Helping Your Clients with Sticky Benefits Scenarios

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Housekeeping Notes

We have muted all lines

• Please type your questions in chat
• Slides are available from [www.ncoa.org/ncboewebinars](http://www.ncoa.org/ncboewebinars)
• Recording and follow-up Q&A will also appear at this link
• Thank you for joining us!
Presenters

• Casey Schwarz, Medicare Rights Center
• Mike Klug, SHIP Resource Center
• Ann Kayrish, NCOA
• Brandy Bauer, NCOA
Agenda

- Scenario 1: Welcome to Medicare!
- Scenario 2: Part A conditional enrollment for clients applying for a Medicare Savings Program
- Scenario 3: The big nursing home bill
- Scenario 4: SNAP medical expense deduction
- Scenario 5: Retirement plans, the Initial Enrollment Period (IEP) and Special Enrollment Periods (SEP)
Scenario 1: Welcome to Medicare! (Hooray! Oh no?)

- Nora is 64 and will be 65 in 3 months. For the past 4 years, since she had a stroke and lost her job, she’s had Medicaid – thank goodness her state expanded coverage for single/childless adults. She uses a lot of health care services – she gets some help at home, has a number of prescription drugs, and has been hospitalized twice. She applied for SSDI, but was denied, and she is looking forward to getting on Medicare – which she believes from the news is much better than Medicaid (after all, they are talking about Medicare for all, not Medicaid for all, right?)
- But, then she got a notice from her state saying that once she has Medicare, her Medicaid will stop the month after her Medicare starts!
Poll

• Could the notice be correct?
  a. Yes
  b. No
But why?

- Income change as a result of collecting Social Security Retirement
  - Could also be deemed income based on the duty to avail one’s self of potentially available income
- Income rules change from expansion to ABD Medicaid
- Asset rule change from expansion to ABD Medicaid
For Nora, it’s because of the asset test

- She doesn’t have a lot of savings, but she has some, about $4,000. She is understandably freaked out about losing Medicaid – but knows she’ll have Medicare. Her income isn’t changing because she started collecting her Social Security early, at 62, and she tells you its “pretty low.”
Survey

• Which is a likely immediate change for Nora?
  a. Termination of her homecare
  b. Increase in Part B premium payments
  c. Increase in prescription premiums/out-of-pocket costs
  d. Changes to her hospital costs
  e. a, b, & d
  f. b & d
  g. All of the above
  h. Not fair! We need more information

Take a moment and write down a few strategies to mitigate any or all of these changes
Considerations

• Extra Help – she’ll have it for the next year (she will have both Medicare and Medicaid for a month after July, so will be deemed).
  o Screening for the MSP – especially QMB – is a really good place to start.

• States should be conducting reviews of other eligibility for anyone who loses Medicaid, but it’s always a good idea to check

• On the homecare question . . .
What do you need to know?

a. What services is she getting?
   i. Skilled Nursing or Therapy Services?
   ii. On an intermittent basis?

b. Is she homebound?
   i. Is it very difficult for her to leave the home?

c. Has her doctor/ would her doctor sign a certification of her need for these services and her homebound status?

d. Could she have a face-to-face meeting with the prescribing doctor?

e. Is she getting care from a Medicare Certified Home Health Agency?
What can she do? (Poll)

a. Appeal the denial of homecare

b. Pay for homecare out of her pocket until her savings are low enough that she qualifies for Medicaid again

c. Talk to an attorney about setting up a special trust that won’t “count” towards the Medicaid asset test
Scenario 1b: What if…?

Nelly is the same age as Nora, but her income is a bit higher, and she’s had a plan on the exchange for the past few years. She’s gotten a subsidy to help with the premiums, and though she’s paid a bit more than she wishes for her prescriptions, she’s been pretty happy with her coverage. She’s Nora’s twin, and Nora told her that Medicare is a terrible deal, and to avoid it if she can – “unlike Medicaid, I heard that the Exchange plans can’t kick you off when you turn 65!”
Poll

• Can (and should) Nelly decline Medicare?
  a. Yes, because she has creditable coverage under her exchange plan
  b. No, because she won’t have a SEP to enroll in Part B later and will have a penalty.
  c. Yes, but only if she declines Part A AND Part B.
  d. No, but she should keep her exchange plan, with subsidies as inexpensive secondary coverage.
More information…

• Issue Brief: Toward Seamless Coverage: Expansion Medicaid to Medicare Transitions
  https://www.ncoa.org/resources/toward-seamless-coverage/

• FAQ:
  https://www.ncoa.org/resources/expansion-medicaid-faq/
Scenario 2: Part A Conditional Enrollment

• March 2018: Ms. Green, 66, a SC resident, seeks assistance in enrolling in Medicare A and B, which she has delayed because she can not afford the premiums

• Ms. Green’s income is $11,500 annually with no additional resources or assets. Ms. Green has worked for 30 quarters.

• How do you assist Ms. Green?
Background: Part A Conditional Enrollment

- Part A enrollment is required to qualify for MSP/QMB
- The conditional enrollment process allows an individual to apply for Part A but only get coverage if the state approves the QMB application, whereby the state pays the Part A premium
- If the QMB application is denied, the individual will not be enrolled in Part A
Background Part A Conditional Enrollment

• **Buy-in States** are those states that include Premium-Part A in their State Buy-in agreements. In Part A Buy-in States, individuals can complete the conditional enrollment process at any time.

• **Group Payer States** are those states that did not include Premium-Part A for QMBs in their State Buy-in agreements. In Group Payer States, individuals must complete the conditional enrollment process during a prescribed enrollment period.
  - January 1-March 31 enrollment period for a July 1 effective date
# List of Group Payer States

<table>
<thead>
<tr>
<th>Alabama</th>
<th>Kansas</th>
<th>New Mexico</th>
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<tbody>
<tr>
<td>Arizona</td>
<td>Kentucky</td>
<td>South Carolina</td>
</tr>
<tr>
<td>California</td>
<td>Missouri</td>
<td>Utah</td>
</tr>
<tr>
<td>Colorado</td>
<td>Nebraska</td>
<td>Virginia</td>
</tr>
<tr>
<td>Illinois</td>
<td>New Jersey</td>
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</tbody>
</table>
Counseling Considerations – Group Payer States

- Confirm QMB eligibility (income and assets thresholds)
- Explain that an application for Part B and a “conditional enrollment” for Premium Part A must be filed with SSA during the state’s prescribed enrollment period (January 1- March 31). The effective date will be July 1.
- Ensure that the “Remarks” section of the application contains the following language
  - I wish to enroll in Part A. I understand that:
    - I’m not eligible for Premium-Free Part A. By enrolling, I’m buying Part A coverage.
    - I must also have Part B. I must pay monthly premiums for Part A and Part B coverage.
    - (if Applicable) I only want Part A coverage if my State approves my application for the Qualified Medicare Beneficiary (QMB) program. I do not want Part A coverage to begin before my State starts paying my monthly premiums. I understand that if I lose my QMB status, I must pay the monthly premiums to keep my Part A coverage.”
Counseling Considerations Group Payer States

- Advise client to obtain a copy of the screen shot documenting their conditional enrollment in Part A
- Complete/or direct the client to the State Medicaid office to complete a QMB application. Include/attach a copy of the SSA screen shot with the application
- Explain that a QMB is automatically eligible for LIS
- QMB eligibility must be recertified annually
Scenario 2b: Buy-In State

- March 2018: Ms. Green, 66, a MD resident, seeks assistance in enrolling in Medicare A, which she has delayed because she can not afford the premiums.

- Ms. Green’s income is $11,500 annually with no additional resources or assets. Ms. Green has worked for 30 quarters.

- How do you assist Ms. Green?
Counseling Considerations Buy-In States

- Confirm QMB eligibility (income and assets thresholds)
- Complete/or direct the client to the State office to complete a QMB application. She does not need to file an application for conditional Part A at SSA
- Explain that a QMB is automatically eligible for LIS
- QMB eligibility must be recertified annually

Note: If the State (MD) approves the QMB application, the state will enroll her in the State Buy-In which covers both Part A and B premiums, the month after she is found eligible for QMB.
## Buy-In vs Group-Payer State Comparison

<table>
<thead>
<tr>
<th>Local SSA Office Accepts Part A Conditional Enrollments Application</th>
<th>Client Has Part B</th>
<th>Client Does Not Have Part B</th>
<th>Coverage Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Buy-In States</strong></td>
<td>Any time</td>
<td>File a QMB application with State Medicaid anytime</td>
<td>File an application for Part B and Part A Conditional Application with SSA, then QMB application with State Medicaid anytime</td>
</tr>
<tr>
<td><strong>Group-Payer-States</strong></td>
<td>Only during prescribed enrollment periods</td>
<td>File a Part A Conditional Application with SSA, then a QMB application with State Medicaid during prescribed enrollment period only</td>
<td>File an application for part B and Part A Conditional Application with SSA, then a QMB application with State Medicaid during prescribed enrollment period only</td>
</tr>
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Additional Information & Resources

- Conditional Part A enrollment does not change eligibility criteria for Part A
- Beneficiaries are allowed to complete conditional applications even if they owe Medicare premiums
- Part B does not have a conditional enrollment provision
- Part A premium amounts: https://www.ncoa.org/resources/medicare-premiums-and-cost-sharing-chart/
Scenario 3a: The big nursing home bill

Lorene’s daughter, Marge, calls to ask for help with a $3,000 bill for her mother’s two week nursing facility stay. “Shouldn’t Medicare be paying for this?” she asks. “Mom got a notice from Medicare that says it won’t pay. Now, the nursing home is billing her and bugging me because I’m her representative.” Marge reports that Lorene was hospitalized for five days to treat sepsis caused by a recurrent infection in her leg tissue.
Poll

What do you need to know before you can address Marge’s question?

a. Was the nursing facility owned and operated by a for-profit chain or a county government?
b. Was the nursing facility a “swing bed unit” within the hospital?
c. Was Lorene admitted as a hospital inpatient?
d. Was Lorene eligible for Medicaid?
Scenario 3b: The big nursing home bill

Marge recalls that Lorene’s physician admitted her to the hospital as an inpatient. She received IV antibiotics there. Under doctor’s orders, the hospital’s discharge planner arranged Lorene’s transfer to a Medicare-certified skilled nursing facility (SNF) directly from the hospital. Marge says that a ramp-equipped van transported her mom because she could barely stand on her own and needed a wheelchair.
Check-In Poll

- Since Lorene was hospitalized as an inpatient for 5 days and admitted to the SNF under a physician’s orders, what else could explain Medicare’s coverage denial?
  a. She didn’t receive skilled nursing care on a daily basis.
  b. She didn’t receive physical therapy on a daily basis.
  c. She didn’t have to be in a SNF to get the care she needed.
  d. All of the above.
Scenario 3c: The big nursing home bill

Marge excuses herself to go look for the Medicare denial notice. When she returns to the phone, she reads a note that says Lorene didn’t qualify for SNF coverage because she could have received skilled care in a less intensive setting like her home with home health care.
Check-In Poll

• What can Marge and Lorene do?
  a. Appeal the coverage denial.
  b. Sign up for Medicaid so it pays the bill retroactively.
  c. Stop paying the nursing home bill.
  d. Buy a Medigap policy to insure against something like this happening again.
Go to the source

• The “practical matter” test for SNF coverage (Medicare Benefit Policy Manual, Chapter 8, §30.7)

As a “practical matter,” daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:

- An excessive physical hardship;
- Less economical; or
- Less efficient or effective than an inpatient institutional setting.
The “Practical Matter” Test

• The availability of capable and willing family or the feasibility of obtaining other assistance for the patient at home should be considered. Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be ineffective because the patient would have insufficient assistance at home to reside there safely. (emphasis added)
Scenario 4: SNAP medical expense deduction

Elaine, 61, lives in Arkansas with a disability. Elaine has been receiving a modest SNAP benefit amount ($40/month), but recently, she acquired a dog trained to provide her support for her disability, and she calls your office wondering if the dog’s food and veterinary costs are considered medical expenses. If so, can they be counted toward the SNAP medical expense deduction, thereby possibly increasing her SNAP award?
Two Considerations for Counselors

1. What does the state SNAP policy manual say about qualified medical expenses that count toward the deduction?
   – For service animals, are there any licensure qualifications? Specific animal types included/excluded?
   – Does your state have a standard deduction?
   – What about recurring vs. non-recurring expenses?

2. What is the mechanism to have your state agency reconsider a client’s SNAP benefit amount?
   – Are there specific timeframes?
   – What documentation is needed?
Finding Your State SNAP Policy Manual

• Go onto the website of the agency that administers SNAP in your state and search for policy manual
  ○ Look in section on Determining Eligibility or Deductions

• The Center on Budget & Policy Priorities (CBPP) has a handy short-cut page linking to most state manuals at:
### SNAP Certification Manual – Section 6000

**6500 Medical Deduction**

<table>
<thead>
<tr>
<th>Allowable Medical Costs</th>
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<tbody>
<tr>
<td>(A) Cost of eyeglasses or contact lenses</td>
<td>Prescribed by a physician skilled in eye diseases or an optometrist</td>
</tr>
<tr>
<td>(F) Costs associated with any animal specially trained to serve the needs of elderly or disabled program participants are allowable for purposes of the excess medical deduction when the service animal is prescribed or approved by a licensed practitioner authorized by state.</td>
<td>Includes food, veterinarian bills and other related expenses.</td>
</tr>
<tr>
<td>(G) Reasonable cost of mileage cost established for state employees is allowed when individual is her own personal vehicle. Actual cost must be used for all other vehicle costs.</td>
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**South Carolina (top)**

vs

**Arkansas (left)**

- Costs for the purchase of sickroom supplies such as bandages and gauze for a surgical patient or bed pads and protective linens for bedfast patients;
- Costs for the lease or purchase of medical equipment such as crutches, wheelchairs, wheelchair ramps, hospital beds and portable oxygen tanks.
- Costs for the purchase, maintenance, and training of seeing-eye dogs for the blind, and service dogs for people with mobility disabilities. This includes the cost of food and veterinarian’s bills for the dog. If a deaf person is otherwise aged or disabled, the costs of the purchase, maintenance and training of a dog used to “hear” for the deaf person are also considered a medical expense.
- Costs for the purchase and maintenance of a “lifeline” service intended to be used by an elderly or disabled individual to call for assistance in the case of an emergency. Related telephone costs are not allowable since they would be covered by the telephone standard.
Reconsidering SNAP Benefit Amount

• All states require clients to report changes in income at any time to the determining agency
  o Most states allow the client to report the medical expenses at any time as they would any other change in household income or expenses
  o Some require clients to wait until the time of interim reporting or recertification and report the medical expenses then

• Check your state’s policy manual and client’s SNAP caseworker

• Separate issue: If your client has already submitted documentation and been denied SNAP or a change in award, they can request a fair hearing within 90 days of benefit decision
Related Resources

- USDA Food & Nutrition Service SNAP information: https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap

- NCOA Resources:
  - Webinar: Maximizing SNAP Benefits Through the Medical Expense Deduction: https://www.ncoa.org/resources/maximizing-snap-benefits/

Scenario 5: Retirement plans, the IEP, and SEP

George turns 65 on July 27th this week. He works for a large medical equipment manufacturer and has group health coverage through his employer. He intends to retire this fall, starting in October, after 30 full years on the job. He’s read about a Special Enrollment Period (SEP) for older workers and wants to know if he should plan to use the SEP in September so his Medicare Part B coverage will take effect on October 1.
Poll

• Can George use the SEP in September to enroll in Part B on October 1?
  a. Yes, because the SEP takes priority over his Initial Enrollment Period (IEP).
  b. Yes, but only if George can prove that he has creditable coverage.
  c. No, because George will be eligible for COBRA coverage when he retires.
  d. No, because the Initial Enrollment Period takes priority over the SEP.
Social Security POMS (HI 00805.275)

- In the case where an individual qualifies for more than one enrollment period, the order for Medicare enrollment periods is:
  1. Initial Enrollment Period (IEP)
  2. Special Enrollment Period (SEP)
  3. General Enrollment Period (GEP)

  - Both the Special Enrollment Period and the General Enrollment Period are only available following the end of an individual’s IEP.
Reminder: Get the slides, recording and follow-up Q&A at: www.ncoa.org/ncboewebinars

Ask further questions: centerforbenefits@ncoa.org