charges: This is the amount Medicare didn't pay.

Amount Medicare Paid: This is the amount Medicare paid your inpatient facility.

Maximum You May Be Billed: The amount you may be billed for Part A services can include a deductible, coinsurance based on your benefit days used, and other charges.

For more information about Medicare Part A coverage, see your "Medicare & You" handbook.

2 Definitions of Columns

Benefit Days Used: The number of covered benefit days you used during each hospital and/or skilled nursing facility stay. (See page 2 for more information and a summary of your benefit periods.)

Claim Approved?: This column tells you if Medicare covered the inpatient stay.

June 18 – June 21, 2013

Otero Hospital, (555) 555-1234
PO Box 1142, Manati, PR 00674
Referred by Jesus Sarmiento Forasti

	Benefit Days Used	Claim Approved?	Non-Covered Charges	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
4	Benefit Period starting May 27, 2013	4 days	Yes	\$0.00	\$4,886.98	\$0.00
	Total for Claim #20905400034102		5	\$0.00	\$4,886.98	\$0.00 A,B 7

5 Approved Column
This column lets you know if your claim was approved or denied.

6 Max You May Be Billed
This is the total amount the facility is able to bill you. It's highlighted and in bold for easy reading.

7 Notes
Refer to the bottom of the page for explanations of the items and supplies you got.

Notes for Claims Above

A Days are being subtracted from your total inpatient hospital benefits for this benefit period. The "Your Benefit Periods" section on page 2 has more details.

B \$2,062.50 was applied to your skilled nursing facility coinsurance.

Last Page – How to Handle Denied Claims

1 Get More Details

Find out your options on what to do about denied claims.

2 If You Decide to Appeal

You have 120 days to appeal your claims. The date listed in the box is when your appeal must be received by us.

3 If You Need Help

Helpful tips to guide you through filing an appeal.

Jennifer Washington THIS IS NOT A BILL | Page 4 of 4

How to Handle Denied Claims or File an Appeal

1 Get More Details

If a claim was denied, call or write the hospital or facility and ask for an itemized statement for any claim. Make sure they sent in the right information. If they didn't, ask the facility to contact our claims office to correct the error. You can ask the facility for an itemized statement for any service or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

2 If You Disagree with a Coverage Decision, Payment Decision, or Payment Amount on this Notice, You Can Appeal

Appeals must be filed in writing. Use the form to the right. Our claims office must receive your appeal within 120 days from the date you get this notice.

We must receive your appeal by:

January 21, 2014

3 If You Need Help Filing Your Appeal

Contact us: Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your facility: Ask your facility for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

Find Out More About Appeals

For more information about appeals, read your "Medicare & You" handbook or visit us online at www.medicare.gov/appeals.

4 File an Appeal in Writing

Follow these steps:

- 1 Circle the service(s) or claim(s) you disagree with on this notice.
- 2 Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.
- 3 Fill in all of the following:
Your or your representative's full name (print)

Your or your representative's signature

Your telephone number

Your complete Medicare number
- 4 Include any other information you have about your appeal. You can ask your facility for any information that will help you.
- 5 Write your Medicare number on all documents that you send.
- 6 Make copies of this notice and all supporting documents for your records.
- 7 Mail this notice and all supporting documents to the following address:

Medicare Claims Office
c/o Contractor Name
Street Address
City, ST 12345-6789

4 Appeals Form

You must file an appeal in writing. Follow the step-by-step directions when filling out the form.

Chapter Four: Medicare

Page 1 – Your Dashboard

1 DHHS Logo

The redesigned MSN has the official Department of Health & Human Services (DHHS) logo.

2 Your Information

Check your name and the last 4 numbers of your Medicare number, as well as the date your MSN was printed and the dates of the claims listed.

3 Your Deductible Info

You pay a yearly deductible for services before Medicare pays. You can check your deductible information right on page 1 of your notice!

Page 1 of 4

Medicare Summary Notice
for Part B (Medical Insurance)

The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

JENNIFER WASHINGTON
TEMPORARY ADDRESS NAME
STREET ADDRESS
CITY, ST 12345-6789

THIS IS NOT A BILL

2 Notice for Jennifer Washington

Medicare Number	XXX-XX-1234A
Date of This Notice	March 1, 2013
Claims Processed Between	January 1 – March 1, 2013

3 Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met **\$85.00** of your **\$147.00** deductible for 2013.

Be Informed!

Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

4 Title of your MSN

The title at the top of the page is larger and bold.

5 Your Claims & Costs This Period

Did Medicare Approve All Services?	NO
Number of Services Medicare Denied	1
See claims starting on page 3. Look for NO in the "Service Approved" column. See the last page for how to handle a denied claim.	
Total You May Be Billed	\$90.15

6 Providers with Claims This Period

January 21, 2013
Craig I. Secosan, M.D.

7 Help in Your Language

For help in a language other than English or Spanish, call 1-800-MEDICARE and say "Agent." Tell them the language you need for free translation services.

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
如果需要国语帮助, 请致电联邦医疗保险, 请先说 "agent", 然后说 "Mandarin". 1-800-MEDICARE (1-800-633-4227)

Chapter Four: Medicare

Page 2 – Making the Most of Your Medicare

1 Section Title

This helps you navigate and find where you are in the notice. The section titles are on the top of each page.

2 How to Check

Medicare offers helpful tips on what to check when you review your notice.

3 How to Report

Help Medicare save money by reporting fraud!

4 How to Get Help

This section gives you phone numbers for where to get your Medicare questions answered.

Jennifer Washington THIS IS NOT A BILL | Page 2 of 4

1 Making the Most of Your Medicare

1 How to Check This Notice
Do you recognize the name of each doctor or provider? Check the dates. Did you have an appointment that day?

2 Did you get the services listed? Do they match those listed on your receipts and bills?
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

2 How to Report Fraud
If you think a provider or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633-4227).

3 Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.
You can make a difference! Last year, Medicare saved tax-payers **\$4.2 billion**—the largest sum ever recovered in a single year—thanks to people who reported suspicious activity to Medicare.

4 How to Get Help with Your Questions

4 1-800-MEDICARE (1-800-633-4227)
Ask for "doctors services." Your customer-service code is 05535.
TTY 1-877-486-2048 (for hearing impaired)
Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call 1-555-555-5555.

5 Medicare Preventive Services
Medicare covers many free or low-cost exams and screenings to help you stay healthy. For more information about preventive services:
• Talk to your doctor.
• Look at your "Medicare & You" handbook for a complete list.
• Visit www.MyMedicare.gov for a personalized list.

5 Remember, Medicare covers many preventive tests and screenings to keep you healthy.

6 Your Messages from Medicare
Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment.
To report a change of address, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.
Want to see your claims right away? Access your Original Medicare claims at www.MyMedicare.gov, usually within 24 hours after Medicare processes the claim. You can use the "Blue Button" feature to help keep track of your personal health records.

6 These messages get updated regularly, so make sure to check them!

Chapter Four: Medicare

Page 3 – Your Claims for Part B (Medical Insurance)

1 Type of Claim

Claims can either be assigned or unassigned.

2 Definitions

Don't know what some of the words on your MSN mean? Read the definitions to find out more.

3 Your Visit

This is the date you went to your doctor. Keep your bills and compare them to your notice to be sure you got all the services listed.

4 Service Descriptions

User-friendly service descriptions will make it easier for you to know what you were treated for.

Jennifer Washington THIS IS NOT A BILL | Page 3 of 4

1 Your Claims for Part B (Medical Insurance)

Part B Medical Insurance helps pay for doctors' services, diagnostic tests, ambulance services, and other health care services.

Your provider has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

2 Definitions of Columns

Service Approved: This column tells you if Medicare covered this service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. It may be less than the actual amount the provider charged.

Amount Medicare Paid: This is the amount Medicare paid your provider. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you, and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

January 21, 2013
Craig I. Secosan, M.D., (555) 555-1234
 Looking Glass Eye Center PA, 1888 Medical Park Dr, Suite C, Brevard, NC 28712-4187

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits (92014)	Yes	\$143.00	\$107.97	\$86.38	\$21.59	6
Destruction of skin growth (17000)	NO	68.56	0.00	0.00	68.56	A
Total for Claim #02-10195-592-390		\$211.56	\$107.97	\$86.38	\$90.15	B 7

5 Approved Column
 This column lets you know if your claim was approved or denied.

6 Max You May Be Billed
 This is the total amount the provider is able to bill you. It's highlighted and in bold for easy reading.

7 Notes
 Refer to the bottom of the page for explanations of the services you got.

Notes for Claims Above
A This service was denied. The information provided does not support the need for this service or item.
B Your claim was sent to your Medicare Supplement Insurance (Medigap policy), Wellmark BlueCross BlueShield of N. Carolina. Send any questions regarding your benefits to them.

Chapter Four: Medicare

Last Page – How to Handle Denied Claims

1 Get More Details

Find out your options on what to do about denied claims.

2 If You Decide to Appeal

You have 120 days to appeal your claims. The date listed in the box is when your appeal must be received by us.

3 If You Need Help

Helpful tips to guide you through filing an appeal.

Jennifer Washington THIS IS NOT A BILL | Page 4 of 4

How to Handle Denied Claims or File an Appeal

1 Get More Details

If a claim was denied, call or write the provider and ask for an itemized statement for any claim. Make sure they sent in the right information. If they didn't, ask the provider to contact our claims office to correct the error. You can ask the provider for an itemized statement for any service or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

2 If You Disagree with a Coverage Decision, Payment Decision, or Payment Amount on this Notice, You Can Appeal

Appeals must be filed in writing. Use the form to the right. Our claims office must receive your appeal within 120 days from the date you get this notice.

We must receive your appeal by:

July 13, 2013

3 If You Need Help Filing Your Appeal

Contact us: Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your provider: Ask your provider for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

Find Out More About Appeals

For more information about appeals, read your "Medicare & You" handbook or visit us online at www.medicare.gov/appeals.

File an Appeal in Writing

Follow these steps:

- 1 Circle the service(s) or claim(s) you disagree with on this notice.
- 2 Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.
- 3 Fill in all of the following:
Your or your representative's full name (print)

Your or your representative's signature

Your telephone number

Your complete Medicare number
- 4 Include any other information you have about your appeal. You can ask your provider for any information that will help you.
- 5 Write your Medicare number on all documents that you send.
- 6 Make copies of this notice and all supporting documents for your records.
- 7 Mail this notice and all supporting documents to the following address:
Medicare Claims Office
c/o Contractor Name
Street Address
City, ST 12345-6789

4 Appeals Form

You must file an appeal in writing. Follow the step-by-step directions when filling out the form.

Chapter Four: Medicare

QUALIFIED MEDICARE BENEFICIARY (QMB), SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB), AND QUALIFYING INDIVIDUALS (QI-1) APPLICATION

Name	Social Security Number	Medicare Number	Date
Telephone Number ()	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Address (number, street)	City	State	Zip Code

This information is to help you apply for the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or the Qualifying Individual-1 (QI-1) programs. The State will pay Medicare Parts A and B premiums, deductibles, and coinsurance fees for persons eligible for the QMB program. The State will pay Medicare Part B premiums for persons eligible for SLMB or QI-1. You may apply for QMB, SLMB, or QI-1 by completing and mailing this form to your local county social services agency.

To be eligible for QMB, SLMB, or QI-1, you must

- Be eligible for Medicare Part A (hospital insurance).
- Be eligible for Medicare Part B (medical insurance).
- Meet the following income requirements
 - QMB:** Net countable income at or below 100% of the Federal Poverty Level (FPL) (at or below \$981* for a single person, or \$1,328* for a couple).
 - SLMB:** Net countable income below 120% of the FPL (below \$1,177* for a single person, or \$1,593* for a couple).
 - QI-1:** Net countable income below 135% of the FPL (below \$1,325* for a single person, or \$1,793* for a couple)

*If you have a child living in the home with you, these amounts may be higher. These amounts are expected to increase each year in April. If you received a Title II Social Security cost of living adjustment in January, this amount will not be counted until April.

- Have no more than \$7,280 in nonexempt property for a single person or \$10,930 for a couple.
- Meet certain requirements and conditions, such as being a resident of California.

IMPORTANT

You may be eligible for other Medi-Cal programs in addition to the QMB and SLMB programs, such as food stamps and/or Medi-Cal with a monthly spenddown (share-of-cost). You may also be eligible for Medi-Cal with a monthly share-of-cost if you are **over** the income limits of the QMB, SLMB, and QI-1 programs. This coverage would include payment of the Medicare Part B premium. If you wish to apply for these other programs, check yes and the county will send you other forms to complete. Yes No

Do you wish to apply for three months of retroactive coverage for the SLMB and QI-1 programs (there is no retroactive coverage for QMB). Yes No

List all persons living in your household (spouse/children). If you have more than three persons living with you, you may list them on a separate page.

Name	Social Security Number	Sex M=Male F=Female	Date of Birth	Relationship to You

MAIL COMPLETED FORM TO YOUR COUNTY SOCIAL SERVICES AGENCY. SEE LINK BELOW FOR ADDRESSES.

<http://www.dhcs.ca.gov/formsandpubs/forms/Forms/MEB%20Translated%20Forms/mc14a-cntylist-sp.pdf>

Chapter Four: Medicare

A. COUNTABLE INCOME

1. Fill in the MONTHLY unearned income received by the QMB/SLMB/QI-1 applicant:

- | | |
|---|-----------------|
| a. Social Security check | \$ _____ |
| b. VA benefits | \$ _____ |
| c. Interest from bank accounts or certificate(s) of deposit | \$ _____ |
| d. Retirement income | \$ _____ |
| e. Any other unearned income | \$ _____ |
| f. Total UNEARNED INCOME—add lines a. through e. | \$ <u>_____</u> |

2. If you are married and living with your SPOUSE, fill in the MONTHLY unearned income received by your spouse:

- | | |
|---|-----------------|
| g. Social Security check | \$ _____ |
| h. VA benefits | \$ _____ |
| i. Interest from bank accounts or certificate(s) of deposit | \$ _____ |
| j. Any other unearned income | \$ _____ |
| k. Retirement income | \$ _____ |
| l. Total SPOUSE'S UNEARNED INCOME—add lines g. through k. | \$ <u>_____</u> |

3. Fill in the MONTHLY earned income received by the QMB/SLMB/QI-1 applicant and spouse:

- | | |
|---|----------|
| m. Gross earnings for the person who wants to be a QMB, SLMB, or QI-1 | \$ _____ |
| n. Gross earnings for the spouse | \$ _____ |
| o. Total—add lines m. through n. | \$ _____ |
| p. Subtract \$65 | \$ _____ |
| q. Remainder | \$ _____ |
| r. Divide by 2 | \$ _____ |

4. Total Income:

- | | |
|--------------------------------------|----------|
| Add lines f., l., and r | \$ _____ |
| s. Minus \$20 (any income deduction) | \$ _____ |

5. TOTAL COUNTABLE INCOME

\$ _____

6. Potential QMB, SLMB, or QI-1 eligibles:

- You are potentially eligible as a QMB if your income is at or below 100% of the FPL (at \$981* for a single person, or at \$1,328* for a couple).
- You are potentially eligible as a SLMB if your income is below 120% of FPL (below \$1,177* for a single person, or below \$1,593* for a couple).
- You are potentially eligible as a QI-1 if your income is below 135% of FPL (below \$1,325* for a single person, or below \$1,793* for a couple).

*If you have a child in the home, these amounts may be higher.

COUNTY USE

Applicant's unearned income (line f) \$ _____	
Spouse's unearned income (line l) + _____	

Any Income deduction	- _____
Net unearned income	_____
Net earned income (line r)	+ _____

Total net income	_____

MFBU size	_____

Compare to QMB/SLMB/QI-1/QI-2 income limit.	

If over income limit, is there a spouse and/or children in the home? Complete the MC 176-2 A QMB/SLMB/QI-1 form.	

Chapter Four: Medicare

B. PROPERTY

A QMB, SLMB, or QI-1 who is not married or not living with his/her spouse may have countable property which is equal to or less than \$7,280. A QMB, SLMB, or QI-1 who is married and living with his/her spouse must have countable property which is equal to or less than \$10,930.

The following are examples of countable property. **Important:** The home you and/or a spouse live in does not count. One car used for transportation **does not** count. If you apply at the county welfare department as a QMB, SLMB, or QI-1, the county may treat the property listed on this form differently. There are other types of property which the county welfare department, will also look at, i. e., certificate(s) of deposit. This other property **may** or **may not** count towards the property limit.

Fill in the value of the following property which belongs to you, your spouse, or both of you.

- | | | |
|---|------|--|
| 1. Checking accounts | \$ | |
| 2. Savings account | \$ | |
| 3. Certificate(s) of deposit | \$ | |
| 4. Stocks | \$ | |
| 5. Bonds | \$ | |
| 6. A second car (value minus amount owed) | \$ | |
| 7. A second home (value minus amount owned) | \$ | |
| 8. The cash surrender value of life insurance policies if the face value of all policies combined exceeds \$1,500 (Do not include "term" insurance policies) | \$ | |
| 9. Total PROPERTY- add lines 1 through 8 | **\$ | |
- **This total cannot exceed \$7,280 for a single person or \$10,930 for a couple.

COUNTY USE

Additional information: You may be eligible for **up to three months of retroactive coverage** of your Medicare Part B premiums under the SLMB and QI-1 programs.

NOTE: Individuals enrolled in traditional Medi-Cal, (but not QMB/SLMB/QI-1 programs) may be subject to Estate Recovery. Medi-Cal benefits received by an individual after age 55 may be recoverable by the State. Recovery may be made from the estate or the distributee/heir of the Medi-Cal beneficiary if the beneficiary does not leave a surviving spouse, minor children, or a totally disabled or blind son or daughter. **Individuals enrolled in the QMB/SLMB/QI-1 programs (either in combination with Medi-Cal or without), however, are not subject to Estate Recovery for Medicare premiums, deductibles or co-payments.**

I declare under penalty of perjury, under the laws of the United States of America and the State of California, that information I have given on this form is true, correct, and complete.

Signature (or mark) of applicant ➤	Date
County Use <input type="checkbox"/> QMB approved <input type="checkbox"/> SLMB approved <input type="checkbox"/> QI-1 approved <input type="checkbox"/> QMB/SLMB/QI-1-denied	
Eligibility Worker's signature ➤	Date