Medicare Overview, Hot Topics & Updates

Life Care Planning Firms Association

March 15, 2019

The Center for Medicare Advocacy is a national non-profit law organization, founded in 1986, that works to advance access to comprehensive Medicare and quality health care

- Headquartered in CT and Washington, DC
- Staffed by attorneys, advocates, a nurse, and technical experts
- Education, legal analysis, writing and assistance
- Systemic change – Policy & Litigation
  - Based on our experience with the problems of real people
- Medicare appeals
- Medicare/Medicaid Third Party Liability Projects

MEDICARE BASICS

- Enacted in 1965
- 50% people ≥ 65 years old did not have insurance
- Now, almost all do
- Increased access to health care *and* economic security

MEDICARE BASICS (CONT.)

Eligibility:

- Based on age or disability, not income
- 65 or over
- Social Security Disability for 24 months
- End-stage renal disease (ESRD), ALS

MEDICARE BASICS (CONT.)

- **Part A -** Hospital Insurance
  - Covers inpatient hospital, SNF, home health, hospice care
  - Most beneficiaries do not have to pay for Part A
    - (If have 10-year work history of self or spouse, paying into Medicare)
- **Part B** - Medical Insurance
  - Covers physician services, some outpatient services, some preventive services, ambulance services, durable medical equipment

MEDICARE BASICS (CONT.)

- **Part C** - "Medicare Advantage" (MA) Program
  - Alternate delivery systems for Medicare coverage
    - Private plans
  - Same coverage rules and at least same benefits as traditional Medicare
  - Recent benefit enhancements, but less consumer protections, CMS encouraging MA enrollment
- **Part D** - Prescription Drug Benefit
  - Assistance with outpatient drugs, all through private insurance plans
  - Cost-sharing subsidies for low-income beneficiaries

MEDICARE COVERAGE

- Part A Covers:
  - Inpatient Hospital Care
  - Skilled Nursing Facility Care
  - Home Health Care
  - Hospice Care

MEDICARE COVERAGE

- Part B Covers:
  - Physician Services
  - Home Health Care
  - Outpatient Services and Therapy
  - Durable Medical Equipment
  - Prosthetics and Orthotics
  - Ambulance Services
  - Certain Preventive Services

MEDICARE COST-SHARING

2019 Deductibles

- Hospital: $1,364 / Benefit Period
  - AKA "Spell of illness"
- Part B: $185 / year

MEDICARE COST-SHARING

2019 Part A Premiums

- Part A (**No premium if ≥ 40 quarters paid into Medicare through employment**)
- Part A $240/month (If 30-39 coverage quarters)
- Part A $437/month (If 29 or fewer quarters)

MEDICARE COST-SHARING

2019 Part B Premiums

- **$135.50/Month (Ind. Income ≤ $85,000/year)**
- $189.60/Month (≥ $85K-$107K/year)
- $270.90/Month (≥ $107K-$133.5K/year)
- $352.20/Month (≥ $133.5K-$160K/year)
- $433.40/Month (≥ $160K - $500K/year)
- $460.50/Month ($500k or above)

MEDICARE COST-SHARING

2019 Coinsurance

- **Hospital**
  - Days 1-60: $0
  - Days 61-90: $341/day
  - Days 91-150: $682/day - *Lifetime Reserve Days*
- **Skilled Nursing Facility**
  - Days 1-20: $0
  - Days 21-100: $170.50
- **Part B** (For many services): 20%

TRADITIONAL MEDICARE

- Access to all Medicare-participating providers nationwide
- No limits on pre-existing conditions
- But –
  - No cap on out-of-pocket costs
  - Cost-sharing can be a problem
  - No routine vision, dental or hearing aid coverage

MEDICARE ADVANTAGE (MA)

- **Part C**
  - Private insurance plans that contract with Centers for Medicare & Medicaid Services (CMS) to provide Medicare coverage
  - MA plans combine Part A and Part B, and sometimes Part D (prescription drug coverage)
  - MA plans have limited provider networks – Ind.'s home area
  - Plans can terminate provider contracts / reduce providers in network during the year

MEDICARE ADVANTAGE (MA) (Cont.)

- MA plans must provide at least as much coverage as traditional Medicare
  - Can, often do, provide some other benefits (more in future?)
- Enrollment is an MA plan is not "in addition to"/ "on top of " Medicare, it <u>is</u> the enrollee's Medicare
- Deductibles, copayments or coinsurance are still generally paid out-of-pocket; sometimes included as an "extra benefit" by the MA plan
- Medigap policies can not be sold to people enrolled in MA

Note: Administration giving more latitude to MA plans to market/"communicate" and to add more non-medical services

TRADITIONAL MEDICARE VS. MA Summary

Choosing Between Traditional Medicare and an MA Plan is an important decision and requires consideration of:

- Need for an open network /full choice of providers
- Need for access to care outside one's own geographic area
- Individual's financial & personal circumstances
- Place of residence: Could you switch back to traditional? Medicare if MA does not serve you well?
  - Could you wait for the next enrollment period?
  - Could you get a Medigap plan?

TRADITIONAL MEDICARE VS. MA
Updates / Concerns

- Recent CMS Policies, Materials, Education favor Medicare Advantage
  - More latitude to market / "communicate" plans, less consumer protection
  - More latitude to offer non-medial supplemental benefits (not available in traditional Medicare) such as housing accommodations, HH aide
    - Will be these actually be offered and valuable
  - More latitude for companies to offer numerous plans, less constraints that they be meaningfully different
    - Will this make it harder for individuals to make informed choice?

TRADITIONAL MEDICARE VS. MA
Updates / Concerns

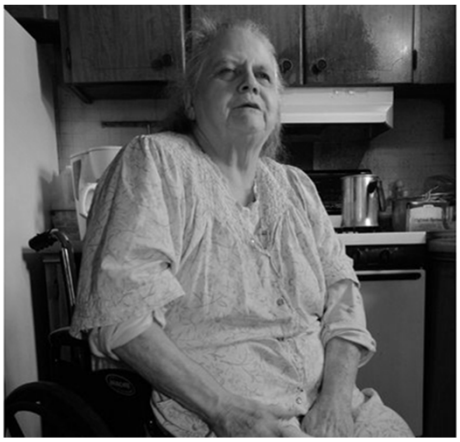
- Inadequate education/support for traditional Medicare
  - Referring to it as a "plan option"
  - Targeted emails re MA enrollment
- Not adding supplemental benefits that are added to MA
- Not insisting on parity between traditional and MA re. payment per enrollee and benefit offerings
- Emphasizing choice – Studies show people don't change (and often don't choose wisely initially)
- MA may not be best if Ind. becomes really ill or injured

Minimizing key advantage of traditional Medicare v. MA: Access to all Medicare health care providers nationwide vs. local geographic network.

IMPROVEMENT STANDARD

- Medicare-coverage is available for skilled nursing and therapy to maintain an individual's condition or slow decline, not just to improve
  - In nursing home, home health and out patient therapy settings.

***Jimmo v.. Sebelius*, NO. 5:11-CV-17, D. VT.)**
(Settlement Approved Jan. 24, 2013; Corrective Action Plan, 8/2017)



"Glenda Jimmo, of Lincoln, VT, was one of the plaintiffs in the class-action lawsuit challenging the cutoff of Medicare payments for physical therapy and other treatments for patients who were not improving." NY Times, 2/2013

WHY LITIGATION?

- People, like Ms. Jimmo, in need of skilled care to maintain their condition, deter or slow decline, constantly denied Medicare
- Particularly therapy (PT, ST, OT)
- Even after Fox. Even in CT
- Providers convinced maintenance not covered
- Need for systemic solution

WHY LITIGATION?

- Law: Medicare generally covers reasonable and necessary services only if the patient requires skilled care (therapy and/or nursing)
- True in various ways in various care-settings:
  - Skilled Nursing Facility (SNF)
  - Home Health
  - Outpatient Physical Therapy
  - Inpatient Rehabilitation Hospital (IRF)

WHY LITIGATION?

- Service is "so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel." 42 C.F.R. § 409.32(a)
- A condition that does not ordinarily require skilled services, may require skill because of special medical conditions. 42 C.F.R. § 409.32(b)
- Must be documented.

WHY LITIGATION?

- "Restoration potential is not the deciding factor in determining whether skilled care is required. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities." 42 C.F.R. § 409.32(c)
  - SNF, HH
- Nonetheless, denials of coverage & care continued

JIMMO V. SEBELIUS, NO. 5:11-CV-17
(D. VT., SETTLEMENT APPROVED JAN. 24, 2013; CORRECTIVE ACTION PLAN DEC. 2017)

- Federal class action to eliminate improvement standard in skilled nursing facilities (SNFs), home health (HH), outpatient therapy (OPT).
- Filed Jan. 18, 2011 by CMA and Vermont Legal Aid
- Plaintiffs: 5 individuals and 6 organizations
  1. National MS Society
  2. Alzheimer's Association
  3. National Committee to Preserve Social Security & Medicare
  4. Paralyzed Veterans of America
  5. Parkinson's Action Network
  6. United Cerebral Palsy

RESULTS OF *JIMMO*

- CMS revised Medicare policy manuals, guidelines, instructions to "clarify":
  - Coverage does not turn on the presence or absence of potential for improvement but rather on the need for **skilled care**.
  - Services can be skilled and covered when:
    - Needed to maintain, prevent, or slow decline or deterioration; or
    - Skilled professional is needed to ensure services are safe and effective.

RESULTS OF *JIMMO*

- Jimmo/ CMS revised Medicare policies apply to:
  - **SNF, HH, and Outpatient Therapy** – PT, ST/SLP or OT, collectively = Outpatient Therapy (OPT)
    - Skilled maintenance therapies and nursing are covered by Medicare
  - **Inpatient Rehabilitation Hospital** (Facility) (IRF)
    - Claim should never be denied because patient:
      - Cannot achieve complete independence in self-care
      - Cannot be expected to return to prior level of functioning

RESULTS OF *JIMMO*

- CMS conducted Educational Campaign about policy revisions
  - Completed February 2014
- Explained Settlement and new policies to:
  - Medicare Contractors, Medicare adjudicators, providers

THERAPY TO MAINTAIN FUNCTION OR SLOW DETERIORATION

"Maintenance Therapy – Therapy services in connection with a maintenance program are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. … Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary' requires skilled care for the safe and effective performance of the program."

Medicare Benefit Policy Manual, Chapter 8, §30.4.1.2.E
(Skilled Nursing Facility)

THERAPY TO MAINTAIN FUNCTION OR SLOW DETERIORATION

"Maintenance Therapy – Where services that are required to maintain current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to perform the procedures safely and effectively, the services would be covered physical therapy services."

Medicare Benefit Policy Manual, Chapter 7, §40.2.2.E
(Home Health Care)

THERAPY TO MAINTAIN FUNCTION OR SLOW DETERIORATION

"Delivery of maintenance programs – … skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that the specialized judgement, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program. … coverage of therapy services to carry out a maintenance program does not depend on the presence or absence of the patient's potential for improvement from the therapy."

Medicare Benefit Policy Manual, Chapter 15, §220.2.D
(Outpatient Therapy – PT, OT, ST)

NURSING TO MAINTAIN FUNCTION OR SLOW DETERIORATION

- Maintenance nursing is a Medicare-covered service if nurse needed to provide or supervise care
  - E.g., observation & assessment by a skilled nurse when there is a "reasonable probability" for a complication or acute episode, even if it does not occur. Medicare Benefits Policy Manual, Ch. 8, §30.2.3.2 ex. 6
- Decision regarding coverage should turn on whether skill is needed, not whether individual is expected to improve.

INDIVIDUALIZED ASSESSMENT

- Medicare should not use "rules of thumb," such as
  - Lack of restoration potential
  - "Determination of whether skilled nursing care is reasonable and necessary **must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time**."

Home Health Regs. 42 CFR §409.44(b)(3)(iii)

MEDICARE PROHIBITS THE USE OF RULES OF THUMB

Certain phrases may indicate Rules of Thumb have been used to deny coverage.

Examples:

- Individual has "plateaued."
- Individual has "reached baseline."
- Individual is "chronic and stable."
- Individual needs "maintenance therapy only."

FAQS RE *JIMMO* SETTLEMENT

- Is *Jimmo* limited to certain diagnoses, diseases, conditions?
  - No! Jimmo applies to anyone who needs skilled care.
- What types of services are covered?
  - Skilled nursing and skilled therapies.
- Does *Jimmo* add to number of covered SNF days or change other underlying coverage rules?
  - No. Coverage rules and limits remain (Examples: HH/Homebound OPT/Annual payment caps)
- Does Jimmo apply to Medicare Advantage plans?
  - Yes! Medicare Advantage plans *must* cover the same benefits as original Medicare. MA plans must apply the clarified standard under *Jimmo*.

JIMMO SUMMARY

Questions to Ask:

- Is a skilled professional needed to ensure nursing or therapy is safe and effective? Yes → Medicare coverable.
- Is a qualified nurse or therapist needed to provide or supervise the care? Yes → Medicare coverable.

Regardless of whether the skilled care is needed to improve, or maintain, or slow deterioration of the condition.

Or if condition is "chronic" or "stable" or has "plateaued."

JIMMO SUMMARY

- Coverage turns on whether skilled care is required
- Restoration potential is not the deciding factor
- Medicare should not be denied because the beneficiary has a chronic condition or needs services to maintain his/her condition
- An "Individualized Assessment" of each claim is required
- Rules of thumb should not be used

See: *Important Message About Jimmo Settlement*
https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html

CMS.GOV
Important Message About The Jimmo Settlement

- The Centers for Medicare & Medicaid Services (CMS) reminds the Medicare community of the *Jimmo* Settlement Agreement (January 2013), which clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare's skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the *Jimmo* Settlement Agreement required manual revisions to restate a "maintenance coverage standard" for both skilled nursing and therapy services under these benefits:
- Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.
- Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.
- The *Jimmo* Settlement Agreement may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The *Jimmo* Settlement Agreement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.

JIMMO UPDATE

- We continue to hear about problems
- Meeting/working with CMS

Contact the Center if you experience concerns: Improvement@MedicareAdvocacy.org

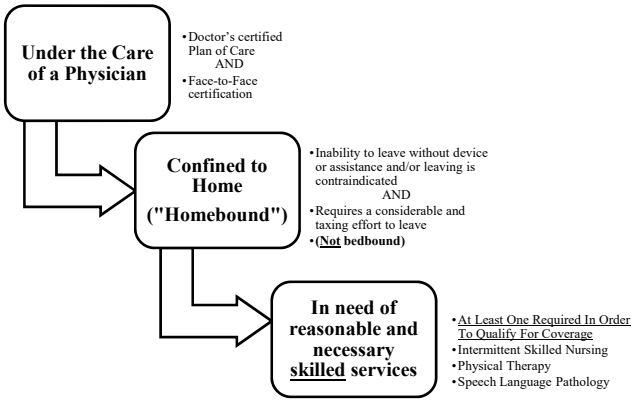
HOME HEALTH COVERAGE SUMMARY

- To qualify for coverage
  - Need Doctor's order, "Plan of Care"
  - Homebound
  - Need Intermittent Skilled Nursing, or PT or SLP
- Covered Services
  - Nurse, PT, SLP, OT, HH Aides, Med Social Services
  - Can "Split Bill" (Medicare + another payment source)
- Restoration potential is not the deciding factor
- No duration of time limitation

HOME HEALTH ACCESS

- Medicare home health coverage and access to care is shrinking
- CMS constantly expresses the benefit, incorrectly, as a short-term, acute care benefit
- Even people who are clearly homebound and require skilled nursing or therapy are denied
- People can only get bare minimum home health aides
  - ~ 1-3 Hrs/week for bath
- **Center working to ensure full legal coverage is available**

HOME HEALTH COVERAGE CRITERIA



Reference - Federal Regulation: 42 C.F.R. § 409.40 et seq

UNDER THE CARE OF A PHYSICIAN

Certifying physician must:

- Establish a written Plan of Care
  - Order specific medical and therapy treatments, including type of services, and frequency
  - Review at least every 60 days
- Conduct, or sign off on, a "Face-to-Face" meeting

Reference: 42 C.F.R. § 409.40 et seq; 42 C.F.R. § 424.22

CONFINED TO HOME ("HOMEBOUND")

Intent: To provide care at home for people who lack an ordinary ability to leave home

- The individual must require assistance of another person or supportive device to leave home; OR
- It is contraindicated for him/her to leave alone due to his or her medical, cognitive, psychological condition; and
- There is a normal inability to leave home; and
- It requires a "considerable and taxing effort" to leave home.

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1

SERVICES THAT QUALIFY AN INDIVIDUAL FOR COVERAGE

- To begin coverage, the beneficiary must require a **skilled** service:
  - Intermittent skilled nursing services; or
  - Skilled Physical Therapy (PT) or Speech Language Pathology (SLP) services
- To continue coverage, also:
  - Occupational Therapy (OT) [Not to begin coverage]

Reference: 42 C.F.R. § 409.40 et seq

SKILLED SERVICES

- "Skilled" means a qualified professional is needed for the care to be safe & effective
  - To provide or supervise the care (nursing or therapy)
- Skilled Nursing / Therapy **d**efined at 42 C.F.R. §409.33
  - List of services that = skilled nursing/therapy (42 C.F.R. §409.42)

No duration of time limit. Medicare home care coverage is available so long as skilled care required

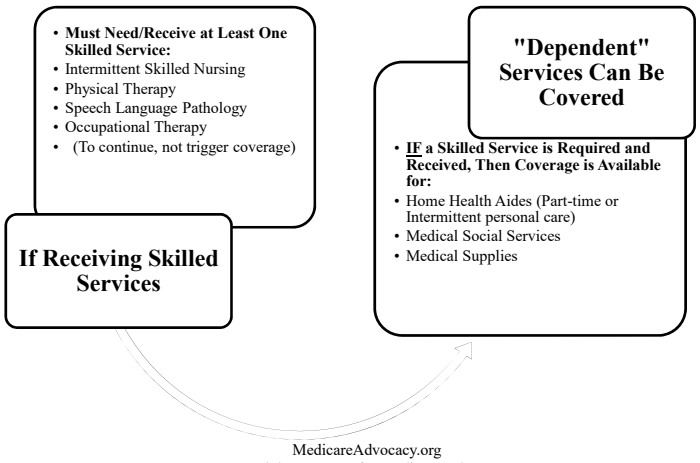
Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1
Unlimited # of home health visits: 42 CFR 409.48(a) and (b)

IMPORTANT KEY POINTS

1. An individualized assessment regarding eligibility for coverage is required
2. Restoration potential is not the deciding factor
3. Medicare should not be denied because the beneficiary has a chronic condition or needs services to maintain his/her condition
4. Skilled therapy and other services can be covered to:
   - Preserve current capabilities
   - Prevent further deterioration
5. Home Care can continue so long as qualifying criteria are met

- Home health agencies must submit claims to Medicare if a beneficiary requests (but the individual is responsible for payment until/unless Medicare coverage is granted)

"DEPENDENT" COVERED SERVICES



DEPENDENT SERVICES
Home Health Aides

Home health aides (can be Part-time or Intermittent)

Home health aides, combined with skilled nursing, can be provided up to 28 hours per week and any number of days per week as long as they are provided less than 8 hours each day

- Subject to review on case by case basis, they may be available up to 35 hours per week

Reference: 42 U.S.C. §1395x(m)(7)(b); 42 CFR §409.45(b) 1- 4

DEPENDENT SERVICES
HOME HEALTH AIDES

- HH Aides provide personal, hands-on-care
  - Bathing, dressing, grooming, feeding, toileting, skin care. 42 C.F.R. § 409.45(b) 1 – 4 (Not just bath)
- Homemaker services alone are *not* covered
  - Only allowed if incident to personal hands-on care
- Medicare Act specifically establishes home health aide ("custodial care") as a covered service under the Medicare benefit. 42 U.S.C. § 1395x(m)

NOTE: The amount of skilled services does not determine the amount of dependent services

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IS COVERAGE AVAILABLE IF CAREGIVERS ARE AT HOME?

- A patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services …
- Ordinarily it can be presumed that there is no able and willing person at home to provide services rendered by the home health aide or other HH personnel

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 20.2

REMINDER: JIMMO AND PRIOR LAW REQUIRE AN ASSESSMENT OF EACH INDIVIDUAL'S SITUATION

- **Medicare should not use "rules of thumb"**
- Specifically applies to home health coverage
- Rather, "Determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time."

Reference: 42 C.F.R. §409.44(b)(3)(iii); See also, 42 C.F.R. §409.44(a)

IF HOME HEALTH AGENCY SAYS MEDICARE WON'T COVER

- Tell the agency to submit a "Demand Bill" to Medicare for all the coverable services included on the plan of care
  - Up to 28- 35 hrs. / wk. of home health aide and nursing combined
  - And PT, SLP, OT, other "dependent services"
  - Home Health Agency should use "Code 20" on the claim form so a medical review is done

NEW HOME HEALTH CONCERNS

- Proposed New Payment Model: Incentives for patients who are admitted to home care after a prior hospital stay and have short-term care needs
- MedPAC considering prior hospital stay requirement
- MA plans allowed to offer HH aides w/o homebound or skilled care requirement?
- While HH aides dramatically less available under current traditional Medicare HH benefit

OBSERVATION STATUS

"'When I use a word,' Humpty Dumpty said in rather a scornful tone, 'it means just what I choose it to mean--neither more nor less.'" — Lewis Carroll

OBSERVATION STATUS

- Beneficiary is in a hospital bed, receiving medical & nursing care, tests, treatments, drugs, food, supplies, etc.
- But is said to be in "outpatient, observation status," not inpatient
- Entire stay may be considered "outpatient"
  - Covered by Medicare Part B
  - Not inpatient, covered by Medicare Part A.

OBSERVATION STATUS

- Time spent in observation status prior to (or instead of) an inpatient admission does not count toward the 3-day qualifying inpatient stay needed to qualify for SNF care.
  - Medicare Benefit Policy Manual, CMS Pub. No. 100-02, Ch. 8, §20.1.
  - *Landers v. Leavitt*, 545 F.3d 98 (2d Cir. 2008)
  - "Inpatient" means what CMS says it means, someone who has been formally admitted to a hospital – doesn't matter what services actually were.

OBSERVATION STATUS: HOW IT'S "CALCULATED"

- "2-Midnight policy": Time-based decisions based on physician expectation.
  - ≥ 2 midnights: appropriate for inpatient admission
  - < 2 midnights: appropriate for "outpatient" observation
    - Auditors won't focus on claims meeting these criteria
  - **Doesn't change 3-day (midnight) requirement for SNF coverage**
  - Dr. can consider all time in making forecast, but inpatient status only starts with admission order **(2+1≠3)**
    - Very difficult to predict length of stay

OBSERVATION STATUS: WHY IT MATTERS

- Consequences for beneficiaries placed in observation can include:
  - No Part A coverage for hospital stay
  - No Part A coverage for prescription drugs
  - No Part A coverage for SNF stay
  - Some beneficiaries who cannot afford SNF care go home or to assisted living, forgoing needed care
  - If individual does not have Part B, must cover "sticker price" for entire hospital stay

FEDERAL NOTICE LAW: THE "MOON"

- Effective March 8, 2017: Written notification and oral explanation is required within 36 hours of placing a patient on observation status
  - Medicare Outpatient Observation Notice / MOON
    - Must include reasons and implications of status for hospital costs and subsequent SNF care

But – Patient does not have right to appeal

STATE NOTICE LAWS

- CT also requires hospitals to provide notice to patients placed on observation. (Before federal MOON)
  - Not later than 24 hours after s/he is designated "observation status"
  - Notice must inform patients they have not been admitted as inpatients and possible implications for Medicare and other insurances, costs and care, and;
  - The notice must recommend patients contact their insurance company or CT Office of Healthcare Advocate for help.

OBSERVATION STATUS: WHAT CAN YOU DO?

- Find out patient's status while still in the hospital
- Try to get it changed while still in hospital – difficult! Try asking primary care Dr. to talk to hospital Dr. ("Hospitalist") and hospital's UR
- If in for 3 days (midnights) but not classified as "inpatient" and need post-hospital care:
  - If enter SNF w/o changing observation status, patient will be responsible for cost of SNF stay
    - Could still get Medicare Part B for PT,OT, ST
  - Home health care?

CONGRESSIONAL ACTION?

- Count all time in hospital towards 3-day inpatient stay requirement for SNF coverage
  - Improving Access to Medicare Coverage Act of 2017: H.R. 1421, S. 568
  - Bipartisan bills being introduced in new Congress
    - Other options: Eliminate 3-day requirement entirely? Reduce prior hospital requirement to 1 day?
  - Note: Most MA plans/ACOs can/do waive 3 day requirement

Stay tuned. Contact Congressional Delegation

OBSERVATION STATUS: WHAT CAN YOU DO?

- Contact Congressional offices re problems, stories, need for solution
  - Especially Rep. Joe Courtney (2nd District, CT)
  - Senator Sherrod Brown (Ohio)
  - Senator Susan Collins (ME), Senator Bill Cassidy (LA)
- Contact professional associations
  - **SNF:** Leading Age, AHCA ▪ HH: NAHC
- Contact CMS

Oppose additional prior-hospital stay requirements. Oppose payment models that increase provider payments if there is a prior hospital stay.

MEDICARE MATTERS

Watch out for it's future

- Protect traditional Medicare
  - Ensure parity with Medicare Advantage – coverages and payment
  - Resist continued privatization & fragmentation
- *"Medicare" for All*? What does it mean?
  - If improve Medicare for all beneficiaries, could be best for all concerned.
- Decrease (Increase?) age of eligibility?
- Voucher/Premium Support plans?

MEDICARE MATTERS

- Add Out-Of-Pocket cap to traditional Medicare
- Add Rx to Part B
- Add audio, vision, oral health to traditional Medicare
- Add "stand alone" home health aide benefit
- Negotiate Rx prices on behalf of all 60 million Medicare beneficiaries
- Reduce all payments to Medicare Advantage to no more than paid per enrollee in traditional Medicare
- Delete costly/worthless second level of appeal

Center for Medicare Advocacy

For further information, or to receive the Center's free weekly electronic newsletter, ***CMA Alert,*** update emails and webinar announcements, contact:

Communications@MedicareAdvocacy.org

Or visit

MedicareAdvocacy.org