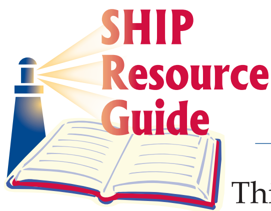

Overview of the Medicare Program

This section covers:

- Medicare in a Nutshell
- Who Runs Medicare?
- Highlights in Medicare History: A Timeline
- Sources of Medicare Eligibility, Coverage, and Payment Rules
- Where to Learn More

Medicare in a Nutshell

Medicare is a federal health insurance program that began in 1965. States are not involved in the program's administration. In general, the rules governing Medicare's operation are the same nationwide, though more detailed rules sometimes apply in specific states or regions and payments rates often vary from one region to another. Still, the program is virtually the same throughout the country.

Medicare is not free for the people, called beneficiaries, who benefit from the program. Congress designed Medicare so beneficiaries would share the total cost of health care with the federal government through:

- Premiums
- Deductibles
- Coinsurance charges, and
- Payment for non-covered (excluded) services and items

Eligibility for Medicare is available to three groups: those who are 65 and older, people with disabilities, and people with end-stage renal disease (ESRD). Medicare eligibility is open to people regardless of income. Eligibility is not based on financial need. In that respect, Medicare differs greatly from Medicaid, the state-sponsored health insurance program for low-income older Americans and others. Instead, Medicare is tied largely to employment. The financing for Medicare Part A's Hospital Insurance benefits, for example, derives from a FICA withholding tax applied to wages.

Medicare has a fairly comprehensive set of covered benefits. It also offers a number of service delivery options. Beneficiaries have the option to receive services through the "Original Medicare" program (Medicare Parts A and B, also called "Traditional Medicare") or through a variety of privately sponsored "Medicare Advantage" plans. Regardless of the choice they make between these options, beneficiaries have coverage for

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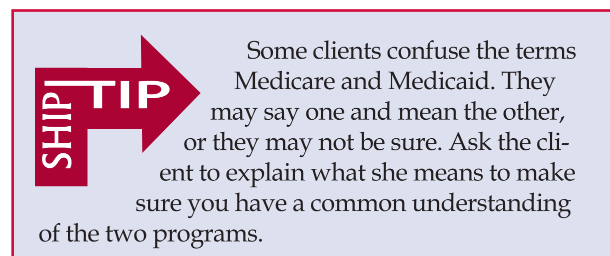
the Part A benefits that include inpatient hospital, skilled nursing facility, home health, and hospice care services. They also have coverage for Medicare Part B's benefits that include physician, outpatient hospital, home health, ambulance, and preventive services, along with medical equipment, supplies, and many other services and items.

The Medicare Advantage program (formerly called Medicare + Choice) is another name for Medicare Part C. Congress enacted Part C in 1998, and through it set up several different systems for delivering Medicare-covered benefits and services through private contractors. These contractors, called "health plan sponsors" or Medicare Advantage Organizations (MAOs), offer Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private-Fee-for-Service (PFFS) plans, and more, to Medicare beneficiaries. These private plans must cover the same services and benefits that are available through the Original Medicare program.

In 2003, Congress enacted the Medicare Modernization Act (MMA) and created the Medicare Part D prescription drug program. From the start, the Original Medicare program did not cover most outpatient prescription drugs. Medicare Part D addresses this shortcoming by delivering drug coverage through privately-sponsored prescription drug plans (PDPs) and Medicare Advantage plans with Part D drug coverage (MA-PDs). The Part D program also offers assistance for low-income Medicare beneficiaries through a low-income subsidy (LIS), or "Extra Help" program.

Medicare covers health care services only when they meet Medicare's definitions for medical necessity. With some exceptions, a service must be "reasonable and necessary in the diagnosis or treatment of an illness or injury" in order to qualify for Medicare payments. Nonetheless, Congress has added a number of health care screening and preventive care services to Medicare's covered benefits since 1990.



Regardless of medical necessity, Medicare specifically excludes some services and items from its covered benefits. Medicare's exclusions include:

- Most care received outside the United States (with exceptions for emergencies along the Canadian and Mexican borders)
- Custodial care, including most long-term nursing home care
- Hearing aids
- Routine dental care
- Routine eye care
- Routine foot care
- Eyeglasses (except in connection with cataract surgery)

- Dentures
- Routine physical exams (except for a one-time exam for new Medicare beneficiaries)
- Acupuncture and homeopathic care
- Cosmetic surgery (except in connection with an illness or injury)
- Private duty nursing

Who Runs Medicare?

Medicare's administration is the combined work of federal agencies and contractors. Here are brief descriptions of the main actors:

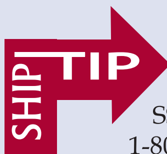
- **The Centers for Medicare & Medicaid Services (CMS)**

  Formerly known as HCFA, CMS is the federal agency that administers Medicare and Medicaid. Its headquarters are in Baltimore, with Regional Offices (ROs) in 10 cities around the country. It is the largest agency within the Department of Health & Human Services (HHS). CMS contracts with many private companies that handle aspects of Medicare's program operations including claims processing, monitoring the quality of care for patients, handling complaints, and reviewing appeals.

- **The Social Security Administration (SSA)**

  SSA handles Medicare eligibility and enrollment for Social Security recipients. SSA sends enrollment packets and Medicare cards to new Medicare beneficiaries. It also processes applications for Medicare Part D's low-income subsidy (LIS) program. The Railroad Retirement Board's (RRB) role is similar to SSA's. It handles Medicare eligibility and enrollment for Railroad Retirees.

1-800-MEDICARE: CMS contracts with a company called Vangent to operate the agency's nationwide, toll-free, Medicare beneficiary Service Center. The Service Center is set up to answer questions about billing and claims, to provide information on Medicare health plans, to receive complaints, and to order publications. Customer service representatives are available 24 hours a day, seven days a week.



Social Security replaces lost and damaged Medicare cards free of charge. Refer clients to SSA's toll-free phone number, 1-800-772-1213, or to SSA's Medicare Card Replacement website, https://secure.ssa.gov/apps6z/IMRC/main.html. SSA takes about 30 days to replace a Medicare card. Railroad retirees should call the RRB at 1-800-808-0772.

The Social Security Administration is not the best place to get answers to Medicare coverage and payment questions. While local SSA offices carry general Medicare publications, the agency's role in Medicare is limited mainly to eligibility and enrollment issues, including enrollment in the program that provides "Extra Help" in paying for prescription drugs for those with limited incomes.

- **The Office of Medicare Hearings and Appeals (OMHA)**
  OMHA is a separate agency within the federal Department of Health and Human Services (HHS). It employs Administrative Law Judges (ALJ) to provide hearings in the Medicare appeals process.

CMS is in the midst of a six-year effort called "Medicare Contracting Reform" for the Original Medicare program. It stems from the Medicare Modernization Act of 2003 and aims to integrate the claims processing functions of Part A Fiscal Intermediaries (FI) and Part B Carriers into one organization called an A/B Medicare Administrative Contractor (MAC). FIs, Carriers, and MACs are private companies that contract with CMS to process claims. Where FIs and Carriers typically handled operated in one state, or part of a state, by 2011 several A/B MACs will be under contract with CMS to process most Original Medicare claims for 15 multi-state/territory regions or jurisdictions. Original Medicare's payment contractors currently include:

- **Fiscal Intermediaries (FIs)** who contract with CMS to process Part A inpatient and Part B outpatient claims for hospitals and Part A claims for skilled nursing facilities in a state or part of a state.
- **Carriers** who contract with CMS to process most Part B claims, including those for physician and ambulance services, in a state or part of a state.
- **A/B Medicare Administrative Contractors (A/B MACs)** who contract with CMS to process Part A claims for hospitals and skilled nursing facilities and Part B claims for hospital outpatient services, physicians, ambulance providers, and others in a multi-state/territory region. As of January 2009, CMS had selected nine companies to work as the payment contractors in the 15 A/B MAC jurisdictions.
- **Regional Home Health Intermediaries (RHHIs)** who contract with CMS to process claims for home health agencies and hospice organizations in four multi-state regions. Through Medicare Contracting Reform, CMS eventually will contract with four Home Health/Hospice Medicare Administrative Contractors (HH MACs).
- **DME Medicare Administrative Contractors (DME MACs)** who contract with CMS to process Part B claims for durable medical equipment (DME) and supplies, including Part B drugs, in four multi-state regions. CMS has phased out the former Durable Medical Equipment Regional Carriers (DMERCs).

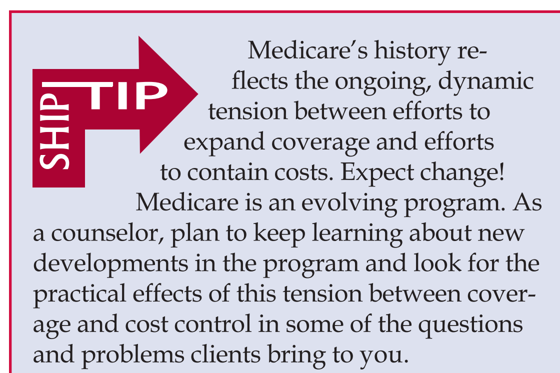
CMS also contracts with private companies to investigate quality of care complaints and to review coverage and payment decisions at certain points in the Medicare appeals process. These contractors include:

- **Quality Improvement Organizations (QIOs)** who contract with CMS to investigate complaints about poor care, review hospital discharge decisions, and handle expedited review requests for skilled nursing facility and home health service terminations. QIOs also work with providers on quality of care improvement projects. They typically work in one state. See http://www.cms.hhs.gov/QualityImprovementOrgs/.

- **Qualified Independent Contractors (QICs)** who contract with CMS to review coverage denials in the second stage of the Original Medicare appeals process called "reconsideration." QICs handle Part A reconsiderations for east and west regions, Part B reconsiderations for north and south regions, and DME reconsiderations for all the states and territories. See http://www.cms.hhs.gov/OrgMedFFSAppeals.

Highlights in Medicare History: A Timeline

In 1965, nearly half of those 65 and older had no health insurance. Today, about 97 percent of older Americans have health insurance through Medicare. Medicare covers more than 45 million older Americans and people with disabilities.



Medicare's history reflects the ongoing, dynamic tension between efforts to expand coverage and efforts to contain costs. Expect change! Medicare is an evolving program. As a counselor, plan to keep learning about new developments in the program and look for the practical effects of this tension between coverage and cost control in some of the questions and problems clients bring to you.

1965: Medicare is enacted as Title XVIII of the Social Security Act, creating a comprehensive health insurance program for Older Americans under Medicare Part A and Part B.

1972: Medicare adds coverage for persons with disabilities.

1982: To contain rising inpatient hospital costs, Congress creates a prospective payment system by which hospitals receive set payments based on the patient's diagnosis.

1985: Beneficiaries in some areas now can join Medicare HMOs, private insurance plans under contract with Medicare that offer a managed care option to the Original Medicare (Part A and Part B) program.

1989: Medicare adopts a resource-based payment system for physicians, ending the old reasonable charge formula tthat paid the lowest of the actual, customary, and prevailing charges. Medicare also requires physicians to submit claims on patients' behalf.

1990: States start to adopt federal rules for 10 standard Medicare Supplement (Medigap) insurance policies and to regulate Medigap marketing and sales practices.

1991: Federal funding for State Health Insurance Counseling & Assistance Programs (HICAPs or ICAs, now called SHIPs) begins.

1996: Health Insurance Portability & Accountability Act (HIPAA) creates new funding and tools to reduce fraud and abuse in Medicare. Senior Medicare Patrol programs are authorized.

1997: Balanced Budget Act (BBA) of 1997 creates Medicare Part C, adding the Medicare+Choice (now called Medicare Advantage) with several managed care and other health plan options, to the Medicare program. BBA also expands Medicare coverage for preventive services and creates new payment systems for home health, skilled nursing facility, inpatient rehabilitation, and outpatient hospital services.

2003: Medicare Modernization Act (MMA) of 2003 creates Medicare Part D, which adds prescription drug coverage to the program through private prescription drug plans and other Medicare health plans. The law also increases payments to private Medicare Advantage plan sponsors.

2006: Medicare Part D prescription drug coverage started on January 1. In addition, Congress enacts the Deficit Reduction Act (DRA), creating the Long-Term Care Partnership program.

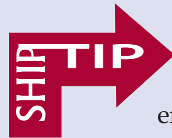
2008: Congress passes the Medicare Improvements for Patients and Providers Act (MIPPA). The law raises the asset limits for the Medicare Savings Programs (MSP), taking effect on January 1, 2010. The law also strengthens consumer protections in the marketing of Medicare Advantage (MA) plans, with some of the provisions taking effect in November 2008 and others on January 1, 2009.

2009: States adopt a revised Medigap model regulation, effective June 1, 2010. It eliminates four of the original standard policies and adds policies M and N

Sources of Medicare Eligibility, Coverage, and Payment Rules

Congress enacts the Medicare statutes in which the lawmakers broadly define Medicare's terms and its scope of benefits. CMS, the federal Medicare agency, issues federal regulations, policy manuals, and other guidance documents that interpret the Medicare statute and gives details about CMS's coverage and payment rules.

- The Medicare Statutes, known as Title XVIII of the Social Security Act and codified at 42 United States Code (USC) Section 1395, were enacted and are often amended by Congress.
- The Medicare Regulations are found at 42 Code of Federal Regulations (CFR), Parts 400-429, available at http://www.access.gpo.gov/cgi-bin/cfrassemble.cgi?title=200842. CMS publishes proposed regulations in the Federal Register and seeks public comment before finalizing the regulations that eventually appear in the Code of Federal Regulations.
- The Medicare Policy Manuals appear on-line at CMS's website at http://www.cms.hhs.gov/Manuals/IOM/list.asp. The "Internet Only Manuals" contain CMS's interpretation of the Medicare statute and regulations. They also include "Medicare National Coverage Determinations" that guide Medicare coverage decisions throughout the country on certain services, procedures, and devices.
- Medicare Program Transmittals, available at http://www.cms.hhs.gov/Transmittals/ are sent by CMS to its contractors to put new or revised policies into action.
- Local Coverage Determinations that Medicare's payment contractors create to clarify payment policy on some Medicare coverage issues. Visit http://www.hapnetwork.org/assets/ncd-lcd-database.pdf for more information on how to find specific Medicare coverage determinations.



You may be able to find answers to clients' unusual questions about Medicare coverage for procedures, drugs and equipment in the Medicare National Coverage Determinations manual. This manual, for example, answers the question, "Does Medicare cover a cane for a person with visual impairment as a durable medical equipment item?" The answer is, "it doesn't!"

Where to Learn More

For general information about Medicare benefits and coverage, see:

- *Medicare and You*. CMS's handbook for Medicare beneficiaries available for free by calling 1-800-MEDICARE or available online at http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf. Every year CMS sends a revised copy of the booklet to beneficiary households.

For more on Medicare's history and program development, see:

- The CMS website contains a history section with timelines and an oral history section, available at http://www.cms.hhs.gov/History.
- The Kaiser Family Foundation website, available at http://www.kff.org, offers an extensive library of fact sheets, issue briefs, and charts on Medicare coverage and financing issues. One piece to note is "Medicare: A Primer," available at http://www.kff.org/medicare/upload/7615-02.pdf.
- The National Academy of Social Insurance (NASI) website, available at http://www.nasi.org, offers a wide range of publications and briefing papers on topical Medicare policy issues.

For the names and contact information for Medicare's various contractors and other important agencies go to the Medicare website at http://www.medicare.gov and click on the "Find Helpful Phone Numbers and Websites" link.