



Kansas
Foundation
for Medical Care, Inc.

To Your Health!

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November 2005

CMS Announces Approved Drug Plan

Late September, the Centers for Medicare & Medicaid Services (CMS) identified the prescription drug plans and Medicare Advantage plans that will offer prescription drug coverage to Medicare beneficiaries starting January 1, 2006. The drug plans will begin marketing to beneficiaries on October 1, 2005. KFMC, the Quality Improvement Organization for Kansas will offer quality improvement assistance to drug plans.

The new plans will offer prescription drug coverage to everyone on Medicare, regardless of their income or how they get their Medicare coverage. Every state but Alaska has at least one prescription drug plan offering a premium of less than \$20 a month. Ten organizations are offering drug coverage nationwide. Extra assistance is

available to those with limited incomes and resources.

In early October, the Medicare & You 2006 handbook was mailed to every Medicare household. In mid-October, specific information to help beneficiaries find the drug coverage that suits their needs will be available on Medicare's website, www.medicare.gov, and it's 24-hour toll-free number 1-800-MEDICARE (1-800-633-4227).

For a list of plans by state, visit: www.cms.hhs.gov/map/map.asp.

CMS: Critical Error in 'Medicare & You' Handbook

Read full story on page 2

Don't Let the Flu Bug Bite!



Cooler temperatures are here and that means one thing...flu season is quickly approaching! Did you know that more people die from flu than from any other vaccine-preventable disease?

Every year, over 36,000 people in the United States die from flu. Most of these victims are 65 or older.

Influenza is a highly contagious disease that can cause high fever, headache, and body pain. You can also have a stuffy nose, sore throat, and a cough. Furthermore, the flu can result in pneumonia and make other serious problems worse.

According to the CDC, the single best way to prevent the flu is to get vaccinated each fall. *continued on page 3*

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News For Health Care Consumers

Spanish Version of Home Health Compare Now Available

On September 20, 2005, the Centers for Medicare & Medicaid Services (CMS), announced the launch of a Spanish-language version of Home Health Compare, an online resource that includes 10 publicly reported measures of home health care quality in a consumer-friendly format. The original version (English) of Home Health Compare has been available since November 2003.

Now, Spanish-language residents will have access to

information that can help them make decisions about nearly 7,000 Medicare-certified home health agencies across the country. To access the Spanish-language version of Home Health Compare, visit www.medicare.gov and click on “Español” in the upper right-hand corner. Then scroll down to select Compare Home Health Agencies in Your Area.

CMS: Critical Error in ‘Medicare & You’ Handbook

The Centers for Medicare & Medicaid Services (CMS) announced that an error was published in the new “Medicare & You 2006” handbook recently mailed to Medicare households. The error may cause some beneficiaries who qualify for “Extra Help” to believe they will pay no monthly premium for coverage with certain plans when, in fact, they would need to pay the difference between a regional benchmark and their chosen plan’s premium.

In an email to the American Healthcare Quality Association (AHQA), CMS stated the nature of the error:

“In the series of charts listing the specific Medicare Prescription Drug Plans (PDPs), the last column of the charts is entitled ‘If I qualify for Extra Help, will my Full Premium be Covered?’ For each plan listed, this column should show ‘Yes’ if the plan’s premium is at or below the regional benchmark, and a beneficiary who qualifies for the low-income subsidy would pay no premium for this plan. The column should show ‘No’ if the plan’s premium is above the regional benchmark and a beneficiary who qualifies for the low-income subsidy would pay the difference between the regional benchmark and the plan’s premium. *Due to an error, this column lists ‘Yes’ for every plan.*”

The error occurs for approximately 60 percent of the PDPs listed in the handbook. It does not impact Medicare Advantage plans and will have no effect on auto enrollment.

The agency is using multiple resources to make beneficiaries aware of this error. Beneficiaries can obtain accurate information regarding premium amounts by:

- Downloading the corrected Medicare & You Handbook online www.medicare.gov;
- Using the Medicare Prescription Drug Plan finder, which will be available soon on www.medicare.gov;
- Calling the organization offering the prescription drug plan;
- Calling 1-800-Medicare; or utilizing personalized counseling in the community.

For more information, please contact Ann Rush, KFMC Beneficiary Services Coordinator at 1-800-432-0407.

Your Right to Request a Coverage Review

If you or a family member are among the thousands of older Americans receiving care from a home health agency, skilled nursing facility, comprehensive outpatient rehabilitation facility or hospice, you have guaranteed rights and protections as a person with traditional, fee-for-service Medicare coverage.

For example, if you are told care is no longer needed and will no longer be covered by Medicare, you may now appeal to the Kansas Foundation for Medical Care (KFMC) if you disagree with this decision.

The new Benefits Improvement and Protection Act (BIPA) regulations allows for an expedited appeal when the beneficiary disagrees with the discharge or termination. When KFMC receives an appeal request, the provider will be notified by telephone. The provider is then required to send documentation for the appeal to KFMC no later than close of business on the day of notification, including weekends and holidays.

The new appeal process begins once a provider gives you a valid written, two-day advance notice that services will be discontinued. This notice is called the *Notice of Medicare Provider Non-Coverage*. If you disagree with the healthcare provider's decision to discontinue services, you or your representative can contact KFMC and

ask for an appeal. KFMC is available seven days a week during business hours to receive requests for appeals. After the appeal request, KFMC will immediately notify the provider and examine medical and other records pertaining to the services in question.

You will continue to receive Medicare covered services until the date/time designated on the termination notice unless KFMC reverses the provider's service termination decision.

KFMC will make a decision within 72 hours on whether ending Medicare coverage is the correct choice.

KFMC would notify you and your provider of our decision, give you the reason we made the decision, and explain the Medicare payment consequences and the date you become fully liable for services. If you don't agree that Medicare should stop covering your care, the notice explains how you can request another opinion.

You can learn more about this expedited appeal process and the Notice of Medicare Provider Non-Coverage by logging on to the CMS website at www.cms.hhs.gov/medicare/bni. The detailed notice, along with instructions on the appeal process are located here.

You can also call 1-800-MEDICARE (1-800-633-4227), TTY/TTD 1-800-766-3777, or contact the KFMC Case Review Team at 1-800-432-0407.

Be sure and share this information with your family!

**Medicare Consumer Rights Toll-Free Help Line
1-800-432-0407**



Don't Get Bit

[continued from page 1](#)

It is recommended that everyone over age 50 and all individuals who have chronic illnesses (such as diabetes, asthma, heart and lung disorders) or weakened immune systems should receive an annual influenza vaccination. Those persons over age 65 should receive a one-time dose of the pneumonia vaccine.

For those with Medicare Part B,

Medicare pays for an annual flu vaccination. There is no coinsurance and no Part B deductible for flu and pneumonia immunizations, if the doctor accepts assignment.

Even if you've never had the flu before, if you're 50 or older or have a chronic illness, you're at risk. Don't take any chances. Get vaccinated and protect yourself!



Medicare to Help Kick Habit

It's hard to quit smoking and the longer you've been a smoker, the harder it is to quit. The Centers for Medicare & Medicaid Services (CMS) wants to give people with Medicare who smoke and have smoke-related illnesses some special help to quit smoking.

If you are a Medicare beneficiary who has an illness caused by or made worse by tobacco use, Medicare now covers smoking and tobacco-use cessation counseling when prescribed by your physician. Heart and lung disease, blood clots, and weak bones are among the illnesses covered by this change.

CMS says that millions of Medicare beneficiaries have smoked for many years and are now affected by heart problems, breathing problems and other serious diseases that smoking can cause. CMS urges smokers with Medicare who are just starting to have heart or lung problems or high blood pressure to take advantage of this new step. When Medicare's new prescription drug benefit begins in 2006, smoking cessation treatments that are prescribed by a physician will be covered.

If you smoke and have a smoke-related illness, ask your doctor if you qualify for this new benefit.



To Your Health is a free, quarterly publication provided by the Kansas Foundation for Medical Care, Inc. If you, or someone you know, would like to receive this newsletter by email, please contact:

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