Original Medicare

Basic SHIP Counselor Training

SHIP
State Health Insurance Assistance Program

disabilityrights | WISCONSIN

Acknowledgement

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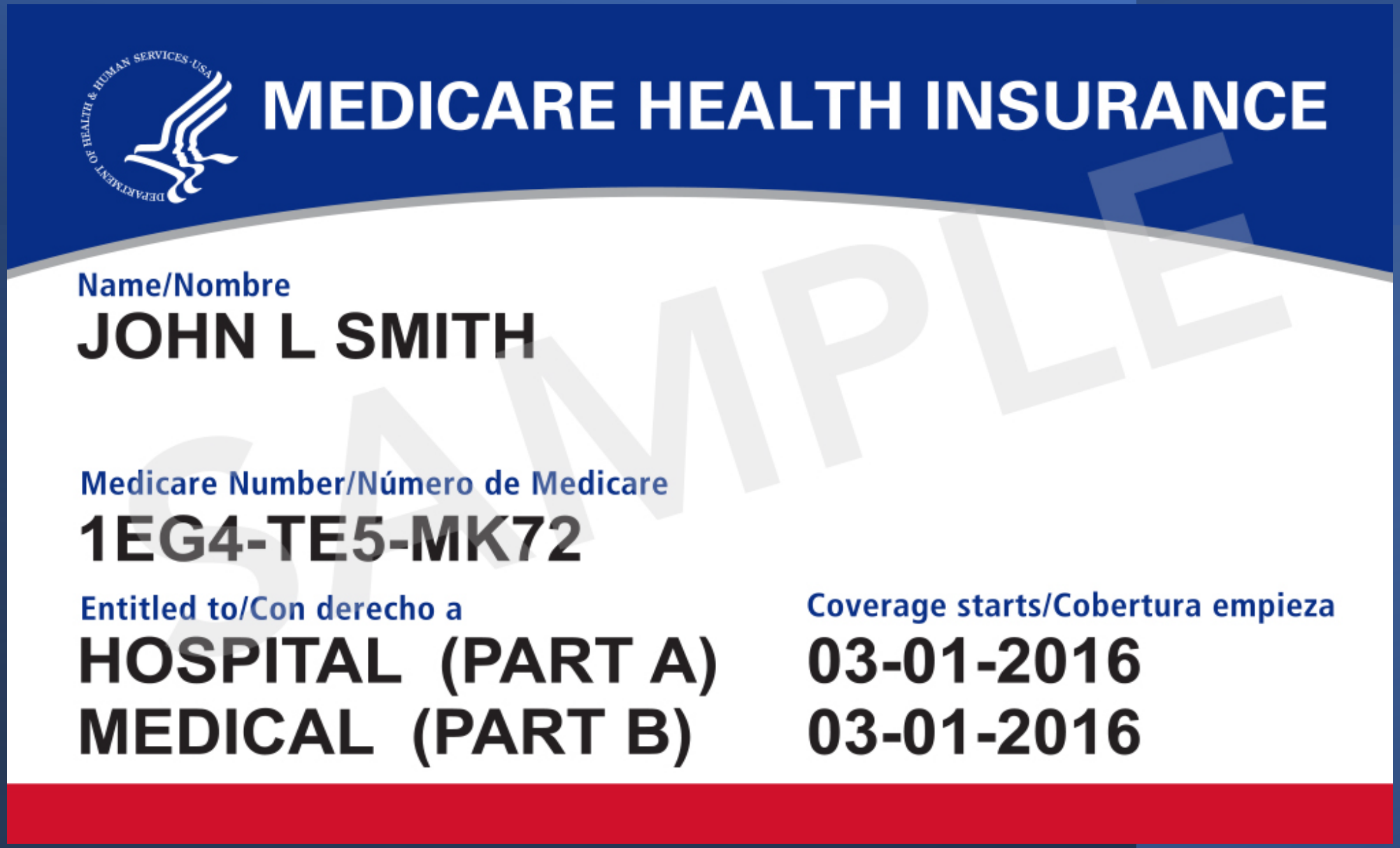
Objective

- Build on your Knowledge of Original Medicare
  - Medicare eligibility and enrollment
  - Medicare enrollment periods
  - Benefits and costs of Original Medicare
  - Medicare appeals
- Practice explaining Original Medicare


MEDICARE HEALTH INSURANCE
Name/Nombre
JOHN L SMITH
Medicare Number/Número de Medicare
1EG4-TE5-MK72
Entitled to/Con derecho a
Coverage starts/Cobertura empieza
HOSPITAL (PART A) 03-01-2016
MEDICAL (PART B) 03-01-2016
SAMPLE

Agencies Responsible for Medicare

Social Security
Enrolls most people in Medicare

Railroad Retirement Board (RRB)
Enrolls both railroad retirees and active employees in Medicare

Office of Personnel Management (OPM)
Handles federal retirees' premiums

Centers for Medicare & Medicaid Services (CMS)
Forms Medicare policy and administers Medicare coverage, benefits, and payments

What is Medicare?

Health insurance for those:

- 65 and older
- Under 65 with disabilities approved through Social Security
- Any age with End-Stage Renal Disease (ESRD)
- Signed into law 1965

Questions?

Medicare Eligibility

Who can get Medicare?

Medicare Eligibility

- Must be a US citizen or lawfully present for 5 years
- Eligibility begins at age 65
  - For premium free Part A must have worked minimum of 40 Quarters and paid into Social Security
    - Quarters do not have to be consecutive
  - Can become eligible from spouse's record
- If working and turn 65
  - In most cases, should apply for Medicare Part A
  - Must check with employer plan for continuing GHP eligibility requirements
- Can be eligible before age 65
  - Due to a Social Security determined disability

Medicare Eligibility, continued

- The disabled child or spouse (including a divorced spouse) of a worker (living or deceased) who has worked enough quarters and paid into Social Security or in a Medicare-covered government job.
- Spouse (living or deceased, including divorced spouses) receives or is eligible to receive Social Security benefits or Railroad Retirement Benefits.

Counselor Note: If not sure, refer the client to SSA for assistance. SSA is the clerical arm of Medicare and processes all Medicare enrollment applications.

Medicare Eligibility with SSDI/ALS/ESRD

Under age 65:

- Those who receive Social Security Disability Insurance (SSDI)
  - Eligible after receipt of 24 months of SSDI payments.
  - Medicare begins month 25
- Those with Amyotrophic Lateral Sclerosis (ALS),
  - Medicare begins the same month as SSDI
- People with End Stage Renal Disease (ESRD)
  - Medicare eligibility works differently for those with ESRD.
  - Can have varying times of eligibility

Counselor Note: Because of the variations on timelines and interactions with employer health plans, ESRD clients with questions about Medicare eligibility should be referred to a benefit specialist for assistance.

Medicare and Supplemental Security Income (SSI)

- Medicare begins at age 65

Questions?

Medicare Enrollment

How and When to Enroll in Medicare

How to Enroll in Medicare

For most turning 65 years old

- Call Social Security 1-800-772-1213
- Go to a local Social Security Field Office
- Go online to The United States Social Security Administration | SSA

For those turning 65 years old and working for the railroad

- Go online to Home | RRB.Gov
- Call (877) 772-5772

Counselor Note: It is very easy to enroll in Medicare A and B online. Your client may need to set up a Social Security account. If your client is not able to set up an account, then direct them to a local field office or call Social Security.

Medicare Enrollment

Social Security enrolls all who are eligible into Medicare

- ✓ **Enrollment is automatic for individuals who receive:**
  - Social Security benefits
    - Disability
    - Retirement
- ✓ **Enrollment is <u>NOT</u> automatic for individuals who:**
  - Are employed
  - **Not** employed and **NOT** receiving any type of SSA benefits

Medicare Enrollment for those still Employed

- Many Group Health Plans (GHP) require Medicare enrollment at age 65
- Medicare can be either primary or secondary
  - Primary if 20 or less employees-65+
  - Secondary if 20 or more employees-65+
  - Primary if 100 or less employees-under 65
  - Secondary if 100 or more employees-under 65
- May only need to enroll in Part A
- When retired or leave the employer can enroll in Part B
  - 8 month SEP to enroll in Part B

When to Apply for Medicare

- Initial Enrollment Period (IEP)
- General Enrollment Period (GEP)
- Special Enrollment Period (SEP) (only in certain circumstances)

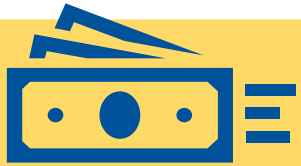
Initial Enrollment Period (IEP)

7-Month Period

If apply **before** 65th birthday month, coverage starts the month turning 65.

If apply **during** the 65th birthday month, coverage starts the next month.

If apply **after** 65th birthday month, coverage begins the next month.



If enrolled after the IEP, there may be a late enrollment penalty

General Enrollment Period

3-Month GEP each year

Coverage Begins the month after enrollment

Can sign up for:

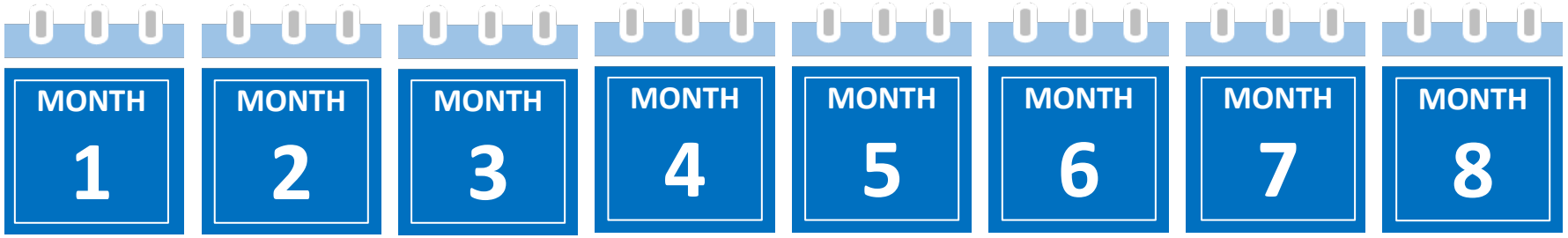
- Part A (if not premium free)
- Part B

May have late enrollment penalties

Special Enrollment Period

Starts after Medicare IEP and having GHP coverage based on current employment

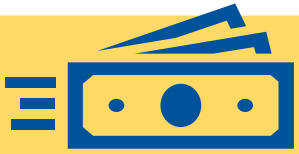
Continues for 8 Months after GHP Coverage Based on Current Employment Ends



You can sign up for Part A (if you have to pay for it) and/or Part B:

- Anytime still covered by the GHP
- During the 8-month period that begins the month after the employment ends or the coverage ends

Usually no late enrollment penalties



Exceptional Circumstances Special Enrollment Period (SEP)

A SEP has been allowed for those who because of the Public Health Emergency were not able to enroll in Medicare when first eligible.

- This SEP can only be used in certain circumstances
  - Loss of Medicaid after 1/1/2023
  - PHE

Counselor Note: Because of the specific timeframes and circumstances for using this SEP, it is recommended you ask for assistance or refer to Benefit Specialist

Medicare Enrollment and Health Savings Accounts (HSA)

- Cannot have both Medicare and a Health Savings Account
- Individuals with a HSA should **stop contributing six months before enrolling in Part A** (or applying for Social Security benefits) to avoid tax penalties.

Medicare Enrollment for Veterans and their Families

- Veterans **should** enroll in Medicare
- Family members eligible for Tricare for Life **should** enroll in Medicare

Counselor Note: Medicare Coordination of Benefits (COB) for VA and TriCare for Life are different and will be discussed later.

Check Your Knowledge

Why is the Initial Enrollment Period (IEP) important?

a. Missed enrollment deadlines could result in penalties

b. It's the first opportunity to enroll in Medicare

c. When a person enrolls impacts when their coverage begins

d. All of the above

Countdown timer: Answer the question before the bar disappears!

Practice Enrollment Scenario

Chuck Y. is looking for information about Medicare. Now that he has turned 65, he is getting a lot of mail and getting calls on his home landline about Medicare. He tells you he works for Union Pacific, and this is his 2 weeks off and will be going to Utah next week for 2 months. He does not want to retire for at least another few years.

What do you ask and tell him?

Questions?

Medicare Coverage and Costs

What the different parts of Medicare cover

The Parts of Medicare

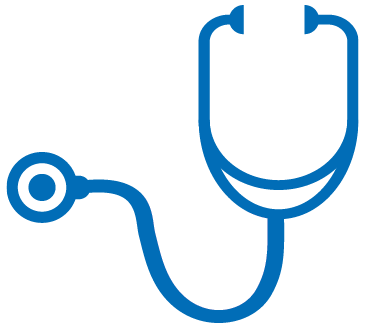
Part A
(Hospital Insurance)

Part B
(Medical Insurance)

Part D
(Drug coverage)

Parts of Original Medicare

Part A
(Hospital Insurance)



Part B
(Medical Insurance)

Part A Costs - Premium

Most do not pay a premium for Part A

- If the beneficiary and/or spouse paid FICA taxes for at least 10 years, Part A is free
- There may be a premium if 39 or less work quarters
- **There may be a penalty** if did not enroll when first eligible for non premium free Part A
  - Monthly premium may increase 10% for each year not enrolled
  - Will have to pay the higher premium for twice the number of years did not have Part A and did not enroll

Part A Hospital Insurance

- **Inpatient care in a hospital, including:**
  - Semi-private room
  - Meals
  - General nursing
  - Drugs
  - Other hospital services and supplies

Part A
Hospital Insurance

- **Inpatient care in a skilled nursing facility (SNF)**
  - Covered after a related 3-day inpatient hospital stay

Part A Hospital Insurance (continued)

Part A helps cover:

- Blood (inpatient)
- Hospice care
- Home health care
- Inpatient care in a religious nonmedical health care institution (RNHCI)

Part A
Hospital Insurance

Part A costs

- Copays
  - Extended stay in hospital
  - Skilled Nursing Facility
- Deductible
  - Hospitalization

Refer to WI SHIP Cheat Sheet for current copay amounts.

It is found on the GWAAR Medicare Outreach and Assistance Resources webpage under Tools for Professionals (https://gwaar.org/medicare-outreach-and-assistance-resources).

Part A Costs - Hospitalization

- Part A Deductible
  - Days 1- 60
- Part A copays after first 60 days of continuous hospitalization
  - Days 61-90
- Higher Part A copays after 90 days of continuous hospitalization
  - Days 91-150
  - aka Lifetime reserve days (one time use)
- After day 150
  - All costs are the patient’s responsibility

Part A Costs - Skilled Nursing Facility (SNF)

- Only limited coverage -100 days
  - Days 1-20 All costs paid by Medicare Part A
  - Days 21-100 Copay for each day
- After Day 100
  - Patient is liable for all costs

Counselor Note: if a beneficiary contacts you about a notice that Medicare will no longer pay for a stay in a nursing home after 20 days, refer immediately to a benefit specialist.

Part A Benefit Periods

- **Each benefit period:**
  - Begins the first day of inpatient care in hospital or SNF
    - If readmitted for any reason/diagnosis still remain in current Benefit Period
  - Ends after being home for 60 days in a row (not in a hospital or skilled care in a SNF)
- Pay Part A deductible for each benefit period
- No limit to number of benefit periods in the year

Counselor Note: Benefit periods can extend over a calendar year.

Check Your Knowledge

Part A helps pay for all of the following when medically necessary and requirements are met, EXCEPT for…

a. Diabetic testing supplies

b. An inpatient hospital stay

c. An inpatient skilled nursing facility (SNF) stay

d. Hospice care

Countdown timer: Answer the question before the bar disappears!

Part A Scenario

Charles W. come into your office with a bill for $3200 for his stay in the hospital. Part A deductible for 2023 is $1600. He was admitted on January 2, 2023 and discharged on January 9. He was readmitted on February 21 for a different medical condition and discharged on February 23. He tells you Medicare should pay for both stays in the hospital.

Should he have received a bill and why?

YES. Everyone pays the Part A deductible when admitted.

How much is he liable to pay and why?

$1,600 because he was in the same benefit period for both hospitalizations.

Questions?

Part B Costs and Coverage

Part B
(Medical Insurance)

Part B Costs

- Everyone pays the Part B premium
  - Those with lower income and assets can get help
- Premium changes every year
  - Those with lower income may not pay the current premium
  - Social Security Hold Harmless provision
- Those with higher income may pay more
  - Income Related Monthly Adjustment Amount (IRMAA)
- If did not enroll in Part B when first eligible may incur
  - Late Enrollment Penalty (LEP)

Part B Late Enrollment Penalty (LEP)

- 10% of the current Part B premium
  - Incurred for every 12 months not enrolled in Part B
  - Amount will change every year depending on the current Part B premium
- Liable for payment of LEP as long as enrolled in Medicare
- Can be waived if eligible for Part B premium assistance
  - Medicare Savings Programs

Part B Premium and Income Related Monthly Adjustment Amount (IRMAA)

- Those with higher income may pay an increased Part B premium
- The increase Is based on the tax return from the previous 2 years
  - 2024 IRMAA is based on 2022 tax return

Check WI SHIP Cheat Sheet for current year amounts

Part B Covers

- Doctors' services
- Outpatient medical and surgical services and supplies
- Clinical lab tests
- Durable medical equipment (DME) (like walkers and wheelchairs)
- Diabetic testing equipment and supplies
- Preventive services (like flu shots and a yearly wellness visit)
- Home health care
- Medically necessary outpatient physical and occupational therapy, and speech-language pathology services
- Outpatient mental health care services

Home Health Services

- Part B may also cover part-time home health care: skilled nursing care, physical therapy, occupational therapy, and more.
- Individuals must meet eligibility criteria for Part B to cover home health care.

Preventive Services

- Part B covers most preventive services for free
  - The “Welcome to Medicare” and yearly “Wellness” visits are health risk assessments, not a physical.
- COVID-19 vaccines and other vaccines are free
  - Flu shots
  - Pneumonia
  - Shingles is covered under Part D, not B
- Coverage timeframes may vary (for example, once every 24 months)
- Certain screenings many turn into an actual Part B covered service
  - The doctor sees something during a screening and takes action to test

Part B Preventive Services

- Abdominal aortic aneurysm screening
- Alcohol misuse screenings and counseling
- Bone mass measurements
- Cardiovascular behavioral therapy
- Cardiovascular disease screenings
- Cervical and vaginal cancer screenings
- Colorectal cancer screenings
- Counseling to prevent tobacco use and tobacco-caused disease
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- Hepatitis B Virus infection screening
- Hepatitis C screening tests
- HIV (Human Immunodeficiency Virus) screenings
- Lung cancer screenings
- Mammograms
- Medicare Diabetes Prevention Program
- Nutrition therapy services
- Obesity behavioral therapy
- Pneumococcal shots
- Prostate cancer screenings
- Sexually transmitted infection (STI) screenings & counseling
- “Welcome to Medicare” preventive visit
- Yearly “Wellness” visit

Durable Medical Equipment (DME)

- Medicare will only cover medically necessary durable medical equipment that is:
  - Prescribed by a Medicare-enrolled doctor.
  - Provided by a Medicare-enrolled supplier.
- Medicare may require that the DME be rented or bought.

Counselor Note: An appeal of a denial of DME should be referred to a benefit specialist for assistance.

Durable Medical Equipment (DME)

Durable medical equipment must be:

- Durable (can withstand repeated use).
- Used for a medical reason.
- Useful only to someone who is sick or injured.
- Used in the home.
- Expected to last at least three years.

Part B Prescriptions

- Medicare Part B can cover:
  - Drugs administered by a provider or at a dialysis facility.
  - Some outpatient drugs
    - oral cancer and immunosuppressive medications.
  - Drugs used with DME
    - an infusion pump.

- Some drugs can be covered by Part B or Part D.

Counselor Note: B v D drug coverage can be extremely tricky. Consult with a helpline for assistance.

Medicare Observation Stay

- Observation stay is not an admission to the hospital
  - Even if put in a bed on a non emergency floor
- Can be for any length of time
- Can be billed for medications received during the stay
  - Medication may be covered under Part D
- Stay is covered under Part B, not Part A

Counselor Note: Notice must be given to the patient within 24 hours if not admitted to the hospital and under observation only. This notice is called Medicare Outpatient Observation Notice (MOON).

What's Not Covered by Part A & Part B?

Some of the items and services that Part A and Part B do not cover include:

- Most dental care
- Vision (for prescription glasses)
- Dentures
- Cosmetic surgery
- Massage therapy
- Routine physical exams
- Hearing aids and exams for fitting them
- Long-term care
- Concierge care
- Covered items or services you get from an opt out doctor or other provider

Note: Some of these may be covered by Medicaid or a Medicare Advantage Plan

Check Your Knowledge

For Part B, in most cases, everyone pays:

a. A monthly premium

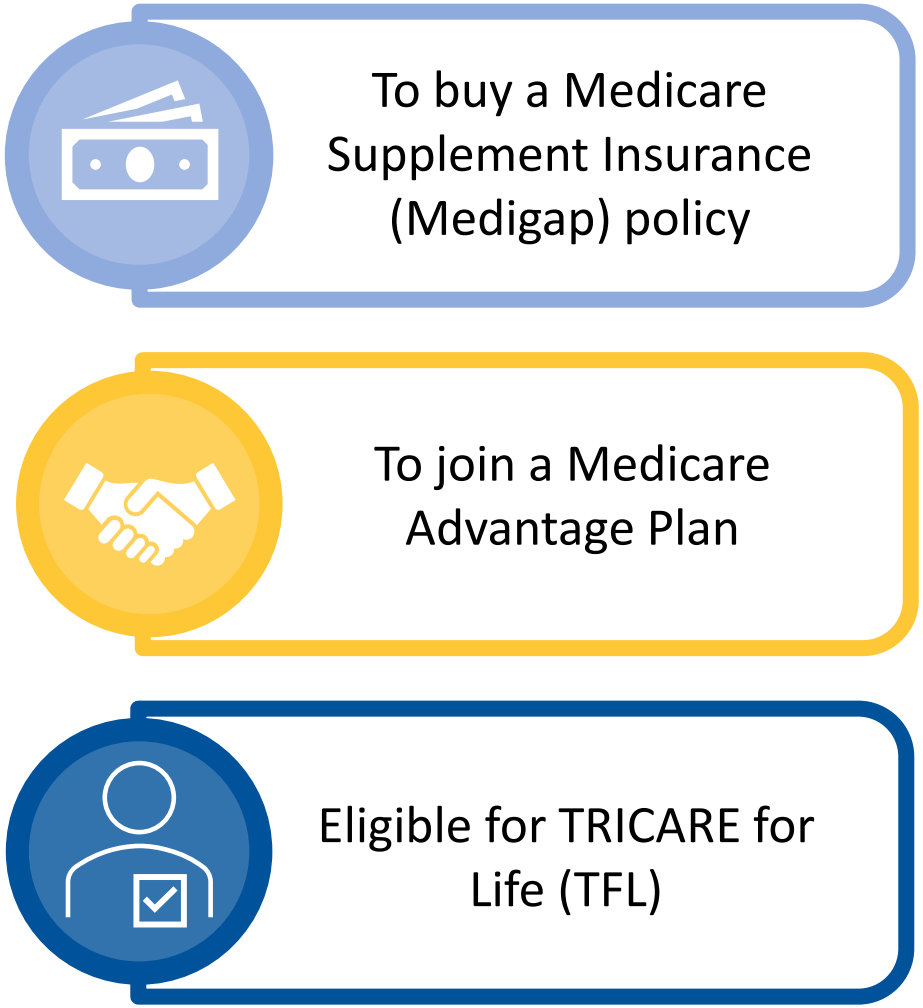
b. A yearly deductible

c. 20% coinsurance for most covered services

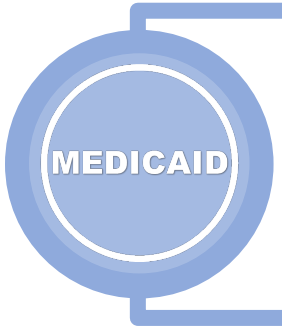
d. All of the above

Countdown timer: Answer the question before the bar disappears!

When is Part A & Part B needed?

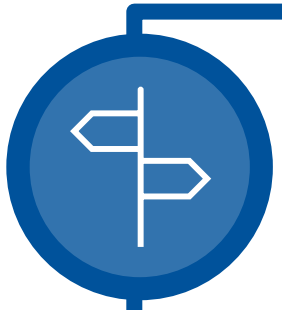


Key Points to Remember



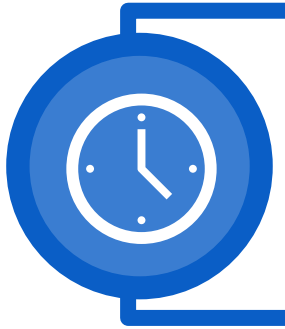
Medicare is a health insurance program

Medicare doesn’t cover all health care costs



There are choices in how to get coverage

Decisions affect the type of coverage



Certain decisions are time-sensitive

There are programs for people with limited income and resources

Part B Scenario

Charles W. is back to see you with another bill. He went to his doctor and had a colon cancer screening. He remembers that the Medicare and You book said the screening was free. Now he has a bill.

What question should you ask him and how do you explain the bill?

Did the doctor remove a polyp?

If the doctor removed a polyp, then the it is no longer free as a preventive service. It is a Medicare covered service under Part B.

Questions?

Medicare Coverage

Billing and Claims

Medicare Providers-More than just MDs

There are number different types of Medicare providers

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- Nurse Practitioners and Physician Assistants
- Clinical Psychologists and Clinical Social Workers
- Occupational and Physical Therapists
- Certified Nurse Midwives

And, in some cases

- Dentists
- Chiropractors

Medicare Providers, continued

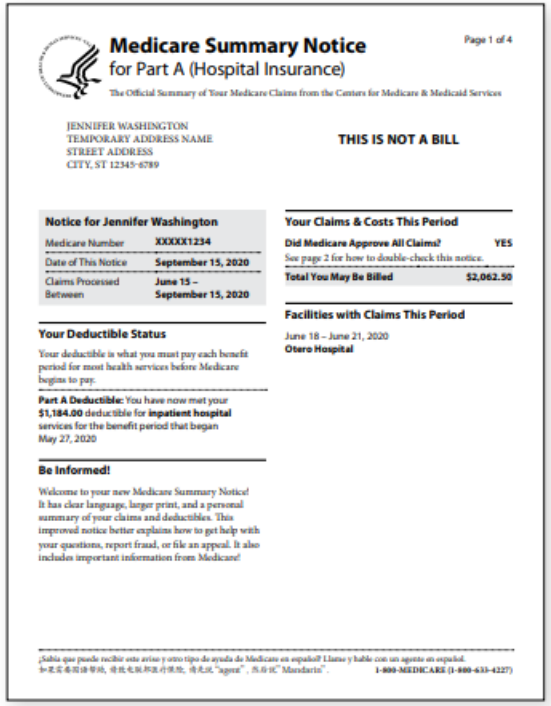
- Providers must apply with CMS to receive a National Provider Identifier (NPI)
  - Participating provider
  - Renew participation annually
- Participating providers agree to accept Medicare fee schedule payment for Medicare covered services
  - Accept assignment
  - Accept 80% payment
  - Bill Medicare patients for allowable 20% coinsurance for a covered service
- Non Participating providers (still a Medicare provider with a NPI)
  - Do not accept assignment, but must file claims
  - Can bill patients 15% more.
- Providers can opt out of participating in Medicare
  - Must inform patients they do not accept Medicare
  - Can bill their Usual and Customary fees

Medicare Bills and Claims

- Beneficiaries should rarely, if ever, need to file a claim
  - Providers are required to submit claims
- Claims must be submitted timely
  - Providers cannot hold a claim
  - Claims must be submitted within 12 months of provision of service
- Providers can bill for coinsurance/copay amounts
  - For Medicare covered services

Medicare Summary Notice (MSN)

- MSN for Part A and Part B are sent every quarter.
- An explanation of:
  - Services billed.
  - What the beneficiary may owe.
  - Billing codes and modifiers.
  - Denial rationale (if applicable)
- Explains appeal deadlines



Medicare Summary Notice
for Part A (Hospital Insurance)

Page 1 of 4

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

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

THIS IS NOT A BILL

Notice for Jennifer Washington

Medicare Number	XXXXX1234
Date of This Notice	September 15, 2020
Claims Processed Between	June 15 – September 15, 2020

Your Deductible Status

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

Part A Deductible: You have now met your **$1,184.00** deductible for **inpatient hospital** services for the benefit period that began May 27, 2020

Be Informed!

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

Your Claims & Costs This Period

Did Medicare Approve All Claims?	**YES**

See page 2 for how to double-check this notice.

Total You May Be Billed	**$2,062.50**

Facilities with Claims This Period

June 18 – June 21, 2020
Otero Hospital

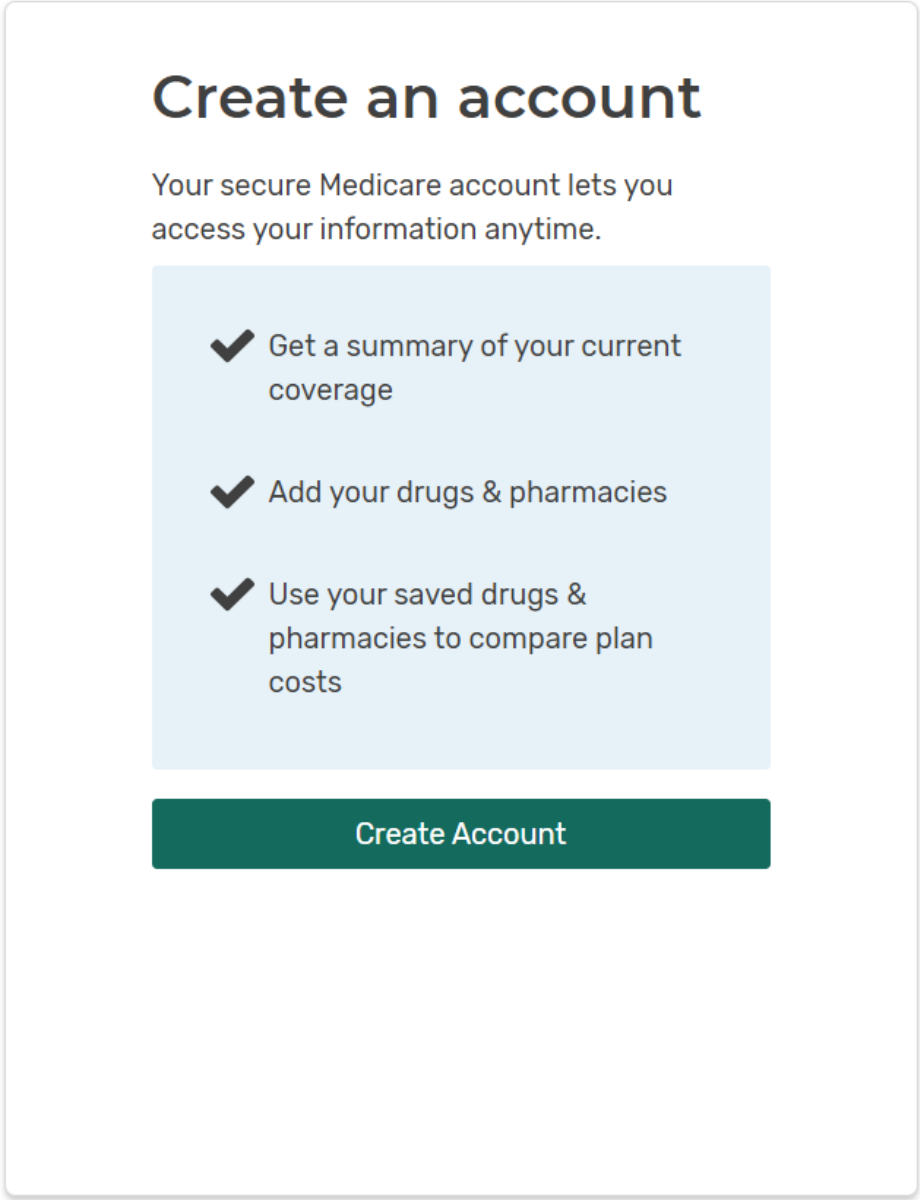
¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
1-800-MEDICARE (1-800-633-4227)

[Medicare Summary Notice Part A]

[Medicare Summary Notice Part B]

Medicare Account

- Clients should create an account
- Allows beneficiary ability to check
  - Claims
  - Medicare/other Insurance coverage
  - Prescription drug lists
  - Print out Medicare card



New Medicare Part B-Immunosuppressive Drug Benefit

- Part B-ID
  - 2024 premium $103
  - Subject to deductible, 20% coinsurance and IRMAA
- For those with ESRD and a Medicare covered Kidney transplant
  - Effective after loss of Medicare 36 months post transplant
  - Can enroll at any time
- Coverage for FDA approved immunosuppressive drugs covered under Medicare Part B only
  - No other medications or services are covered
- Coverage up to 36 additional months.
  - Cannot have any other health insurance

Coverage of immunosuppressant drugs and vitamins for people with ESRD - Medicare Interactive

Medicare Coordination of Benefits (COB)

How does Medicare work with other coverage

Medicare and Other Insurance

- Medicare will coordinate with Medicaid
  - Medicare is primary
- Medicare will coordinate with other insurances
  - Liability and no fault insurance after an accident
  - Worker Compensation
- Medicare will coordinate with Employer Group Health Plans
  - If retired with Employer Health Plan, Medicare is always primary
  - If still working, can be either primary or secondary

When Medicare is primary and secondary - Medicare Interactive

COB with Employer Plans

- Age 65 and covered by current Employer Health Plan
  - Group Health Plan with <20 employees
    - Medicare is Primary
  - Group Health Plan with >20 employees
    - Medicare is Secondary
- Under age 65 and covered by current Employer Health Plan
  - Group Health Plan with <100 employees
    - Medicare is Primary
  - Group Health Plan with >100 employees
    - Medicare is Secondary

Medicare and VA and TriCare for Life

- VA benefits and Medicare do not work together.
- Medicare and TriCare for Life **do** work together
- Medicare does not pay for any care provided at a VA facility
- VA does not pay outside of the VA center
  - Except in very certain circumstances
- Not enrolled in Part B
  - May have late enrollment penalty
  - Not covered for Part B services received from private providers

Medicare Appeals


MEDICARE
APPEALS

Medicare Appeals

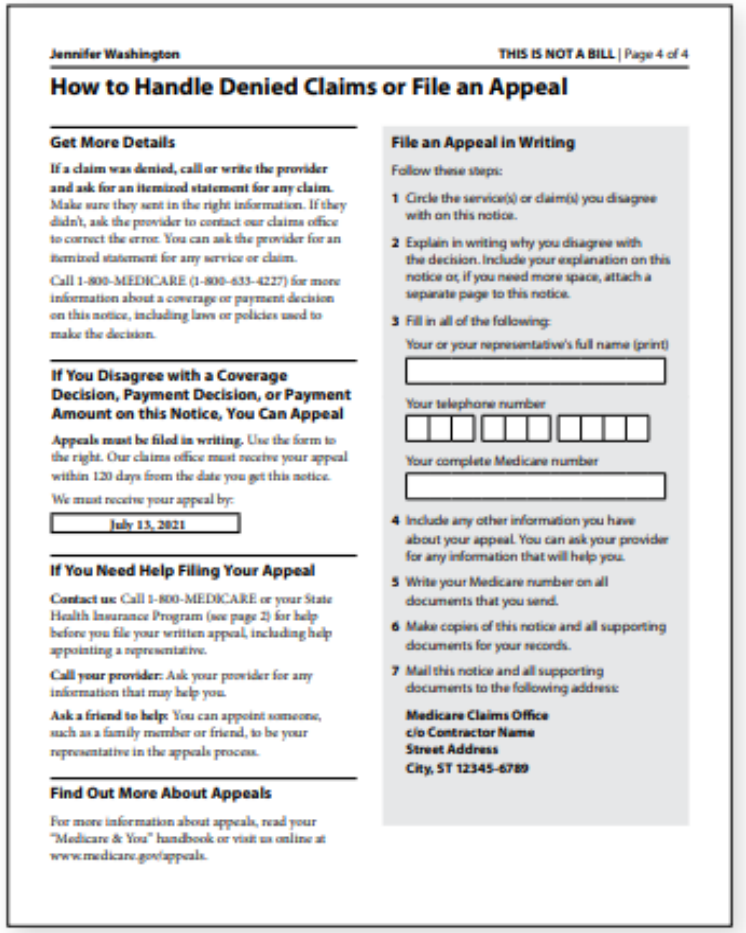
- Medicare has a unique appeals process.

- Appeals cases are considered complex counseling that requires referral to a benefit specialist.

Counselor Note: As a Basic Certified SHIP Counselors you should understand appeal rights to be able to answer common appeal and coverage questions.

Original Medicare Overview of Appeals Process

With Original Medicare Part A Hospital Insurance and Part B Medical Insurance, beneficiaries often appeal bills for services already received.



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

How to Handle Denied Claims or File an Appeal

Get More Details

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

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

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

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

We must receive your appeal by:

July 13, 2021

If You Need Help Filing Your Appeal

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

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

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

Find Out More About Appeals

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

File an Appeal in Writing

Follow these steps:

1 Circle the service(s) or claim(s) you disagree with on this notice.

2 Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.

3 Fill in all of the following:

Your or your representative's full name (print)

Your telephone number

Your complete Medicare number

4 Include any other information you have about your appeal. You can ask your provider for any information that will help you.

5 Write your Medicare number on all documents that you send.

6 Make copies of this notice and all supporting documents for your records.

7 Mail this notice and all supporting documents to the following address:

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

Standard Coverage Appeals Process

- **Before appealing,** it is best practice for the beneficiary to contact their provider's billing office to check if a service was correctly billed
- **To appeal**, beneficiaries should complete the last page of the Medicare Summary Notice (MSN) within 120 days of receiving the MSN.
- **If the appeal is unsuccessful,** the beneficiary can escalate the appeal. There are five appeal levels.

Appeal Levels

1. **First Level of Appeal:** Redetermination by a Medicare Administrative Contractor (MAC)
2. **Second Level of Appeal:** Reconsideration by a Qualified Independent Contractor (QIC)
3. **Third Level of Appeal:** Decision by the Office of Medicare Hearings and Appeals (OMHA)
4. **Fourth Level of Appeal:** Review by the Medicare Appeals Council
5. **Fifth Level of Appeal:** Judicial Review in Federal District Court

Medicare

Final Thoughts

Review

- **Remember, unless already receiving benefits from Social Security, no notice is sent of Medicare eligibility.**
- Medicare Summary Notices are received quarterly
- Beneficiaries should create a Medicare Account
- **There are no couples in Medicare.**
  - Each beneficiary should be considered separately for coverage and benefits

When to Refer

"Basic-level" SHIP counselors should be able to:

- Describe Medicare and use the plan finder
- Explain and assist with enrollment
- Recognize when assistance is needed with coverage of prescriptions and/or needed uncovered medical services
- Recognize when an individual may qualify for financial help.

NOTE: Refer a client to a benefit specialist or a helpline for further assistance with Medicare, Medicare Advantage and/or Part D unique coverage questions or appeals.

How to determine with what your client needs help

Sample questions:

1. When did your Medicare start?
2. When did your Medicare Advantage plan start?
3. Did you have or lose employer health coverage?
4. Do you have VA, Tricare or any other health care coverage?
5. Are you eligible for Medicaid?
6. Why was your medication/service not covered?
7. Do you have paperwork?

Practice Scenario

Original Medicare Scenario

Mr. and Mrs. Smith have lots of questions about Medicare enrollment. They both are turning 65 in July. They are still working, and both served and retired from the military. They went to a seminar their individual employers held regarding Medicare and employer/retiree insurance. While you are discussing Medicare, Mr. Smith tells you he lost a foot during his service in the Navy. Neither want to enroll in Medicare.

How will you explain Medicare?

Why should they enroll in Medicare?

Resources

Where to go for help

Resources

- **SHIP Technical Assistance (TA) Center**
  - https://www.shiptacenter.org/
  - Webinars, handouts, outreach materials, and counselor resources for SHIP counselors
- **Centers for Medicare and Medicaid Services (CMS) National Training Program**
  - https://cmsnationaltrainingprogram.cms.gov/
  - Free webinars, PowerPoints, self-paced online training, and train-the-trainer workshops

Resources

Wisconsin SHIP Cheat Sheet Packet

Found on the:

- SHIP TA Center (search “WI SHIP Counselor Cheat Sheet packet)
- GWAAR Medicare Outreach and Assistance Resources webpage (https://gwaar.org/medicare-outreach-and-assistance-resources) under Tools for Professionals

Resources

Medicare.gov

- Check current costs, eligibility, and enrollment information.
- Use the search function to see if a service or item is covered by Medicare.

Contacts

Questions are encouraged! You can go to the following SHIP counselors for help:

- **Your local SHIP supervisor**
- **Disability Rights Wisconsin**
  Medicare Part D Helpline:
  - 1-800-926-4862
  - medd@drwi.org
- **The Board on Aging and Long Term Care**
  - Medigap Helpline: 1-800-242-1060
  - BOALTCMedigap@wisconsin.gov
  - Medigap Part D and Prescription Drug Helpline: 1-855-677-2783
  - BOALTCRXHelpline@wisconsin.gov

Request CEU/CEH

- Complete the Zoom survey following this training to request a CEU/CEH certificate
- You must attend the entire live training to be eligible to receive a certificate.
  - Attendance will be verified using Zoom attendance reports
- The CEU/CEH is being provided through University of Wisconsin-Stevens Point, an accredited university. The continuing education certificate may cover several professions from social workers, counselors, educators, etc. The training attendee can submit the CEH certificate to their area of practice for approval.

Please send CEU/CEH questions to Pamela Watson, MIPPA grant program coordinator, pamela.watson@dhs.wisconsin.gov

Ginger Rogers
Medicare Part D Program Coordinator
Disability Rights Wisconsin
6737 W. Washington Suite 3230
Milwaukee, WI 53214
ginger.rogers@drwi.org
414-773-4646