

805.5 Introduction

A national health insurance program, better known as Medicare, was enacted in 1965 (Title XVIII of the Social Security Act) for individuals age 65 and over who are insured under the Social Security Act or the Railroad Retirement Act. Subsequent legislation has included disabled beneficiaries, individuals with chronic renal disease and uninsured individuals.

The Medicare program has four parts:

- Medicare Part A: Medicare hospital insurance (Part A) helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, hospice care, and respite care. Part A has deductibles and coinsurance, but RRB Medicare beneficiaries do not have to pay premiums for Medicare Part A. Uninsured individuals may file an application during an enrollment period and pay a monthly premium. This program is called Premium HI and is only available through the Social Security Administration (SSA).
- Medicare Part B: Medicare medical insurance (Part B) helps pay for doctors' services, outpatient hospital services, durable medical equipment and various other medical services and supplies not covered by Medicare Part A. Part B has premiums, deductibles, and coinsurance amounts that an enrollee must pay. Participation is voluntary. Part B is also referred to as Supplementary Medical Insurance benefits or SMI. Part B claims for RRB Medicare beneficiaries are paid by the RRB's Speciality Medicare Administrative Contractor (SMAC).
- Medicare Part C: Medicare Advantage Plans (Part C) are health plan options similar to Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Medicare approved private companies offer these plans. All Medicare Advantage (MA) plans cover emergency and urgent care, but do not cover hospice care. Medicare Advantage plans may offer extra cover coverage such as vision, hearing, dental, and/or other health and wellness programs. In addition to the Part B premium, there is a monthly premium for the Medicare Advantage plan. An enrollee must have both Medicare Part A and Medicare Part B in order to enroll in a Medicare Advantage Plan. The RRB can deduct Part C premiums if the beneficiary makes the request for deductions through their Part C plan. Refer to [FOM-I-1540.15.8](#) for more on Part C.
- Part D: Medicare prescription drug coverage (Part D) is offered to everyone enrolled in Medicare Part A. The RRB can deduct Part D premiums if the beneficiary makes the request for deductions through their Part D plan Refer to [FOM-I-860](#) for additional information about Part D benefits.

805.10 Program Administration

Refer to Article 3 of the RCM for information about the administration of the Medicare program and the responsibilities of various organizations. Here are links to the pertinent sections:

3.1.3	General Assignment of Responsibility
3.1.4	Role of CMS
3.1.5	Role of RRB
3.1.6	Role of Operations' Medicare Section
3.1.7	Role of the Field Offices
3.1.17	Intermediaries and Carriers
3.1.18	State Health Agencies

805.15 Financing

Refer to [RCM 3.1.8](#) for information about Part A financing and [RCM 3.1.9](#) for information about Part B financing.

805.20 Hospital Insurance Benefits (HIB)

Refer to [RCM 3.1.60](#) through [3.1.72](#) for information about the services covered by Part A of Medicare and how Part A payments are made. Here are links to those sections:

3.1.60	General
3.1.61	Benefit Periods
3.1.62	How Medicare Pays for Part A Services
3.1.63	Inpatient Hospital Services
3.1.64	Hospital Inpatient Reserve Days
3.1.65	Coverage of Blood Under Part A
3.1.66	Care in a Psychiatric Hospital

3.1.67	Care Outside the United States
3.1.68	Care in a Christian Science Sanatorium
3.1.69	Prospective Payment System
3.1.70	Skilled Nursing Facility Care
3.1.71	Home Health Care
3.1.72	Hospice Care

805.25 Supplementary Medical Insurance Benefits

Refer to [RCM 3.1.80](#) through [RCM 3.1.89](#) for information about the services covered by Part B of Medicare and how Part B payments are made. Here are links to those sections:

3.1.80	What Medicare Part B Includes
3.1.81	Deductible and Coinsurance Amounts Under Part B
3.1.82	Doctors' Services Covered by Medicare Part B
3.1.83	Second Opinion Before Surgery
3.1.84	Services of Special Practitioners
3.1.85	Outpatient Hospital Services
3.1.86	Other Services and Supplies Covered by Medicare
3.1.87	Drugs and Biologicals
3.1.88	Medicare Payments for Non-Hospital Treatment of Mental Illness
3.1.89	Services Rendered Outside the United States

805.30 Medicare Advantage Plans (Part C)

Medicare Advantage Plans, also referred to as Part C of Medicare, are health plan options, like Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), that are approved by the Centers for Medicare & Medicaid Services (CMS), but are run by private companies. Medicare Advantage Plans (or MA

plans) combine Part A and Part B benefits. They must cover at least all of the medically-necessary services that the Original Medicare plan, i.e. the traditional fee-for-service plan, provides. Some Medicare Advantage plans also include Part D prescription drug coverage. Medicare Advantage plans first became available as an option for receiving Medicare benefits on February 1, 1985 (Public Law 97-248). The plans were originally referred to as Health Maintenance Organizations or HMOs, then as Medicare + Choice plans, and beginning in 2004 as Medicare Advantage plans.

805.30.1 Election of Medicare Advantage Plan

A beneficiary enrolls in a Medicare Advantage Plan directly with the plan or provider; district offices are not involved. A beneficiary must meet these requirements:

- Have Part A and Part B.
- Live in the service area of the plan.
- Not have end-stage renal disease (except when special circumstances exist.)

Beneficiaries usually compare plans that provide services near their residence, then choose the one which best satisfies their needs. It is not necessary that a beneficiary notify the RRB regarding such enrollments, since there is NO change in the RRB's Medicare record or in the collection of Medicare premiums.

805.30.2 Medicare Advantage Election Periods

The Balanced Budget Act of 1997 provides for Coverage Election Periods. During Coverage Election Periods, eligible beneficiaries may enroll in Medicare Advantage health plans.

Do not confuse Medicare Advantage Coverage Election Periods with the Initial Enrollment Period (IEP), General Enrollment Period (GEP), and Special Enrollment Period (SEP) of Medicare Part B. IEPs, GEPs, and SEPs are still in effect for beneficiaries who enroll only in Medicare Part B.

There are four types of Medicare Advantage Coverage Election Periods.

1. Initial Coverage Election Period (ICEP)

The ICEP is the period during which an individual newly eligible for MA may make an initial enrollment request to enroll in a MA plan. This period begins three months before a beneficiary becomes entitled to coverage under Medicare Parts A and B. An ICEP ends the last day of the month preceding the month of the beneficiary's entitlement.

Once an ICEP enrollment request is made and enrollment takes effect, the ICEP election has been used.

Coverage under the health plan starts the first day of the month in which the beneficiary is entitled to Medicare Parts A and B.

Note: If a beneficiary enrolls in a MA during their IEP, they can change to another MA (with or without drug coverage) or go back to Original Medicare (with or without a drug plan) within the first 3 months they have Medicare.

2. Annual Election Period (AEP)

The Annual Enrollment Period runs from October 15 through December 7 each year. During this time beneficiaries can choose to enroll in a stand-alone Medicare Prescription Drug Plan (PDP), a Medicare Advantage Plan (MA), a Medicare Advantage Plan with Prescription Drug Coverage (MA-PD), or other Medicare Health Plan, or switch to another plan. Coverage under the health plan starts January 1 of the following calendar year.

No action is required by beneficiaries during the AEP who are currently enrolled in a plan and do not want to change plans.

3. Open Enrollment Period (OEP)

Beginning in 2007, the OEP is from January 1 through March 31. The following limitations apply to the OEP:

- Only one election is allowed during the OEP.
- An individual who is enrolled in an MA-PD plan may elect another MA-PD plan, or disenroll from the MA-PD plan by enrolling in a PDP. (A Special Election Period allows the individual to enroll in a PDP under these circumstances.) Either action will generate an automatic disenrollment from the current MA-PD plan.
- An individual enrolled in a PDP may elect an MA-PD during the OEP. Such an individual may **not** elect an MA plan that does not provide qualified prescription drug coverage.
- An individual who is enrolled in an MA plan and who does not have qualified prescription drug coverage may elect another MA plan that does not provide drug coverage or may elect to disenroll from the MA plan during the OEP.
- An individual enrolled in Original Medicare but not a PDP may elect an MA plan that does not provide qualified prescription drug coverage during the OEP. Such an individual cannot elect an MA-PD plan during this period. (**Note:** The Tax Relief and Health Care Act of 2006 allows people with Original Medicare to join a Medicare Advantage plan that doesn't include Medicare prescription drug coverage at any time in 2007 or 2008. If they want to join a Medicare Advantage

plan that offers prescription drug coverage, they must enroll during the Annual Enrollment Period from October 15 through December 7.)

The following chart summarizes the OEP limitations.

If current coverage is	Can use OEP to get	Cannot use OEP to get
Medicare Advantage with prescription drug coverage (MA-PD)	MA-PD <u>or</u> Original Medicare + PDP	MA-only <u>or</u> Original Medicare only
Medicare Advantage with no prescription drug coverage (MA-only)	MA-only <u>or</u> Original Medicare only	MA-PD <u>or</u> A different PDP to use with Original Medicare
Original Medicare and a prescription drug plan (PDP)	MA-PD	MA-only <u>or</u> Original Medicare only
Original Medicare only	MA-only	MA-PD <u>or</u> Original Medicare + PDP

Coverage under the health plan starts the first day of the month following the election.

4. Medicare Advantage Special Election Period (MA SEP)

- During a Medicare Advantage SEP, a beneficiary may discontinue the election of a MA plan and enroll in Original Medicare, switch from Original Medicare to a MA plan, or change from one MA plan to another MA plan, except for Medicare Medical Savings Account (MSA) plan enrollees.
- A MA SEP may occur at any time, other than an Initial, Annual or Open Election Period, for the following reasons:
 - The health plan terminates service in the area in which the beneficiary resides.
 - The beneficiary moves out of the service area of the health plan.
 - The beneficiary shows a provision of the Medicare Advantage contract was violated by the plan or the marketing of the plan materially misrepresented the provisions of the plan.

- The beneficiary or a group of beneficiaries meets exceptional conditions specified by CMS, including on a case-by-case basis. A few examples of some SEPs that CMS has established include:
- Beneficiaries making MA enrollment requests into or out of employer sponsored MA plans.
- Beneficiaries may disenroll from an MA plan at any time in order to enroll in the Program of All-inclusive Care for the Elderly (PACE).
- Beneficiaries that become entitled to Medicare Parts A and B, and also receive any type of Medicaid assistance, or who lose their dual-eligibility.
- Beneficiaries with ESRD whose entitlement determination is made retroactively.
- Beneficiary whose Medicare entitlement determination is made retroactively.

The Centers for Medicare & Medicaid Services will determine the beginning and ending dates of the MA SEP on a case-by-case basis.

The Medicare health plan is not required to accept the beneficiary's enrollment. However, if a plan is open to new enrollees, the plan may then accept a beneficiary's enrollment. Coverage under the new health plan starts at such a time as to avoid any disruption in benefits.

805.30.2.1 Special Rules for Medical Savings Account (MSA) Plans

There are special enrollment rules for a beneficiary who elects a Medicare Medical Savings Account (MSA) Plan.

1. A beneficiary may elect a MSA Plan ONLY during:
 - an Initial Coverage Election Period (ICEP) or
 - the Annual Election Period (AEP).
2. A beneficiary who elects an MSA Plan during an ICEP MUST STAY in the plan through the last day of the calendar year in which he or she made the election.
3. A beneficiary may disenroll from an MSA Plan ONLY between October 15 and December 7 of each year during the AEP. Disenrollment will be effective January 1 of the next year.

EXCEPTION: A beneficiary who never previously elected an MSA Plan and who elects one during an AEP may revoke the election no later than December 15 of the same year. They still only have until December 7 to join another health or

drug plan. After December 7 and up until December 15, they can only return to Original Medicare.

805.30.3 Disenrollment from a Medicare Advantage Plan

The Centers for Medicare & Medicaid Services' 1-800-MEDICARE customer service representatives (CSRs) process requests for disenrollment from Medicare Advantage plans. CMS requires that all disenrollments be made by calling a 1-800-MEDICARE CSR, or by submitting a request to the Medicare Advantage (MA) plan, either in writing, by fax, or if the plan allows, by Internet.

Field Office Procedures

Field office claims representatives should direct all beneficiaries requesting disenrollment, including requests received by telephone, mail and walk-in, to call Medicare directly at 1-800-MEDICARE (1-800-633-4227). TTY users should be instructed to call 1-877-486-2048 to request disenrollment.

RRB claims representative may assist walk-in requests by calling 1-800-MEDICARE for the beneficiary while he or she is in the office. It is important that the claims representative advise the beneficiary that he or she does not have to place the call from the RRB office; the beneficiary may call 1-800-MEDICARE on their own.

Refer all disenrollment inquiries (e.g., individual requesting to disenroll from a MA plan, individuals following up on a disenrollment request, etc.) to 1-800-MEDICARE.

Beneficiary Disenrollment Process

Beneficiaries will need the following information when they call 1-800-MEDICARE to disenroll:

- Name
- Medicare Claim Number
- Date of Birth

In addition, for the protection of their identity, beneficiaries will need to provide at least 3 of the following pieces of information:

- Telephone number
- SSN
- Street Address
- City, State, Zip

- Part A/Part B coverage
- Part A/Part B effective

Here is a description of the process beneficiaries follow when calling 1-800-MEDICARE to disenroll from a Medicare Advantage plan. (Beneficiaries will hear an automated introduction before being connected to a CSR after saying the word “Agent.”)

- The beneficiary will select English or Spanish
- The beneficiary should wait for the introduction to finish and then say “Agent.”
- When an agent answers, the beneficiary should state that he or she wants to disenroll from a Medicare Health Plan.
- The agent will transfer the beneficiary to a disenrollment customer service representative.
- The customer service representative will ask questions (e.g. name, Medicare number, date of birth, etc) as described above to verify the beneficiary’s identity.

Note: If the individual does not have this information at the time of the call, the individual will be asked to call back when he or she has the information available.

- After identifying information is provided, the CSR will verify the plan that the beneficiary is currently enrolled in (and would like to disenroll from).
- The CSR will input the disenrollment.
- Once the Medicare systems confirm the disenrollment, which takes approximately 1 week, a confirmation letter will be mailed to the beneficiary.

Status Inquiries/Congressional Inquiries

Instruct beneficiaries who inquire to follow up on a disenrollment request to call 1-800-MEDICARE.

Congressional inquiries on behalf of constituents with disenrollment questions should be referred to the appropriate CMS regional office. Here is a list of the CMS regional offices with email addresses and telephone numbers:

Region 1 Boston	(617) 565-1232 ROBOSORA@cms.hhs.gov	Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, Vermont
------------------------	----------------------------------------	-------------------------------------------------------------------------

Region 2 New York	(212) 616-2222 RONYCORA@cms.hhs.gov	New Jersey, New York, Puerto Rico, Virginia Islands
Region 3 Philadelphia	(215) 861-4140 ROPHIORA@cms.hhs.gov	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
Region 4 Atlanta	(404) 562-7500 ROATLORA@cms.hhs.gov	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
Region 5 Chicago	(312) 353-7180 ROCHIORA@cms.hhs.gov	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
Region 6 Dallas	(214) 767-6423 RODALORA@cms.hhs.gov	Arkansas, Louisiana, New Mexico, Oklahoma, Texas
Region 7 Kansas City	(816) 426-5233 ROKCMORA@cms.hhs.gov	Iowa, Kansas, Missouri, Nebraska
Region 8 Denver	(303) 844-1568 ROREAORA@cms.hhs.gov	Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
Region 9 San Francisco	(415) 744-3501 ROSFOORA@cms.hhs.gov	Arizona, California, Hawaii, Nevada, Pacific Territories
Region 10 Seattle	(206) 615-2354 ROSEA_ORA2@cms.hhs.gov	Alaska, Idaho, Oregon, Washington

805.30.4 Disenrollment Effective Date

The effective date of disenrollment is the first day of the month after the month in which the beneficiary requests disenrollment.

805.30.5 Resolving Beneficiary Problems with Medicare Advantage Plans

If a beneficiary in a Medicare Advantage plan is unhappy with the quality of the care he or she is receiving or needs to resolve differences with his or her plan, the beneficiary can:

- follow the Medicare Advantage plan's grievance procedure, or
- contact the local Quality Improvement Organization (QIO). The beneficiary can call 1-800-MEDCARE to get the telephone number of the local QIO.

If a person believes that the MA plan made an incorrect decision on the coverage of benefits or payment of a claim, the person can exercise their appeal rights. Those rights are similar to those provided under traditional Medicare. See CMS Publication No. 10112 and [RCM 3.1.115](#) for more information about appeals.

A. Possible MA Plan Problems - Some of the problems that could develop because of MA plan involvement are:

- beneficiary should be enrolled in an MA plan, but the Entitlement Database (EDB) and Medicare Beneficiary Database (MBD) do not indicate MA plan involvement;
- beneficiary should be disenrolled from an MA plan but the EDB and MBD still indicate MA plan involvement;
- beneficiary was never enrolled in an MA plan but EDB and MBD indicate MA plan involvement;
- beneficiary should not be disenrolled from an MA plan but the EDB and MBD indicate the beneficiary is disenrolled;
- beneficiary complains about an incorrect MA plan effective date on the EDB and MBD;
- beneficiary complains about an incorrect disenrollment date on the EDB and MBD.

B. Resolving MA Plan Problems - Problems with MA plans are generally resolved in CMS's Regional Offices. However, the following steps should be taken first to try to resolve the problem:

- MU or the field office should determine if the inquiry or letter contains enough information to determine what the problem is. If not, secure a statement and whatever other proof the beneficiary may have.
- When enough information is obtained, it should be determined what is on the EDB. Check ELMO to see what is on EDB. Based on what is on the EDB, take one of the following actions:
- If the EDB has recently been updated to show correct information, advise the beneficiary accordingly. No further action is necessary.
- If the EDB has not been updated, MU will call CMS's Regional Office about the problem. The field office should forward the inquiry to MU. MU will discuss the problem with CMS. If it cannot be resolved over the phone, MU will refer the inquiry and other related material to CMS's Regional Office to resolve. The beneficiary will be advised with a short letter, with a copy to

CMS's Regional Office, of the referral. In the letter, explain that CMS's Regional Office will contact them about the problem. A copy of the letter should be included with the package being referred to CMS's Regional Office. See [FOM-I-805.30.3](#) and [Exhibit 17](#) of RCM 3.1 for a listing of CMS's Regional Offices and the States they service. See [Exhibit 16](#) of RCM 3.1 for a sample letter.

If MU receives a manual payment/account correction from the Part B carrier when there is MA involvement, a manual payment should not be authorized. The package should be returned to the Part B carrier to verify their records. The Part B carrier should process the claim in accordance with the instruction in their carriers' manual. The Part B carrier should either pay, deny, or transfer the claim to the MA plan.

If the beneficiary still protests or complains and the necessary information and proofs are submitted, MU will call CMS's Regional Office to see if the problem can be resolved.

805.35 Medicare Prescription Drug Plans (Medicare Part D)

Medicare Part D prescription drug plans are private plans that contract with the Centers for Medicare & Medicaid Services (CMS) to provide drug coverage to people with Medicare who live within a certain geographic area.

Refer to FOM I 860.05 through FOM I 860.15.4 for additional information regarding the Medicare prescription drug plan (Part D). Here are the links:

860.05	Background
860.10.1	Part D Eligibility Requirements
860.10.2	Part D Enrollment Periods
860.10.3	Part D Enrollment Penalty
860.12	Payment of Part D Premiums
860.10.4.2	No Part D Subsidy
860.10.4.3	Entitled to Part D Subsidy
860.15.4	Subsidy Enrollment Periods

