OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

SHIBA July CE
MA HMO & PPO workbook

July, 2024

Statewide Health Insurance Benefits Advisors (SHIBA)

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Message from the SHIBA program team

Dear Volunteers,

As we continue our journey in making a positive Medicare counseling impact, it is essential to equip ourselves with the necessary knowledge and skills. The case scenario and activities included in this workbook aim to enhance your effectiveness as Medicare counselors.

Please take the time to engage with the content, reflect on the case, and make notes on the slide discussions. We encourage you to discuss your thoughts with fellow volunteers during our upcoming sessions.

Thank you for your commitment to making a positive impact, and we hope you find this workbook beneficial in your journey of continuous learning.

Your dedication and efforts contribute significantly to our mission. Thank you for being an essential part of our team.

Best regards,

SHIBA team

Learning objective

By the end of this session, you will be able to effectively explain the key differences between HMO and PPO plans, including network restrictions, provider choice flexibility, referral requirements, and cost implications.

Medicare Advantage: PPO vs HMO

Medicare Advantage plans, also known as Medicare Part C, provide an alternative way for Medicare beneficiaries to receive their Medicare benefits through private insurance plans.

Two common types of Medicare Advantage plans are:

- Health Maintenance Organization (HMO) and
- Preferred Provider Organization (PPO) plans.

Here are the key differences between HMO and PPO Medicare Advantage plans:

Network Structure

HMO

- **Primary Care Physician (PCP):** HMO plans typically require beneficiaries to choose a primary care physician (PCP) from within the plan's network.
- **Referrals:** In most cases, beneficiaries need a referral from their PCP to see a specialist.
- **Network restrictions:** HMO plans usually have strict network restrictions, and services received outside the network may not be covered except in emergencies.

PPO

- **No PCP requirement:** PPO plans do not always require beneficiaries to choose a primary care physician, and they can see any healthcare provider, both in and out of the plan's network.
- **Referrals not required:** PPO plans typically do not require referrals to see specialists.

- **Flexibility:** PPO plans offer more flexibility in choosing healthcare providers, even those outside the plan's network, although the costs may be higher.

Coverage and cost sharing

HMO

- **Predictable costs:** HMO plans often have lower out-of-pocket costs and predictable copayments for in-network services. There is a maximum out-of-pocket (MOOP) limit that is set by the plan, not to exceed the yearly limit (in 2024, $8,850).
- **Limited coverage out of network:** Coverage for services obtained outside the network may be limited, and beneficiaries may be responsible for a higher percentage of the costs.

PPO

- **Variable costs:** PPO plans may have a broader range of cost-sharing structures, with varying copayments and coinsurance for in-network and out-of-network services. In 2024, the MOOP for Medicare Advantage Plans is $8,850, but plans may set lower limits. PPO plan will set two annual MOOP limits. One limit is for in-network costs and the other is for combined in-network and out-of-network costs.
- **Higher costs out of network:** While beneficiaries can see out-of-network providers, they will typically pay more for such services.

Out-of-network coverage

HMO

- **Limited coverage:** HMO plans may not cover any out-of-network services except in emergencies or urgent situations.

PPO

- **Partial coverage:** PPO plans often provide partial coverage for out-of-network services, but beneficiaries will usually pay more compared to in-network services.

Geographic coverage

HMO

- **Local focus:** HMO plans often have a more localized or regional focus, making them suitable for individuals who primarily stay within a specific geographic area.

PPO

- **Broader network:** PPO plans may have a broader network that extends beyond a specific geographic area, making them more suitable for individuals who travel frequently or spend time in different locations.

Summary[1] of cost comparison: PPO vs. HMO Medicare Advantage plans

To help you understand the differences between PPO and HMO plans, we'll be using two specific plans offered in Thurston County as examples:

- Premera Blue Cross Medicare Advantage (HMO), Plan ID: H7245-001-0
- AARP Medicare Advantage from UHC WA-0002 (PPO), Plan ID: H1278-029-0

By comparing these two plans, you'll gain a clearer understanding of cost structure differences between HMO & PPO plans.

Monthly premiums

Both Plans: $0.00

Health deductible

Both Plans: $0.00

Drug plan deductible

PPO: $0.00

HMO: $160.00

Maximum out-of-pocket (MOOP) costs

PPO: $9,550 (In and Out-of-Network)

HMO: $6,300 (In-Network)

[1] For more detailed cost comparison between the AARP Medicare Advantage from UHC (PPO) and the Premera Blue Cross Medicare Advantage (HMO) plans please see Appendix C and individual plan details.

Health and drug premiums

Both Plans: $0.00

Part B premium

Both Plans: $174.70

Copays for services

Primary doctor visits

PPO: In-network: $0 copay | Out-of-network: $25 copay per visit

HMO: $5 copay per visit

Specialist visits

PPO: In-network: $0-45 copay per visit | Out-of-network: $65 copay per visit

HMO: $40 copay per visit

Diagnostic tests & procedures

PPO: In-network: $50 copay | Out-of-network: 30% coinsurance

HMO: $60 copay

Lab services

PPO: In-network: $0 copay | Out-of-network: $0 copay

HMO: $10 copay

Diagnostic radiology services (e.g., MRI)

PPO: In-network: $0-250 copay | Out-of-network: 30% coinsurance

HMO: $180 copay

Copays for services (cont.)

Outpatient X-rays

PPO: In-network: $15 copay | Out-of-network: $30 copay

HMO: $15 copay

Emergency care

PPO: $120 copay per visit (always covered)

HMO: $90 copay per visit (always covered)

Urgent care

PPO: $0-40 copay per visit (always covered)

HMO: $35 copay per visit (always covered)

Inpatient hospital coverage

PPO: In-network: $390 per day for days 1-5; $0 per day for days 6-90; $0 per day for days 91 and beyond

Out-of-network: $595 per day for days 1-17; $0 per day for days 18 and beyond

HMO: $450 per day for days 1-4; $0 per day for days 5-90

Outpatient hospital coverage

PPO: In-network: $0-390 copay per visit | Out-of-network: $595 copay per visit

HMO: $350 copay per visit

Preventive services

PPO: In-network: $0 copay | Out-of-network: 0-30% coinsurance

HMO: $0 copay

Additional benefits

Hearing aids

PPO: $99-$1249 copay (In-network and Out-of-network)

HMO: $0 copay (In-network)

Preventive dental (e.g., oral exams and cleanings)

PPO: $0 copay (In-network and Out-of-network)

HMO: $0 copay (In-network)

Comprehensive dental (e.g., root canal and implants)

Both Plans: Some coverage (See plan details)

Eyeglasses (frames & lenses)

PPO: $0 copay (In-network and Out-of-network)

HMO: $0 copay

Skilled nursing facility

PPO:

In-network: $0 per day for days 1-20; $203 per day for days 21-100

Out-of-network: $225 per day for days 1-43; $0 per day for days 44-100

HMO: $0 per day for days 1-20; $160 per day for days 21-60; $0 per day for days 61-100

Additional benefits (cont.)

Durable medical equipment (e.g., wheelchairs & oxygen)

PPO: In-network: 20% coinsurance per item | Out-of-network: 50% coinsurance per item

HMO**:** 20% coinsurance per item

Diabetes supplies

PPO: In-network: $0 copay per item | Out-of-network: 50% coinsurance per item

HMO: $0 copay

Conclusion

PPO Plan: Offers more flexibility with provider choice and coverage for out-of-network services but generally comes with higher copays and out-of-pocket costs.

HMO Plan: Provides lower copays and maximum out-of-pocket costs but requires beneficiaries to stay within the network and obtain referrals for specialist care.

Consider the beneficiary's healthcare needs, provider preferences, and financial situation to present the most appropriate options.

Services: medical necessity & prior authorization[2]

Medical necessity

Medicare Advantage organizations must follow certain rules when deciding if a basic Medicare benefit is necessary. They must:

- Follow the medical necessity requirements stated in § 422.101(c).
- Consider the individual patient's situation, including their medical history, doctor's recommendations, and clinical notes.
- Adhere to the established Original Medicare coverage criteria.

If there are no clear Medicare rules for a particular benefit, MA organizations can use their own internal guidelines. These internal guidelines must be publicly accessible and based on the latest evidence from widely accepted treatment guidelines or clinical studies.

Prior authorization

Medicare Advantage plans can use prior authorization to ensure patients meet the necessary guidelines.

However, they cannot use it for:

- Emergency services,
- Urgent care,
- Stabilization services, or
- Out-of-network services covered by MA PPO plans.

[2] https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf

Purpose of prior authorization

It can only be used to confirm diagnoses or other medical criteria, ensure services or benefits are medically necessary, or verify that supplemental benefits are clinically appropriate. It should not delay or discourage care.

Duration of authorization

Once approved, a prior authorization for a treatment plan must be valid for as long as it's medically necessary to avoid care interruptions. The duration is based on coverage criteria, the patient's medical history, and the provider's recommendation.

New enrollees must have a minimum 90-day transition period during which their new MA plan cannot require prior authorization for ongoing treatments, even if started with an out-of-network provider.

Assisting beneficiaries: PPO or HMO

When assisting a beneficiary in choosing between a PPO and an HMO Medicare Advantage plan, it's important to gather information about their healthcare preferences, lifestyle, and priorities. Use the questions below to gather information and determine which plan option might be more suitable for them.

Provider preferences

- Do you have a preferred primary care physician (PCP) or specialist that you want to continue seeing?
- Are you willing to change your current healthcare providers to be in-network if needed?
- How important is the flexibility to see specialists without a referral?
- _____
- _____
- _____

Cost considerations

- Are you comfortable with a plan that generally has lower monthly premiums but higher out-of-pocket costs for each service? (HMO)
- Do you prefer a plan with higher monthly premiums but lower out-of-pocket costs and more flexibility in choosing healthcare providers? (PPO)
- Are you concerned about potential out-of-network costs?
- _____
- _____
- _____

Healthcare usage and needs

- How often do you visit healthcare providers and/or specialists?
- Are you generally healthy, or do you have chronic conditions that require ongoing specialist care?
- Do you anticipate needing medical services outside of your local area?
- _____
- _____
- _____

Referral and coordination of care

- Are you comfortable having a primary care physician (HMO) and obtaining referrals to see specialists, or do you prefer the flexibility to see specialists without referrals (PPO)?
- How important is it for you to have a coordinated approach to your healthcare with a primary care physician overseeing your care?
- _____
- _____
- _____

Network accessibility

- Do you plan to stay within a specific geographic area for most of the year, or do you travel frequently or live in multiple locations?
- How important is it for you to have access to a broader network of healthcare providers? (PPO)
- Are you willing to restrict your healthcare services to a more local network? (HMO)

- _____
- _____
- _____

Prescription drug coverage

- Are you aware of the prescription drug coverage offered by each plan and any associated costs?
- _____
- _____
- _____

Overall plan preferences

- What features of a Medicare Advantage plan are most important to you?
- Are there any specific concerns or preferences you have that would influence your choice between an HMO and a PPO?
- _____
- _____
- _____

Analysis

Based on the responses collected, analyze the following to guide the beneficiary to learn more about the plans.

PPO plan indicators:

- Strong preference for current providers and unwillingness to change.
- High importance on flexibility to see specialists without referrals.
- Frequent travel or need for out-of-network coverage.
- Willingness to pay higher premiums for more provider options.
- _____
- _____
- _____

HMO plan indicators:

- Willingness to change providers to stay in-network.
- Preference for lower premiums and out-of-pocket costs.
- Less frequent travel and lower need for out-of-network coverage.
- Comfort with needing referrals to see specialists.
- _____
- _____
- _____
- _____

By addressing these questions, you can help beneficiaries evaluate their priorities and make an informed decision based on their individual healthcare needs and preferences. It's also important to encourage them to review the specific details of each plan's benefits, network, and costs before making a final decision.

Plan details

Not all Medicare Advantage plans—even plans of the same type—work the same way.

It's essential for Medicare beneficiaries to carefully review plan details, including network restrictions, cost-sharing, and coverage rules, to choose the Medicare Advantage plan that best meets their healthcare needs and preferences.

If they have questions, encourage beneficiaries to contact plans for more information.

Counseling case work

Learning objective

To improve counselor's skills and ensure that a beneficiary has the necessary information and tools to actively participate and make informed decision about their healthcare coverage.

Counseling session activities

Listen to the counseling session or read its transcript and evaluate it.

What did they do well?	What can they do better next time?

Session transcript: phone counseling

Client: Hello!

Counselor: Hi, is this Charlie?

Client: Yes, it is

Counselor: OK. This is Gina with Washington SHIBA. I'm calling because you called for some help with Medicare. First, do you mind if I call you Charlie?

Client: Please do.

Counselor: Thank you. How can I help you?

Client: Yes, thank you so much for calling me back. I'm having a problem with my current plan. I have Premera Blue Cross.

I needed to see a dermatologist, so my physician gave me a referral to somebody in Olympia, and I was going to go see them. But when I called the office. It was a 4 month wait for an appointment.

Right after that I was visiting my best friend in Spokane. She also has the Premera Blue Cross plan**,** and a dermatologist - Myrna Bouton - that she really likes. Dr. Bouton had an opening while I was there, so I went saw her.

But then I got a bill for over $400, which I don't really understand, because I had a referral for a dermatologist.

Counselor: Do you have a Medicare Advantage plan?

Client: Yes.

Counselor: And do you know if it is an HMO or PPO?

Client: It's an HMO.

Counselor: Okay. So one of the tricky things about HMOs is that they only cover services with in-network providers. So providers that you see must be in network for the charge to be covered.

Client: So I did check that, and the provider in Spokane was in network with my plan.

Counselor: Okay, that's good to know. Unfortunately, you also have to have a referral from your primary care provider for that specific provider.

Blue Cross can decline to cover the charges because you didn't have a referral to that provider

Client: Oh, so I would have had to have my doctor write me a second referral for Dr. Bouton, not just the specialty.

Counselor: Right.

Client: OK, well that stinks. Can I change to something different?

I travel a lot. I would like to be able to go back to Dr. Bouton in Spokane and see providers in the different areas I visit without having to get a referral every single time.

Counselor: Yes, the option for that - if you want to stay with a Medicare Advantage Plan - is a PPO.

As you know, the HMO that you have now only covers services you get from in-network providers.

PPOs cover both in-network and out-of-network charges. Generally, in-network services will have co-pays for many services, and out-of-network services have costs that are a percentage of the charge. So in-network costs are lower and more predictable than out-of-network costs, but you will be covered.

Counselor: You also don't need to get referrals from your primary care provider with the PPO. You can go right to the specialist and get that service, and the company will cover it for whatever amount they allow for that service.

Client: Okay. So if my plan had been a PPO and I had done the exact same thing, and that provider in Spokane was in network, which they are, then my plan would have covered it.

Counselor: Yes, at least a portion of it. There are some other differences between HMOs and PPO, too.

One is that your out-of-pocket limit – the maximum you have to pay for medical care in a year - works a little differently.

HMOs only have one maximum-out-of-pocket amount because they only cover charges for in-network services. It is generally thousands of dollars. Are you familiar with this?

Client: I think so. I think mine is $6,500.

Counselor: That sounds right.
Since PPOs cover in-network and out-of-network charges, there are 2 maximums – one for in-network alone, and one for in and out-of-network combined.

Let's say the in-network limit is $6,000. Once you have been charged $6,000 for in-network medical care you'll you won't be responsible for any more costs for in-network care for the rest of the year. But you'll also have an in and out-of-network limit, which might be like something like $10,000. So even if you've hit the $6,000 limit on your in-network provider charges you would still have to pay about $4,000 for out-of-network providers before you reach the in and out-of-pocket limit.

Client: Okay. Is there anything else I should know?

Counselor: You will still need to get prior authorizations for treatments like physical therapy and procedures like outpatient surgery, so that won't change.

Counselor: You mentioned that you travel quite regularly.

Client: Yes, I go to Spokane several times throughout the year, and I'm thinking about starting to spend my winters in Arizona.

Counselor: OK - Many plans have a travel status that allow you to use medical services in places you are visiting like an in-network provider. The rules and requirements vary, so you might want to check on this by calling or looking at the plans' websites. This could be true for the plan you have now, as well as any you might consider for next year.

Client: Oh, okay.

Counselor: One of the things that's the same for HMOs and PPOs is that you get emergency care and urgent care wherever you go as long as the as long as the facility accepts Medicare.

But the PPO offers more flexibility once you are looking at on-going medical care. For examples, if you are in Arizona for the winter, and break your ankle, that would be emergency or urgent care. But physical therapy afterward is on-going care. If there is no place that's convenient to go to that is in-network for your plan, even with the travel benefits, then you'd have that out-of-network coverage if you have a PPO, when it would not be covered at all with an HMO.

Client: Can I change to a PPO right now, or do I have to wait for open enrollment?

Counselor: That depends on whether you're eligible for low income assistance programs. Do you have Apple Health benefits or Extra Help that lowers costs for prescriptions now?

Client: No

Counselor: OK, Do you mind if I ask you some questions, to see if you'd be eligible for low income assistance?

Client: Sure.

Counselor: Great, so first, are you single, or are you married?

Client: I'm single.

Counselor: Okay? And do you have income of less than about $2,000 a month?

Client: No, it's closer to $3,000 a month.

Counselor: Okay, that means that you're not eligible for any of the low-income assistance that would allow you to make a change before open enrollment.

But if you do want to change for next year and want help with that, be sure to call us. Helping people review their coverage for next year one of the major things that we do during open enrollment.

Client: Oh, okay. That would be really helpful.

Counselor: Good. Do you have any other questions?

Client: No, I guess that's it, for now, so I know not to see a specialist unless I have a referral from my primary care to that physician…and I will look into changing my plan in the fall.

Counselor: Yes, and hopefully by then you will know if you are going to Arizona and want to continue seeing someone Dr. Bouton or want to establish a relationship with a local dermatologist. When you look at your options during open enrollment, you will probably want to have a list of any other providers you want to see as well, so you can see if they are in network.

Client: OK

Counselor: So we covered quite a bit. Do you feel like you understand the differences between HMO and PPO – the referrals, use of in-network or out-of-network providers and the maximum-out-of-pocket limits?

Client: I do.

Counselor: Good – and don't forget you can look into the travel benefits available through your plan now that may help you get lower costs if you are traveling to Spokane and seeing Dr. Bouton or anywhere else that you would want to see providers.

Do you have any other questions?

Client: I don't think so, but I know where to call if I do. Thank you!

Counseling session activities: checklist

- Go through the checklist (see Appendix A) and evaluate each item using the following criteria:
    - **Yes:** The item was fully addressed in the counseling session.
    - **Somewhat:** The provided information was incomplete.
    - **No:** The issue was not addressed but should have been addressed in the session.
    - **Not Applicable (N/A):** The item didn't apply in this case.
- Provide brief explanations for your evaluations in "Comments."
    - For any checklist items marked as "No," explain why the counselor should have addressed them.
    - For any checklist items marked as "Somewhat," suggest how the counselor could have incorporated the missing elements into the session.
    - For any checklist items marked as "Not Applicable," explain why.

Counseling session reflections

Imagine you are about to enter a session with a client who needs assistance in choosing the right Medicare Advantage plan.

- Identify and list the resources you would quickly master to provide effective guidance to your client.
- Explain why you chose these resources and how they would help you assist your client in making an informed decision.
- Consider including resources such as specific plan details using plan comparison tools in Plan Finder and any other relevant information. Describe how each resource will help you address potential questions or concerns and ensure the client understands the differences between HMO and PPO plans.

Questions	Resource/tools

STARS

Activities

Review the Beneficiary Contact Form (BCF) (see Appendix B). There are filled and highlighted (yellow) fields. Please highlight any additional item for which you believe the necessary information is missing.

Fields	Your comments

Please review the BCF notes and assess them. Are there any details or insights that can be added to enhance their accuracy?

Answer:

Final reflections

Beneficiary's responsibilities

- Contact each plan to determine which benefits are provided and how they compare to their present plan.
- Evaluate each plan to determine how provided services and costs fit their needs.
- Ensure that their current providers (if they prefer to stay with them) are in plan's network.
    - Call providers (billing office) to confirm.
- Ensure that the providers listed in the plans network are acceptable and take new patients.
    - Call providers (billing office) to confirm.
- Ensure that plan provides them with best coverage when it comes to their medications.

SHIBA responsibilities

- Inform beneficiary about their choices.
- Remind them of their responsibility to do their due diligence when evaluating their choices in terms of their priorities.
- Remind them of their enrollment timeline.

Learning outcome

After completing the training, do you feel more confident in your ability to counsel clients on the key differences between HMO and PPO plans, including network restrictions, provider choice flexibility, referral requirements, and cost implications, using specific plan examples such as the Premera Blue Cross Medicare Advantage (HMO) and the AARP Medicare Advantage from UHC WA-0002 (PPO)?

Keep learning

Reflecting on the training, think how you would guide a beneficiary who is unfamiliar with Medicare Advantage plans.

What key considerations would you emphasize to ensure they make an informed decision about their healthcare coverage?

Share with us!

Share an idea for how the SHIBA team and sponsors can help support the volunteer advisors even more/better via email at: **OICMedicareTrainingFeedback@oic.wa.gov**

Or call SHIBA Curriculum & Training Coordinator Elena Garrison: **360-725-7107**

Thank you for your participation!

Appendix A

Counseling checklist Medicare Advantage plans – HMO & PPO

Description of step or sub-step	Yes/No Somewhat N/A	Tool/Resources/ Comments
1. Introduce yourself – name, sponsor & SHIBA		
2. Establish rapport – how to address client, etc.		
3. Is client currently on Medicare, New to Medicare, other?		
4. How can I help?		
5. Listen to client's questions/concerns. **Relieve client distress (if any).** **Rephrase their response to check for understanding.**		
6. Do they have retiree, VA or Tribal benefits that help with Medicare costs?		
7. Complete income screening for low-income or IRMAA (Checklist).		
8. Counsel for client's situation/needs • For this scenario: HMO & PPO		
8a. Verify client coverage related to HMO or PPO. • Does client have an HMO or PPO		

plan? Plan info:		
8b. Explain what HMO and PPO are. • **Health Maintenance Organization (HMO):** A type of Medicare Advantage plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency, out-of-area urgent care, and temporary out-of-area dialysis. An HMO may require the client to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness. • **Preferred Provider Organization (PPO):** A type of Medicare Advantage plan where the client will pay less if they use providers in the plan's network. Clients can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.		
8c. Explain key similarities between HMO and PPO. • **Networks** – both HMO and PPO plans have networks of doctors, other health care providers, and hospitals. • **Premiums** – both HMO and PPO		

plans typically have a monthly premium, in addition to the Part B premium • **Part D coverage** – both HMO and PPO plans typically have drug coverage • **Prior authorization** – both HMO and PPO plans require approval for treatment be valid for as long as the treatment is deemed medically necessary. The plan cannot ask the client to get additional approvals once it is approved. If getting treatment and switching to a new plan, the client will have at least 90 days before the new plan can ask to get a new prior authorization for the ongoing treatment. • **Charge limits for certain services** – both HMO and PPO plans can't charge more than Original Medicare for certain services like chemotherapy, dialysis, and skilled nursing facility care. **Maximum out-of-pocket (MOOP) limit** – both HMO and PPO have a limit for in-network services set by the plan, but not to exceed the yearly limit (in 2024, $8,850).		
8d. Explain key differences between HMO and PPO. • **Referrals to specialists** – are required for HMO. Are not required for PPO.		

• **How to get care** – HMO can only go to in-network providers. PPO can go out-of-network for a higher cost. **MOOP limit** – PPO has an additional MOOP limit set by the plan for out-of-network services.		
8e. **Ask client what they like/dislike about current plan related to HMO and PPO similarities and differences from steps 8c and 8d.** Likes: Dislikes:		
8f. Check understanding with client. "I have written down that your likes include…and your dislikes include…is this correct?"		
8g. Open Plan Finder. **Select that client has MSP.** **Enter client's medications.**		
8h. **Do they have a particular pharmacy they like and want to continue using?** • Are they open to using another pharmacy if it saves them money? o IF NO – add only client's preferred pharmacy in Plan		

Finder. o IF YES – ask if selections nearby in Plan Finder are OK or if there are any pharmacies they do not want to use. Include "mail order pharmacy" to get a baseline for costs.		
8i. Beyond medical, what services/benefits are important to client? • Dental. • Vision. • Hearing aids. • Gym. • Transportation. • Over the Counter/flex benefits for food/utilities. Other _____.		
8j. Explain which options seem most in line with client's priorities. (Do client's likes/dislikes align with OM or MA/D-SNP?)		
8k. Check "Add to compare" for plans that align with client's priorities. • Three at a time • Use filters as appropriate o Use "Special Needs Plans" filter for D-SNPs. Select "Plans for people who have both		

Medicare and Medicaid".		
8l. Explain issues/coverage concerns for any option given client location or needs.		

8m. Does client have providers they want to keep or be able to use?
 	
• YES – client should verify providers accept their preferred coverage (OM or MAPD).
  ○ MA: Compile list of companies/plans to check from Plan Finder, send via email if possible – ask them to write down if no email.
  ○ If gym is important, recommend they check gym network so it can be considered for plan choice. Fitness program options:
  ▪ Silver Sneakers.
  ▪ Silver & Fit.
  ▪ Renew Active Fitness (add to email).
  ○ Suggest they speak to billing at medical practice, gym, etc. and/or plan.
 	
NO – advise client they will need to ensure providers accept the coverage/are in-network to minimize costs.		

8n. Advise client to enroll through company if comfortable with chosen plan. Contact SHIBA if they need further clarification.		
9. Review actions taken and discuss next steps • Recap discussion, check for understanding • (If applicable) Schedule follow-up or explain how follow-up will occur • Remind client of importance of plan reviews during open enrollment		
10. Any questions?		
11. Thank client & remind them to call SHIBA or sponsor if they have Medicare questions. SHIBA Helpline: 1-800-562-6900 Sponsor SHIBA phone: _____		
12. Enter Beneficiary Contact Form in STARS		

Appendix B

Counseling session Beneficiary Contact Form (BCF) activities

BENEFICIARY CONTACT FORM			
*** Items marked with asterisk (*) indicate required fields**			
Date of Contact *: 6/20/2024			
MIPPA Contact *:	❑ Yes ❑ No		
Send to SMP:	❑ Yes ❑ No	**SIRS eFile ID:** (***required** **if sending record to SMP)**	This field will automatically utilize the SIRS eFile ID entered on the Session Conducted By user's SHIP Team Member form
Counselor Information *			
Session Conducted By* : Gina	ZIP Code of Session Location * : 99203	State of Session Location * : Washington	
Partner Organization Affiliation* : Washington OIC SHIBA	County of Session Location * : Spokane - WA		
Beneficiary & Representative Name and Contact Information			
Beneficiary First Name: Charlie Beneficiary Last Name: _____ Beneficiary Phone: (123) – 456 – 7890 Beneficiary Email: _____	Representative First Name: _____ Representative Last Name: _____ Representative Phone: (_____) -_____ -_____ Representative Email: _____		
Beneficiary Residence *			

State of Bene Res. * : WA Zip Code of Bene Res. * : 98501 County of Bene Res. * : Thurston - WA

How Did Beneficiary Learn About SHIP * (select only one):

- ❑ CMS Outreach
- ❑ Congressional Office
- ❑ Employer
- ❑ Friend or Relative
- ❑ Health/Drug Plan
- ❑ Partner Agency
- ❑ Previous Contact
- ❑ SHIP Mailings
- ❑ SHIP Media
- ❑ SHIP Presentation
- ❑ State SHIP Website
- ❑ SHIP TA Center
- ❑ SSA
- ❑ State Medicaid Agency
- ❑ 1-800 Medicare
- ❑ Other
- ❑ Not Collected

Method of Contact * (select only one):

- ❑ Phone Call
- ❑ Email
- ❑ Web-based
- ❑ Postal Mail or Fax
- ❑ Face to Face at Session Location/ Event Site
- ❑ Face to Face at Beneficiary Home/ Facility

Beneficiary Age Group * (select only one):

- ❑ 64 or Younger
- ❑ 65 – 74
- ❑ 75 – 84
- ❑ 85 or Older
- ❑ Not collected

Which of the following best represents how you think of yourself? (Multiple selections allowed):

- ❑ Lesbian or gay
- ❑ Straight, that is, not gay or lesbian
- ❑ Bisexual
- ❑ Don't know
- ❑ Prefer not to answer
- ❑ I use a different term

Other Orientation Term: _____

What is your current gender? (select only one):

- ❑ Female
- ❑ Male
- ❑ Transgender
- ❑ Don't know
- ❑ Prefer not to answer
- ❑ I use a different term

Other Orientation Term: _____

Do you consider yourself to be transgender? (Select only one): ❑ Yes ❑ No ❑ Prefer not to answer

Beneficiary Race * (multiple selections allowed):

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Not Collected

Beneficiary Language *:

English is Beneficiary's Primary Language ❑ Yes ❑ No

Have you or a family member ever served in the military?

❑ Yes ❑ No ❑ Unsure

Receiving or Applying for Social Security Disability or Medicare Disability * (select only one):

❑ Yes ❑ No

Beneficiary Monthly Income * (select only one):

- ❑ Below 150% FPL
- ❑ Not Collected
- ❑ At or Above 150% FPL

Beneficiary Assets * (select only one):

- ❑ Below LIS Asset Limits
- ❑ Not Collected
- ❑ Above LIS Asset Limits

Topics Discussed * (At least one Topic Discussed selection is required. Multiple selections allowed)

Original Medicare (Parts A & B)

- ❑ Accountable Care Organizations (ACOs)
- ❑ Appeals/Grievances
- ❑ Benefit Explanation
- ❑ Claims/Billing
- ❑ Conditional Enrollment
- ❑ Coordination of Benefits
- ❑ Eligibility
- ❑ Enrollment/Disenrollment
- ❑ Equitable Relief
- ❑ Fraud and Abuse
- ❑ Late Enrollment Penalty
- ❑ Provider Participation
- ❑ QIO/Quality of Care

Medigap and Medicare Select

- ❑ Application Assistance
- ❑ Benefit Explanation
- ❑ Claims/Billing
- ❑ Complaints
- ❑ Eligibility/Screening
- ❑ Fraud and Abuse
- ❑ Guaranteed Issue Rights
- ❑ Plan Non-Renewal
- ❑ Plans Comparison

Medicare Advantage (MA and MA-PD)

- ❑ Appeals/Grievances
- ❑ Benefit Explanation
- ❑ Chronic Condition Special Needs Plans
- ❑ Claims/Billing
- ❑ Disenrollment
- ❑ Dual Eligible Special Needs Plans
- ❑ Eligibility/Screening
- ❑ Enrollment
- ❑ Fraud and Abuse
- ❑ Institutional Special Needs Plans
- ❑ Marketing/Sales Complaints & Issues
- ❑ Plan Non-Renewal
- ❑ Plans Comparison
- ❑ Provider Network
- ❑ QIO/Quality of Care
- ❑ Supplemental Benefits

Please explain:

_____
_

Part D Low Income Subsidy (LIS/Extra Help)

- ❑ Appeals/Grievances
- ❑ Application Assistance
- ❑ Application Submission
- ❑ Benefit Explanation
- ❑ Claims/Billing
- ❑ Eligibility/Screening
- ❑ LI NET/BAE

Other Prescription Assistance

- ❑ Manufacturer Programs
- ❑ Military Drug Benefits
- ❑ Prescription Discount Cards
- ❑ State Pharmaceutical Assistance Programs
- ❑ Union/Employer Plan

Medicaid

- ❑ Appeals/Grievances
- ❑ Benefit Explanation
- ❑ Claims/Billing
- ❑ Duals Demonstration
- ❑ Eligibility/Screening
- ❑ Fraud and Abuse
- ❑ Medicaid Application Assistance
- ❑ Medicaid Application Submission
- ❑ Medicare Buy-in Coordination
- ❑ Medicaid Expansion (ACA) Transition to Medicare
- ❑ Medicaid Recertification
- ❑ Medicaid Managed Care
- ❑ Medicaid Spend Down
- ❑ MSP Application Assistance
- ❑ MSP Application Submission
- ❑ MSP Recertification
- ❑ Program of All-Inclusive Care for the Elderly (PACE)
- ❑ Provider Participation
- ❑ QMB Improper Billing

Other Insurance

- ❑ Active Employer Health Benefits
- ❑ COBRA
- ❑ Indian Health Services
- ❑ Long Term Care (LTC) Insurance
- ❑ LTC Partnership
- ❑ Marketplace Transition to Medicare
- ❑ Other Health Insurance
- ❑ Retiree Employer Health Benefits
- ❑ Tricare For Life Health Benefits
- ❑ Tricare Health Benefits
- ❑ VA/Veterans Health Benefits

Topics Discussed (multiple selections allowed) (continued from p. 2)*

Medicare Part D

- ❑ Appeals/Grievances
- ❑ Benefit Explanation
- ❑ Claims/Billing
- ❑ Disenrollment
- ❑ Eligibility/Screening
- ❑ Enrollment
- ❑ Fraud and Abuse
- ❑ Late Enrollment Penalty
- ❑ Marketing/Sales Complaints & Issues
- ❑ Pharmacy Network
- ❑ Plan Non-Renewal
- ❑ Plans Comparison

Additional Topic Details

- ❑ Ambulance
- ❑ COVID-19
- ❑ Dental/Vision/Hearing
- ❑ DMEPOS
- ❑ ESRD
- ❑ Health Savings Account(s)
- ❑ Home Health Care
- ❑ Hospice
- ❑ Hospital
- ❑ Income Related Monthly Adjustment Amount
- ❑ Mail Order Prescription
- ❑ Medicare Card
- ❑ Medicare.gov Account
- ❑ Mental Health
- ❑ New to Medicare
- ❑ Opioids
- ❑ Physical Therapy
- ❑ Preventive Benefits
- ❑ Skilled Nursing Facility
- ❑ Substance Misuse/Fraud/Abuse
- ❑ Telehealth
- ❑ Transportation

Total Time Spent on This Contact *

____ Hours 8 Minutes

Status

❑ In Progress ❑ Completed

Special Use Fields

Original PDP/MA-PD Cost: _____

New PDP/MA-PD Cost: _____

Field 3: _____

Field 4: _____

Field 5: _____

Notes

Client has a Premera Blue Cross HMO plan. She saw an out-of-network dermatologist and didn't understand why she had to pay the full cost. Explained key similarities and differences of HMO and PPO plans – networks, covered services, coinsurance and copays, referrals, MOOP(s), and emergency care. Screened client for MSP and LIS – they were not eligible. Explained they would need to wait for Open Enrollment to make a change and to call back if they had any other questions.

Appendix C

Let's compare PPO & HMO costs

Thurston, WA

	AARP Medicare Advantage from UHC WA-0002 (PPO)	Premera Blue Cross Medicare Advantage (HMO)
	$0.00 Medicare Advantage and drug monthly premium	$0.00 Medicare Advantage and drug monthly premium
Overview		
Star rating	★★★½☆	★★★☆☆
Health deductible	$0	$0
Drug plan deductible	$0.00	$160.00
Maximum you pay for health services	$9,550 In and Out-of-network $6,300 In-network	$6,500 In-network
Health premium	$0.00	$0.00
Drug premium	$0.00	$0.00
Part B premium	$174.70	$174.70

	AARP Medicare Advantage from UHC WA-0002 (PPO) $0.00 Medicare Advantage and drug monthly premium	Premera Blue Cross Medicare Advantage (HMO) $0.00 Medicare Advantage and drug monthly premium
Benefits & Costs		
Primary doctor visit	In-network: $0 copay Out-of-network: $25 copay per visit	$5 copay per visit
Specialist visit	In-network: $0-45 copay per visit Out-of-network: $65 copay per visit	$40 copay per visit
Diagnostic tests & procedures	In-network: $50 copay Out-of-network: 30% coinsurance	$60 copay
Lab services	In-network: $0 copay Out-of-network: $0 copay	$10 copay
Diagnostic radiology services (like MRI)	In-network: $0-250 copay Out-of-network: 30% coinsurance	$180 copay
Outpatient x-rays	In-network: $15 copay Out-of-network: $30 copay	$15 copay
Emergency care	$120 copay per visit (always covered)	$90 copay per visit (always covered)
Urgent care	$0-40 copay per visit (always covered)	$35 copay per visit (always covered)
Inpatient hospital coverage	In-network: $390 per day for days 1 through 5 $0 per day for days 6 through 90 $0 per day for days 91 and beyond Out-of-network: $595 per day for days 1 through 17 $0 per day for days 18 and beyond	$450 per day for days 1 through 4 $0 per day for days 5 through 90
Outpatient hospital coverage	In-network: $0-390 copay per visit Out-of-network: $595 copay per visit	$350 copay per visit
Preventive services	In-network: $0 copay Out-of-network: 0-30% coinsurance	$0 copay

	AARP Medicare Advantage from UHC WA-0002 (PPO) $0.00 Medicare Advantage and drug monthly premium	Premera Blue Cross Medicare Advantage (HMO) $0.00 Medicare Advantage and drug monthly premium
Extra benefits		
Hearing aids	In-network: $99-$1249 copay Out-of-network: $99-$1249 copay	In-network: $0 copay
Preventive dental (like oral exams and cleanings)	In-network: $0 copay Out-of-network: $0 copay	$0 copay
Comprehensive dental (like root canal and implants)	Some coverage	Some coverage
Eyeglasses (frames & lenses)	In-network: $0 copay Out-of-network: $0 copay	$0 copay
Wellness programs (like fitness & nursing hotline)	Covered	Covered
Transportation	Not covered	Not covered

Glossary

Costs

Coinsurance—An amount you may be required to pay as your share of the cost for benefits after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for benefits after you pay any deductibles. A copayment is a fixed amount, like $30.

Deductible—The amount you must pay for health care or prescriptions before Original Medicare, your Medicare Advantage Plan, your Medicare drug plan, or your other insurance begins to pay.

Maximum Out-of-Pocket Limit—Plans have a yearly limit on what you pay out of pocket for services Part A and Part B cover. Once you reach your plan's limit, you'll pay nothing for Part A and Part B services the plan covers for the rest of the year.

Notices

Annual Notice of Change includes any changes in coverage, costs, provider networks, service area, and more that will be effective in January. Your plan will mail a copy to you, typically before September 30.

Evidence of Coverage gives you details about what the plan covers, how much you pay, and more. Your plan will send you a notice (or printed copy) by October 15, which will include information on how to access the Evidence of Coverage electronically or request a printed copy.

Limits

Advanced plan approval required - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless

specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.

Plan limits - There may be limits on how much service or benefit the plan will provide.

Network - A network is a group of doctors, hospitals, and medical facilities that contract with a plan to provide services.