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Staff Editor
Kiara Carchi

REMINDER! We are changing our CRIER name to **WCAAA Insider** – look for the new newsletter including new format beginning in October. Also, check out our new web-site – www.wcaaa.org. As always, we would love to hear from you and receive your feedback. Thank you!



The CT Partnership for Long-Term Care Insurance

According to the State of Ct. Office of Policy and Management, the average cost per day for Long Term Care (typically a Nursing Home stay) in Connecticut in 2017 was \$422.49 per day, a 2% increase from the year before. These costs have increased by an average of 2% over the last 5 years. In the past, most people relied on Medicaid to pay for this care, but an increasing number of people are turning to Long Term Care Insurance to meet their needs.

Connecticut instituted The State of Ct. Partnership for Long Term Care which is an alliance between the State and private insurance industry. It creates an option that lets you pay for Long Term Care without depleting all of your assets. Partnership policies carry a special endorsement from the State for meeting additional consumer protection standards. Partnership Policies also provide special guarantees that other Long-Term Care policies do not.

For instance, you are usually only allowed to keep only \$1600 in assets when you apply for Ct. Medicaid Long Term Care benefits. Under the Ct. Partnership Program, you are allowed to keep assets equal to the amount of your benefits. Partnership Policies guarantee a minimum daily benefit. Also, Partnership Policies automatically increase at a compound rate of 3.5% per year up to age 65 to account for inflation. Additional inflation protection is available depending on the policy that you purchase. Policy holders are also guaranteed to receive a 5% discount on nursing facility rates in Ct.

Here's an example of how a Ct. Partnership policy might work: An age 55 person buys a policy with 5% compound inflation protection. This person pays premiums totaling \$75,300 over the next 30 years. By age 85, the policy would provide \$820,300 worth of benefits, due to 30 years of 5% compounded inflation protection. If the person then needed long term care, the policy would pay benefits up to this amount. If the benefits were exhausted, the person could then apply for Medicaid. However, instead of the usual \$1600 asset limit (may change annually), the person would be allowed to keep assets in the amount of \$820,300. Buying at age 55 instead of waiting until later results in lower lifetime premiums and greater overall benefit amounts. If an age 75 person wanted to purchase a policy that would provide him or her with the same benefits at age 85 as the age 55 person in this example, he or she would have to purchase a \$690 daily benefit to start at an annual premium of \$26,358 or \$263,580 over 10 years.

The Ct. Partnership's consumer information service provides free publications, speakers or groups and trained staff to answer questions. Call 1-800-547-3443, or visit CT.gov/OPM, CT. Partnership link.

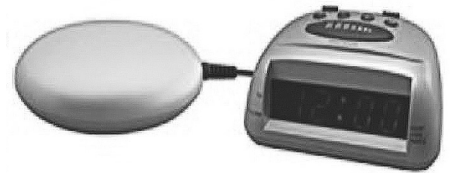
Article by Bill Shugrue-WCAAA Staff

Source: [Ct.gov. \(OPM\)-aging/basics-of-evidence-based-programs/about-evidence-based-programs/](http://Ct.gov.(OPM)-aging/basics-of-evidence-based-programs/about-evidence-based-programs/)

Assistive Technology Center: Gadgets & Gizmos To Make your Life Easier

The WCAAA Tech Center provides free, personalized or group demonstrations of assistive devices such as magnifiers, smart pens, ipads, phone amplifiers, vibrating alarm clock and talking watch, to name a few.

Do you have trouble getting up in the morning? Do you have trouble hearing the alarm clock? Then this month's featured device may work for you. It is the **360 Global Alarm Clock with Bed Shaker**. Wake up to an audible alarm (soft or loud), vibration (bed shaker included) or a combination of both. Connect the 12 volt bed shaker to the "GLOBAL 360" and place it under your mattress or pillow. When the alarm time is activated or the Countdown Timer reaches zero, Strong Pulse vibrations are sure to awaken you. This unique Alarm Clock can be programmed to give you alerts as often as you need them. Set the Auto Repeat Countdown Timer to wake you up or remind you day or night.



Don't miss another call! **Krown's Amplified Ringer with Strobe Light** It monitors your phone line for incoming calls. A thoughtful gift, also ideal for warehouse, factory or any noisy environment. When receiving a call, the Ringer Amplifier with Strobe Light will alert you with a amplified ringer, and bright flashing strobe light. Features: Adjustable ringer, up to 120 dB Ringer operated by line power Ringer hi/mid/low switch Powerful strobe light Tone control hi/low switch Line triggered strobe light AC Adapter included - output 6V/1000MA Easy Installation Wall mountable 3 AA batteries required for backup, not included 1 year Manufacturer's Warranty

Talking Big Button Braille Phone. This phone has many features. Amplifies incoming sounds up to 37 decibels * Extra-large Braille buttons with Electronic Voice repeats each number as it is dialed * Three programmable one-touch emergency buttons with Braille characters and 10 Memory buttons * Record customer voice announcements for the number buttons, memory buttons and emergency buttons * Adjustable incoming volume and tone controls * Extra Loud ringer * Bright visual ringer, missed call and voicemail indicator * Ringer pitch and volume controls * Redial, Flash, Hold and Program functions * Tone/Pulse switch * Desk or wall mount option * Hearing Aid and T-Coil compatible.



Please call Charlene @203-757-5449 ext. 101 to make an appointment for a presentation or email cwicks@wcaaa.org

Keep Healthy Financial Habits with *my* Social Security



It is a perfect time to focus on awareness, prevention, education, and family. Social Security encourages you to support people everywhere in their efforts to stay healthy. Part of staying healthy and happy is re-

ducing the amount of stress in your life. That's where opening a *my* Social Security online account can help. Our online services make doing business with Social Security Administration fast and easy.

With a *my* Social Security account, you can:

- Keep track of your earnings and verify them

every year;

- Get an estimate of your future benefits, if you are still working;
- Get a letter with proof of your benefits, if you currently receive them;
- Manage your benefits, like changing your address, your direct deposit. Request a replacement Medicare card; & get a replacement SSA-1099 or SSA-1042S for tax season.

Visit www.socialsecurity.gov/myaccount to learn about the healthy number of features they have to offer.



How Can I Get a Hospital Bed Covered by Medicare?

Dear Marci:
How can I get a hospital bed covered by Medicare?
- Jack (Portland, ME)

Dear Jack,
Hospital beds are covered by Medicare as Durable Medical Equipment (DME). In order to get Medicare to cover your DME, whether you have Original Medicare or a Medicare Advantage Plan, you must meet the following two conditions:

Your doctor or primary care provider (PCP) must sign an order, prescription, or certificate after a face-to-face visit.

In this document, your PCP must state that the required office visit occurred, that you need the hospital bed to help a medical condition or injury, and that the equipment is for home use. Your face-to-face visit must take place no more than six months before the prescription is written.

Once you have your doctor or PCP's order or prescription, you must take it to the right supplier to get coverage. Be sure to only use suppliers with approval from Original Medicare or your Medicare Advantage Plan.

If you have Original Medicare, the type of supplier you use depends on where you live and the type of equipment you need.

If you live in a competitive bidding area, Original Medicare only covers certain DME items from a select group of suppliers, known as contract supplier. Competitive bidding is a program designed to lower DME costs and improve DME quality in certain parts of the country.

If you do not live in a competitive bidding area, or the item you need is not part of the program, you should get your DME from a Medicare-approved supplier that takes assignment. Taking assignment

means that the provider accepts Medicare's approved amount as full payment. For many Medicare-covered services, providers can only charge up to 15% above the Medicare-approved amount, this is known as the limiting charge. DME is not subject to a limiting charge, so if you get your hospital bed from a supplier who does not take assignment, the supplier could bill you for the entire balance of your item in excess of Medicare's approved amount.

You can call 1-800-MEDICARE to learn if you are affected by the competitive bidding program and to find a contract supplier or supplier who takes assignment.

If you have a Medicare Advantage Plan, you must follow the plan's rules for getting DME. Your plan may require that you:

- Receive approval from the plan before getting your hospital bed
- Use a supplier in the plan's network of suppliers
- You may get little or no coverage if you use an out-of-network supplier.
- Use a preferred brand
- You may pay a higher cost when using a non-preferred brand.

People with Medicare Advantage Plans are not affected by competitive bidding. Contact your plan to learn more about its DME coverage rules before ordering your DME.

-Marci

Dear Marci is a biweekly e-newsletter designed to keep you—people with Medicare, social workers, health care providers and other professionals—in the loop about health care benefits, rights and options for older Americans and people with disabilities. "This information is republished with the permission from the Medicare Rights Center. For more info visit source www.medicarerights.org." On the internet: The URL is www.medicareinteractive.org.

DRINKING ENOUGH FLUIDS



It's important for your body to have plenty of fluids each day. Water helps you digest your food, absorb nutrients, and then get rid of the unused waste. With age, some people may lose their sense of thirst. To further complicate matters, some medicines might make it even more important to have plenty of fluids.

Drinking enough fluids every day also is essential if you exercise regularly. Check with your doctor, however, if you've been told to limit how much you drink.

Go4Life has the following tips:

- Try to add liquids throughout the day.
- Take sips from a glass of water, milk, or juice between bites during meals.
- Have a cup of low-fat soup as an afternoon snack.
- Drink a full glass of water if you need to take a pill.
- Have a glass of water before you exercise or go outside to garden or walk, especially on a hot day.
- Remember, water is a good way to add fluids to your daily routine without adding calories.
- Drink fat-free or low-fat milk, or other drinks without added sugars.
- If you drink alcoholic beverages, do so sensibly and in moderation. That means up to one drink per day for women and up to two drinks for men.
- Don't stop drinking liquids if you have a urinary control problem. Talk with your doctor about treatment.

Source: Go4life From the National Institute on Aging at NIH: <https://go4life.nia.nih.gov/>

WHAT ARE MEDICARE ADVANTAGE PLANS?

A Medicare Advantage Plan (like an HMO or PPO) is another way to get your Medicare coverage. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by Medicare-approved private companies that must follow rules set by Medicare. If you join a Medicare Advantage Plan, you’ll still have Medicare but you’ll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan, not Original Medicare. You’ll generally get your services from a plan’s network of providers.



Medicare Advantage Plans cover all Medicare Part A and Part B services. In all types of Medicare Advantage Plans, you’re always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the services that Original Medicare covers. However, if you’re in a Medicare Advantage Plan, Original Medicare will still cover the cost for hospice care, some new Medicare benefits, and some costs for clinical research studies. Most Medicare Advantage Plans offer extra coverage, like vision, hearing, dental, and other health and wellness programs. Most include Medicare prescription drug coverage (Part D). In addition to your Part B premium, you might have to pay a monthly premium for the Medicare Advantage Plan.

Medicare Advantage Plans Must Follow Medicare’s Rules: Medicare pays a fixed amount for your coverage each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to doctors, facilities, or suppliers that belong to the plan’s network for non-emergency or non-urgent care). These rules can change each year. The plan must notify you about any changes before the start of the next enrollment year. Remember, you have the option each year to keep your current plan, choose a different plan, or switch to Original Medicare.

Read the Information You Get From Your Plan If you’re in a Medicare Advantage Plan, review the “Evidence of Coverage” (EOC) and “Annual Notice of Change” (ANOC) your plan sends you each year. The EOC gives you details about what the plan covers, how much you pay, and more. The ANOC includes any changes in coverage, costs, provider networks, service area, and more that will be effective in January. If you don’t get these important documents before the start of Open Enrollment, contact your plan.

What else should I know about Medicare Advantage Plans?

- You have Medicare rights and protections, including the right to appeal.
- You can check with the plan before you get a service to find out if it’s covered and what your costs may be.
- You must follow plan rules. It’s important to check with the plan for information about your rights and responsibilities.
- If you go to a doctor, other health care provider, facility, or supplier that doesn’t belong to the plan’s network for non-emergency or non-urgent care services, your services may not be covered, or your costs could be higher. In most cases, this applies to Medicare Advantage HMOs and PPOs.
- Providers can join or leave a plan’s provider network anytime during the year. Your plan can also change the providers in the network anytime during the year. If this happens, you may need to choose a new provider. You generally can’t change plans during the year if this happens.
- Plans may include fitness and wellness benefits.
- Medicare Advantage Plans can’t charge more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility care.
- Medicare Advantage Plans have a yearly limit on your out-of-pocket costs for medical services. Once you reach this limit, you’ll pay nothing for covered services. Each plan can have a different limit, and the limit can change each year. You should consider this when choosing a plan.

Prescription Drug Coverage: You usually get prescription drug coverage (Part D) through the Medicare Advantage Plan. In certain types of plans that can’t offer drug coverage (like MSA plans) or choose not to offer (like some PFFS plans) drug coverage, you can join a separate Medicare Prescription Drug Plan. If you’re in a Medicare Advantage HMO or PPO, and you join a separate Medicare Prescription Drug Plan, you’ll be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.

Who can join? You must meet these conditions to join a Medicare Advantage Plan:

- You have Part A and Part B.
- You live in the plan’s service area.
- You don’t have End-Stage Renal Disease (ESRD).
- You’re a U.S. citizen or lawfully present in the United States.

Source: Medicare and You Book 2018 <https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf>



The Opioid Epidemic

We've all heard about the opioid epidemic across the U.S., but not everyone knows what opioids are and what steps are being taken to combat this crisis. Opioids are described as a class of drug that is used to reduce pain. Examples of opioids include; oxycodone, morphine, and methadone. A research by Centers for Medicare and Medicaid Services (CMS) found that opioids killed more than 42,000 people in 2016 and 40% of deaths due to opioid overdose involved a prescription opioid. The research also showed that three out of four people who used heroin misused prescription opioids first. Since CMS is one of the largest payers of healthcare services, it has begun to take steps towards addressing the opioid epidemic. CMS is currently combating the opioid crisis through prevention, treatment, and data collection.

Prevention: It is always best to address a problem before it begins. CMS is pushing providers to manage pain by first offering safer alternatives before prescribing opioids. Incentives will be put in place for providers who practice safe and appropriate prescribing. Monitoring of systemic overprescribing will also be enforced, and CMS hopes to partner with law enforcements to stop egregious prescribers.

Treatment: For people who have already developed an opioid disorder, there are some resources to help treat dependency. Call the State of Connecticut Department of Mental Health and Addiction Services' (DMHAS) access line at 1-800-563-4086. Computer users can access more information through the DMHAS website at ct.gov/DMHAS. For more information and general questions please call the CHOICES Department at Western CT Area Agency on Aging at (203)757-5449.

Article by: Jose L. C. Maposito—WCAAA Staff

Sources: CDC: <https://www.cdc.gov/drugoverdose/data/index.html> / HHS: <https://www.hhs.gov/opioids/about-the-epidemic/index.html> / SAMHSA: https://www.samhsa.gov/sites/default/files/aatod_2018_final.pdf

Will Medicare cover a power wheelchair?

Visit your doctor: To find out if your power wheelchair will be covered by Medicare, you must first visit your doctor. It is important to visit your doctor up to 45 days before placing an order for a power wheelchair because your doctor's prescription or signed order will help determine if Medicare will cover this durable medical equipment. Your doctor must first determine if a power wheelchair is a medical necessity for you by assessing the following:

- If you struggle to move around your home due to your health conditions, even with the use of a cane or a walker.
- If you struggle with daily living activities such as; getting to the toilet, getting in and out of bed, dressing and/or bathing.
- If you are unable to use a manual wheelchair or scooter, but can safely use a power wheelchair.

If your doctor found all the above conditions to be true, he/she must indicate so in a signed order or prescription.

Ordering a power wheelchair: Take your doctor's order or prescription to the right supplier, otherwise your power wheelchair will not be covered by Medicare. Since Connecticut is considered a "competitive bidding area," Original Medicare will only cover an order if it is placed from a select group of suppliers known as contract suppliers. To find out who the right suppliers are, you can contact our agency at (203)757-5449 and speak with a CHOICES counselor or you may also find a full list of contract suppliers online at: www.medicare.gov/supplierdirectory/search.html. Keep in mind that Medicare Part B will only cover 80% of the amount they approve for the power wheelchair and you will be responsible for the remaining 20%, as long as you have already met your yearly deductible. If you are on a Medicare Advantage plan (Medicare Part C), you must follow your plans guidelines regarding how to obtain a power wheelchair. Most Medicare Advantage plans have preferred brands of power wheelchairs that you will need to order from to be covered by your plan. Please call your Advantage plan to find out how to obtain a power wheelchair and if you will be responsible for any cost sharing.

It is important to keep in mind that Medicare will not cover a Durable Medical Equipment under the same category within five years of a previous order. For example; if you have ordered a scooter, there will be a minimum of a five year wait time before you can order a Medicare covered scooter, power wheelchair or any other DME within the same category. If there is another DME you need, that is not in the same category, you may order it just as long as your doctor finds it to be medically necessary. You should also consider renting your DME as you take into account whether your health condition or disability is long or short term.



Article by: Jose L. C. Maposito—WCAAA Staff

Source: <https://www.medicare.gov/Pubs/pdf/11046-Medicare-Wheelchair-Scooter.pdf>

Medicare is Age 52; are Major Changes Coming?



Medicare was signed into law in July 1965. While Medicare benefits have certainly changed in the last 53 years, we see more changes being proposed. The reasons? The number of

Medicare eligible beneficiaries has increased dramatically as we live longer (the number of eligible individuals is projected to almost double). Health care costs are increasing in total and by type of service as more prescription drugs, medical equipment, and related services are approved for coverage. We've read about raising the eligibility age to 67, changing Medicare to a voucher system, expanding coverage to more individuals, and allowing states to conduct more pilot coverage programs though "waivers." Since we are approaching election time, it might

be important to ask some of the questions below:

- Do you believe that Medicare should be cut to reduce the Federal budget and if so, how?
- What are your priorities in the Federal budget?
- Do you believe that Medicare should be converted to a voucher program and how could this work?
- Would you support a sliding fee scale or means testing?
- Are you in favor of including hearing, vision, and dental care as Medicare covered benefits and at what level?
- Would you be agreeable to an asset test with eligibility benchmarks?
- Are there safeguards to be instituted on Durable Medical Equipment to reduce costs?

Article by: Mary A. Moran-WCAAA Staff.

Medicare Open Enrollment October 15-December 7, 2018

Did you know that you are not permanently "locked-in" to your current Medicare prescription plan, or your Medicare Advantage plan? During every Medicare Open Enrollment Period, Medicare beneficiaries can review their insurance benefits and make changes to their Medicare insurance coverage, effective for the following year. Open Enrollment is right around the corner- **beginning October 15, 2018 and ending December 7, 2018**. If you are currently experiencing issues with your Medicare insurance coverage, it may be time for you to consider scheduling an appointment with a WCAAA-CHOICES counselor, who can review your benefits and introduce you to options! The CHOICES department helps older adults and Medicare Beneficiaries understand current Medicare coverage and health care options, while also offering free and unbiased information (at your convenience).



Some reasons to consider changing your insurance coverage may include:

- A change in your prescription drug plan's formulary (ex. a prescription that was once covered by your plan is no longer covered),
- One of your favorite doctors/specialists is now out of network with your current insurance plan, or your health status has changed significantly since last year.

If you feel overwhelmed by high cost medications, high copays for doctor's appointments, or you consider that your current insurance coverage no longer meets your needs, there may be better options available to you, and the CHOICES team would love to help you find them. If you are interested in scheduling your Open Enrollment appointment, please call (203) 757-5449 to speak with a WCAAA CHOICES counselor.

Article by: Francesca Robles—WCAAA Staff

Source: "Medicare Open Enrollment." CMS.gov Centers for Medicare and Medicaid Services, 14 May 2018, www.cms.gov/Outreach-and-Education/Reach-Out/Find-tools-to-help-you-help-others/Medicare-Open-Enrollment.html.

Medicare Coverage for In-Home Health Needs

Many Medicare beneficiaries run into confusion and difficulties obtaining in-home health services following a hospital discharge or a change in their medical needs. In many cases, this is due to beneficiaries having misinformation about Medicare insurance coverage. If a service is deemed medically necessary, Medicare covers up to 80% of the costs- but how does it work?

Both Medicare Part A-Hospital and Part B-Medical insurance covers home health services like Part-time or intermittent skilled nursing care, Part-time or intermittent home health aide care, Physical therapy, Occupational therapy, and Speech-language pathology services.

To qualify for home-health coverage, your physician must have signed your plan of care, you must be homebound, you must need skilled nursing on an intermittent basis, or physical/speech therapy, and the care must be provided by a Medicare-certified home health agency. When individuals hear the term “Homebound”, the assumption is that the individual must be “bedbound” or unable to leave their home for any reason. This is not true. Medicare defines “Homebound” as an individual who has trouble leaving their home without help of a wheelchair, walker, cane, special transportation, or the help of another person. Someone who is homebound can leave their home for medical treatment, and/or infrequent non-medical reasons like attending church services, for example.

Now, what about getting insurance coverage to help you with personal care? Medicare will not cover custodial care or personal care needs (like bathing, dressing, mobility, transfer and meal preparation) if it's the only assistance that you need. However, your physician can request personal care assistance/custodial care to be covered by Medicare if the services are paired with an abovementioned medically necessary home health service. This means that if you are currently enrolled in Medicare Part A-Hospital and Medicare Part B-Medical coverage and you require in home services like skilled nursing care, and need help with executing your daily living activities, your Medicare insurance can provide you with coverage to meet your needs!

If you have questions about Home Health coverage through Medicare, and would like to learn more, please call the **WCAAA's CHOICES Program at (203) 757-5449 extension 134.**

Article by: Francesca Robles—WCAAA Staff

Resources: “Your Medicare Coverage.” Medicare.gov - the Official U.S. Government Site for Medicare, www.medicare.gov/coverage/home-health-services.html. & “Center for Medicare Advocacy || Home Health Care.” Center for Medicare Advocacy, www.medicareadvocacy.org/medicare-info/home-health-care/.



The Donut Hole

One key point that is based on the Bipartisan Budget Act of 2018 (BBA) enacted in February 2018 is that the brand-name Donut Hole discount will increase to 75% in 2019. The pharmaceutical industry will be responsible for 70% of this 75% Donut Hole discount, with your Medicare part D plan covering the remaining 5%. So, if your monthly retail drug costs are over \$318, you will reach the 2019 Donut Hole, pay 25% of retail brand-name drug prices, and get 95% of the brand-name retail drug cost credited to your out-of-pocket spending limit (or TrOOP). And this means you may exit the 2019 Donut Hole faster than you expected and enter Catastrophic Coverage. Based on historical drug purchasing, CMS estimates that if you have monthly retail drug costs over \$678, you will exit the 2019 Donut Hole. The 2019 generic drug Donut Hole discount has not changed.



Article by: Darylle Willenbrock –WCAAA Staff
Source: Q1 Medicare.com/2019



What is Time-Limited Equitable Relief?

Dear Marci,

I turned 65 a while ago and I didn't enroll in Medicare Part B. I instead kept my Marketplace plan. How can I enroll in Medicare?

– Noah (Portland, OR)

Dear Noah,

In general, if you do not enroll in Medicare during your Initial Enrollment Period (IEP), you must wait for the General Enrollment Period (GEP) to sign up for Medicare. The GEP runs January 1 through March 31 of each year, and if you enroll during this period, your Medicare benefits will start on July 1. This means that you may experience gaps in coverage. You will also likely have a late enrollment penalty for not signing up for Medicare when you were first eligible.

You will likely have to use the GEP to enroll in Medicare if (a) you kept your Marketplace plan and did not enroll in Medicare when you were first eligible, or (b) you enrolled in premium-free Part A and kept your Marketplace plan when you became eligible for Medicare. You will likely have to use the GEP to enroll in Medicare Part B.

Currently, you may be able to request time-limited equitable relief to enroll in Part B outside of the GEP. Time-limited equitable relief is a process you can use to enroll in Part B and/or eliminate a Part B late enrollment penalty (LEP). You may be eligible to request time-limited equitable relief if you delayed Medicare Part B enrollment while you had a Marketplace plan. For example, maybe you enrolled in Medicare Part A and declined Part B when you first became eligible for Medicare because your Marketplace plan with cost assistance was cheaper than Part B. You may not have realized that you were supposed to sign up for Medicare and that you would lose your cost assistance because of your Medicare eligibility. In some instances, you may have continued to receive cost assistance even after enrolling in Part A. In other situations, you may have faced Marketplace plan coverage problems once your plan realized that Medicare should be covering costs. For example, the Marketplace plan may have stopped paying primary for your health costs.

Time-limited equitable relief is a limited process that allows you to either (a) enroll in Medicare Part B without penalty, or (b) eliminate or reduce your Part B LEP if you are already enrolled in Part B but had delayed enrollment when you had a Marketplace plan.

In order to qualify for time-limited equitable relief, you must be enrolled in premium-free Part A and (a) have an Initial Enrollment Period (IEP) that began April 1, 2013 or later, or (b) have been notified of retroactive premium-free Part A on October 1, 2013, or later.

To request time-limited equitable relief you will need to contact the Social Security Administration or visit a local Social Security office and ask to use time-limited equitable relief to enroll in Part B and/or eliminate your Part B LEP. You should bring proof that you are enrolled in a Marketplace plan, like a recent premium bill. If you received a letter about being enrolled in Medicare and a Marketplace plan, you can also bring that letter as proof. The opportunity to request time-limited equitable relief lasts until September 30, 2017.

Noah, if you think you are eligible to use time-limited equitable relief, please contact the Medicare Rights Center's national helpline at 800-333-4114 for further assistance.

– Marci

Dear Marci is a biweekly e-newsletter designed to keep you—people with Medicare, social workers, health care providers and other professionals—in the loop about health care benefits, rights and options for older Americans and people with disabilities. "This information is republished with the permission from the Medicare Rights Center. For more info visit source www.medicarerights.org." On the internet: The URL is www.medicareinteractive.org.



Get your Medicare Summary Notices electronically

Go paperless and get your "Medicare Summary Notices" electronically (also called "eMSNs"). You can sign up by visiting MyMedicare.gov. If you sign up for eMSNs, we'll send you an email each month when they're available in your MyMedicare.gov account.

The eMSNs contain the same information as paper MSNs. You won't get printed copies of your MSNs in the mail if you choose eMSNs.

Source: Medicare and You Book 2018

<https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf>

Safe Disposal of Medications

Do you find yourself not knowing what to do with unused medications? According to the Substance Abuse and Mental Health Services Administration (SAMHSA); Americans fill over 4 billion prescriptions each year, but up to 40% of those drugs go unused. That is about 200 million pounds of prescribed medications!



It is recommended that all expired, unwanted or unused medications should be thrown away immediately to avoid confusion, and to minimize the risk of those drugs getting into the wrong hands. However, unwanted medication **should not be flushed down the toilet or sink!** And here is why: Sewage treatment systems cannot remove all the medications from the water released into lakes, rivers or oceans. Research has shown that continuous exposure to low levels of medications has altered the behavior and physiology of fish and aquatic organisms that are later consumed by the population.

The SAMHSA offers the two following safer ways to dispose unwanted medications:

1. **Medication “Take-Back” Program:** This program allows you to bring unused drugs to a central location for proper disposal. The CT Department of Consumer Protection has taken the initiative to place “Prescription Drug Drop Boxes” at local police departments. You can contact your local law enforcement officials to find a Drug Enforcement Administration (DEA) -authorized collector in your community. You can also contact the Prescription Monitoring Program at (860) 713-6073; or visit the household drug take back program at <https://portal.ct.gov/DCP/Drug-Control-Division/Drug-Control/Local-Drug-Collection-Boxes>, to find out if there is an event taking place near you. Inquiring about this program with your pharmacist is also a good idea. Some pharmacies have mail-back programs and disposal kiosks for unused medicines. Furthermore, some communities join the “National Prescription Drug Take Back Day.” This is a nationwide event held twice-a year, where people can take their old medicines and dispose them in an environmentally safe way. You can always call the DEA’s Registration Call Center to find box locations or other disposal sites at 1-800-882-9539 or go to <https://nabp.pharmacy/initiatives/awarxe/drug-disposal-locator/> or www.deadiversion.usdoj.gov/drug_disposal/index.html.
2. **Disposal in Household Trash:** If the Medication Take-Back Program is not available in your area; and there are no specific disposal instructions in the product package insert, the U.S. Food & Drug Administration suggests that you dispose your unused medicine in your household trash following these three simple steps:
 - A) Remove them from their original containers and conceal or remove any personal information, including the Rx number from the container to protect your identity and privacy.
 - B) Remove the drugs from their original containers and mix them with something undesirable/inedible; such as coffee grounds, dirt, or cat litter. This will make the disposed medicine unrecognizable to someone who might intentionally go through the trash looking for drugs. It will also be less appealing to children and/or pets.
 - C) Place the mixture in something you can close (a re-sealable zipper storage bag, empty can, or other container) to prevent the drug from leaking or spilling out.

Article by: Kiara Carchi-WCAAA staff.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA): <https://store.samhsa.gov/shin/content/SMA17-5053-10/SMA17-5053-10.pdf>, Connecticut State Department of Consumer Protection: <https://portal.ct.gov/DCP/Prescription-Monitoring-Program/Proper-Disposal-of-Prescription-Drugs>, CT Department of Energy and Environmental Protection <http://www.ct.gov/deep/cwp/view.asp?a=2718&q=437868> and the U.S. Drug Enforcement Administration: https://www.deadiversion.usdoj.gov/drug_disposal/index.html.

Medicare Advantage Open Enrollment Period



In 2019, we will no longer have the Medicare Advantage Disenrollment Period (MAPD) that started on January 1st and continued through February 14th. **Instead, we will return to the Medicare Advantage Open Enrollment Period (OEP) starting on January 1st and ending on March 31st.** This Open Enrollment Period (OEP) will allow people “enrolled” in an MA plan, including newly MA-eligible individuals, to make a one-time election to go to another (Medicare Advantage) plan – or to leave their Medicare Advantage plan, join a stand-alone Medicare Part D plan and return to Medicare A and B. An example of this would be if an individual had enrolled in a MA-PD plan and decided to use the OEP as an opportunity to switch to 1) Another MA-PD; 2) An MA only plan; or 3) Original Medicare with or without a PDP. The OEP will also allow an individual enrolled in an MA-only plan to switch to 1) Another MA-only plan; 2) an MA-PD plan; or 3) Original Medicare with or without a PDP. This enrollment period **does not** allow for Part D changes for individuals enrolled in Original Medicare.

Article by: Darylle Willenbrock– WCAAA Staff

Source: Q1 Medicare.com/2019

Understanding Medicare Coverage of Outpatient Therapy.

Medicare Part B covers outpatient therapy, including physical therapy, speech-language pathology, and occupational therapy.

If a beneficiary meets Medicare's eligibility requirements, Medicare covers therapy on a temporary basis to improve or restore their ability to function or on an ongoing basis to prevent their condition from getting worse. Medicare should cover outpatient therapy regardless of whether a beneficiary's condition is temporary or ongoing (chronic).

Outpatient therapy includes therapy received:

- At therapists' or doctors' offices
- At comprehensive outpatient rehabilitation facilities (CORFs)
- At skilled nursing facilities (SNFs) when beneficiaries are there as outpatients or are otherwise ineligible for Medicare Part A-covered stays
- At home through therapists connected with home health agencies when beneficiaries are ineligible for Medicare's home health benefit.

Medicare's coverage rules for outpatient therapy do not apply if a beneficiary is receiving therapy as part of a Medicare-covered SNF stay or if they are receiving Medicare-covered home health care.

Outpatient Therapy Costs

In the past, there was a dollar limit, also known as the therapy cap, on how much outpatient therapy Original Medicare covered annually. However, this year, the therapy cap was removed. This means that a beneficiary and their doctor no longer have to appeal for an exception once the beneficiary meets the old therapy cap amount.

Although the therapy cap has been eliminated, Medicare still requires providers to confirm that continued therapy is medically necessary once outpatient therapy costs meet a certain amount. A beneficiary's provider will need to use the proper code (known as the KX modifier) to bill Medicare for covered therapy beyond the threshold. The provider should also keep all medical documentation in case of an audit.

In 2018, Original Medicare covers up to:

- \$2,010 for physical therapy and speech-language pathology before requiring the provider to indicate that continued therapy is medically necessary
- \$2,010 for occupational therapy before requiring the provider to indicate that continued therapy is medically necessary.

Original Medicare covers outpatient therapy at 80 percent of the Medicare-approved amount. When a beneficiary with Original Medicare receives services from a participating provider (one who accepts Medicare and the Medicare-approved amount for services as full payment), the beneficiary pays a 20 percent coinsurance after they meet the Part B deductible (\$183 in 2018).

Since Medicare pays for up to 80 percent of the Medicare-approved amount for services, this means that Original Medicare covers up to \$1,608 (80 percent of \$2,010) before a beneficiary's provider is required to confirm that continued outpatient therapy services are medically necessary. If Medicare denies coverage because it finds that care is not medically necessary, the beneficiary can appeal.



Here to Help

SHIP counselors can help beneficiaries understand Medicare coverage rules for outpatient therapy and appeal if Medicare denies coverage. Counselors can also supply information to providers who may not be aware of policy changes or what they need to do to bill Medicare for outpatient therapy beyond the threshold amount.

Source: SHIP Watch, July 2018 \ SHIP NATIONAL TECHNICAL ASSISTANCE CENTER | www.shiptacenter.org. Author: Emily Whicheloe, Education Coordinator, Medicare Rights Center and SHIP TA Center. <https://shiptacenter.org/media/4243/whicheloe-costs-july-18.pdf>

To Live a Healthy Life in my 60's, 70's, 80's and 90's :

It is always a good time to make your health and priority and build positive health habits for life. You can start by reading this checklist below and choose to take one or all, of the steps on the list. You can also use your checklist to get the conversation started at your next wellness visit.

Why Should I Follow the Steps on my Checklist? These steps are the foundation for good health at every age.

Every Day I Will Try To:	
<input type="checkbox"/> Eat Healthy.	<input type="checkbox"/> Limit alcohol use to one drink or less.
<input type="checkbox"/> Get at least 30 minutes of physical activity. -Talk to my doctor about any limiting chronic conditions.	<input type="checkbox"/> Wear a helmet when riding a bike and wear protective gear for sports.
<input type="checkbox"/> Get at least 7 to 8 hours of sleep.	<input type="checkbox"/> Wear a seatbelt in cars and not text and drive.
<input type="checkbox"/> Reach and maintain a healthy weight.	<input type="checkbox"/> Not use illegal drugs or misuse prescription drugs.
<input type="checkbox"/> Get help to quit or don't start smoking.	

Talk to My Doctor at Least Once a Year About:	
<input type="checkbox"/> My weight, height, diet, and physical activity level.	<input type="checkbox"/> Depression and any other mental health concerns
<input type="checkbox"/> My Tobacco and alcohol use	<input type="checkbox"/> Who will make health care decisions for me if I am unable to.
<input type="checkbox"/> Any violence in my life Wear a seatbelt in cars and not text and drive.	

Ask if I Need These Tests, Medicines, or Vaccines This Year:			
<input type="checkbox"/> Low-dose aspirin (70 and younger)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mammogram	<input type="checkbox"/> Sexually Transmitted infections
<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Flu	<input type="checkbox"/> Osteoporosis (65 and older)	<input type="checkbox"/> Tetanus, diphtheria or whooping cough
<input type="checkbox"/> Chickenpox.	<input type="checkbox"/> Hepatitis B & C	<input type="checkbox"/> Pap and HPV (65 and younger)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> HIV	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Shingles
<input type="checkbox"/> Colorectal Cancer	<input type="checkbox"/> Lung Cancer		

*The decision to get any medical test or procedure is a personal one between you and your doctor, at any age. These age ranges are suggested by the U.S. Preventive Services Task Force recommendations and may not apply to every person. These guidelines are based on recommendations from the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, the Women's Preventive Services Guidelines, the 2015–2020 Dietary Guidelines for Americans, and the 2008 Physical Activity Guidelines for Americans.

Source: Office on Women's Health

https://www.womenshealth.gov/files/documents/nwhw-2018_checklist-60s.pdf

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