

## Medicare Part D and Home and Community Based Waivers

Since Medicare Part D began on January 1, 2006, Medicare beneficiaries on Medical Assistance residing in a nursing home have not paid any co-payments for their prescription drugs.

Beginning January 1, 2012, Medicare beneficiaries on Medical Assistance Home and Community Based Waivers will no longer have to pay co-payments for prescription drugs covered by Medicare Part D.

This includes Medicare beneficiaries enrolled in the following waivers in Minnesota:

- Elderly Waiver
- Brain Injury Waiver
- Community Alternative Care Waiver
- Community Alternatives for Disabled Individuals Waiver
- Developmental Disabilities Waiver

This change does not apply to Alternative Care enrollees.

## Observation Stay in the Hospital: Medicare May Not Cover Your Nursing Home Stay

If you are in the hospital and you have Medicare, are you an inpatient or an outpatient? It may sound simple, but it isn't. It may be hard to imagine when you are in a hospital gown in a hospital bed on an upper floor of the hospital, wearing a hospital band on your wrist and filling out a meal form, that you may not actually be an inpatient, but are instead in the hospital for an "observation stay".

Observation is a word used by Medicare when a patient's care does not meet required guidelines for hospital inpatient status — a hospital stay with full services. Although you are in a hospital room and bed and receive services that are similar to a hospital inpatient stay, observation is not the same as being an inpatient at the hospital. Patients may have both observation days and inpatient hospital days during the same hospital stay.

Observation days in the hospital are covered under Part B Medicare services rather than Part A, which covers inpatient services. As a patient in observation, you may have to pay a co-payment for each service you receive.

Generally, prescription drugs and over-the-counter drugs are not covered under Part B while in observation.

### **Ask the critical question**

When in the hospital, you or a family member should ask, "Am I being placed in observation status?"

### **The impact on Nursing Home Medicare coverage**

The Senior LinkAge Line® has received appeal requests from an increasing number of Medicare beneficiaries who had a hospital stay classified as "Observation" and were admitted to a nursing home for skilled care and/or skilled rehab services. They were unable to get any Medicare coverage for their stay because they did not have a three day hospital inpatient stay, which is a requirement to qualify for Medicare Part A coverage in the nursing home. Days spent in a hospital for observation services do not count toward meeting the three day hospital requirement.

To find out more about observation status or to get help with an appeal, call the Senior LinkAge Line® at 1-800-333-2433.

## Keeping Yourself Healthy: Use Your Medicare Preventive Benefits

Medicare covers many preventive services. As long as you meet basic eligibility standards, you have the right to receive these services no matter if you have Original Medicare or a Medicare Advantage Plan.



**Minnesota's connection to disability-related information and assistance**

|                          |                      |
|--------------------------|----------------------|
| Housing                  | Employment           |
| Personal care assistance | Disability benefits  |
| Transportation           | Assistive technology |

***and much more!***

## Preventive Services Covered By Medicare

| Service   | Medicare covers...  |
|---|---|
| <b>Diabetes Screening</b>                                 | 100% of the Medicare-approved amount (no Part B deductible)   |
| <b>Diabetes services and supplies</b>                     | 80% of the Medicare-approved amount (after Part B deductible)   |
| <b>Medical Nutritional Therapy</b>                        | 100% of the Medicare-approved amount (no Part B deductible)   |
| <b>Glaucoma screening</b>                                 | 80% of the Medicare-approved amount (after Part B deductible)   |
| <b>Blood tests for heart disease</b>                      | 100% of the Medicare-approved amount (no Part B deductible)   |
| <b>Bone mass measurement</b>                              | 100% of the Medicare-approved amount (no Part B deductible)   |
| <b>Screening mammograms</b>                               | 100% of the Medicare-approved amount (no Part B deductible)   |
| <b>Pap smears, pelvic exams and clinical breast exams</b> | 100% for pap lab test, pap test collection, pelvic exam and clinical breast exam (no Part B deductible)   |
| <b>Colon cancer screening</b>                             | 100% for fecal occult blood test, flexible sigmoidoscopy, and colonoscopy (no Part B deductible); 80% of the Medicare-approved amount for barium enema (no Part B deductible)<br><b><i>(Please note: if provider removes polyps, costs will apply including co-insurance because the screening became a diagnostic procedure)</i></b> |
| <b>Prostate cancer screening</b>                          | 100% for PSA test (no Part B deductible); 80% of the Medicare-approved amount for digital rectal exam (after Part B deductible)   |
| <b>Flu shot</b>   | 100% of the Medicare-approved amount (no Part B deductible)   |
| <b>Pneumonia vaccine</b>                                  | 100% of the Medicare-approved amount (no Part B deductible)   |
| <b>Hepatitis B vaccine</b>                                | 100% of the Medicare-approved amount for people at medium or high risk of hepatitis (no Part B deductible); covered by Part D for people with low risk  |
| <b>Annual Wellness Visit</b>                              | 100% of the Medicare-approved amount (no Part B deductible)   |
| <b>Abdominal Aortic Aneurysm (AAA) screening</b>          | 100% of the Medicare-approved amount (no Part B deductible) for people at increased risk for an AAA who receive a referral during their Welcome to Medicare preventive visit  |
| <b>"Welcome to Medicare" preventive visit</b>             | 100% of the Medicare-approved amount (no Part B deductible)   |

## PREVENTIVE BENEFIT SPOTLIGHT: ANNUAL WELLNESS VISIT

Medicare covers an annual wellness visit. There has been some confusion since Medicare coverage for this preventive service began in January, 2011. While it is not a head to toe physical covered by Medicare, it can be an important part of managing your health.

During the first Annual Wellness Visit, you and your doctor or health care provider will create a prevention plan based on your needs. During the visit, your doctor will:

- Take your medical and family history.

- Make a list of your current providers, suppliers and medications. Medications include both prescription medications and vitamins and supplements that you may take.
- Create a written 5-10 year screening schedule or check-list.
- Identify risk factors and current medical and mental health conditions along with related current or recommended treatments or care.
- Check your height, weight, blood pressure, and body mass index.
- Screen for cognitive issues.
- Review risk factors for depression.
- Review your functional ability and level of safety.

This includes screening for hearing impairments and your risk of falling. Your doctor must also assess your ability to perform activities of daily living such as bathing and dressing and also your level of safety in your home.

- Give health advice and referrals to health education or preventive counseling services or programs aimed at reducing identified risk factors and promoting wellness. These include weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

Annual Wellness Visits after your first visit will be slightly different. During subsequent wellness visits, your doctor will:

- Update your medical and family history.
- Check your weight and blood pressure.
- Update your list of current medical providers and suppliers.
- Screen for cognitive issues.
- Update your written screening schedule that you received at your first wellness visit.
- Update your list of risk factors and conditions and the care you are receiving or that is recommended.
- Provide health advice and referrals, to health education or preventive counseling services or programs.

There is no co-insurance or deductible if you see doctors or other health care providers who accept the Medicare approved amount in full.

**Note:** If you receive any additional services or screenings during the Annual Wellness Visit, then you may have an additional charge for those services. Services not included in the Annual Wellness Visit will be billed separately. You may be charged your usual co-pay and deductible if the additional service is covered by Medicare.

If you receive any additional services not covered under Medicare, such as a routine hearing exam, then you or your supplemental insurance will be responsible for 100 percent of its cost.

## Minnesota Medicare Supplement Insurance (Medigap)

**What is a Medicare Supplement?** A Medicare Supplement is private health insurance that is sold by private insurance companies to supplement Original

Medicare and cover the “gaps.” Minnesota Medicare Supplement plans are offered by multiple insurance companies.

**Enrollment:** If the Medicare beneficiary chooses a Medicare Supplement, enrollment must take place within 6 months of enrolling in Part B. Otherwise health screening will be applied and the application may be denied. If the beneficiary has “guaranteed issue rights,” the insurance company is required by law to sell or offer a Medicare Supplement even if the applicant has pre-existing health conditions

### Cost Sharing:

- **Premium** Member pays a monthly premium to the Medicare Supplement Insurance company. In Minnesota, everyone pays the same premium regardless of age, medical condition, or when the policy was purchased (Minnesota Community Rating Law). A company may charge different premiums for urban vs. rural and smoker vs. non-smoker. The member must also pay the monthly Medicare Part B premium.
- **Deductibles and Co-insurance** Part A and Part B deductibles and co-insurance are “gaps” in Original Medicare. The amount of coverage for these gaps is dependent on the Medicare Supplement the member chooses.
- **Co-pay** A co-pay is a set amount that a member pays at the time a service is received. Among the Medicare Supplements, only Plan N imposes co-pays.
- **Part B excess** The Part B excess charge applies only to physician services received outside of Minnesota and durable medical equipment (DME) providers who do not accept assignment. In Minnesota, the Limiting Law prohibits Minnesota physicians from charging the Part B excess.

### Benefits:

- All Minnesota Medicare Supplement options are standardized and must offer the same benefits regardless of which insurance company the member purchases their policy from. For instance, all “Basic” policies offer the same benefits – only the policy cost will vary between companies.
- Basic, Basic w/ Riders, Extended Basic, and Alpha Plan F, K, L, M, & N members are not limited by a provider network and may see any doctor or medical provider that accepts Medicare payment. Medicare SELECT Plan members must use specific hospitals and in some cases network doctors to get full insurance benefits.