Medicare Updates

Medicare Getting Started Webinar

The Centers for Medicare and Medicaid Services (CMS) are offering a webinar on May 21 that provides an introduction to Medicare, Medicaid, and the Children’s Health Insurance Program. This may be a useful resource for counselors who are new to navigating Medicare and Medicaid. Space is VERY limited (the webinar is offered nationally), so it will be important to log on early if you wish to listen to this webinar. See the information on the next paragraph to join. (Please note: This is not an MMW webinar. We just thought that some of you may be interested in the extra resource!)

Medicare Getting Started Webinar (offered by Centers for Medicare and Medicaid Services)
May 21, 2014 2:00 – 3:00 p.m. Central Time
“This webinar provides basic knowledge about Medicare, Medicaid, and the Children’s Health Insurance Program, and key resources for people that assist people with Medicare. Space is limited to 150 participants. Join the audio portion of the webinar on 1-877-267-1577, conference ID: 994 261 929 and join the webinar at https://webinar.cms.hhs.gov/gettingstartedmay2014/”

Important Medicare Information for People in Same-Sex Marriages

On June 26, 2013, the Supreme Court ruled in United States vs. Windsor that Section 3 of the Defense of Marriage Act was unconstitutional. This means that individuals who are married to another person of the same sex may now receive Medicare benefits based on their spouse’s work record. After this decision, Social Security had to make changes to their systems to be able to process these applications. Social Security is now processing Medicare enrollments for same-sex spouses. Also, on Thursday, April 3, the Department of Health and Human Services issued a press release announcing that Social Security can now take requests for Medicare Part A and B special enrollment periods from individuals who were originally unable to enroll in Medicare because their spouse was of the same sex. Social Security can also now process requests for reductions in Part A and/or Part B late enrollment penalties that were due to the same issue.

For more information, see the press release here and the Medicare resource page here.
Cost Sharing for Medicare Mental Health Services Now at 20%

In the past, Medicare’s coinsurance rate for mental health services was higher than the coinsurance rate for other outpatient services. (Prior to 2008, the standard outpatient coinsurance rate was 20%, but mental health services had a coinsurance rate of about 50%.) In 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) changed this, so that Medicare cost-sharing for mental health services decreased gradually each year until it became the same as the standard outpatient coinsurance rate. In 2014, the coinsurance rate for mental health services under Medicare has finally reached that point – the coinsurance for mental health services is now 20%. To see this rate and a full list of Medicare’s premiums, deductibles, and cost-sharing for 2014, visit the Medicare website here (to see the mental health coinsurance, click on “Medicare Part B” under the heading “Detailed Medicare Cost Information for 2014.”)

2014 Medicare Savings Program (MSP) Asset Limits

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires Medicare Savings Programs (QMB, SLMB, QI) asset limits to be adjusted every year to be equal to the asset limits for full Extra Help (also called Low Income Subsidy or LIS). MSP helps Medicare beneficiaries pay for their Medicare premiums and/or cost sharing. The Illinois Department of Healthcare and Family Services (HFS) processes MSP applications, and unlike Social Security for the LIS program, HFS does not automatically include the $1,500 burial expense for each person. Applicants must have the $1,500 in a specified funeral or burial plan and provide proof of the policy name and account number of his/her burial plan on the application in order to receive this exemption.

The 2014 MSP asset limits are as follows:

- $8,660 (single) or $13,750 (married) if the applicant(s) has a pre-paid funeral or burial account
- $7,160 (single) or $10,750 (married) without a prepaid funeral or burial account.

Click here for a fact sheet created by the Center for Medicare Advocacy for more information about the alignment of the Extra Help and Medicare Savings Program (MSP) asset limits.

Click here for a chart from the Senior Health Insurance Program (SHIP) displaying the 2014 Medicare Savings Program income and asset limits.

“Improvement Standard” No Longer Used in Approving or Denying Medicare Skilled Nursing and Therapy Services

In January 2013, a U.S. District Court approved a settlement in the “Jimmo vs. Sebelius” case, which alleged that Medicare contractors were denying Medicare claims from health care providers for skilled nursing or therapy services in cases when the individual was not showing “improvement.” (“Therapy services" in this case include physical therapy, occupational therapy, and speech therapy services.) The practice of denying claims because an individual was not “improving” was essentially a rule-of-thumb practice; the Medicare policy had already stated that skilled nursing and therapy services can also be provided in cases when an individual needs those services to prevent additional decline in their health. (The Medicare regulation at 42 CFR 409.32(c) says “…restoration potential of a patient
is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.”) The settlement in the Jimmo vs. Sebelius case reiterated this Medicare policy and stated that **determinations of Medicare coverage for skilled nursing and therapy services should be based on whether the services are necessary, not whether the beneficiary will “improve.”** The settlement’s guidance applies to services received in a skilled nursing facility, an outpatient center, or in someone’s home. The guidance also applies equally to fee-for-service Medicare and Medicare Advantage plans. For more information about this settlement and what it means for Medicare coverage of skilled nursing and therapy services, please view the Center for Medicare Advocacy’s Frequently Asked Questions document [here](#) and the Centers for Medicare and Medicaid Services fact sheet [here](#).

Please note that the guidance in this settlement is retroactive to the date the lawsuit was filed (January 18, 2011). If individuals received a non-appealable Medicare denial for skilled nursing or therapy services based on the “improvement” standard between January 18, 2011 and January 23, 2014 (non-appealable means that the person already tried to appeal the denial and lost), they can file a request to have those services re-reviewed by Medicare. The review form is available [here](#).

### Medicaid Updates

#### Medicaid Redeterminations

The Illinois Department of Healthcare and Family Services (HFS) has a new procedure for Medicaid’s annual redetermination of benefits. (Each year, a Medicaid recipient’s case must be reviewed to make sure the individual/family continues to be eligible for benefits.) The new procedure is called the Illinois Medicaid Redetermination project and was created by the Save Medicaid Access and Resources Together (SMART) Act. Through this new process, many individuals with Medicaid will receive a letter and redetermination form once a year explaining that it is time to renew their Medicaid coverage. The letter will indicate whether the individual needs to send in any documentation to support their redetermination. **It is critically important that individuals respond to these letters in a timely fashion. If they do not respond within the necessary time frame, they could lose their Medicaid benefits.** HFS has released a Frequently Asked Questions document that provides information about this new process. (Click [here](#) to see the Frequently Asked Questions in Spanish.) They have also issued letters to health care providers that offer some guidance in how to best assist consumers with this redetermination process (click [here](#) for a copy of that letter). Finally, you can view copies of the redetermination forms being sent to Medicaid recipients at the links below.

Click [here](#) for a copy of the letter being sent to older adults and people with disabilities on AABD Medicaid (Aid to the Aged, Blind, and Disabled).

Click [here](#) for a copy of the letter being sent to families, pregnant women, former foster care recipients, and the new Affordable Care Act (ACA) adults group.
Resources for Using the New Application for Benefits Eligibility (ABE) System

We know that many of you are using the new ABE system to assist consumers in submitting applications for Medicaid and other Department of Human Services (DHS) benefits (SNAP/food stamps, Medicare Savings Programs, and DHS cash benefits), so we wanted to share a list of resources that may be useful in navigating the ABE system. We have shared some of these resources already in past MMW Alerts.

Written Guides to Navigating ABE:
The Department of Healthcare and Family Services (HFS) has released multiple guides for using ABE. Here are links to a guide for consumers/applicants as well as a guide for Community Partners (agencies/counselors who are assisting consumers with applications).

Webinars on Navigating ABE:
HFS provided this recorded webinar in October 2013 on how to use ABE to file an application for benefits.

Our partners at Health & Disability Advocates, EverThrive, and the Shriver Center for National Poverty Law and AAAAA also provided a Starting Strong Collaborative webinar on ABE on November 21, 2013 that includes a couple of walk-through examples. (Please note that this link is to a Windows Media Player file, so you will need Windows Media Player to view the recording, and the file may take some time to download.) The slides from that webinar are also available here, and you can view the related Questions and Answers document here.

Other ABE Resources:
HFS continues to update a Frequently Asked Questions document about ABE here. We encourage everyone to bookmark this link and check it regularly, as it may be updated at any time.

HFS also issued a list of enhancements made to ABE in February 2014. You can view that list of enhancements here.

Finally, the Benefits Access Project through AgeOptions created a cover sheet template (and corresponding instructions) to assist counselors in collecting and organizing the necessary documentation for filing applications for DHS programs. The cover sheet is designed to help DHS local offices know which program(s) the client is applying for, as well as the types of supporting documents the client is submitting as part of the application process. The cover sheet and instructions are available here.

Affordable Care Act Updates

Marketplace Extension and Special Enrollment Periods

The 2014 Open Enrollment Period for the Affordable Care Act Marketplace ended on March 31, 2014. However, if individuals were “in line” to apply for coverage before March 31, they will have an extension to complete their applications by April 15. “In line” means that the individual tried to apply for Marketplace coverage but encountered some barrier (some examples of possible “barriers” include the following: they couldn’t start or finish an application due to heavy traffic on the
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healthcare.gov website or to the Marketplace call center, they couldn’t use the healthcare.gov website due to maintenance, they encountered error screens on the website or other technical issues, they tried to get an appointment with a Navigator but there were no appointment times available before the deadline, they sent in an application via mail but did not get an eligibility result before March 31, etc.). For more information about this extension, see information on the healthcare.gov website here.

In addition to this Marketplace extension, many individuals will qualify for Special Enrollment Periods (SEP’s) to enroll in a Marketplace plan outside of the regular Open Enrollment Period. Circumstances that qualify an individual for an SEP include getting married, having a baby, adopting a child or placing a child for adoption or foster care, moving to a new area, losing other health coverage, gaining citizenship, leaving prison/incarceration, or gaining status as a member of a Native American tribe. Additional SEP circumstances include complex situations that prevent an individual from enrolling in a plan properly, such as experiencing a natural disaster or a medical emergency during the Open Enrollment Period, receiving misinformation from Marketplace staff or Navigators, or other enrollment errors that were the fault of the Marketplace or Marketplace website. Finally, individuals who are enrolled in Marketplace plans may be eligible for an SEP to change their enrollment if they experience a change in income or household status that affects their eligibility for premium tax credits or cost-sharing reductions. For more information about who qualifies for an SEP and how they can apply for a plan, see the healthcare.gov webpages here and here.

**Marketplace Roadmap Resource on How to Use Insurance and Health Care**

The Centers for Medicare and Medicaid Services (CMS) released a new resource for individuals who are new to using insurance coverage and/or obtaining preventive health care services. This booklet defines important health insurance terms like “copayment” and “network;” explains the various numbers and information listed on an insurance card (with an example image); and gives tips on how to find a provider, make an appointment, what to bring with you to your first appointment, questions to ask at appointments, etc. We encourage everyone to review this new resource and share it with consumers if you find it helpful.

**Other Updates**

**February 2014 Chart of Benefits**

AgeOptions issued a new Chart of Benefits resource in February 2014. The Chart of Benefits is a document that lists the income, asset, and eligibility requirements for various public programs, including Supplemental Security Income (SSI), AABD Medicaid, Medicare Savings Programs, Extra Help, SNAP (food stamps), the Community Care Program, the Benefits Access Programs, LIHEAP and Weatherization assistance programs, and property tax assistance programs. The Chart of Benefits is meant to be a ‘cheat sheet’ for professionals who are already familiar with these programs – it is not a training document for professionals new to these programs, and it should not be shared directly with consumers under any circumstances.

The February 2014 Chart of Benefits is available here.
As always, feel free to contact us with any comments or questions. If you would like to unsubscribe and not receive updates and information from the Make Medicare Work Coalition, please contact us by calling (708)383-0258 or emailing Georgia.Gerdes@ageoptions.org, Alicia.Donegan@ageoptions.org or Erin.Weir@ageoptions.org.