



REPORT to the COMMUNITY on

Senior Care Today

From **Mount Vernon Nursing and Rehabilitation Center**

Navigating the Medicare Maze

Many older adults, when faced with the need for short-term rehabilitation or long-term skilled nursing care, have concerns, questions and misconceptions surrounding Medicare qualifications, benefits and/or financial requirements.

In fact, according to a recent report by the *Journal of the American Geriatrics Society*, roughly one third of surveyed Medicare beneficiaries from across the United States considered themselves to be generally unfamiliar with the program's benefits.

That should not be surprising since most Americans spend their pre-retirement years covered under a variety of privately-purchased and employer-subsidized health plans. These group plans generally guarantee reimbursement of a significant part of their health care costs and continue to pay benefits for as long as they are needed. Based on this experience, many people naturally assume that Medicare just picks up where their insurance plans left off, with the same scope of services, flexibility and personal choice. However, this is not always the case. The fact is, beneficiaries



should understand Medicare's unique set of eligibility criteria, financial requirements, coverage restrictions and limitations.

Another common misconception is that Medicare is an entitlement, automatically conferred on all Americans once they reach the age of 65. The reality is that Medicare is another form of insurance. It is not free. You must qualify for Medicare by having contributed to Social Security either individually or through your place of business. Once individuals are qualified for Social Security, they may also request to receive their Medicare benefits. Those who are not eligible for Social Security benefits must apply for Medicare several months

before they reach the age of 65 in order to qualify for coverage and avoid penalties.

This issue of *Senior Care Today* focuses on common questions and concerns regarding Medicare and related coverage issues. Hopefully, the answers offered will shed some light on these important subjects.

We hope you find this information useful and we welcome any additional questions you may have.

- Betty Solomonson, RN, CNP, LNHA, Administrator

Medicare: Security, safety net or shortfall?



Medicare is a government insurance plan created to help cover the health care costs of older Americans and people with certain disabilities who may be under age 65. Administered by the Centers for Medicare and Medicaid Services, Medicare coverage is divided into four parts, referred to as Medicare Parts A through D.

Most people are eligible to receive Medicare the month they turn 65. However, because eligibility is not automatic and coverage requirements are rarely the same as under private-pay or work-subsidized insurance plans, seniors transitioning to Medicare often find the change confusing. Following are answers to some of the more general questions that typically arise, which we hope will shed additional light on these important issues.

Q *I'll be turning 65 in a few months and anticipate applying for Medicare. What should I take into consideration?*

If you are entitled to benefits through Social Security or the Railroad Retirement Board (RRB), you will automatically be enrolled in Medicare Part A and B once you turn 65. You should be receiving your Medicare card about three months before your 65th birthday. If you are not eligible for Social Security or RRB benefits, you may purchase Medicare Part A and B coverage during the following times:

- Initial Enrollment Period. This is the 7-month period that begins three months before and ends three months after the month of your 65th birthday. So, if your birthday is in May, your Initial Enrollment Period is February through August.
- General Enrollment Period. You may also enroll during the months of January through March of every year thereafter.

- Special Enrollment Period. If you are waiting to enroll because you or your spouse are still employed and covered by a work-related health care plan, you may enroll in Medicare while you are still covered and for eight months following termination of your work and/or work-related coverage.

It is important to understand that Medicare does not cover all health care services, nor does it pay the total cost for most covered medical services or supplies. The extent of your benefits is also dependent on whether you are enrolled in Medicare Part A, Part B, or both. Medicare Part A typically pays for inpatient hospital expenses and Medicare Part B typically covers outpatient health care expenses, including doctors' fees.

Although Part A may be fully subsidized by the federal government, Part B is not. Once enrolled, you will be required to pay a premium each month based on your marital status and yearly income. Services covered under Parts A and B may also be subject to deductibles.

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Medicare Part A

Medicare Part A, also known as Hospital Coverage, helps pay for inpatient care in hospitals, specialty care facilities, and rehab stays in nursing homes. It also covers hospice and home health services. Although Medicare Part A does not require most participants to pay a monthly premium, you will be responsible for deductibles and co-payments.

Q *Who is eligible for Medicare Part A coverage?*

Anyone who is entitled to benefits through Social Security or the Railroad Retirement Board (RRB) is eligible for Medicare Part A coverage at age 65.

Individuals who did not work, did not pay enough Medicare withholding while they were employed, or those under age 65 who are disabled, may be able to receive Medicare Part A coverage. However, they will be required to pay for coverage.



While Medicare covers prescribed rehab services in a skilled nursing facility after a hospitalization, coverage stops when the patient can no longer benefit from rehabilitation.

Q *If I'm covered by Medicare and hospitalized, who decides if I need rehab when I'm discharged? What criteria are used? What is the extent of allowed coverage and length of stay?*

Following a minimum 3-day covered hospital stay for a related illness or injury, your doctor or discharge planner will determine if you require additional sub-acute or rehabilitative care in a designated skilled nursing or sub-acute facility. Based upon the extent of your disability, you may receive treatment for as long as your doctor feels it would be beneficial for your recovery, up to a total of 100 days per benefit period. (A benefit period begins on the day you first require treatment and ends 60 days after you stop receiving any type of related treatment.) Unlike many private pay contracts, Medicare patients pay nothing for the first 20 days of treatment, and \$137.50 per day for the next 80 days, if they are still receiving residential care. After 100 days, the patient is responsible for 100% of the cost of care.

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Medicare Part A *Continued from page 3*

Q *If I need outpatient therapy following a covered rehab stay, will it be covered under Medicare?*

Medicare helps pay for medically necessary outpatient physical and occupational therapy and speech-language pathology services when:

- Your doctor or therapist sets up the plan of treatment, and
- Your doctor periodically reviews the plan to see how long you will need therapy.

You can get outpatient services from a participating hospital, skilled nursing facility, home health agency, rehabilitation agency, or public health agency. Also, you can get services from a Medicare-approved physical or occupational therapist, in private practice while in his or her office or in your home.

Medicare is required to limit how much it pays for outpatient therapy services per year. This is called an annual financial limitation, or cap. There is no cap if you go to a hospital outpatient therapy department.

Beginning January 1, 2010 Medicare coverage was expanded nationwide to include rehabilitation for patients with COPD (chronic obstructive pulmonary disease).

Q *Under Medicare, am I able to choose the facility where I want to receive rehab, or does the hospital decide?*

Unlike many HMOs or managed care plans, Medicare lets you choose your own health care providers and

certified rehab facilities. However, since not all providers accept Medicare, be sure to confirm ahead of time that the physician or facility accepts Medicare payments and whether a facility has the proper certification. Failure to do so may result in your being asked to pay the bill for your entire stay.

Q *What kinds of rehab treatments are covered under Medicare?*

Medicare covers a wide range of services that may be needed on a short-term basis. These may include physical, occupational and speech therapy as well as any skilled nursing care required during the rehabilitative stay. Services may be provided for a period of up to 100 days per benefit period, as determined by a qualified physician.

Q *What if I feel I'm just not quite ready to go home when my rehab is complete?*

You may choose to stay on after your Medicare-covered rehab period is complete. You will not require a physician's authorization. However, you will be responsible for the entire cost of care from your own funds.

Q *If I can't recover sufficiently to resume living at home, will Medicare Part A cover the cost of a nursing home? If not, what are my options?*

Medicare Part A does not cover the cost of long-term skilled nursing care. Consequently, many people approaching retirement age are opting to supplement their coverage with some form of long-term care insurance. While not inexpensive, long-term care insurance may save you tens of thousands of dollars should you or a spouse require nursing care in your later years. Like any form of insurance, purchasing coverage is more cost-effective when you are younger, especially if you are in good health.





Medicare Part B

While Medicare Part A pays for inpatient care, Medicare Part B helps pay for doctors' bills and many other medical services and expenses. Unlike Medicare Part A, Medicare Part B participants pay a monthly premium, which is automatically deducted from your Social Security payments.

Q *How much does Medicare Part B cost?*

In 2010, Medicare Part B costs recipients \$88.50 per month, plus 20% of the Medicare-approved amount for services. There is also a \$155.00 annual deductible. These costs may go up from year to year. If you do not sign up for Medicare Part B when you are first eligible, you may have to pay a higher monthly premium.

Q *What is covered under Medicare Part B?*

Medicare Part B benefits were designed to cover medically necessary costs such as doctor's visits (inpatient or outpatient), laboratory tests and x-rays, ambulance services, medical equipment and supplies, and some home health care costs. It may also cover radiology treatments, emergency room services, surgical fees and anesthesia, blood transfusions, and certain mental health services. For a complete list of covered items, please log onto www.Medicare.gov.

To be covered, services must be either medically necessary or deemed to have certain accepted preventive benefits, like health screenings for breast cancer or heart disease.

Services that are not covered by Medicare Part B include chiropractic services, acupuncture, cosmetic surgery, dental care, routine vision and hearing tests, annual wellness check-ups and health care services while traveling outside the US.

Q *Can I have Medicare Part A without Part B?*

Yes, you may begin receiving Medicare Part A benefits without choosing to enroll in Medicare Part B, but if you choose to enroll later, you may pay a higher cost for your coverage. In fact, for most people, the premium for Medicare Part B goes up every year they don't apply for benefits after they become eligible, unless they qualify for a Special Enrollment Period.

Medicare only covers about 80% of Part B expenses. The other 20% is up to you.

Q *Under what circumstances would I not opt for Medicare Part B?*

If you still have coverage through a work-related health plan, you may not want the more basic benefits of Medicare Part B. If you fall into this category, you qualify for a Special Enrollment Period, during which you may enroll in Medicare Part B without penalty once your work-related coverage expires.

Q *Will Medicare Part B cover all the costs of my medically necessary services?*

Costs for Part B services vary depending on the type of service. Some services will be fully covered, some will cost you a co-payment, and some will be subject to both co-payments and a yearly deductible.

Medicare Part C

Many people do not realize that the government also authorizes several supplemental programs designed to fill in the gaps left by Medicare Parts A and B. Offered by private insurance companies, these plans are included under what is often referred to as Medicare Part C.

Q *What types of plans should I consider to supplement my Medicare coverage?*

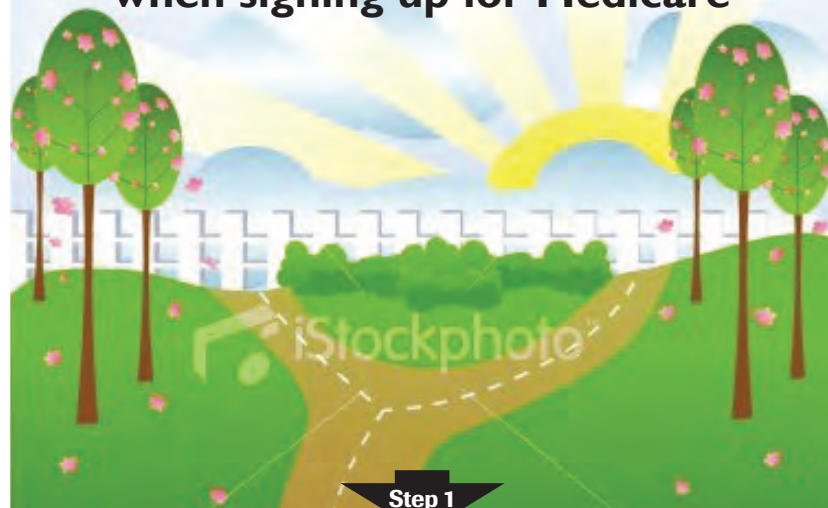
Medigap plans include coverage and terms that are standardized by the federal government. They generally begin paying as soon as your regular Medicare benefits run out and allow you to go to any doctor or hospital that accepts Medicare. Although Medigap plans extend your healthcare coverage beyond Medicare, they are NOT intended to cover long-term nursing care.

Medicare Advantage managed care plans offer you the benefits of Medicare, plus additional coverage for services like routine vision care, dental and hearing expenses. There are several options to choose from, some of which allow you to pay extra to use providers outside the plan's network of participating providers and/or seek care without referrals.

On average, people on Medicare spend about 30% of their incomes on out-of-pocket health costs, including premiums for supplemental coverage.

Since supplemental policies are offered by commercial insurance companies, you pay a premium for this coverage every month just as you would a private pay plan. Coverage options and pricing vary, so it is important to weigh the various options carefully in order to determine the plan that best meets your needs.

Here are the basic CHOICES when signing up for Medicare



Step 1 Original Medicare or Medicare Advantage?	
<p>Original Medicare</p> <ul style="list-style-type: none"> ▶ Includes Part A (hospital) and Part B (outpatient) ▶ Monthly premium, based on income, for Part B ▶ Choice of doctors, hospitals and other providers 	<p>Medicare Advantage- Part C</p> <ul style="list-style-type: none"> ▶ Included Parts A and B; offered by private insurers ▶ Works like an HMO/PPO; pre-selected network of providers ▶ Monthly premium, in addition to Part B premium
Step 2	
<p>Do you want drug coverage?</p> <ul style="list-style-type: none"> ▶ If yes, must choose and join a Part D plan ▶ Run by private companies 	<p>Do you want drug coverage?</p> <ul style="list-style-type: none"> ▶ If yes – and if offered through Advantage plan – typically must use that coverage ▶ If yes – and if not offered through Advantage plan – must choose and join a Part D plan
Step 3	
<p>Do you want Medigap/ supplemental coverage?</p> <ul style="list-style-type: none"> ▶ Covers some costs not paid under Parts A and B ▶ Sold by private insurers; premiums vary by company and policy ▶ Employers/unions may offer similar coverage to retirees 	<p>Do you want Medigap/ supplemental coverage?</p> <ul style="list-style-type: none"> ▶ Normally not needed for Advantage plans ▶ If switching to an Advantage plan, Medigap policy can't be used to pay out-of-pocket costs under Advantage plan

Source: Centers for Medicare and Medicaid Services

Medicare Part D

The most recent addition to Medicare is Medicare Part D, which is designed to help cover the cost of prescription drugs. You can take advantage of Medicare Part D either by joining a Medicare prescription drug plan offered by a private insurer, or by joining a Medicare Advantage plan that includes prescription drug coverage. Either way, your savings can be significant. Most Medicare Part D plans require you to pay a monthly premium and possibly a yearly deductible. In addition, you will be asked to pay a portion of the cost of your prescription drugs. Depending on your prescription drug use, you may opt for more coverage for a higher premium. Before you choose a plan, be sure to carefully check the list of drugs covered by that plan, as this may vary from provider to provider.



Q *If I require a long course of prescription drugs, will Medicare Part D coverage continue to pick up the bulk of the cost indefinitely?*

Most Medicare drug plans have a coverage gap. This means that once your plan has paid a specified amount for covered drugs per year, you will have to pay all further costs out-of-pocket until you reach a predetermined limit. At that point, your coverage will once again pick up the costs (minus a small co-payment). This gap in coverage is often referred to as the “donut hole,” and may represent thousands of dollars in out-of-pocket costs.

Q *How do I protect myself against “donut hole” costs?*

If you require multiple prescription drugs on an ongoing basis, certain Part D plans include coverage during the “donut hole” gap, although a higher monthly premium is required. Some alternatives offer brand name prescriptions, while others cover only generic drugs during the gap. Before choosing any Part D plan, be sure your particular prescription drugs are included in the coverage.

What is the best Medicare prescription drug plan for you? Ask yourself these questions:

- ▶ What are your current prescription costs?
- ▶ What would your out-of-pocket costs be for the Part D plan in consideration?
- ▶ Are your medications in the list of drugs that a Part D insurer covers?
- ▶ How easy is it to get a prescription filled?
- ▶ If you have high drug expenses, does the plan provide at least some coverage when your annual outlay is over \$2,400? Many Part D plans don't offer coverage in this range.

We hope the information in this issue has helped answer some of your questions and given you a better understanding of Medicare-related issues. If you would like additional information, please call **703-360-4000**. We will be happy to address your comments and concerns.



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Q *Do all doctors accept Medicare payment?*

Although many physicians accept Medicare payment, they are free to choose whether or not to accept Medicare or, for that matter, any form of insurance. Consequently, patients need to confirm a doctor's participation in Medicare before obtaining any medical services.

Q *How does Medicaid differ from Medicare? Under what circumstances would I be eligible for Medicaid?*

Medicaid is a combined federal-state program usually operated by state welfare or health departments and is designed to furnish basic health care services to low-income individuals. Income limits vary from state to state, and you may be eligible for both Medicare and Medicaid at the same time depending on your Social Security status and current income.

People who qualify for Medicaid may also receive services that are not fully covered by Medicare, such as nursing home and home health care. Under financial hardship, Medicaid may also be used to pay your Medicare premiums, deductibles and co-insurance.