

MEDICARE BASICS

Pi-Yi Mayo, CELA*
5223 Garth Road
Baytown, TX 77521
281-421-5774

*Certified Elder Law Attorney by the National Elder Law Foundation

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I.

INTRODUCTION TO MEDICARE

In 1965 Congress enacted our only national health insurance program. Officially known as “Health Insurance for the Aged and Disabled” Title XVIII of the Social Security Act was intended to provide a basic level of health care for the aged.ⁱ Medicare was based on a private health insurance model. It requires deductibles and copayments by the insured and it pays only a portion of the cost of certain services. It is not a welfare program, and eligibility is not based on assets or income of the insured. It is overseen by the Centers for Medicare and Medicaid Services (CMS) formerly known as the Health Care Financing Administration (HCFA). It is financed entirely with federal sources of income.ⁱⁱ There are two parts or programs that make up the Medicare system. The first is called “Hospital Insurance Benefits for the Aged and Disabled” also known as “basic Medicare” or “Part A Medicare”. It provides basic protection against the costs of inpatient hospital and other institution-provided inpatient care and home health care. It is referred to as “Part A” because the basic law is found in Part A of Title XVIII of the Social Security Act.

The second part of the Medicare program is called “Part B” officially known as “Supplementary Medical Insurance Benefits for the Aged and Disabled.” This part of the program is voluntary in that an insured must elect to have this coverage and pay a premium for the benefit. The premium is quite low for the coverage the program affords. This part of Medicare covers physicians’ services, durable medical equipment, outpatient therapy, diagnostic x-rays, and laboratory tests.

These two programs are the backbone of the health care system for the majority of our elderly population. Almost every client the elder law attorney will encounter will be covered under these parts of the Medicare program or under the Medicare HMO program known as “Part C”. It has been the author’s experience that the majority of Medicare recipients are fairly well satisfied with the Medicare program as it is today. Since most Medicare enrollees are in traditional fee for service, Medicare, they are able to select the doctor of their choice and almost always able to obtain hospital care at the hospital of their choice. Experience shows that the main complaint that most beneficiaries have concerns what is called a Medicare Summary Notice (MSN) formerly known as an Explanation of Medicare Benefits (EOMB). These are the notices that are sent to the person when Medicare Part B pays a bill. Although several attempts have been made over the years to simplify these statements they are still undecipherable by most humans.

It is critical for the elder law attorney to be knowledgeable about the Medicare program because one of the primary concerns of elder clients will be obtaining and paying for medical care. The quickest way for an elder law attorney to build trust and confidence with the elder client is to differentiate their practice from other law offices by demonstrating that you are aware of the things that matter most to your clients and that you have special knowledge concerning these matters. A thorough knowledge of the Medicare program is essential to advising elders about health care matters. Further, no matter what other characteristics elder clients have in common besides their chronological age they will almost always be Medicare recipients.

There is one other critical part to understanding Medicare and the importance of the program to an elder law attorney. The Medicare program has been amended many times since its inception. The current Medicare program is subject to major changes by bills pending in the Congress during the writing of this

paper. The possible changes in the Medicare program and the coverage it provides are the source of more worry and anxiety among our elderly population than words can convey. By staying abreast of the changes in the Medicare program and assisting elderly clients in understanding and dealing with the inevitable changes the elder law attorney provides an invaluable service to clients by helping them deal with the stress, anxiety and worry that invade their life every time they turn on the evening news or read

the daily paper. Not only must the elder law attorney learn and understand the workings of the current program he or she must continually update that knowledge in light of the changes that occur in the system almost daily.

II. GOVERNING LAWS, REGULATIONS AND POLICIES.

The law creating the Medicare program is Title XVIII of the Social Security Act, and can be found at 42 U.S.C. § 1395 *et seq.* The regulations concerning the program are found at 42 C.F.R. Pt. 400. One of the best resources for assistance in researching and studying the regulations is CCH Incorporated's 5 volume loose-leaf reporter the Medicare and Medicaid Guide. It can be found in the library of most Federal District Courthouses. It covers the regulations and provides updates on case law that affects the regs.

These are the official sources of the rules for the Medicare program but in reality the workings of the Medicare program are controlled in large part by "informal rules". The informal rules form the basis of the coverage decisions that affect most beneficiaries.ⁱⁱⁱ These informal rules take several forms one of which will be informal guidelines issued by CMS. CMS will set forth a guideline for use in determining coverage of a specific item or service to the financial intermediaries and carriers that administer the program. These "informal rules" can take the form of bulletins or memoranda or sometimes they are referred to as CMS transmittals and identified by a number. In addition to these bulletins CMS issues coverage manuals to the intermediaries and carriers. These CMS writings purport to interpret the statute and regulations set forth above. More often than not the criteria and interpretations created by the rules will be more restrictive than that set forth in the Medicare Act.

These CMS publications do not carry the force of law. If a CMS guideline affecting coverage deviates from the law and regulations then that can be grounds for an administrative appeal or a federal court challenge. Administrative law judges and federal judges will rule based on the Medicare statute or regulations and not CMS's guidelines and rules of thumb. Since initial coverage decisions are based on the manuals CMS provides to the intermediaries and carriers and not on the law and statutes set forth above many denials of coverage are reversed on appeal.^{iv} Medicare is a national program. Medicare procedures and qualifying criteria should not vary significantly from state to state or by CMS regional office. In practice differences between rulings of different regions can be quite dramatic. Anytime criteria being applied to a client appear to be more restrictive than the law allows the standard used in other regions or states should be investigated and compared with the criteria.

III. ADMINISTRATION

Medicare is administered by the Centers for Medicare and Medicaid Services (CMS) formerly known as the Health Care Financing Administration (HCFA) a federal agency in the Department of Health and Human Services. CMS has 10 regional offices. The regional office in Texas is in Dallas and the phone number is 214-767-6401. The Social Security Administration (SSA) enrolls people in Medicare and collects Medicare premiums. The SSA (1-800-772-1213) can answer questions about enrollment issues, premiums and can replace a lost Medicare card.

CMS contracts with commercial insurance carriers to process and pay Medicare claims and generally to provide the administration of the program. Part A of the Medicare program is administrated by fiscal “intermediaries” and Part B of the program is administrated by “carriers.” Peer Review Organizations (PROs) are groups of practicing doctors and other health care professionals that CMS contracts with to monitor the quality of care provided to Medicare patients in hospitals.

Fiscal Intermediaries pay Part A claims and make initial coverage determinations as well as handle the early stages of beneficiary appeals.^v The first stage of the appeal process for a Part A claim is called a reconsideration. When a claim is covered under Part A the insured are seldom involved. The hospital or other provider files the claim directly with the intermediary. The intermediary will send a Benefits Notice to the insured showing what was billed and the part of the bill Medicare will pay and how much the insured are responsible for paying. Any question’s concerning the charges and payments should be directed to the intermediary.

Carriers are the private insurance companies that process Medicare claims and make payments for services and supplies covered under Part B. Carriers also handle initial appeals known as review for Part B. When a Medicare beneficiary goes to the doctor, the doctor is required to file the claim with the carrier. The carrier will send the aforementioned Medicare Summary Notice. The MSN shows charges made by the doctor, how much is the medicare-approved amount for the service and how much the patient owes. The medicare-approved amount can be very important and will be explained below in the section about assignment. Any questions concerning the payment decision should be directed to the carrier, the carrier’s name and phone number is printed at the top of the MSN. The current carrier for the state of Texas Trailblazer Health Enterprises (1-800-442-2620).

The Peer Review Improvement Act of 1982 established the utilization and quality control peer review program.^{vi} This program set up peer review organizations (PRO) that are responsible for determining whether the health care services provided by hospitals are reasonable and medically necessary; furnished effectively in the most economical setting and meet professional standards. The PRO’s are now called Quality Improvement Organizations (QIO). Although they also have responsibility for quality control of what is known as the prospective payment system

the direct importance of the QIO to the patient is that the QIO makes initial determinations on Medicare coverage of hospital admissions and denials of coverage.

The QIO for Texas is the Texas Medical Foundation (1-800-725-8315). The QIO does not handle any payments to the hospital. They only make coverage decisions, the payments are made by the intermediary. QIO's must conduct a review of all written complaints from beneficiaries about the quality of services furnished and provide the beneficiary with information about the disposition of the complaint.

The prospective payment system for Medicare provides that a hospital is paid a fixed amount for each Medicare discharge. The amount paid to the hospital is based upon the diagnosis-related group (DRG) into which the discharge is classified. The amount is paid to the hospital regardless of length of stay of the patient or the services actually received. There are currently 495 recognized DRGs. The hospital is paid a set rate, if the costs of treating a patient are less than the DRG rate the hospital keeps the difference; if the cost of treating the patient exceeds the rate, the hospital incurs a loss.^{vii} Previously hospitals were paid under a reasonable cost system that paid based on the reasonable cost for the treatment given the patient. The intent of the PPS was to control the costs the Medicare system was paying for hospital care. The PPS has resulted in what some advocates had coined the "quicker, sicker system." Since the imposition of the PPS there has been a substantial reduction in the length of hospital stays and an increase in same-day surgical procedures performed in outpatient surgical centers.^{viii}

The hospital has a direct financial incentive to discharge the patient as soon as possible. If the time in the facility exceeds the set amount allowed by the DRG for the treatment of the patient then the hospital can lose money. Hospitals are allowed to issue "denial notices" to patients that inform the patient that his or her stay in the hospital will no longer be covered by Medicare and they are therefore being discharged. Sometimes the decisions to discharge a patient because Medicare payments are ending will be in error. QIOs are required to review discharge notices when requested to do so by the patient. If the beneficiary makes a timely request for review of the discharge notice then the hospital cannot charge the beneficiary for services provided before noon of the day the PRO decision is received by the beneficiary.

IV. ENROLLMENT AND ELIGIBILITY

As a general rule there are very few problems with most people enrolling in Medicare. The reason for this is simple, if the person elects to receive their Social Security at age 65 or they will receive Railroad Retirement benefits then they are automatically entitled to and enrolled in Medicare both Part A and B. Since Part B is voluntary if the person does not want the benefit they must purposely opt out of Part B. A person is eligible from the first day of the month they turn 65 even if their birthday is on the 29th of the month. If the person has established eligibility for Social Security they do not need to file a separate application for Medicare, this is the case if the person elected to take Social Security benefits at age 62. If a person decides to delay

receiving Social Security benefits past age 65 they are entitled to enroll in Medicare but they must file an application for benefits.

A beneficiary will receive their Medicare card about 3 months prior to their 65th birthday. The Medicare card is a red, white and blue card that has the person's name and Medicare claim number the types of coverage Part A or B and the date the coverage begins. The person's claim number will be their Social Security number followed by a letter or number.

Enrollment is automatic to other individuals including persons receiving Social Security Disability Benefits or Railroad Retirement Board Disability Benefits for a period of 24 months.

Persons under age 65 who are renal disease patients can also obtain Medicare coverage but these persons are required to file an application to obtain benefits. The benefits can start the third month in which dialysis is started and end 36 months after the person receives a transplant or 12 months after dialysis treatment ends.

Certain government employees are eligible for Medicare coverage. To qualify for benefits their employment must be "Medicare-qualified government employment."^{ix} Most federal retirees 65 or over who became eligible for federal retirement benefits after January 1, 1989 are eligible for Medicare. State and local government employees 65 and older who were hired after April 1, 1986, are likewise eligible. There are some exceptions to these general categories but they mostly concern inmates in correctional facilities and temporary workers. Persons in these categories must also file an application to receive benefits.

Persons who are not otherwise automatically qualified for enrollment may purchase Part A and B Medicare coverage. To be eligible to purchase Part A coverage a person must be age 65 or older and a citizen or lawfully admitted alien for permanent residence who has resided in the country for at least 5 years prior to the month of enrollment. The person also must purchase part B coverage. The cost for purchase of Part A coverage depends on the time after age 65 the person obtains the coverage. For both Part A and B there is an initial enrollment period.^x The initial enrollment period begins 3 months before the person's 65th birthday and ends 7 months later. If a beneficiary does not enroll during this initial enrollment period then they can only enroll during an open enrollment period. The open enrollment period begins January 1st and ends March 31st of each year. If a person delays their purchase of Part A coverage more than 12 months past their 65th birthday, the premium for Part A increases 10 percent. In 2003 the premium for Part A is \$316.00 per month if the person has less than 30 quarters of Medicare-covered employment and \$174.00 per month with more than 30 quarters but fewer than 40 quarters of Medicare-covered employment.

Persons eligible for Part A are also eligible for Part B benefits but individuals seeking to purchase Part B are not required to purchase Part A benefits. Everyone enrolled in Part B must pay a premium. The premium in 2003 is \$58.70 The premiums charged for Part B are suppose

to pay 25 percent of the cost of the program. Interestingly, the cost of the coverage was set by statute for 1991-95 but in beginning in 1996-1998 the law specifies a formula to be used to determine the amount of the premium. The premium set by law in 1995 was \$46.10 a month but the amount calculated by the formula to reflect 25 percent in 1996 was \$42.50, therefore there was a decrease in the premium from 1995-1996. Currently, the law also provides that if a person has their premium deducted from their Social Security check, an almost universal practice, and the cost of living adjustment for Social Security in any year is less than the increase in the Part B premium then the premium increase will be reduced to prevent a decrease in the person's Social Security check.^{xi} Similar to Part A if the purchase of Part B benefits is delayed beyond the initial enrollment period the premium increases. The premium increases 10 percent for each 12 months that the person was otherwise eligible to enroll but delayed. If a person delays enrollment beyond the date of their 65 birthday then the effective date of their coverage may be delayed for as much as 3 months after they enroll. There is an exception to this rule for individuals age 65 and over who have group insurance coverage as a result of their own employment or that of a spouse. A delay in enrollment will not cause these individuals' premium to increase. Almost all of the proposed changes in the Medicare program include an increase in the monthly premium for Part B as a method of decreasing the cost of the Medicare program to the government.

V. COVERAGE

As previously stated Medicare has two parts, Part A which covers inpatient care, skilled nursing care, home health care, hospice care and blood after the first 3 pints.^{xii} Part B covers medical care and services provided by physicians, durable medical equipment, some outpatient services and home health services not otherwise covered by Part A. Medicare will generally only pay for services rendered within the 50 states and some U. S. territories. Services rendered aboard ships that are in a U.S. port or within six hours of departing or arriving at a U.S. port will be covered. This is important as many elderly citizens vacation aboard cruise ships and do not realize that they lose Medicare benefits while abroad. Medicare likewise does not provide coverage for most preventive care. In order for the service to be covered by Medicare the services must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."^{xiii} There is an exception to this general rule for hospice services. The reasonable and necessary standard excludes most medical procedures that are considered experimental or unproven such as acupuncture; gastric balloon for treatment of obesity; transcendental meditation training or use; Laetrile and related substances; thermography; food allergy testing and treatment; nutritional supplementation under Part B; and artificial hearts and related devices.^{xiv}

VI. PART A BENEFITS

A. **Inpatient Acute Care Hospital Benefit**

1. Specifically included items. Subject to time limits, deductibles and coinsurance amounts the hospital benefit program covers services provided to “inpatients” by qualified acute care hospitals that participate in the Medicare program. The definition of inpatient includes a person admitted to the hospital with the expectation of remaining overnight even if they do not stay the night in the hospital.^{xv} Most hospitals in the U.S. will be Medicare participating institutions but there is also coverage afforded for non emergency treatment in some hospitals in Canada and Mexico if treatment is closer or more accessible to the person’s home. The treatment must be medically necessary and coverage specifically includes:
 - a. bed and board in a semi private room unless a private room is medically necessary or is the only room available;^{xvi}
 - b. regular nursing services, operating rooms, intensive care and coronary units;
 - c. services ordinarily furnished by a hospital such as drugs, supplies, appliances, equipment, medical social services, reasonable and necessary physical, occupational therapy, speech pathology, medical or surgical services provided by an intern or resident in training;
 - d. alcohol detoxification, treatment for drug abuse and chemical dependency;
 - e. inpatient services for dental procedures when necessary due to an underlying medical condition.
 2. Specifically excluded items include:
 - a. private-duty nurses;
 - b. Items and services not usually provided by the hospital.
- B. Part A Rehabilitation hospital coverage.** Part A provides a benefit for rehabilitation hospital coverage with the same limits as the acute care hospital benefit. This type of facility is primarily engaged in providing rehabilitation services for rehabilitation of injured, disabled, or sick persons. A doctor must certify that the patient needs relatively intense, multi disciplinary rehabilitation provided by a coordinated team of physical therapists, occupational therapists, speech-language pathologists, nurses, and other professions supervised by a physician with experience or training in rehabilitative medicine.^{xvii}
- C. Coverage limitations, deductibles and coinsurance.**
1. Benefit periods and regular days. The coverage for care that is available under Part A is measured in “benefit periods” or “spell of illness.” A

beneficiary is entitled to receive coverage for up to 90 days for each “spell of illness.” A spell of illness begins with the first day of inpatient care (at a hospital or skilled nursing facility) during which the person is entitled to Part A benefits and ends after the beneficiary has been out of the hospital or skilled nursing facility for 60 or more consecutive days. A person can be discharged and readmitted several times during the same spell of illness. The next time a person is readmitted a new benefit period begins and the 90 day benefit is renewed.^{xviii} There is no limit to the number of benefit periods a person can have. At the beginning of each benefit period the insured must pay a deductible of \$840.00 in 2003, after that payment Medicare pays all covered costs for the first 60 days. Starting with the 61st-90th day of a benefit period the beneficiary is responsible for a coinsurance amount of \$210.00 a day. The coinsurance amount is 1/4 of the deductible amount. These 90 days of full coverage are often referred to as the beneficiary’s “regular days.” The deductible and coinsurance amounts are the reason most Medicare beneficiaries purchase Medigap insurance. A beneficiary could face the cost of the deductible and coinsurance payments several times in one year depending on the timing of their admission or discharge from a facility.

2. Reserve days. If a beneficiary remains in the hospital after the 90th day in a single spell of illness, they have coverage for an additional 60 days called “lifetime reserve days.” The 60 reserve days are not renewable. Beginning with the 91st-150th day of coverage, the beneficiary must pay a coinsurance double the coinsurance amount of the 61st-90th day of \$420.00 a day. The lifetime reserve coinsurance is ½ of the deductible amount. A beneficiary may elect to pay the charges due after the 90th day and save their lifetime reserve days for a later time. The limit on the regular and lifetime reserve days may sound harsh and very final. In reality it is not that bad as very few people ever stay in the hospital long enough to exhaust the 90 day benefit and fewer still ever exhaust the lifetime reserve days. Remember, even if the lifetime reserve days are used on a previous stay in the hospital once a new benefit period is started the 90-day benefit is renewed.
3. Blood deductible. Both Part A and Part B cover payments for whole blood, units of packed red blood cells, or blood components. The deductible is the cost of the first 3 pints received in a calendar year. The deductible can be satisfied under either Part A or B of any combination thereof. The deductible can be met by actual replacement of the blood rather than payment. The replacement can be from the beneficiary or others on their behalf.^{xix}

4. Psychiatric hospitalization limit. Coverage for care in a Medicare participating psychiatric hospital is limited to 190 days in a beneficiary's lifetime. There are no provisions for resetting this benefit. Psychiatric care provided in a general hospital is not subject to the 190 day limit. There are some additional restrictions on psychiatric care if the person was in the hospital at the time they became eligible for Medicare benefits.^{xx}
5. Swing beds. A patient hospitalized in an acute care facility that no longer qualifies for hospital care can nonetheless receive coverage if they require discharge to a skilled nursing facility and no beds are available at a skilled nursing facility.^{xxi}

D. **Skilled Nursing Facility (SNF)**

1. Coverage. Part A provides payment if a beneficiary is discharged from the hospital and enters a Medicare participating skilled nursing facility.^{xxii} The Social Security Act refers to this benefit as post hospital extended care services.^{xxiii} Many times the skilled nursing facility will be part of the same institution where the acute care was delivered. A skilled nursing facility is a licensed nursing facility which meets specific standards for skilled nursing or rehabilitation care. The care must be furnished pursuant to a physician's orders and require the skills of technical or professional personnel, like registered nurses, physical therapists, or occupational therapists. The care must either be performed or provided under the supervision of licensed nursing personnel. Additional requirements for coverage include:
 - a. The services must be required on a daily basis and can only be provided in a skilled facility.
 - b. The stay in the hospital lasted at least 3 days not counting the day of discharge.
 - c. The admission to the SNF took place within 30 days after the discharge from the hospital.
 - d. The reason for the admission to the SNF was for the same condition or a condition that arose during the time the beneficiary was in the hospital.

The covered services include nursing services, bed and board, physical, occupational, or speech therapy, medical social services, drugs, supplies, and equipment, and such other health services necessary to the health of the patient that are generally provided by skilled nursing facilities.

2. Limits and coinsurance.

Medicare will pay for up to 100 days of care per spell of illness in an SNF if all the conditions set forth above are met. There is no deductible required for this benefit. The first 20 days of the stay in an SNF Medicare pay the full cost of covered services. On the 21st -100th day the beneficiary must pay a coinsurance of 1/8 of the inpatient hospital deductible in 2003 that amount is \$105.00 a day. After the 100th day in an SNF the beneficiary must pay the entire bill as all Medicare benefits are exhausted for that spell of illness. Note that if the beneficiary is receiving only custodial care even if they are in a skilled facility the time will count toward the 60 days required to reset the spell of illness.

E. Home Health Benefit

1. Coverage

Medicare covers home health services in full with no deductibles and no coinsurance. A prior stay in a hospital is not required to qualify for home health care. There is no limit on the coverage as long as it is medically reasonable and necessary.^{xxiv} Coverage is provided for:

- a. Part time of intermittent nursing care provided by or under the supervision of a registered professional nurse;
- b. Physical, speech, or occupational therapy;
- c. Medical social services under the direction of a physician;
- d. Part-time or intermittent services of a home health aid;
 - (1) Part-time is generally considered less than eight hours per day;
 - (2) Intermittent is generally considered less than daily but at least once every 60 days;
 - (3) Home health aid provides direct personal care services to the patient such as bathing, laundry, food preparation, and light cleaning;
- e. Medical supplies (other than drugs and biologicals) and durable medical equipment;
- f. Medical services of interns or residents-in-training in cases where the home health agency is affiliated with a hospital and provided under an approved teaching program.

2. Excluded items

The following items are specifically excluded:^{xxv}

- a. Any service that would not be covered if furnished to an inpatient of a hospital;
- b. Food service arrangements such as Meals-on-wheels;
- c. Housekeeping services unrelated to patient care;
- d. Transportation services;
- e. Drugs and biologicals except osteoporosis drugs;
- f. Endstage renal disease services;
- g. Prosthetic devices covered under Part B;
- h. Medical social services provided to a beneficiary's family.

3. Requirements for coverage^{xxvi}

Medicare pays for home health care under the following conditions:

- a. The beneficiary is confined to home (does not mean bedridden)
- b. The beneficiary requires intermittent skilled nursing care, physical therapy or speech language pathology;
- c. The care is provided under a care plan providing for home health service which is established and periodically reviewed by a physician;
- d. The home health agency providing the care is a Medicare-certified provider;
- e. The services are reasonable and necessary for the treatment or diagnoses of illness or injury or to improve the functioning of a malformed body member.

F. Hospice Care

Hospice care is palliative care and support care for a terminally ill person and their families that does not have as its goal the treatment or cure of the underlying medical condition.^{xxvii} In order to qualify for hospice care the patient must be certified terminally ill, that is having a medical prognosis of six or fewer months to live. The beneficiary must elect to forego other Medicare coverage except physicians' services. The care must be provided by a Medicare participating hospice program. The benefit includes coverage for two 90 day periods and one 30-day period and can be followed by a fourth unlimited period of hospice coverage. There are no deductibles and only a \$5.00 coinsurance payment on prescription medication and a coinsurance equal to 5% of the payment made by CMS about \$5.00 a day for respite care. Hospice services include a variety of services not usually covered by Medicare including the following:

1. Nursing care;
2. Physician services;
3. Counseling services for the patient and the family or other caretakers;
4. Medical social services;
5. Physical, occupational, and speech therapy;
6. Home health aide and homemaker services;
7. Medical supplies, equipment, appliances and biologicals including pain medication;
8. Short-term inpatient care or respite care to provide temporary relief to that patient's usual caregiver.

VII. PART B BENEFITS

A. **Supplementary Medical Insurance Benefits**

Part B of Medicare covers medical care for the beneficiary outside the institutional settings described above such as hospitals and SNF. Part B covers a wide range of medical services and supplies but the most important benefit is the coverage it provides for doctor bills.

1. Deductibles and coinsurance. The Part B benefit has a \$100.00 a year deductible. The full deductible must be met no matter what time of the year the beneficiary became eligible for coverage. The deductible is based on what is called the Medicare approved rate which in some instances can be different from the rate charged by the doctor. After the annual deductible was met Medicare will pay *80% of the Medicare approved rate* and the beneficiary is responsible for the remaining portion of the bill.^{xxviii}
2. Assignment and Participating Doctors. As set forth above a doctor can charge a fee in excess of the amount that Medicare approves for a service. Medicare will pay 80% of the approved rate and the doctor bills the beneficiary for the remaining balance. If the doctor charges more than the approved rate then the part of the bill, the beneficiary will owe will exceed the 20% coinsurance amount that they are liable for under Part B. Most Medigap policies will pay the 20% of the approved rate that remains unpaid on the bill. However, most Medigap policies *only cover 20% of the approved amount*. If the doctor charges more than the approved amount the beneficiary may have to pay even if they have Medigap insurance. This process wherein the beneficiary is required to pay more than 20% of the bill or to pay even though they have Medigap insurance is known as “balance billing.” In the past there were no limits on how much above the Medicare approved rate a doctor could bill which left many beneficiaries with large medical bills even after Medicare and Medigap paid. Currently there is a limit on how much above the approved amount that a doctor can balance bills. This is 15% above the Medicare approved charge.

A beneficiary can avoid any balance billing by always using a doctor that accepts assignment. If the doctor accepts assignment, they will not bill more than the approved Medicare rate for that service. For most beneficiaries that have a Medigap policy that means they will not have any out of pocket expense for the service. Not all physicians take assignment.

Some will accept assignment for certain procedures or services but not for others. In order to assure themselves that they will never be subject to balance billing the beneficiary can go to what are called participating doctors or suppliers. Participating doctors or suppliers sign agreements with Medicare to accept assignment on all Medicare claims.

3. Covered services. The major benefit of part B is payment of doctor bills but Part B also covers durable medical equipment, outpatient therapy, diagnostic x-rays and laboratory tests. Part B also covers the following:
 - a. Physician services including osteopaths, chiropractors, optometrists, dentists, and podiatrists;
 - b. Services and supplies incidental to physicians' professional services, including drugs and biologicals which cannot be self administered;
 - c. Outpatient hospital services;
 - d. Physical and occupational therapy services;
 - e. Speech pathology services;
 - f. X-ray, laboratory, and other diagnostic tests;
 - g. X-ray, radium, and radioactive isotope therapy;
 - h. Surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations;
 - i. Durable medical equipment (DME) that meets the following definition;
 - (1) able to withstand repeated use;
 - (2) primarily and customarily used to fulfill a medical purpose;
 - (3) is generally not useful to a person in the absence of illness or injury;and
 - (4) appropriate for use in the home;
 - j. Ambulance services;
 - k. Prosthetic devices;
 - l. Braces, trusses, and artificial legs, arms, and eyes;
 - m. Physician assistants and assistants at surgery;
 - n. Services of nurse practitioners;
 - o. Comprehensive outpatient rehabilitation facility services (CORF);
 - p. Rural health clinic services;
 - q. Mental health services including clinical psychologist and social worker services;
 - r. End-stage renal disease services and supplies rendered to outpatients;
 - s. Antigens, blood-clotting factors and hepatitis B vaccine;
 - t. Immunosuppressive drugs provided after an organ transplant;
 - u. pneumococcal, influenza and without a deductible or coinsurance payment;
 - v. Nurse-midwife services as a substitute for covered physician services if

the nurse-midwife is certified and the services are authorized under state law;

- w. Pap smears for the detection of cervical cancer; and
- x. Mammogram to screen for breast cancer.

4. Excluded services. Part B covers many medical needs and services however there are certain items and services excluded from coverage:^{xxix}
 - a. Services that are not medically reasonable or necessary;
 - b. Routine physical
 - c. Eye examination and eyeglasses unless needed after cataract operation;
 - d. Hearing aids and examinations for hearing aids;
 - e. Dental services;
 - f. Routine foot care;
 - g. Orthopedic shoes and other supportive devices unless intended as an instrumental part of a leg brace;
 - h. First three pints of blood;
 - i. Cosmetic surgery;
 - j. Immunizations except for vaccinations to prevent hepatitis B, pneumococcal pneumonia, and influenza;
 - k. Custodial care; and
 - l. Personal comfort or convenience items that do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member.

VIII. INTRODUCTION TO MEDICARE HMO's

This part of the paper attempts to explain the new wave of the Medicare Program. It assumes that the reader already has a working knowledge of the current Medicare program. In the event that the reader is unfamiliar with the "traditional Medicare Program" it is recommended that the reader take time to obtain a basic knowledge of the Medicare Program both Part A (hospital insurance) and Part B (medical insurance) to provide the background for the remainder of this article.

As most Americans are aware, the cost of Medical care in our country continues to escalate. Most of us who purchase our medical insurance coverage through private companies have experienced increases in our premiums. In an attempt to save money on insurance cost many Americans are enrolling in Health Maintenance Organizations commonly referred to as HMO's. The HMO offers the promise of health care at a cheaper rate than traditional fee for service type coverage.

The efficiency and lower cost delivery of healthcare by HMO's have not escaped the eye of

Congress as current newspaper coverage shows. Additionally, Congress is well aware of the inefficiencies, fraud, waste and abuse that have plagued the traditional Medicare Program. Whether for good or bad reasons it is undisputable that the HMO provides healthcare at a cheaper cost than traditional Medicare.

The savings brought about by shifting Medicare beneficiaries to HMO's is very attractive from a political prospective for the government. An immediate savings of 5% per person is obtained without any perceived changes in the person's benefits. Once the majority of Medicare beneficiaries are shifted to HMO's the overall cost of operation and management of the Medicare system will be greatly reduced. The responsibility for preventing fraud by healthcare providers and others is shifted to the private companies that run the HMO.

The companies that run the HMO's are profit oriented and must control cost to maintain profits. As a general rule in the traditional Medicare Program the cost of any particular course of treatment or care was not a major part of the decision by the healthcare provider in determining the type of treatment the beneficiary would receive. **Under the HMO Medicare system the cost of the healthcare a beneficiary receives will play a major part in treatment decisions and care a person will receive.** It will be the Elder Law Advocate that will ultimately assure that the profit motive of the private insurance company does not result in loss of quality of care to our elderly clients.

The Medicare health maintenance organization (HMO) benefit is a unique means of receiving Medicare benefits for two main reasons. First, like the Medicare hospice beneficiary, the HMO beneficiary must specifically opt to receive Medicare coverage through a different organization, but unlike the hospice benefit, which is designed to provide only palliative care, HMO Medicare coverage is designed for the treatment of an illness or injured body member. Second, a beneficiary who chooses to receive coverage through an HMO must, generally, receive all of his or her care through the HMO in order to have Medicare cover that care. This requirement is known as the lock-in, since beneficiaries are locked into receiving their care through the HMO. Most of the advantages, as well as the disadvantages, of choosing Medicare HMO coverage arise out of this lock-in provision. In order to appreciate these advantages and disadvantages, an understanding of the Medicare HMO benefit, its coverage, and its procedural requirements is essential.

XV. THE HMO STRUCTURE

There are two types of Medicare HMOs: risk HMOs and cost-basis HMOs. The distinction between these two types is generally based upon the manner in which the HMO is reimbursed by the Centers for Medicare and Medicaid Services (CMS), the federal entity that administers the Medicare program.

Risk HMOs are required to provide the full range of Medicare benefits to an enrollee for a fixed

payment per enrollee. If the cost of providing services to an enrollee exceeds the amount of the fixed payment, the HMO must absorb the excessive cost.^{xxx} Hence, the "risk" involved in providing services.

Cost-basis HMOs are reimbursed on a reasonable cost basis. Under the reasonable cost basis, payment is made to the HMO on an interim basis using a monthly payment per individual. At the end of the HMO's contract year, payments are adjusted to equal the reasonable cost of providing services to the HMO's enrolled Medicare beneficiaries.^{xxxii} However, note that Medicare's definition of a reasonable cost frequently is less than the actual cost to the HMO of providing services. While an HMO may contract with CMS on either a risk or cost basis, an HMO may not contract on a risk basis if CMS is not satisfied that the HMO is capable of bearing potential losses.^{xxxiii}

The manner in which an HMO is reimbursed is relevant to a Medicare beneficiary in several ways. First, only enrollees of risk HMOs are locked in; enrollees of cost-basis HMOs may receive coverage for services from sources other than the HMO.^{xxxiv} Second, regulations require risk HMOs to provide additional services without charge to Medicare enrollees; cost-basis HMOs are not required to provide these services.

HCFA views either type of HMO as advantageous to the Medicare program because both types are designed to save money for Medicare. The risk HMO model, because it places a cap on the amount Medicare will pay to the HMO for each enrollee,^{xxxv} tends to save Medicare more by passing any excessive costs onto the HMO itself. In addition, operating on a risk basis provides the HMO with an opportunity to actually achieve profits. These profits are garnered by providing care at a cost less than the payment that the HMO receives from Medicare. Cost-basis HMOs, by contrast, because they are paid on a reasonable cost basis, will generally only receive reimbursement for actual expenditures and, therefore, will tend only to break even. For these reasons, there are many more risk HMOs than cost HMOs. Consequently, as a practical matter, most Medicare beneficiaries will be enrolled in a risk-basis HMO.^{xxxvi} However, the advocate should be sure to inquire of the HMO whether it is a risk or cost basis HMO.

The HMO not only provides or arranges for direct medical services, but also at initial stages decides what care is reasonable and necessary. This fact, combined with a possible desire on the part of an HMO to spend as little per enrollee in order to turn a profit, causes some advocates to be concerned that health care decisions may be made on the basis of economics rather than on the beneficiary's health care needs, and raises additional concerns about the quality of care provided to enrollees.

X. BENEFICIARY ENROLLMENT AND DISENROLLMENT

Any Medicare beneficiary may enroll to receive his or her Medicare benefits through a participating HMO.^{xxxvii} The beneficiary may be enrolled in both Parts A and Part B of Medicare

or solely in Part B.^{xxxvii} A beneficiary enrolled only in Medicare Part A is not eligible to choose the HMO benefit. The beneficiary must live within the geographic area^{xxxviii} served by the HMO and not be enrolled in any other Medicare-participating HMO.^{xxxix}

HMOs provide services both to Medicare beneficiaries and to individuals not eligible for Medicare who either privately or through employer-sponsored health plans choose to use the HMO's services. Medicare, in order to assure solvency of HMOs and not to have HMOs solely reliant on government programs for their existence, has mandated that no more than 50 percent of an HMO's enrollment may be Medicare and Medicaid beneficiaries.^{xl} As a result of this 50 percent limitation, it is possible that all those Medicare beneficiaries who file an application for enrollment in an HMO may not be accepted immediately.

Enrollment as a Medicare HMO beneficiary is accomplished by first filing an application with the participating HMO. Filing an application does not guarantee enrollment. To assure fairness in the enrollment process (and to avoid having the HMO enroll only those beneficiaries who appear in good health and, therefore, pose less financial risk), each application must be dated as of the day it is received and processed in chronological order by date of receipt.^{xli} Under Medicare regulations, the HMO is required to notify the applicant of acceptance or denial promptly.^{xlii}

A denial may be issued only if acceptance of the individual (1) would cause the number of enrollees to exceed the 50 percent limit; (2) would require the HMO to exceed its overall enrollment capacity; (3) would cause the enrollment to become substantially nonrepresentative of the general population in the HMO's geographic area; or (4) would prevent the HMO from complying with the terms of its contract with CMS.^{xliii} If the HMO has decided to limit enrollments because of its capacity, it must notify CMS^{xliv} of its intent to do so within 90 days prior to its open enrollment period. If the HMO accepts applications from Medicare beneficiaries after it has reached capacity, it must place the individual applicants on a waiting list and enroll them in chronological order as vacancies occur. These are the only bases upon which an application can be denied.

Under provisions of the Medicare policy manual, notification of acceptance or rejection of an application must be made not later than 30 days following the application date (or within 60 days with HCFA approval). If the application is accepted, the applicant must be notified of the date upon which the HMO will make his or her enrollment effective. If the application is accepted but the HMO is enrolled to capacity, the HMO must notify the beneficiary of the procedures that will be followed as vacancies occur.^{xlv} If the application is denied, the notice must state the reasons for the denial.^{xlvi} Application decisions may not be based on the age or health of the applicant.

Hospice patients are not eligible to enroll in the Medicare HMO benefit so long as their hospice election remains in effect.^{xlvii} End-stage renal disease (ESRD) patients may not enroll in the

Medicare HMO benefit as new enrollees; however, if they were already enrolled before the onset of ESRD and are required by the HMO to reenroll periodically, they must be permitted to do so.^{xlvi}

Once an application is accepted, enrollment may be made during an open enrollment period. Each HMO must provide an open enrollment period of at least 30 days each contract year during which Medicare beneficiaries can be enrolled.^{xlix} During this open enrollment period, the HMO must enroll eligible Medicare beneficiaries in the order in which their applications are received and until its enrollment capacity is reached.¹

HMOs must accept as Medicare enrollees individuals who are enrolled in the HMO (through, for example, an employer health plan) during the month immediately prior to the month in which they become eligible for Medicare Parts A and B or Part B alone.^{li} The individual must file an application form with the HMO.^{lii} The individual's conversion from non-Medicare to Medicare HMO enrollee is effective with the first day of the month in which the required Medicare entitlement begins.^{liii}

Upon enrollment, Medicare will make payments to the HMO on behalf of the enrollee.^{liv} Enrollment in the HMO continues until such time as the enrollee is disenrolled voluntarily or involuntarily.

A Medicare enrollee may voluntarily disenroll at any time by giving the HMO a signed, dated request to disenroll. The HMO should have a form designed for this specific purpose. The enrollee may request a specific disenrollment date, but that date may not be earlier than the first day of the month following the month in which the HMO receives the request.^{lv} The HMO must give the enrollee a copy of his or her request for termination of enrollment. Risk organizations must also provide notice to the enrollee that he or she remains enrolled in the HMO until the effective date and that the enrollee is subject to the lock-in provisions until that date.^{lvi} In theory the HMO will notify CMS of the disenrollment and CMS will promptly record the disenrollment, thereby permitting the beneficiary to receive payment under the regular Medicare benefit. In practice, however, some beneficiaries have experienced delays in their disenrollment, having been properly recorded, with consequent denials of claims submitted under the regular benefit. If delay occurs, contacting the intermediary or carrier that has rejected the claim and requesting it to investigate the delay may resolve the problem.

Again, because of concern that an HMO may attempt to disenroll a beneficiary who requires services costing more than that which Medicare pays, Medicare regulations set forth rules designed to prevent arbitrary, involuntary disenrollments. Involuntary disenrollment can take place only under the following circumstances:

Death of the enrollee;^{lvii}

The enrollee fails to pay any premiums or any deductible or coinsurance

payments, but only if the HMO can demonstrate to CMS that reasonable efforts to collect the unpaid amount have been made and gives the enrollee written notice of the disenrollment as well as an explanation of the enrollee's appeal rights;^{lviii}

When the enrollee permanently moves from the HMO's geographic area but does not voluntarily disenroll (the enrollee's move must be established on the basis of a written statement from the enrollee, or other acceptable evidence, that the enrollee has permanently moved outside the geographic area);^{lix}

If the enrollee has made a fraudulent statement on his or her application that materially affects his or her eligibility to enroll in the HMO;^{lx}

If the enrollee has intentionally permitted another to use his or her membership card to obtain services from the HMO;^{lxi}

The enrollee's entitlement to Medicare Part B has terminated;^{lxii}

If the enrollee's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continuing membership in the HMO seriously impairs the HMO's ability to furnish services either to the enrollee or other members (the HMO must make a "serious effort" to resolve the problem and must ascertain that the enrollee's behavior is not related to mental illness or the use of medical services);^{lxiii}

The enrollee fails to convert his or her status from a cost-basis enrollee to a risk enrollee when the HMO has itself converted and CMS has determined that all of the HMO's nonrisk enrollees must convert to risk enrollees (the HMO must give 30 days' notice to the enrollee that failure to convert will result in disenrollment).^{lxiv}

The enrollee may appeal these determinations using the internal grievance procedure below.

The advocate should be aware that HMOs must maintain written membership rules and must provide the enrollee with a copy of the rules upon enrollment and at least annually thereafter.^{lxv}

The rules at a minimum must explain:

All benefits provided under the contract as described in 42 C.F.R. 417.440

The restrictions on coverage for services furnished from sources outside a risk HMO other than emergency services and urgently needed services (the lock-in provisions);

The obligation of the HMO to pay for and provide emergency services;

Procedures for paying premiums and other charges for which Medicare enrollees may be liable;

Grievance and appeal procedures;

Disenrollment rights;

Obligations of enrollees leaving the HMO's geographic area for more than 90 days;

How and where to obtain services from or through the HMO;

- The expiration date of the Medicare contract with HCFA and information about the nonrenewal of the contract and the impact on the individual's enrollment;
- : Advanced directives, the individual's rights concerning their use and the policies and procedures concerning advanced directives as well as provisions for community education regarding advanced directives.

The HMO must furnish a copy of these rules to each member and give at least 30 days' notice of any changes in the rules to the enrollee.⁶⁵ Reference to these rules, or their absence, may be useful in pursuing an appeal. Advocates with experience in this area will recognize that the requirements concerning the written information that must be provided to the enrollee have been greatly expanded over the requirements of prior years.

XI. SERVICES THAT AN HMO MUST PROVIDE A MEDICARE ENROLLEE

The services that an HMO must provide to an enrollee differ, depending upon whether the HMO is a risk or cost-basis HMO. For this reason, the services that must be provided will be discussed separately for each type of HMO.

A. Risk HMOs

Risk HMOs are required to provide those services and supplies that are covered under Parts A and B of Medicare (if the enrollee is entitled to benefits under both programs) or under Part B (if the enrollee is entitled to benefits solely under Part B), except hospice care, and that are available to individuals residing in the geographic area served by the HMO.⁶⁶ This latter requirement would excuse the HMO from, for example, covering a technologically based procedure that is available in certain parts of the country, but not in the geographic area served by the HMO, and it is not common practice to refer patients to sources of the care outside the geographic area.⁶⁷

Although Medicare regulations provide that the enrollee may be charged for deductibles and coinsurance in the same manner in which a regular Medicare beneficiary would be,⁶⁸ as a practical matter these are often waived as an additional benefit, which risk HMOs are required by law to provide to their enrollees. It should be noted that rather than charging actual deductible and coinsurance amounts, based on the specific services provided to the enrollee, HMOs may require an enrollee to pay a premium, membership fee, or similar charge.⁶⁹ The amounts that the HMO may charge must be based on an actuarial value that does not exceed the average amount of deductible and coinsurance that would be charged to a regular Medicare enrollee.⁷⁰

Since all Medicare services covered under Part A and Part B of the regular Medicare benefit must be provided by the HMO, various types of inpatient care

such as inpatient hospital care and skilled nursing facility care are available to Medicare HMO enrollees. It should be noted, however, that all substantive rules that must be met for services and supplies provided under the regular Medicare benefit must also be met in order to receive them while a Medicare HMO enrollee.⁷¹ In addition, time limitations on coverage that exist in the regular Medicare benefit, such as 100 days of skilled nursing facility care, apply to HMO services. Note that in 1990 only, however, the increased benefits provided in the Medicare Catastrophic Coverage Act of 1988 are extended to Medicare risk HMO enrollees, even though they have been repealed for participants in the regular Medicare benefit.⁷² Risk HMO enrollees must receive their services directly from the HMO or through other providers of services that have agreed to supply services under an arrangement with the HMO. An "arrangement" means that the HMO has entered into a written agreement with another entity, such as a hospital, skilled nursing facility, or home health agency, in which the other entity agrees to provide specified services to Medicare HMO enrollees. Under an arrangement, the HMO itself remains responsible for those services and the beneficiary has no obligation to pay for these services.⁷³ The entity with which the HMO enters into an agreement must meet Medicare's conditions of participation.⁷⁴ The HMO may designate one or more sources of care, with which it has made arrangements, where enrollees may obtain needed care. If there are several sources of the same care (for example two hospitals) in the geographic area and the HMO has made arrangements with all or some of those sources, some HMOs require enrollees to choose and use only one.

As a result of the lock-in rule, services received by risk enrollees outside the HMO or from an entity with no arrangement with the HMO will not be paid for by Medicare and the beneficiary will be personally liable for the charges. The only exceptions to this rule are emergency services, urgently needed services, and services denied by the HMO and found, upon appeal, to be services the enrollee was entitled to have furnished by the HMO.⁷⁵ Emergency services are those that are needed immediately because of an injury or sudden illness, and the time required to reach the HMO's designated provider or suppliers would have meant risk of permanent damage to the patient's health.⁷⁶ Urgently needed services are covered services required in order to prevent serious deterioration of an enrollee's health that results from an unforeseen illness or injury if the enrollee is temporarily absent from the HMO's geographic area and receipt of the health care cannot be delayed until the enrollee's return to the HMO's geographic area.⁷⁷

Although the regulations provide for coverage under these circumstances, there are occasions in which the HMO will deny coverage for services falling within these definitions. In these cases an appeal should be made, and the advocate is well advised to obtain written documentation from the attending physician that

demonstrates the practical need to have treated the patient from outside the authorized HMO provider network. Finally, if an enrollee requires medically necessary emergency services and is within the geographic area, such emergency services must be available 24 hours a day, seven days a week.⁷⁸

The third basis for payment for services received outside the HMO, when the HMO has denied those services and upon appeal it has been established that they should not have been denied, can occur in a situation where a denial of an emergency or urgently needed services is overturned or in a situation where services require the HMO's prior approval and are denied before they are actually obtained.

Although HMOs are free to establish their own rules regarding how an enrollee obtains services from an entity under arrangement with the HMO, nearly always the HMO will require that the enrollee obtain prior approval from the HMO before obtaining such services. Similarly, if the enrollee requires specialized care from a provider outside the under-arrangement network, prior approval must be obtained. If such prior approval is not given, the enrollee should request a written denial of the services from the HMO and may appeal the denial. However, the enrollee faces a difficult decision if the denied services are needed quickly. Because the Medicare appeal will undoubtedly take a long time to reach a conclusion, the enrollee may have to decide to receive the services and pay for them out-of-pocket with the expectation of being reimbursed by the HMO upon a successful appeal.

Risk HMOs must also provide additional services to Medicare enrollees. These additional benefits may take the form of either or both a reduction in premiums and deductibles and coinsurance payments ordinarily required to be paid or provision of health benefits or services beyond the required Part A and Part B coverage.⁷⁹

Risk HMOs can, with the approval of CMS, require Medicare enrollees to accept and pay for supplemental services. These supplemental services are those above and beyond both the basic Part A and Part B services and the additional services required to be provided. The requirement that enrollees accept and pay for supplemental services will be approved by CMS only if CMS determines that the requirement will not discourage enrollment in the HMO by Medicare beneficiaries.⁸⁰ If CMS has not approved mandatory acceptance of these supplemental services, the HMO may still offer them to an enrollee as a voluntary option for which the enrollee would pay extra.⁸¹

HMOs may offer to those enrollees covered only under Medicare Part B additional coverage that would be the equivalent of regular Medicare Part A

services. The HMO's charge to the enrollee may not exceed the premium that non-Medicare HMO enrollees would be charged for a similar benefit package.⁸²

These variations in the services that an HMO may offer and the charges that an HMO may impose points out how important it is for a prospective enrollee to examine carefully the benefits and costs of the services offered by the HMO. A comparison of these benefits and costs with regular Medicare and Medicare supplemental policies offered by private insurers should be conducted before selecting the Medicare HMO benefit.

One historically problematic area has been in HMO marketing activities. Although there are proscribed marketing activities, including the prohibition of activities that would mislead, misinform, confuse, or defraud Medicare beneficiaries,⁸³ abuse by some HMOs has been an ongoing problem. The regulations provide no direct remedies that the beneficiary subjected to prohibited marketing activities may pursue.

B. Cost-Basis HMOs

Enrollees of cost-basis HMOs can have payment made for covered services they receive through the HMO or through sources other than the HMO. In these instances the enrollee is referred to as an unrestricted enrollee.⁸⁴ Cost-basis enrollees are, as with risk enrollees, entitled to all services, except hospice care, that are available to non-HMO Medicare beneficiaries in the geographic area.⁸⁵ They are also subject to the same premium, membership fee, or coinsurance requirements as risk enrollees.⁸⁶ Because cost-basis HMO cannot impose a lock-in provision on its enrollees, enrollees have more flexibility than risk enrollees in seeking services outside the HMO, and they are not limited to the emergency services or urgently needed services provisions for seeking care from outside the HMO.⁸⁷

There is an exception to this general rule, however. A cost-basis HMO may offer supplemental services to its enrollees. These may include services above and beyond that ordinarily covered by Medicare Part A and Part B, as well as a reduction in the premiums, coinsurance, and the like that the enrollee may be required to pay.⁸⁸ However, once an enrollee chooses to accept special supplemental coverage, the enrollee becomes locked in for all services.⁸⁹ Also, cost-basis enrollees are not entitled to those additional services provided to risk enrollees at no cost.

C. Conversion of an Enrollee From Cost Basis to Risk Basis

As noted, some HMOs may choose to convert the basis upon which they are reimbursed from the cost-basis method to the risk basis. This conversion may have some impact on enrollees in the converting HMO.

A beneficiary enrolled in the HMO before its conversion may continue to be treated as a cost-basis enrollee rather than as a risk enrollee.⁹⁰ However, CMS may require that all cost-basis enrollees be involuntarily converted to risk-basis enrollees if CMS determines that administrative reasons warrant such a conversion or if there are fewer than 75 cost-basis enrollees remaining in the HMO.⁹¹ If CMS determines that involuntary conversion will be required, CMS must notify each affected enrollee at least 90 days prior to the effective date of the conversion. Affected enrollees who accept the conversion must also sign a written statement acknowledging the consequences of the conversion to them.⁹²

Finally, the HMO itself must provide a written notice of the conversion at least 30 days prior to the effective date.⁹³

Enrollees may also voluntarily convert from being treated as cost-basis enrollees to risk-basis enrollees when the HMO itself has made a conversion.

XII. THE GRIEVANCE AND APPEALS PROCESS

A. Grievances

Each HMO is required to establish internal grievance procedures.⁹⁴ The regulations themselves do not require any specific format for the grievance appeal process, but the grievance procedures must be included in the written membership rules provided to each enrollee and must state the steps to be followed in completing the procedure and the time limits imposed on each step in the process. The grievance procedure adopted by the HMO must be approved by HCFA. The grievance procedure must be used for all cases that do not involve an organizational determination. For example, any controversies involving supplemental services that the enrollee has voluntarily chosen to receive must be appealed through the grievance procedure.

Some advocates are of the opinion that the grievance procedure should be avoided, whenever possible, because the enrollee's rights and the remedies that can be afforded the enrollee are vague. As noted, however, unless the case involves an organizational determination, the grievance procedure will be the enrollee's only avenue of appeal.⁹⁵

B. Immediate QIO review of a determination of noncoverage of inpatient hospital care

If a Medicare beneficiary is a patient in a hospital and receives a notice that the HMO has determined that inpatient hospital care is no longer necessary and the HMO will no longer pay for their stay the beneficiary is entitled to an immediate QIO review of the determination.⁹⁶ The request for review must be submitted in writing or by telephone by noon of the first working day after the receipt of the written notice of the determination. The QIO must make a determination by close of business the first working day after it receives the necessary information from the hospital or HMO that it requires to make its review. The QIO is required to solicit the views of the patient or the patient's representative who requested the review.⁹⁷ Most important to the patient is the requirement that the HMO remains financially responsible for the costs of the hospital stay until noon of the calendar day following the day the QIO notifies the enrollee of its review determination.⁹⁸

C. The Appeals Process

As with the regular Medicare benefit, HMO Enrollees are entitled to use the Medicare appeals process. A written description of the appeals process must be provided to each enrollee.⁹⁹ The appeals process may be used only in cases involving an organizational determination.¹⁰⁰ An organizational determination involves any decision concerning the rights of an enrollee with regard to services payable by Medicare that are furnished by an HMO.¹⁰¹ In addition, an organizational determination involves any determination with respect to (1) reimbursement for emergency or urgently needed services; (2) any other Medicare-covered services furnished by a provider or supplier other than the HMO that the enrollee believes the HMO should have furnished, arranged for, or reimbursed the enrollee for; and (3) the HMO's refusal to provide services that the enrollee believes should be furnished or arranged for by the HMO and the enrollee has not yet received the services outside the HMO.¹⁰²

The regulations specifically provide that organizational determinations do not include any determination regarding services for which the enrollee has no further obligation for payment or regarding items or services included in an optional supplemental plan.¹⁰³ A party to an organizational determination includes (1) the enrollee; (2) an assignee of the enrollee (such as a physician or other provider who accepts assignment of the enrollee's claim); (3) the legal

representative of the deceased claimant's estate; or (4) any other entity considered to have an appealable interest in the proceeding.¹⁰⁴

An HMO must make all organizational determinations regarding a case involving the HMO's refusal to provide services that the enrollee believes should be furnished or arranged for by the HMO and services the enrollee has not yet received outside the HMO.¹⁰⁵ However, at the HMO's choice, it may choose to have all other organizational determinations and reconsiderations (or reviews for Part B claims) processed by an intermediary or carrier. The decision to have an intermediary or carrier process claims must be specified in the HMO's contract with HCFA and must be uniformly applied to all enrollees of the HMO. Of course, the HMO is free to choose to process all organizational determinations and reconsiderations itself.

An organizational determination, made by either the HMO or intermediary or carrier, must be issued within 60 days of receiving the enrollee's request for payment. The notice must state the reasons upon which the determination is based and inform the enrollee of his or her right to request a reconsideration. The failure to provide the enrollee with a timely adverse initial determination constitutes an adverse decision and may be appealed.¹⁰⁶

A request for reconsideration must be filed within 60 days from the date of the notice of the organizational determination, not from the date of receipt of the notice.¹⁰⁷ It must be in writing and must be filed with the HMO, with the intermediary or carrier that made the initial determination, or a Social Security office or Railroad Retirement Board office for those enrollees who are qualified railroad retirement beneficiaries. The request should be filed with only one of these entities. A late filing may be honored if a written request for an extension has been filed and good cause for the failure to file timely has been demonstrated.¹⁰⁸

If the HMO made the organizational determination and is making the reconsideration determination, it may issue only a favorable reconsideration decision. Any cases that the HMO believes will result in an unfavorable reconsideration determination must be forwarded to CMS. CMS will then review the case and, if appropriate, issue the unfavorable reconsideration determination. Pursuant to the government's stipulated agreement in *Levy v. Sullivan*,¹⁰⁹ reconsideration determinations are required to be processed within 30 to 60 days. Under the agreement, CMS is to develop proposed regulations that prescribe the 30-to-60 day timeliness standard for the HMO reconsideration process.

If an unfavorable reconsideration determination is issued, and the amount in controversy is \$100 or more, the enrollee has a right to a hearing before an administrative law judge (ALJ). The request for hearing must be filed within 60 days of the date of the notice of reconsidered determination. The request must be in writing and must be filed with one of the same entities where reconsideration determinations may be filed.¹¹⁰

From the ALJ hearing stage on, the appeal process follows that for Medicare Part A claims under the regular Medicare benefit. The HMO appeal process differs from the regular appeals process, however, at least insofar as Part B type claims are concerned. For example, no carrier-level hearing must be held prior to an ALJ hearing, and the amount that must be in controversy to obtain an ALJ hearing is \$100, even though services that would be covered under Part B in the regular Medicare benefit are at issue.

XIII. CONCLUSION

Many advocates involved in representing Medicare HMO enrollees find that the system is fraught with difficulties. Beginning with the absence of clear explanation, and thus clear understandings on the part of enrollees, as to what services may be covered under what circumstances, to the concern of advocates that economic issues, rather than quality of care, guide some HMOs' coverage determinations, the Medicare HMO process can present large problems to enrollees. The lock-in provision and the requirement that specialty care must be approved in advance are often viewed as disadvantages to the Medicare HMO benefit. This difficult situation is compounded by an appeals system that is often vague (the grievance process) or involves frequent delays (the Medicare appeals process).

On the other hand, there are some advantages to HMO membership. For most enrollees, reduced or no deductibles or coinsurance payments are required, which may obviate the need to purchase a Medicare supplemental health policy (Medigap policy). In addition, there are no claim forms to be filled out.

Certain areas of the country have more HMOs than others. As the presence of HMOs expands and as beneficiaries begin to have the option of participating in Medicare HMOs, advocates may be faced with Medicare problems that they have never before encountered. The nature of the present Medicare HMO system and the possibility of increasing usage of the Medicare HMO option may result in fertile ground for litigation.

- i. 42 U.S.C. §1395 *et seq.*
- ii. Stein, Hulin and Wilson, How to Establish a Medicare Program in Your State, NELA Institute V, November 10-12, 1995 at p.1.
- iii. Medicare Practice Manual (1990), Legal Counsel for the Elderly at p. 2.
- iv. Id.
- v. Medicare Explained, (1996) CCH Incorporated at p 141.
- vi. Id. at p. 142.
- vii. Id. at p. 160.
- viii. Id.
- ix. Soc. Sec. Act § 210 (p), 226(a)(2)(C), P.L. 97-248 § 278; 42 C.F.R. §406.15, P.L. 99-272 § 13205.
- x. 42 C.F.R. § 406.21 and § 407.12.
- xi. Medicare Explained, *supra* at p. 78.
- xii. 42 U.S.C. §§ 1395c, 1395d.
- xiii. *Id.* § 1395y(1)(A).
- xiv. Medicare Explained, *supra* at p. 121.
- xv. Medicare Intermediary Manual § 3101.
- xvi. 42 C.F.R. § 409.11.
- xvii. 42 C.F.R. §§ 412.23(b)(7), 412.29(c), (d), *Medicare Hospital Manual* § 211.
- xviii. 42C F.R. § 409.61 (c).

xix. 42 C.F.R. § 409.87.

xx. 42 C.F.R. § 409.62; *Medicare Hospital Manual §217*.

xxi. Soc. Sec. Act § 1883, 42 C.F.R. §412.42 (c) (1);

xxii. 42 C.F.R. § 409.33.

xxiii. Soc. Sec. Act § 1814(a)(2)(B).

xxiv. 42 C.F.R. § 409.48.

xxv. 42 C.F.R. § 409.49.

xxvi. 42C F.R. § 409.42.

xxvii. 42 C.F.R. § 418 *et seq.*

xxviii. 42C F.R. § 410.52(b).

xxix. 42 U.S.C. Chapter 7 Subchapter XVIII § 1395y (a).

xxx. 42 C.F.R. 417.407(c)(2).

xxxi. Social Security Act §1876(h)(3)

xxxii. 42 C.F.R. 417.410(e)(4) ;

xxxiii. 42C F.R. § 417.448.

xxxiv. Medicare pays the risk health maintenance organization (HMO) 95 percent of the average adjusted actual cost, an actuarial estimate of what the average per capita cost would be for Medicare enrollees if they had received covered services other than through the HMO, that is, through the regular Medicare benefit. This is Medicare's saving in providing coverage through the HMO structure. 42 C.F.R §417.584(b).

xxxv. Note that if a beneficiary enrolled in the HMO benefit while the HMO was a cost-basis HMO, but the HMO had subsequently become a risk HMO, the beneficiary would remain a nonrisk beneficiary and be treated as if he or she were enrolled in a cost-basis rather than a risk HMO. 42 C.F.R §417.444.

xxxvi. In order to be a participating HMO, the HMO must enter into a contract with the Health

Care Financing Administration (HCFA) to provide services to Medicare beneficiaries. The HMO must meet a range of qualifying conditions in order to enter into such a contract. Id. §§ 417.401-417.418

xxxvii. Id. § 417.420(a).

xxxviii. A geographic area, as defined by HCFA, is the area within which the organization furnishes, or arranges for furnishing, the full range of services that it offers to Medicare enrollees. Id. § 417.401.

xxxix. Id. § 417.422.

xl. Id. § 417.413(d)(1). An exception to this rule may be made if Medicare and Medicaid beneficiaries constitute more than 50 percent of the general population in the geographic area and the HMO is making reasonable efforts to enroll non-Medicare and Medicaid beneficiaries. Id. § 417.413(d)(2), (3).

xli. Id. § 417.430.

xlii. Id. § 417.430(b)(3).

xliii. Id. § 417.424.

xliv. Although the regulations require the CMS to notify CMS and set out that CMS will evaluate the HMO's notification, the regulations do not establish any mechanism by which CMS can overrule the HMO's decision to limit enrollment. Id. § 417.426(b).

xlv. Health Care Financing Administration, Medicare Health Maintenance Organization Manual § 2007.

xlvi. 42 C.F.R. § 417.430(b)(5).

xlvii. Id. § 417.423(b).

xlviii. Id. § 417.423(a)(2), 417.434.

xlix. Id. § 417.426.

l. Id. § 417.426(2).

- li. Id. § 417.432(a).
- lii. Id. § 417.432(d).
- liii. Id. § 417.432(b).
- liv. Id. § 417.420(b).
- lv. Id. § 417.461(a)(2).
- lvi. Id. § 417.461(b)(3).
- lvii. Id. § 417.460.
- lviii. Id. § 417.460(3)(c)(I), Note that if the premiums are those charged for supplementary services over and above the basic Medicare coverage, an enrollee may be discontinued from the supplemental benefits, but not disenrolled from the Medicare HMO benefit. Id. § 417.460(3)(c)(iii).
- lix. Id. § 417.460(2). In practical terms, if the enrollee has not informed the HMO of the permanent move, there is little incentive for the HMO to remove the enrollee from the rolls because the HMO will continue to receive its payment from HCFA for the enrollee, but will not be providing services to the enrollee. Meanwhile, beneficiaries who have moved and seek to obtain coverage under the regular Medicare benefit will not be able to have those services paid for because they are still enrolled in the HMO from where they have moved. In light of this potential problem, enrollees who move outside the geographic area should always be sure to disenroll voluntarily or, at the very least, to give written notice to the HMO of the permanent move. See also 42 C.F.R. § 417.460(f), which permits the HMO, with the agreement of the enrollee, to retain an enrollee who permanently moves. The enrollee is then not subject to the lock-in provisions but, rather, is treated as a cost-basis enrollee.
- lx. Id. § 416.460(d)(i).
- lxi. Id. § 417.460(d)(ii).
- lxii. Id. § 417.460(b)(2)(ii)
- lxiii. Id. § 417.460(e).
- lxiv.. Id. § 417.460(g).
- lxv. Id. § 417.436(b).

65. Id. § 417.436.
66. Id. § 417.440.
67. Services are considered "available" if the sources of the services are located within the geographic area or it is common practice to refer patients to sources outside that geographic area. Id. § 417.414(b)(2).
68. Id. § 417.452(a)(1).
69. Id. § 417.452(a)(2).
70. Id. § 417.452(a)(3).
71. For example, in order to receive skilled nursing facility care as an HMO enrollee, one would have to receive daily skilled nursing or rehabilitative services that were reasonable and necessary and that as a practical matter could only be delivered at a skilled nursing facility level of care. This is the same standard applied in determining Medicare coverage for skilled nursing facility services under the regular Medicare benefit.
72. Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L 101-378, § 203(b).
73. 42 C.F.R. § 417.122.
74. Id. § 417.416.
75. Id. § 417.440(a)(2)(ii).
76. Id. § 417.401.
77. Id.
78. Id. § 417.416(e)(1).
79. Id. § 417.440(b)(4)(I), (ii). For an explanation of when additional benefits are required and how the requirement is determined, see 42 C.F.R. § 417.442.
80. Id. § 417.440(b)(3).
81. Id. § 417.440(b)(2).
82. Id. § 417.401, 417.452(e).

83. See 42 C.F.R. § 417.428(b) for a full listing of prohibited marketing activities.
84. Medicare Intermediary Manual § 3360.1.
85. 42 C.F.R. § 417.414.
86. 417.452(a)(1).
87. Id. § 417.448.
88. Id. § 417.440(b)(2),(5). In essence, these optional supplemental services include those "additional services" that a risk HMO is required to provide. Cost-basis enrollees must, however, pay for these supplemental services.
89. Id. § 417.448(b)(3).
90. Id. § 417.444.
91. Id. § 417.444(c).
92. Id. § 417.444(a)(1)(ii).
93. Id. § 417.444(a)(1)(iii).
94. Id. § 417.436(a)(7), 417.600.
95. Id. § 417.606(c).
96. Id. § 417.605)
97. Id. § 417.600 (b) (5)
98. Id. § 417.605 (c)
99. Id. § 417.604(c).
100. Id. § 417.604(a).
101. Id. § 417.606(a).
102. Id. § 417.606(a)(1)-(3).
103. Id. § 417.606(1).

104. Id. § 417.610.
105. Id. § 417.606(a)(3).
106. Id. § 417.608(a) (1)
107. Id. § 417.616(b).
108. Id. § 417.616(c)(1),(2).
109. Medicare & Medicaid Guide (CCH) ¶ 37,809, at 19,747 (C.D. Cal. Mar.14, 1989).
The Levy case was a certified nationwide class action. The class was defined as "all persons who have requested or will request reconsiderations of Medicare health maintenance organization (HMO) denials of coverage of medical services and who have waited or will wait more than sixty days without receiving a reconsideration determination."
110. 42 C.F.R. § 417.632.