Health Care Reform

Frequently Asked Questions

University of Maryland Carey School of Law
Drug Policy and Public Health Strategies Clinic
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Introduction

This collection of "Frequently Asked Questions" was developed by the Drug Policy and Public Health Strategies Clinic of the University of Maryland Carey School of Law following ACA 101 training sessions with substance use treatment programs around Baltimore.[*] During these trainings, the Clinic discovered that many providers share questions about the implementation of the Affordable Care Act in Maryland, including insurance coverage options, affordability programs, plan selection through Maryland Health Connection, and the specific concerns facing people with substance use disorders. We hope that this master FAQ will serve as a resource for other providers and patients who are seeking affordable health coverage.

The Clinic continues to be interested in receiving questions from treatment programs about their experiences related to health reform. To submit a question or request copies of our training and informational materials, you can reach the Clinic by contacting Ellen Weber at eweber@law.umaryland.edu or Geraldine Doetzer at gdoetzer@law.umaryland.edu.

[*]*This FAQ was developed by student attorneys Roberto Berrios, Sara Haneef, Diana-Lynne Hsu, Lindsay Lowe, Joanne Lucas, and Andrew Weissenberg during the Spring 2014 semester. This version was updated in July 2014.*

I. Before You Apply: Who Can Enroll and How To Prepare

1. ***How can I prepare to apply for health insurance?***

The application for Medicaid and Qualified Health Plans (QHPs) is available on Maryland's online marketplace, Maryland Health Connection (http://www.marylandhealthconnection.gov). Maryland Health Connection offers applicants several helpful pre-enrollment tools, including:

- Links to each carrier that sells a health plan on Maryland Health Connection to see and compare the different plans offered by different carriers;
- For Medicaid-eligible recipients, a chart comparing the benefits offered by different Managed Care Organizations (MCOs);
- Provider Search Directory tool to determine whether a desired provider is within a specific QHP network or Medicaid MCO network
- Income eligibility chart to give the applicant a rough estimate of whether he or she will be eligible for Medicaid or premium discounts through advanced premium tax credits (APTCs); and
- A list of documents that would be helpful for the applicant to have on-hand during the application process itself.

To access these tools, click on "Resources" at the top of the Maryland Health Connection homepage link above.

Maryland Health Connection will change in late 2014 to improve user experience and function. Different enrollment materials may be available for consumers who are shopping for 2015 plans. The web address will remain www.marylandhealthconnection.gov.

2. ***How can a person with no income afford health insurance?***

The Affordable Care Act (ACA) requires most people to have health insurance. This means individuals will have to obtain private insurance; insurance offered by an employer; or insurance through a public program like Medicare, the Veterans Administration, or Medicaid. An individual with no income is most likely eligible for Medicaid. This is because Medicaid has expanded to include single adults with incomes from 0-138% of the Federal Poverty Level, which means a single person's income must be less than $1342 a month. Individuals who qualify for Medicaid under these new rules no longer have to meet categorical eligibility requirements. Some groups, including people with disabilities, senior citizens, and foster children are still subject to the old Medicaid rules.

A person applying for coverage on Maryland Health Connection will have to verify his income as part of the eligibility determination process. Maryland Health Connection will request income information from applicants and automatically check with the Social Security Administration and the federal tax database to verify the reported income. If the amounts are not compatible, Maryland Health Connection will send a written request for additional information. If there is no other form of documentation to prove zero income, the individual can attest that he or she does not have any income by providing a statement to the Exchange.

An individual can apply for Medicaid at any time during the year. Applications are available online at www.marylandhealthconnection.gov or in person by going to a local Department of Social Services (DSS) or Local Health Department.

3. ***My adult son lives with me but does not make enough money to file a tax return. How would he enroll in health insurance?***

An adult child who does not earn enough money to pay taxes may be eligible for Medicaid, coverage under a Qualified Health Plan (QHP) that you purchase for your family, or covered through your employer-based insurance policy. His eligibility for insurance depends upon his age, his income and whether you claim your son as a dependent on your tax return.

- If you are currently insured through your employer, your son can stay on your employer-based plan until he turns 26, regardless of whether he is married, living with you, in school, or financially dependent on you.

- If you claim your son on your taxes as a dependent, then his income is combined with your household income to determine whether he is eligible for tax credits or Medicaid. You could claim your son as either a dependent "qualifying child" or "qualifying relative" if he meets certain requirements:

  - If your son is under 19 at the end of the year, or under 24 if he is a full-time student, you may be able to claim him as a "qualifying child" on your taxes if he lives with you for more than half of the year and he does not provide more than half of his own support.

  - If your son is over 19 (or over 24 for a full-time student) you could claim your him as a "qualifying relative" on your taxes if he does not provide more than half of his own support, lives in your home all year, and does not earn more than the personal exemption amount ($3,900 for 2013).

- If you do not claim your son as a dependent on your taxes, then he can apply for coverage on his own, and your income will not be a factor in determining his eligibility for Medicaid or a QHP. In this case, because he earns less than the threshold-filing amount, he will most likely be eligible for Medicaid as a single adult earning less than 138% of the Federal Poverty Level.

4. ***How does my citizenship status affect my eligibility for health insurance?***

Lawfully present non-citizens can apply for health insurance and tax credits through Maryland Health Connection with no waiting period. Non-citizens are considered to be lawfully present if they have been granted permission to reside in the United States for a specified amount of time and have not exceeded that time. This includes lawful permanent residents (green card holders), non-immigrants with work or student visas, and individuals who have been granted permission to stay as a result of other laws.

Applying for health insurance through Maryland Health Connection will not notify federal Immigration and Customs Enforcement (ICE) or any other state or federal law enforcement agencies.

Even if you are lawfully present with a low income, you may not be eligible for Medicaid. Most lawful permanent residents with green cards must wait five years after receiving qualified immigration status to obtain Medicaid coverage. In the state of Maryland, this five-year waiting period does not apply to children or pregnant women. Other legally present non-citizens with incomes under 100% of the Federal Poverty Limit (FPL) may apply for Qualified Health Plans (QHPs) with tax credits on Maryland Health Connection before they meet the five-year requirement.

Individuals who are not United States citizens or lawfully present are not eligible to obtain health insurance through Maryland Health Connection. People who are not lawfully present are not subject to the individual mandate, and will not be penalized for not obtaining health insurance. (For more information about exceptions to the individual mandate, see Question 8.)

5. ***What if people in my household have different citizenship statuses?***

There are many immigrant families who have "mixed" households, in which some members are undocumented while others are legally present. In these households, the family members who are legally present are eligible to obtain health insurance through Maryland Health Connection, while others are not. Applicants are not required to provide citizenship information for family members who are not applying for health insurance. An applicant also cannot be denied benefits for failing to provide citizenship information for individuals who are not applying.

Applying for health insurance through Maryland Health Connection will not notify federal Immigration and Customs Enforcement (ICE) or any other state or federal law enforcement agencies.

6. ***What kind of identification (ID) do I need to enroll in a health plan?***

Applicants using Maryland Health Connection do not need documents (such as Social Security cards, drivers licenses, or photo identification) to apply for health coverage. Individuals who do not know their Social Security Number, or who need to correct a discrepancy between the identity information they provide and the information in the federal databases, can work with assistance personnel to get the documentation they need.

Citizenship or lawful presence in the United States will be verified with the Social Security Administration and the Department of Homeland Security. If records cannot be verified electronically, individuals may be required to provide other proof of their identity, citizenship, or lawful presence, such as a birth certificate or U.S. passport, within ninety (90) days. Temporary Medicaid eligibility is available during this part of the verification process as long as the verification is limited only to citizenship or lawful presence. If citizenship or lawful presence is not confirmed within 90 days, Medicaid coverage will end after 90 days.

If a person is found not to meet citizenship requirements prior to the end of the 90-day term, coverage will end and the case will be closed. There is no lifetime limit on these temporary citizenship verification periods for Medicaid. The same temporary eligibility is also available for individuals enrolling in a Qualified Health Plan (QHP) during the verification process. It should be noted that temporary eligibility for a QHP is available even when the verification involves more than citizenship (including income and household size).

7. ***What is the penalty for not having health insurance?***

The Affordable Care Act requires almost everyone to have insurance coverage. This rule is called the "individual mandate." (For more information about exceptions to the individual mandate, see Question 8.)

Individuals who are required to have health insurance, but do not enroll in Medicaid, purchase a Qualified Health Plan (QHP), or have other insurance (such as employer-sponsored insurance or Medicare) by March 31, 2014, must pay a fee, known as a "penalty" under the Affordable Care Act. The fee is pro-rated for the month(s) in which you do not have required insurance coverage.

The fee for 2014 is the larger of the following two amounts:

- 1% of your yearly household income (for income above the threshold for filing your tax return); or
- $95 per adult for the year and $47.50/child under 18 years of age with a cap of $285 per family.

The fee will increase every year. The fee is paid when you file your tax return for the year in which you do not have coverage. In other words, if you do not have insurance during 2014, you will pay the fee through your 2014 taxes filed before April 15, 2015.

8. ***Are there any exceptions to the new rule that everyone must have health insurance?***

You are not required to have health insurance if you fit into one of the following categories:

- You are not a citizen or lawfully present in the United States; or
- You are currently incarcerated (other than incarceration pending disposition of charges)

You may qualify for an exemption from having to pay the penalty if you:

- Cannot afford insurance coverage because the cost of insurance for one person would be greater than 8% of your household income;
- Have income below the threshold for filing a tax return;
- Are uninsured for less than 3 total months over the course of the year;
- You can demonstrate "hardship";
- Are a member of a recognized religious sect or group that objects to health care insurance coverage;
- Are a member of a recognized Native American tribe/nation; or
- Are a member of a health care sharing ministry.

A hardship occurs when you experience a financial or domestic event that results in unexpected expenses and prevents you from obtaining a Qualified Health Plan (QHP). A hardship may also exist if the cost of a QHP would deprive you of basic necessities, such as food, clothing or shelter.

9. ***Why is there an Open Enrollment Period? Why can't I sign up for a health plan at any time of the year?***

Like many employer-sponsored insurance plans and the federal Medicare program, the Open Enrollment period requires individuals seeking coverage through Maryland Health Connection to enroll in a health plan within a certain time frame. This prevents people from purchasing insurance only after an accident or illness. When an insurance pool includes healthy people as well as sick people, premiums are lower and costs are more predictable.

<u>If you are eligible for Medicaid, you can enroll at any time during the year.</u>

Individuals who are eligible for a Qualified Health Plan (QHP) must enroll via Maryland Health Connection during Open Enrollment. The Open Enrollment dates to get coverage for 2014 were October 1, 2013 to March 31, 2014. The Open Enrollment dates to get coverage for 2015 are November 15, 2014 to February 15, 2015.

If you or someone in your household experiences certain life events that affect your insurance coverage, income, or household size, you may be eligible for a "Special Enrollment Period" that allows you to enroll in a QHP or get discounts outside of the Open Enrollment Period. (For more information about Special Enrollment Periods, see Question 53.)

II. Categories of Coverage: Medicaid, Qualified Health Plans, & Medicare

A. Medicaid

10. ***If I was in the Primary Adult Care (PAC) program, do I automatically get new coverage?***

As of January 1, 2014, individuals who were covered by Primary Adult Care (PAC) were automatically enrolled in the Maryland HealthChoice Program and will receive full Medicaid benefits, which are more generous than those provided under the PAC program. Former PAC members should have received an enrollment packet by January 1, 2014 that explains the transition and provides a new red and white Medical Assistance card. PAC members had the option of staying with their former Managed Care Organization (MCO) or selecting a new MCO from one of the seven MCOs that offers HealthChoice coverage. If a PAC member chose to remain with the same MCO, she can continue seeing the same primary care, substance use disorder, and mental health providers as she did when she was covered by PAC.

11. ***I was enrolled in PAC, but didn't receive a redetermination form this year. Am I still covered?***

All HealthChoice members must verify their eligibility for coverage once a year. This process is known as "redetermination." Because of the changes to PAC and HealthChoice in 2014, Medicaid delayed all redeterminations during the first part of 2014. The agency restarted the redetermination process in May 2014.

If your normal determination date fell between January-July 2014, you will receive a redetermination packet that you must complete and submit by the date provided in the packet to maintain your HealthChoice coverage. In 2015, all former PAC members will reapply for HealthChoice coverage on Maryland Health Connection.

If your mailing address has changed since your last PAC redetermination in 2013, Medicaid may not be able to send the new redetermination form to you, and you could lose coverage. For information about your HealthChoice redetermination deadline and to make sure that Medicaid has your contact information, call the Eligibility Determination Hotline at 1-800-226-2142 or contact your caseworker.

12. ***Which substance use disorders are now covered under HealthChoice?***

Substance use disorder services include the benefits previously covered in the PAC program and additional HealthChoice services highlighted below in bold:

- Evaluations, performed by certified substance abuse treatment programs and health care professionals who are appropriately licensed, certified, or otherwise legally authorized to determine the nature and severity of an enrollee's substance abuse problem and the appropriate level of care. This includes an age-appropriate comprehensive substance use assessment;
- Outpatient and intensive outpatient treatment including individual, group, and family counseling;
- Methadone maintenance treatment and reimbursement for buprenorphine;
- Coordinated case management services for adults and children through the MCO, as appropriate, to ensure coordination of primary, acute and home care;

- **Detoxification treatment;**
- **For enrollees younger than 21 years old, residential substance abuse treatment in an intermediate care-facility (ICF-A), with length to be determined by medical necessity; and**
- **For pregnant and postpartum women and individuals with HIV/AIDS, access to outpatient substance abuse treatment within 24 hours of an enrollee's request and case management services,**

All of the services available for substance use disorders are available on a self-referral basis. This means that you can seek substance use disorder treatment directly without the referral of a primary care provider. This also gives you the opportunity to choose treatment programs outside of your MCO's provider network. (For more information about Medicaid providers, see Questions 17 and 18.) The HealthChoice program, like the PAC program, provides some durational limits on the care provided by an out-of-plan provider, which can be extended based on medical necessity.

HealthChoice also imposes reimbursement limitations on certain services. Reimbursement for Intensive Outpatient services is limited to 4 days per week, and Medicaid does not currently cover Partial Hospitalization services in a community-based setting. Partial Hospitalization may be reimbursed on an outpatient hospital basis. Residential substance abuse treatment is not covered for individuals ages 21 and older under HealthChoice. State and federal grant funds will continue to fund residential care in the publicly funded treatment system.

HealthChoice offers a much wider range of medical benefits than those covered under PAC. Some of the additional Medicaid MCO benefits include: specialty care services, inpatient and outpatient hospital services, outpatient rehabilitative services, dialysis, pregnancy-related services, transplants, home health services, long-term care services, and hospice care. These covered medical services will be an addition to the current primary care services covered by PAC, which will be expanded to match the level of service available under HealthChoice.

Individuals with mental health disorders will continue to receive services under the HealthChoice specialty mental health program, depending upon the individual's diagnosis. A full array of outpatient, rehabilitation, psychiatric day treatment and home health services, and pharmacy services are available.

13. ***Should I provide my monthly or annual income when I apply for Medicaid?***

Medicaid looks at current monthly income when making eligibility determinations. For an individual seeking Medicaid under the Affordable Care Act (ACA) expansion, current monthly income must not exceed 138% of the Federal Poverty Limit (FPL). This is approximately $1,342 per month for a household of one. This amount increases as household size increases. For example, a one-person household making $1,500 a month is ineligible, while a two-person household with the same income would be eligible.

14. ***Will my income be affected if I receive a gift? Is there a difference between cash gifts and property gifts?***

A gift is a special category of "lump sum" payment. (See Question 15 for more information about lump sums.) A gift is made when one individual gives property to another individual (including money) without expecting anything in exchange. The value of cash or property received as a gift

does not count as gross income for the recipient. Additionally, the value of the gift will not count against an individual seeking to enroll in Medicaid under the Affordable Care Act (ACA) expansion.

15. ***How does a lump sum payment affect my eligibility for health coverage?***

A lump sum is a one-time, non-recurring payment, such as an insurance settlement. Medicaid and Qualified Health Plans (QHPs) treat lump sums differently.

- If you are enrolled in a Medicaid Managed Care Organization (MCO), lump sums are counted as income only in the month you receive the money, because they do not recur. After that month, they are considered assets or resources.

  If you receive a lump sum that affects your eligibility for Medicaid, you must report the lump sum to your caseworker within ten days. Once you report the lump sum, your caseworker will verify if you are still eligible for Medicaid in that month. If your caseworker determines that your lump sum causes your monthly income to rise above the Medicaid limit for that month, you will be disenrolled from your Medicaid MCO and can enroll in a QHP for the month that is affected by the lump sum.

  Even if you do not spend the entire lump sum right away, the money will not be included in determining your Medicaid eligibility in any other month. This is because there is no longer an asset limit. Therefore, you should reapply for Medicaid for coverage in the following month, because your income will drop back to the level you reported before receiving the lump sum.

- If you are enrolled in a QHP and you receive a lump sum that is taxable, it will likely change your estimated annual income. Your eligibility for health coverage and cost discounts are based on your annual income and you are required to report any income changes that will affect your eligibility for coverage. You should contact HealthCare Access Maryland (HCAM) at 1-877-223-5201 (Baltimore City, Baltimore County, and Anne Arundel County) or the statewide Consolidated Services Center at 1-855-642-8572 or 1-855-642-8573 (TTY) to re-determine your eligibility for health coverage

16. ***Are the Medicaid income rules the same for someone living in a place with a high cost of living as they are for someone living in a less expensive place? For example, if I move from New York City to Baltimore, do I have to make less money to be eligible for Medicaid?***

Medicaid eligibility is based on household income and state residency, but Medicaid income eligibility does not vary based on the cost of living within a particular state or region. For example, a Medicaid enrollee in Baltimore is not allowed to make more money than a person in a rural area in Maryland, even if the cost of living in Baltimore is greater. In all states that have expanded Medicaid under the Affordable Care Act, income eligibility for the expansion population has increased to 138% of the Federal Poverty Level (FPL), which is about $1342 per month for a single adult. Because many states chose not to expand Medicaid eligibility, a person could gain or lose his Medicaid coverage when he moves to a new state, even if his income remains stable. Income and asset rules for foster children, senior citizens, people with disabilities, and people who need long-term care continue to be very different from state to state.

Eligibility for Medicaid also depends on state residency. A person who moves to Maryland from another state must reapply for Medicaid coverage, even if he had Medicaid in his former state. If a person moves from New York City to Maryland, he must reapply for Medicaid in Maryland by contacting his local Department of Social Services or applying online at Maryland Health Connection, www.marylandhealthconnection.gov. Although you can apply to Medicaid at any time of the year, moving to a new state will also qualify you for a Special Enrollment Period, so a person who is eligible for a Qualified Health Plan (QHP) will also be able to reapply for QHP coverage when she moves to a new state.

17. ***Can new Medicaid patients go to any provider that takes HealthChoice?***

Most Medicaid beneficiaries in Maryland (including all newly-eligible Medicaid enrollees who transitioned to Medicaid from the Primary Adult Care program or became eligible because of the Affordable Care Act) receive their health care benefits through HealthChoice. HealthChoice enrollees receive their benefits through Medicaid Managed Care Organizations (MCOs). Like private insurance companies, MCOs are allowed to restrict coverage to the services that are provided by their network of providers and can also set additional geographic limitations on where an enrollee can seek care within Maryland.

When a patient is considering her MCO options, she should consider both the network of providers covered by each MCO, as well as the geographic scope of the MCO's coverage area. (For more information about Medicaid providers, see Question 12, discussing self-referral options for substance use disorder providers, and Questions 44-46, discussing the Provider Search tool on Maryland Health Connection.)

18. ***What if I am experiencing a medical emergency and can't get to a hospital covered by my Managed Care Organization?***

In very limited circumstances, when experiencing a medical emergency, a Maryland Medicaid enrollee can receive health services outside of the network established by their Managed Care Organization (MCO), or even outside of the state of Maryland. MCOs are required to cover the cost of "emergency services" provided to their members, even if those services were provided by an out-of-network hospital. In order to meet the requirements of "emergency services," the health services must be provided in a hospital emergency room for a patient who is experiencing the sudden onset of severe symptoms (including severe pain) that could reasonably lead to serious bodily harm or death if emergency care is not provided. MCOs cannot require patients to seek prior authorization for emergency services, even if they are provided outside of the provider network or outside of Maryland. The out-of-network provider should bill the MCO, not the patient, for the cost of emergency services.

Once the patient is stabilized, the out of network provider must seek authorization to provide any non-emergency, post-stabilization services. The MCO has one hour to authorize post-stabilization services, and must pay for care provided if the provider cannot reach the MCO. Other types of care, including non-emergency inpatient care, outpatient services, and prescription coverage, generally will not be reimbursed if the patient chooses an out-of-network provider, even if the provider is in Maryland, unless the MCO authorizes treatment in advance.

19. ***If an out of state resident with Medicaid seeks health services in Maryland, is Maryland Medicaid required to cover those services? Will a Maryland Medicaid patient be covered for services received in another state?***

Although the Affordable Care Act (ACA) has made Medicaid eligibility rules somewhat more uniform from state to state, Medicaid coverage is still generally limited to providers within the person's state of residence. In limited circumstances, a Maryland Medicaid beneficiary can receive care out-of-state, however, because all states are required to establish procedures for covering certain out of state Medicaid beneficiaries. These circumstances include medical emergencies or cases when an enrollee's health would be endangered if he were required to travel to his home state for care. Additionally, a state must pay for care if it is general practice in a particular area (for example, on the border of another state), for beneficiaries to use medical services in the other state. Finally, if the state Medicaid agency finds that medical services are more readily available in another state, it must pay for those services provided in the other state. These apply to Maryland Medicaid beneficiaries who seek care in another state, as well as residents of other states who seek care in Maryland, if they are eligible for Medicaid in their home state. (For information on out of state emergency services, see Question 18.)

20. ***Why is my new Medicaid card paper instead of plastic?***

You will use your red and white paper Medicaid card temporarily for all services. If you are approved for Medicaid on Maryland Health Connection, you will need to select a Medicaid Managed Care Organization (MCO) to access your health coverage. When you select an MCO, you will receive a plastic, permanent MCO card in the mail. You must keep y our paper red and white Medicaid card for mental health services.

21. ***How does the Affordable Care Act affect the Maryland Children's Health Program (MCHP)?***

Children in Maryland who live in households with incomes under 300% of the Federal Poverty Level (FPL) continue to be eligible for comprehensive health coverage through Medicaid, the Maryland Children's Health Program (MCHP), or MCHP Premium.

Medicaid, MCHP, and MCHP Premium offer identical benefits for covered children. The only differences between these programs are the eligibility rules for participation. Medicaid serves children under the age of 21. MCHP and MCHP Premium service children under the age of 19. Services include the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. EPSDT provides comprehensive and preventative health services to ensure children receive preventive screening and all "medically necessary" treatment services, even if those services are not otherwise covered under the Medicaid benefit. Among the covered services are low-cost or free prescriptions, substance use disorder treatment, specialty mental health services, emergency services, hospitalization, and dental coverage.

A child is financially eligible for Medicaid if his or her household income is less than 138% of the Federal Poverty Level (FPL). If a child's household income exceeds the Medicaid limit, she is eligible for the same benefits under MCHP if his or her household income is less than 200% FPL.

If a child's household income exceeds the MCHP limit, he or she is eligible for the same benefits under MCHP Premium if his or her household income is less than 300% FPL. MCHP Premium

requires a monthly family contribution or premium (assessed per household, not per child.) The amount of the premium is based on household size and income. For households with incomes between 200-250% FPL, the premium is equal to 2% of the annual income for a family of two at 200% of the FPL ($52 per month). For households with income between 250% and 300% FPL, the premium is equal to 2% of the annual income of a family of two at 250% of the FPL ($65 per month).

Applicants to MCHP Premium must make their premium payment in full no later than thirty (30) days after the request for payment. Enrollees who cannot make the premium payment due to a hardship can contact the Department of Health and Mental Hygiene within ten days of receiving the premium bill to request a hardship waiver. If an applicant fails to make the monthly payment, eligibility will be terminated, effective the first day of the month following the month for which the payment was due. Failure to pay will render the individual ineligible to participate in MCHP Premium for ninety (90) days from the date of the notice of termination or the date payment is made in full, whichever is sooner. You can contact the MCHP Premium Division at 410-767-6883 or 1-866-269-5576.

Unlike Medicaid, a child who is currently covered as a dependent under an employer-sponsored group health plan or under private health insurance is not eligible for MCHP or MCHP Premium. In the past, children had to be uninsured for six months in order to be eligible for MCHP. Effective January 1, 2014, this exclusionary period is no longer imposed, and a child is eligible for MCHP or MCHP Premium as soon as other coverage ends.

Individuals can apply for children's Medicaid, MCHP, and MCHP Premium online through the Maryland Health Connection, over the phone by dialing 1-855-642-8572 or 1-855-642-8573 (TTY), or in person at a local health department, Department of Social Services, or Connector Entity. The Connector Entity for Baltimore, Baltimore County, and Anne Arundel County is HealthCare Access Maryland (HCAM). The telephone number for HCAM is 410-649-0500.

22. ***I have SSI – do I have to reapply for Medicaid on Maryland Health Connection?***

People who receive Supplemental Security Income (SSI) are automatically qualified for Medicaid in Maryland and do not need to do anything to keep their coverage. The Affordable Care Act (ACA) does not affect coverage for people who were already receiving Medicaid before January 1, 2014. The old rules will continue to apply to those people, including senior citizens, foster children, and people with disabilities. If you have SSI, contact your caseworker or the Department of Social Services with Medicaid questions.

If you are applying for SSI but have not yet been approved, you can apply for Medicaid through Maryland Health Connection while you pursue your disability application with Social Security. The new rules extend Medicaid coverage to adults up to 138% of the Federal Poverty Level (FPL), which is about $1342 per month in 2014. Applying for Medicaid on Maryland Health Connection does not affect your SSI application with Social Security. Being approved for Medicaid does not guarantee that Social Security will agree that you are disabled and it does not grant any cash benefits. However, you will be eligible for full HealthChoice benefits and be able to access care for your disability.

23. ***I have SSDI – can I apply for Medicaid on Maryland Health Connection?***

If you have been approved for Social Security Disability Insurance (SSDI), you must still wait 24 months before your eligibility for Medicare begins. You can apply for Medicaid or a Qualified Health Plan (QHP) through Maryland Health Connection during this waiting period, and your eligibility will be based on the rules for the Medicaid expansion population. (For more information about Qualified Health Plans, see Part II-B, starting on page 13.)

When Medicare coverage begins, your eligibility for Medicaid will be re-evaluated based on the original rules. The Medicare savings programs in Maryland, Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB), also look at current monthly income and assets. (For more information about Medicaid eligibility for people with Medicare, see Question 39.)

24. ***Is the provider responsible if a patient doesn't inform Medicaid that he or she is no longer eligible for coverage?***

A provider should verify a patient's Medicaid eligibility through the eligibility verification services (EVS) each time he or she receives services. If a health care provider confirms that a patient is enrolled in an MCO on the date of service, the provider can provide the treatment and submit a claim to the patient's Managed Care Organization (MCO) for payment. If a health care provider confirms that a patient is receives services on a fee-for-service (FFS) basis on the date of service, the provider can provide the treatment and submit a claim to Medicaid FFS for payment. Maryland's Medicaid Provider agreement requires that providers record the recipient's Medicaid ID number and other relevant information obtained from the EVS system for billing and compliance services. Providers must maintain records that justify and describe the nature of the treatment provided to Medicaid beneficiaries for six years.

A Medicaid recipient who fails to report changes in income, resources, or other circumstances is violating Medicaid rules and may be committing Medicaid fraud. A health provider commits fraud if the provider knowingly bills for Medicaid services provided to an individual who no longer qualifies for coverage. Providers can report instances of suspected Medicaid fraud to the Department of Health and Mental Hygiene (DHMH). Reports can be made:

- By phone: 1-866-770-7175 or 410-767-5784
- By fax: 410-333-7194
- Online: http://dhmh.maryland.gov/oig/SitePages/reportfraud.aspx
- By mail: Susan R. Steinberg, Esq.
  Assistant Inspector General
  Department of Health & Mental Hygiene
  201 West Preston Street
  Baltimore, MD 21201

25. ***Has the Affordable Care Act (ACA) changed the use of Eligibility Verification System (EVS)?***

The ACA has not changed the rules for using the Eligibility Verification System (EVS). All Medicaid providers should call the Department of Health and Mental Hygiene (DHMH) EVS to

determine if an individual is enrolled in Medicaid on the day of service. This is because Medicaid eligibility is determined on a month-to-month basis and can change at any given time. Individuals who are enrolled in Medicaid through Maryland Health Connection will be visible in the EVS even if they have not yet received a Medicaid card in the mail. This system is available either online at https://encrypt.emdhealthchoice.org/emedicaid or by calling 1-866-710-1447. Before using EVS, you must be electronically registered for the eMedicaid website.

B. Qualified Health Plans

26. ***What is a Qualified Health Plan (QHP)?***

Qualified Health Plans (QHPs) are the private insurance plans for sale on Maryland Health Connection. In order to get a discount on your premium or out-of-pocket costs, you must purchase a QHP through Maryland Health Connection.

27. ***What are the "metal levels"?***

Under the Affordable Care Act, all plans are categorized by "metal level." The metal levels offer a way to compare the portion of out-of-pocket costs the plan will cover for all services over the plan year. All plans offer the same set of health benefits regardless of metal level.

The different metal levels are:

- ***Bronze Level:*** Insurance pays: 60%; you pay: 40%
- ***Silver Level:*** Insurance pays: 70%; you pay: 30%
- ***Gold Level:*** Insurance pays: 80%; you pay: 20%
- ***Platinum Level:*** Insurance pays: 90%; you pay: 10%

Metal levels do not represent what a particular person will pay for out-of-pocket costs. A patient's out-of-pocket costs will depend on his use of medical care and the cost-sharing rules set by his plan. Costs vary within metal levels based on the plan's specific charges, so that two Silver plans could have different deductibles, copayments, and coinsurance, resulting in very different out-of-pocket costs. Although the premium for a Bronze level plan may be less than the premium for other metal level plans, when a patient is selecting a plan, he should look beyond the metal level to ensure that the specific plan he chooses will be affordable based on his own medical needs.

If your household income falls between 100-250% Federal Poverty Level (FPL), you are eligible for cost-sharing reductions. You **must** buy a Silver-level plan to take advantage of these discounts.

28. ***How can I afford a Qualified Health Plan?***

You may be eligible for discounts on your monthly premiums and out-of-pocket costs. Eligibility for discounts on Qualified Health Plans (QHPs) is based on prospective annual income.

In order to be eligible for advanced premium tax credits to lower the cost of monthly premiums, your household income must be between 100% and 400% of the Federal Poverty Level (FPL). To be eligible for additional cost-sharing reductions that will lower out-of-pocket costs like

deductibles, copayments, and coinsurance, your household income must be between 100% and 250% of the FPL, and you **must** buy a Silver level plan.

You may notice that the income limits amounts overlap with Medicaid's 138% FPL standard. If you are eligible for Medicaid, you cannot receive discounts if you buy a QHP. However, certain individuals are not eligible for Medicaid, even though their incomes are below 138% FPL. The largest group of people in this category is legally-present non-citizens during the first five years they are in the United States. (For more information about citizenship status and health coverage, see Question 4.) People in this situation can still purchase a QHP with discounts if their income is below 400% FPL.

29. ***How do metal levels affect my out-of-pocket costs?***

The plan metal levels offer a way to compare the portion of out-of-pocket costs the plan will cover for all services over the plan year, but they do not represent what a plan will pay for out-of-pocket costs for any particular person. A patient's actual out-of-pocket costs will depend upon his use of medical care and the specific plan's charges for deductibles, copayments and coinsurance.

For example, for a Bronze plan, the carrier will pay an estimated 60% of the costs of services and enrollees will pay an estimated 40% of the costs. When an individual enrollee sees his doctor or gets a blood test, he must pay the applicable deductible and then any copayments or coinsurance for the services. He would **not** pay 40% of the doctor's fee or the laboratory's charge.

Individuals who are eligible for cost-sharing reductions must purchase a Silver plan through Maryland Health Connection to receive those out-of-pocket discounts. All Qualified Health Plans, regardless of the metal level, must cover the same health benefits and services. The health care providers who are considered in-network providers will differ under each plan and metal level.

30. ***Does the metal level of my plan affect the health services I can receive?***

No, all health plans—regardless of metal level—must offer the same health benefits that have been set out in the Affordable Care Act (ACA). These services fall within ten categories of essential health benefits (EHBs): (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services.

Maryland has selected a "benchmark plan" that covers all essential health benefits, and insurance companies must use this model when developing insurance plans that will be sold on Maryland Health Connection. Maryland's benchmark plan provides the most comprehensive behavioral health services available, including:

- Inpatient hospitalization;
- Residential treatment services;
- Outpatient hospital services, including partial hospitalization and intensive day treatment
- Outpatient diagnostic tests;
- Psychological/neuropsychological testing necessary to determine appropriate psychiatric treatment;

- Outpatient and intensive outpatient therapy services;
- Pharmacotherapy (including methadone maintenance treatment); and
- Prescription drugs.

31. ***Is chronic disease care a specific covered service in the Essential Health Benefits (EHBs)?***

Yes, chronic disease management is one of the ten Essential Health Benefits (EHBs), and all individuals enrolled in a Qualified Health Plan (QHP) are entitled to these benefits. Maryland's health plans cover a wide range of services for persons with chronic diseases. Individuals with mental health or substance use disorders may receive a full continuum of services, including diagnostic testing, outpatient, intensive outpatient and medication assisted treatment, partial hospitalization treatment, and inpatient hospital and residential treatment.

QHPs also cover health services for persons with chronic somatic conditions, such as diabetes, cardiac disease and pulmonary disease. For example, individuals with diabetes are entitled to treatment, equipment and supplies necessary to help manage their condition, including insulin pumps. Individuals with significant cardiac disease may be referred for cardiac rehabilitation, which includes medical evaluations, prescribed exercise, risk factor assessments, education and counseling and increased outpatient rehabilitation services. Individuals with chronic conditions may also participate in patient centered medical homes, which develop and supervise a care plan and assist with coordination of care between the individual and health care providers, a nurse coordinator and care coordination team.

Chronic disease management is also available for HealthChoice enrollees. Managed care organizations (MCOs) are required to incorporate screening for substance use disorders in an individual's initial health screen, and when clinically indicated, so that Medicaid enrollees may be referred to appropriate treatment. An MCO must provide outpatient, intensive outpatient services, detoxification services on an outpatient or inpatient basis, and, for individuals under 21, residential substance abuse treatment in an intermediate care facility. An MCO must also refer individuals to appropriate substance use treatment services that are not covered by HealthChoice.

In addition to these substance use disorder services, an MCO must provide its members who have chronic health conditions with a range of primary care and specialty care services. The MCO must provide medically necessary services in a chronic hospital, a chronic rehabilitation hospital, or a nursing facility. An MCO must also provide coordinated health care services to enrollees who fit within the "special needs population" classification, many of whom will have a chronic disease.

For example, individuals with a substance use disorder and individuals with HIV/AIDS are considered to be a "special needs population." For these individuals, an MCO must provide case management services to adult and pediatric enrollees, have the capacity to perform home visits, respond to urgent care needs while in the enrollee's home, and ensure that the primary care provider (PCP) is the admitting or referring provider for all hospital admissions. The MCO must also collaborate with inpatient facilities in organizing preadmission and discharge planning. An MCO must also link an individual with HIV/AIDS, as needed, to additional medical and support services, such as mental health services, substance use services, social services, counseling services, financial services, educational services and housing services.

32. ***How does my age affect my Qualified Health Plan premium?***

Under the Affordable Care Act (ACA), an individual's premium for a health plan is based on four factors: whether the person purchases individual or family coverage; her age, rating area (geographic region), and tobacco use. While the premium will vary based on the enrollee's age, carriers are now limited in the amount they can charge individuals as they get older. Carriers may not charge more than three times the amount for individuals of different ages who are twenty-one (21) years old and older. In other words, an individual who is sixty-three (63) years old may not be charged a premium that is more than three times greater than the premium for a 21-year-old person. This will result in lower premiums for older individuals and slightly higher premiums for younger individuals. In addition, the premium for children up to twenty (20) years of age and adults ages sixty-four (64) and older will not vary within those age ranges based on the individual's age.

33. ***How does the place where I live affect my Qualified Health Plan premium?***

Under the Affordable Care Act (ACA), an individual's geographic region, known as the rating area, is one of four factors that is considered in setting the premium. A carrier may set rates based on the enrollee's geographic location to account for the different cost of care across a state or region. A state must establish the uniform rating areas based on either county boundaries, three digit zip codes, or metropolitan and non-metropolitan statistical areas. Maryland has established four rating areas: the Baltimore metropolitan area, the D.C. metropolitan area, Eastern and Southern Maryland and Western Maryland.

34. ***Do tobacco users pay more for Qualified Health Plans?***

Under the Affordable Care Act (ACA), an individual's tobacco use is one of four factors that may be considered in setting the plan's premium. States can decide whether or not to include this as a factor. In 2014, health insurers in Maryland may charge individuals who legally use tobacco one and a half (1.5) times the premium they charge a non-tobacco user. This is left up to each health insurance company, and some carriers in Maryland chose not charge a higher premium for tobacco users.

Maryland has decided that tobacco use cannot be considered as a rating factor in 2015. That means that plans purchased for coverage beginning January 1, 2015 cannot charge enrollees a higher premium based on their tobacco use.

35. ***Do all insurance companies that offer Qualified Health Plans have the same provider network? Will I have to choose a provider who is in my plan's provider network?***

Insurance companies that offer Qualified Health Plans (QHPs) will have different providers in the provider network for each of their plans. You should carefully check whether your provider(s) are in the plan's network (in-network providers) and whether the plan also offers coverage for out-of-network providers. Some QHPs will pay for services that are provided by both in-network and out-of-network providers and some will limit reimbursement to in-network providers alone. If you purchase a QHP that covers both in-network and out-of-network providers, you will have greater flexibility in selecting your health providers. These plans usually have a higher premium. You will pay more for any services that you get from an out-of-network provider.

You should ask your health care provider for the names of the QHPs in which she is a network provider. You may also check whether your provider is in a plan's provider network by using Maryland Health Connection's Health Care Provider Search Tool. This tool can be found at www.marylandhealthconnection.gov, by clicking on "Resources" and then "Prepare for Enrollment," or directly by going to https://providersearch.crisphealth.org. You can search for a provider using the practitioner's name, but substance use treatment programs are not listed under the program's name in the search tool.

36. ***My employer offers health insurance, but I may be eligible for cheaper coverage if I buy a Qualified Health Plan (QHP). Do I have to purchase the insurance from my employer?***

You must purchase your employer's health insurance policy if it is an "eligible employer-sponsored plan." An employer plan will include those offered by government employers and any other coverage offered by either a small or large employer in Maryland. An employer's plan must be both "affordable" and provide "minimum value" to be considered an eligible employer plan.

An employer's plan is considered "affordable" if the annual premium for individual coverage does not exceed 9.5% of your household income. The affordability test is based on the cost of individual coverage, even if you actually pay for a family plan from your employer. The plan offers "minimum value" if the plan covers at least 60% of the total allowed costs of the benefits provided to an enrollee. This plan is comparable to a Bronze Level plan that is offered on Maryland Health Connection. (For more information about metal levels, see Questions 27-30). If your employer-sponsored plan meets these requirements, you are not eligible for discounts that are available for Qualified Health Plans (QHPs) offered on Maryland Health Connection.

To determine whether your employer's plan meets these two requirements, ask your employer's human resources department for information about your insurance coverage. The employer can use the Employer Coverage Tool, developed by the Department of Health and Human Services (DHHS), to provide information about the plan's value and premiums. The Employer Coverage Tool is available at https://www.healthcare.gov/downloads/ECT_Application_508_130615.pdf.

C. Medicare

37. ***How does the Affordable Care Act (ACA) affect Medicare?***

Most Medicare beneficiaries will **not** experience significant changes in their insurance coverage due to the ACA. The Parts of Medicare, open enrollment periods, cost-sharing requirements, and the doctors who accept Medicare do not change.

The Medicare "Parts" will remain the same and are still organized into four different categories:

- **Part A**: Covers inpatient care in a hospital or skilled nursing facility, very limited nursing-level care in your home after you have been discharged from the hospital, and hospice care at home.
- **Part B**: Covers preventative and diagnostic services, outpatient treatment, and durable medical equipment and some other medical supplies.
- **Part C**: Usually referred to as "Medicare Advantage," Medicare beneficiaries can choose to enroll in private health insurance plans that contract with Medicare to provide all Part A and Part B benefits. Most Part C plans also offer prescription drug coverage.

- **Part D**: Covers prescription drugs through contracts with private prescription insurance plans. Each plan sets its own formulary (the list of medications that are covered and the requirements for getting a medication), and not all plans cover the same medications.

The ACA will reduce the cost of certain kinds of care. First, the prescription drug "donut hole" is being slowly phased out. By 2020, Medicare beneficiaries with Part D will not experience a coverage gap during the year, even if they have high prescription costs. The ACA also requires that Medicare providers offer certain preventative services without any cost-sharing, including an annual wellness visit, flu vaccines, and screenings for individuals at risk of cancer, high blood pressure, and diabetes.

38. ***Do I apply for Medicare on Maryland Health Connection?***

The ACA does not change the way that people apply for Medicare. You cannot use Maryland Health Connection to apply for Medicare, Qualified Medicare Beneficiary (QMB), or Specified Low-Income Medicare Beneficiary (SLMB) programs. Instead, people can continue to apply for Medicare through the Social Security Administration beginning three months before the month they will turn 65. If a person has been found eligible for Social Security Disability Insurance (SSDI) for at least 24 months, then Social Security will contact them with Medicare enrollment information.

Each Part of Medicare requires separate monthly premiums, deductibles, and coinsurance payments. If your income is below 120% of the Federal Poverty Level (FPL) you may be eligible for help with some or all of these costs. (For more information about Medicare, see Question 37. For more information on Medicare Savings Programs, like QMB and SLMB, see Question 39.)

For help with the application process, every state has a designated Medicare counseling agency, known as the Senior Health Insurance Program (SHIP). SHIP counselors can assist with individual questions about Medicare eligibility, coverage, and Medicare Advantage and Part D plan selection. Maryland's SHIP has locations in all 24 counties. Contact information for the SHIP near you is online at: http://www.aging.maryland.gov/SeniorHealthInsuranceProgram.html

39. ***Can I have both Medicare and Medicaid at the same time?***

The Affordable Care Act (ACA) does not change the relationship between Medicare and Medicaid. Individuals can have both Medicare and Medicaid at the same time if they qualify for both kinds of coverage. Medicare beneficiaries are not eligible for Medicaid coverage through the ACA expansion.

A Medicare beneficiary may be eligible for full Medicaid coverage or partial assistance paying for Medicare out-of-pocket costs. The same rules that governed Medicaid eligibility for people over sixty-five (65) or people who have disabilities before the ACA are still used to determine eligibility for those groups. To be eligible for full Medicaid, an individual who is over 65 or who is disabled cannot have income over $350 per month and cannot have assets over $2,500.

If an individual is not eligible for Medicaid, there are two "Medicare Savings Programs" available to Medicare beneficiaries with limited incomes. The Qualified Medicare Beneficiary Program (QMB) is available to individuals who receive Medicare and have incomes under 100% of the Federal Poverty Limit. Under QMB, Medicaid pays for Part A and B premiums, deductibles,

copayments, and coinsurance. QMB will cover cost-sharing for Medicare-covered substance use disorder services but does not cover methadone maintenance treatment, because this is not currently a Medicare-covered service. For an individual to be eligible for QMB, his or her monthly income must be below 100% of the Federal Poverty Limit (approximately $993 for an individual and $1,331 for couples).

The second Medicare Savings Program, called the Specified Low-Income Medicare Beneficiary Program (SLMB), is available to Medicare beneficiaries with incomes between 100 and 120% of the Federal Poverty Limit. Under SLMB, Medicaid only pays for Medicare Part B premiums. Therefore, individuals with SLMB are responsible for out-of-pocket costs related to Medicare, including substance use disorder treatment services. For an individual to be eligible for SLMB, his or her monthly income must be greater than 100% of the Federal Poverty Level (FPL) but less than 120% of the FPL (approximately $1,187 for an individual or $1,593 for couples).

40. ***Can a person with Medicare apply for Medicaid through the Maryland Health Connection website?***

Individuals who qualify for Medicare and want to obtain Medicaid should not visit the Maryland Health Connection website to enroll. Individuals who qualify for Medicare and are seeking enrollment in Medicaid, Qualified Medicare Beneficiary (QMB) Program, or Specified Low-Income Medicare Beneficiary (SLMB) Program should contact their local Department of Social Services to apply. Maryland Health Connection determines Medicaid eligibility only for individuals who are newly eligible for Medicaid based on their incomes because of the Affordable Care Act (ACA). The old Medicaid rules will continue to apply to Medicare beneficiaries, senior citizens, foster children, and people with disabilities.

III. Applying for Health Insurance on Maryland Health Connection

41. ***Can I use Maryland Health Connection's website without creating an account?***

Yes, you can use the website without creating an account, but everyone must create an account in order to actually apply for Medicaid or a Qualified Health Plan (QHP). There are two basic functions for the website: preparing for enrollment and enrollment. Preparing for enrollment does not require you to create an account. You can browse through numerous resources and information on the website to learn more about your eligibility and enrollment options. A list of the pre-enrollment resources that you can use without a user account is available on Maryland Health Connection and includes:

- Frequently Asked Questions;
- Provider Search tool (See Questions 43-44 for more information)
- Income Eligibility Chart;
- Maryland Health Connection Sample Rate Scenarios;
- Authorized Insurance Broker Directory;
- Maryland Health Connection Plan Quality Report;
- Maryland Health Connection Health Care Provider Search;
- Participating Insurance Companies (Maryland Health Connection Qualified Health Plan Companies);

    - By clicking on this link, you can view the participating insurance carriers and the summary of benefits and coverage for the carrier's plans
- Medicaid Managed Care Organization Comparison Chart

Individuals can also access in-person or telephone assistance without first having to create a user account. To reach a Navigator by telephone or set up an appointment, Baltimore residents can call HealthCare Access Maryland (HCAM) at 1-877-223-5201. More information on HCAM can be found at http://www.healthcareaccessmaryland.org.

When you are ready to apply for and enroll in a health plan, you must create an account. If you are working with the call center or a Navigator, assistance personnel can help you to create an account.

42. ***Can I help a family member apply for coverage on Maryland Health Connection?***

Yes, you may help a family member or other person with the mechanics of enrolling in a health plan. If you and your family member are applying by telephone, the applicant must give verbal permission for you to work on the application alone. If the applicant needs greater or ongoing assistance, you can also become his or her formal "authorized representative." You can be designated as an authorized representative either through writing (with the applicant's signature) or by providing proof of legal authority to act on behalf of the applicant. As an authorized representative, some of your duties may include:

- Signing an application on the applicant's behalf
- Submitting and update or responding to a redetermination for the applicant
- Receiving copies of the applicant's notices and other communications with the Maryland Health Benefit Exchange
- Acting on behalf of the applicant on all matters with the Maryland Health Benefit Exchange

An applicant determines the scope of duties for the authorized representative. This means the applicant can limit the authority or power of the authorized representative's duties. Whether you are assisting an individual in enrolling in a health plan or acting as an authorized representative, you must be prepared to provide the individual's Social Security Number, birthdate, employer and income information, policy numbers for current insurance, and job-related insurance information. You and your family member must consider the provider network, medications, and costs when choosing health coverage.

43. ***What is the phone number and website for HealthCare Access Maryland (HCAM)?***

HealthCare Access Maryland (HCAM) is the Connector Entity for Maryland's Central Region, including Baltimore City, Baltimore County, and Anne Arundel County. Residents of those three areas should contact HCAM with questions about health coverage, to get assistance from trained Navigators and Assisters, to apply for coverage or for a Special Enrollment Period, and to report changes in income that affect their eligibility for Medicaid or Qualified Health Plan discounts. HCAM's dedicated call center number is 1-877-223-5201. HCAM's website for health reform is www.healthcareaccessmaryland.org/healthcare-reform.

44. ***What is Maryland Health Connection's Provider Search tool?***

The Provider Search tool, available at https://providersearch.crisphealth.org, is a directory that allows consumers to search for health care providers. This is an important tool for consumers who are trying to decide which Medicaid Managed Care Organization (MCO) or Qualified Health Plan (QHP) carrier they should choose. You can also access the Provider Search tool through the "Preparing for Enrollment" tab on Maryland Health Connection's website. Currently, the tool allows you to search for a provider by name, county, specialty, carrier name, plan name, or ZIP code. The Provider Search tool does not allow you to search for substance use disorder treatment programs by the program name. You can only search for licensed practitioners.

45. ***What are the different ways I can filter search results through Maryland Health Connection's Provider Search tool?***

The Provider Directory allows you to search by Provider Name or Provider County. By clicking on "Advanced Search," you can also search by the specific Provider Specialty, Carrier Name, Plan Name, or Provider ZIP Code.

46. ***I'm a health care provider, but I'm not listed on the Provider Search. What should I do?***

You may not be listed on the Provider Search tool because the tool lists only those licensed practitioners who have contracted with a Qualified Health Plan (QHP) or a Managed Care Organization (MCO). Programs are not listed by name, so patients cannot search for providers using the name of a program. Additionally, if you are a certified practitioner, you will not be listed because carriers do not contract with certified practitioners. Finally, because HealthChoice allows beneficiaries to "self-refer" to substance use disorder providers who do not have contracts with the patient's MCO, there are many SUD providers who treat HealthChoice beneficiaries without having a contract and, therefore, are not listed on the Provider Search tool.

If you are a licensed practitioner with an MCO or QHP contract, however, the Provider Search tool should include accurate information right now. CRISP Health, the creators of the Provider Network Search tool, receives all of its data from carriers and MCOs. If you are not listed in the Provider Directory or your entry contains errors, you should contact CRISP Health by emailing providersearch@crisphealth.org or calling 1-877-952-7477 during business hours and providing your NPI and telephone number. You should also contact the relevant carrier or MCO directly to update your information.

IV. After You Enroll: Appeals, Reporting Changes, & Special Enrollment Periods

47. ***What if I disagree with the State's determination for Medicaid eligibility or plan discounts?***

You have the right to appeal any eligibility determination, including a determination related to Medicaid eligibility, Qualified Health Plan (QHP) eligibility, or the amount of the premium or cost-sharing discount. The State's notice about your eligibility determination must inform you about your right to appeal and how you can begin the appeals process. In many cases, you will learn of the eligibility decision over the phone or online, and you may not receive a formal eligibility notice. Even if you have not received a formal eligibility and appeal notice from the State, you still have the right to appeal the State's eligibility determination. Call the Consolidated Services Center at 1-855-642-8572 or 1-855-642-8573 (TTY) to file the appeal over the phone or to ask for more information about the status of your application.

48. ***Can insurance companies deny me certain types of treatment based on the seriousness of my condition?***

A person can no longer be denied health insurance based on a pre-existing condition, no matter how severe the illness. However, a person may not be eligible for certain services if the insurance carrier determines that the specific service is not "medically necessary." In order for a procedure to be considered "medically necessary," a practitioner must recommend that a patient receive that treatment and the insurance company must approve coverage.

Some procedures may require "pre-authorization." This means that you or your provider will have to ask the insurance company if it will cover the treatment before you receive it. This is the most common for services that are more expensive, including inpatient or residential treatment. If the insurance company denies coverage, the patient and/or the patient's provider may challenge this decision. Insurance plans cannot place more limits on substance use disorder services than medical services.

49. ***What happens if my income changes? Will Medicaid or the Maryland Health Benefit Exchange check my income?***

Individuals enrolled in Medicaid and Qualified Health Plans (QHPs) are required to report changes that may affect eligibility. This may include increases or decreases in income or household size. Your eligibility for Medicaid as well as QHP premium discounts and cost-sharing reductions will be re-determined when you report these changes.

If you are enrolled in a QHP but do not report income changes when they occur during the year, the estimated income that you reported on your QHP application will be compared with your actual income when you file your taxes the next year. This process is called "reconciliation." If your household income increased over the year to the extent it changed your eligibility for a premium discount and you did not report it, you will be required to pay the difference through your taxes. If your household income decreased over the year so that you were eligible for a larger premium discount and you did not report it, you will receive the difference in the form of a tax refund. However, you will not be able to recoup any out-of-pocket costs like copayments or coinsurance. To report changes before that time, you can contact either HealthCare Access Maryland (HCAM) at 1-877-223-5201 (for Baltimore City, Baltimore County, and Anne Arundel

County) or the statewide Consolidated Services Center at 1-855-642-8572 or 1-855-642-8573 (TTY).

Medicaid beneficiaries must report any changes that could affect their eligibility for Medicaid within 10 business days. Individuals who receive Medicaid benefits are subject to ongoing review. Medicaid may conduct this review by contacting employers as well as local, state, and federal agencies to verify the accuracy of information. Medicaid also has access to the Maryland Automated Benefit System (MABS), which provides quarterly reports from the unemployment insurance program. Failure to report changes in income can result in loss of benefits, recovery of improper benefit payments, and other penalties related to Medicaid fraud. If you have Medicaid, but you have experienced a change in circumstances that might affect your eligibility, you should call your caseworker within ten days to report the change. Alternatively, individuals enrolled in Medicaid may contact the Department of Health and Mental Hygiene at (410) 767-1463 or 1-800-492-5231, extension 1463, or the statewide Consolidated Services Center at 1-855-642-8572 or 1-855-642-1473 (TTY).

50. ***What happens if my income fluctuates above and below 138% of the Federal Poverty Level?***

Individuals enrolled in Medicaid and Qualified Health Plans (QHPs) are required to report changes that may affect eligibility for Medicaid or premium and cost-sharing discounts.

For example, a patient who works for a school system may only have income for 10 months out of the year. During the school year, this patient's income is above 138% of the Federal Poverty Level (FPL), so he may be eligible for a QHP. But during July and August, the patient has no income, and so he is eligible for Medicaid in those two months.

The patient must decide whether to continue with a QHP or switch back to Medicaid based on anticipated income changes for the remainder of the year. Eligibility for QHPs is based on prospective income over the course of an entire year, instead of actual income in each month. Therefore, monthly income fluctuations may not have an immediate impact on an individual's eligibility for premium and cost-sharing discounts, unless the changes will affect total income over the course of the whole year. While a person can apply to Medicaid at any point during the year, if additional fluctuations are anticipated, the patient may decide to remain in a QHP in order to keep the same provider network and prescription drug formulary, especially if he knows he will lose Medicaid eligibility after a short time. (See Question 49 for more information about reporting requirements.)

Many individuals in drug treatment programs will move between Medicaid and QHP coverage. This churn between programs can lead to gaps in insurance coverage and significant disruptions in care with the providers of their choice. In addition to the administrative inconveniences involved with changing plans, patients could experience deductible resets changes in networks, and new formularies that may not cover certain prescriptions. Despite these inconveniences, individuals are still required to report changes that may affect eligibility and are encouraged to apply for the health insurance that works best for them.

51. ***What happens if my coverage changes but my provider is not part of the new network?***

On January 1, 2015, certain continuity of care protections will take effect for persons receiving treatment for mental health and substance use disorders who transition to a new health benefit plan

or Medicaid Managed Care Organization (MCO) that does not include their current provider(s). Upon request, individuals with mental health conditions and substance use disorders may continue to receive services from their current provider for 90 days or the duration of the treatment plan (if less than 90 days), even if the provider is not participating in the new plan's provider network. These continuity of care protections also apply to individuals with acute or serious chronic conditions and women who are pregnant. In these situations, the current provider would typically be paid the same rate that the new plan or MCO pays its participating providers offering the same services in the same or similar geographic area. If the provider does not accept the reimbursement rate, it can negotiate for a different rate and is not obligated to provide the care if an acceptable rate is not offered. The patient will be required to pay any copayments, deductibles, or coinsurance that is required by the new benefit plan or MCO. Carriers and MCOs are permitted to provide additional continuity of care protections beyond these minimum requirements.

52. ***Can I switch my plan to one in a different metal level?***

You can change the metal level of your plan during an open enrollment period only if your plan has not taken effect yet. Otherwise, you cannot switch health plans or change the metal level of your plan unless you qualify for a Special Enrollment Period as a result of a qualifying life event. These events generally involve a change of income, household size, or residence that affects your eligibility for insurance coverage or financial assistance to purchase insurance; a change is citizenship status; or the loss of insurance coverage.

You may enroll in Medicaid or Maryland Children's Health Insurance Program (MCHP) at any time during the year. Under Maryland's Medicaid program, you may switch the Medicaid Managed Care Organization that manages your benefits on an annual basis.

53. ***I missed the Open Enrollment deadline. How can I apply for coverage now?***

If you do not enroll in health insurance during the Open Enrollment Period, you may still qualify for a Special Enrollment Period (SEP) if you have a qualifying life event that affects your income or household size. Some of the most common qualifying life events include:

- An individual or dependent loses minimum essential coverage (for example, a person who had coverage through her employer but loses her job has lost minimum essential coverage);
    - *If you lose minimum essential coverage because you failed to pay premiums, you do not qualify for a Special Enrollment Period*
- An individual is determined newly eligible or ineligible for advance payments of the premium tax credit or has a change in eligibility for cost sharing reductions (for example, a change in household income will affect the level of premium discounts or cost-sharing assistance a person is eligible to receive);
- An individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption;
- An individual gains legal status as a citizen, national, or lawfully-present individual (green card holder);

- An individual's enrollment or non-enrollment in a Qualified Health Plan is unintentional and is the result of a mistake on the Exchange's part; or

- An individual gains access to new Qualified Health Plan as a result of a permanent move to a new geographic location.

Several other qualifying life events may trigger a SEP. If you qualify for a Special Enrollment Period, you will have sixty days from the date of the qualifying life event to select a new Qualified Health Plan (QHP). If you think that you have experienced a qualifying life event, contact HealthCare Access Maryland (HCAM) at 1-877-223-5201 (Baltimore City, Baltimore County, or Anne Arundel County) or the statewide Consolidated Services Center at 1-855-642-8572 or 1-855-642-8573 (TTY) for more information and to enroll in a new plan.

If an individual does not meet the Open Enrollment deadline and does not qualify for a SEP, then the individual will not be able to enroll in health insurance through Maryland Health Connection. Additionally, a person who does not have insurance may have to pay a financial penalty. (For more information about the penalty, see Question 7.)

54. ***Can I get a Special Enrollment Period if I lose my insurance due to my age?***

Although a change in age does not trigger a Special Enrollment Period (SEP) on its own, you may qualify for a SEP if you lose minimum essential coverage due to a change in age. For example, if you were insured through your parent's employer-based health plan, and you lose your minimum essential coverage because you turn 26, you qualify for a SEP. You have sixty (60) days from the date you lost health coverage to select a new Qualified Health Plan (QHP). Contact HealthCare Access Maryland (HCAM) at 1-877-223-5201 (Baltimore City, Baltimore County, and Anne Arundel County) or the statewide Consolidated Services Center at 1-855-642-8572 or 1-855-642-8573 (TTY) for more information and to enroll in a new plan.

V. Special Considerations

A. Substance Use Disorder Treatment

55. ***How can I afford substance use disorder treatment?***

Medicaid and Qualified Health Plans (QHP) are required to cover substance use disorder treatment services. Once you receive your eligibility determination, you must select either a Medicaid Managed Care Organization (MCO) or a QHP. If you are eligible for Medicaid, you will receive covered health services and prescription medications for little or no cost. If you are eligible for a Qualified Health Plan and your income is below 400% of the Federal Poverty Level (FPL), you may be eligible for a discount on your monthly insurance payment (the insurance premium). If your income is below 250% of the FPL you are eligible for discounts on the cost of the services you receive (deductibles and copayments) as well as premium discounts. Discounts for health care costs are calculated based on your income and household size. In selecting a QHP, you should select a Silver level plan if you are eligible for cost-sharing reductions. You should also look for a plan that charges co-payments instead of coinsurance for outpatient services, so that you can better estimate your out-of-pocket costs for counseling services you will get on a regular basis (For more information about how to select an affordable QHP for your needs, see Questions 27-29.)

56. ***Are prescription drugs for substance use disorders covered in health plans?***

All health plans have a list of prescription medications that are covered. This list is called the formulary. The formulary for a Qualified Health Plan (QHP) must cover at least two medications used to treat alcohol dependence and two medications for opioid dependence. If you need a specific medication, check before you purchase a particular plan to make sure that your medications are included on that plan's formulary. If you are already covered, contact your insurance carrier to see if the medication is included in the plan's formulary at an affordable cost. If you have a Medicaid Managed Care Organization (MCO), check your MCO's formulary to see if it includes your medication and whether any restrictions apply to obtaining it.

57. ***Do all of the health plans on Maryland Health Connection cover Suboxone?***

When enrolling in health coverage through either a Medicaid Managed Care Organization (MCO) or a Qualified Health Plan (QHP), you must check the plan's formulary – list of covered prescription medications – to make sure the plan covers Suboxone and to identify any restrictions on your access to the medication. The MCO or QHP should provide you with a list of the covered medications, and your treatment provider should be able to help you identify the health plans that cover Suboxone and any limitations.

If you are eligible for HealthChoice, all eight Medicaid Managed Care Organizations (MCOs) cover Suboxone or its generic version (buprenorphine HCL/naloxone HCL SL). MCOs are allowed to restrict coverage. You will usually have to use the generic version unless your doctor explains why you need a brand-name drug. Many MCOs also require a patient to get the MCO's

prior approval (known as "prior authorization") before it will pay for Suboxone. Each MCO can change its formulary rules on a regular basis, but the MCO coverage requirements for Suboxone as of July 2014 are:

- Jai – prior authorization required; quantity limits apply; brand-name film or generic tablets
- Kaiser Permanente – generic tablets only
- Maryland Physicians Care – dosage limit of 24 mg/day and prior authorization required for higher dosage; prior authorization also required for prescriptions for person under age 16; brand-name film or generic tablets
- Medstar – generic tablets covered; film not covered. Other opioids cannot be used for 90 days after the initial prescription.
- Priority Partners – prior authorization; quantity limit of 60 tablets for 25 days; brand-name film or generic tablets
- Riverside – prior authorization required; brand-name film or generic tablets
- United Healthcare MD Medicaid – prior authorization; brand name film or generic tablets
- Amerigroup – prior authorization required; brand-name film and generic tablets

For private health insurance, each QHP has its own formulary and is required to cover at least two medications to treat drug dependence. While a QHP may cover Suboxone, it is not required to cover any specific medication for the treatment of opioid dependence. The QHP, like the MCOs, may also require prior approval and may impose other quantity or dosage limitations. You should contact or ask your provider to contact the QHP to learn whether Suboxone is covered and whether any restrictions apply.

58. ***Can I search for substance use disorder treatment programs on Maryland Health Connection's Provider Search tool?***

Currently, the Provider Directory does not allow you to search for substance use disorder (SUD) treatment programs using the name of the program. The Provider Directory only allows you to search for licensed practitioners who have contracted with a Qualified Health Plan (QHP) or a Managed Care Organization (MCO). The data included in the tool is based on the information that carriers and MCOs provide for the practitioners who have contracts with them. You can search for licensed SUD practitioners under the "Provider Name" tab.

If you are a practitioner, the Clinic recommends that you check to see if you are correctly identified on the Provider Search tool. If there are mistakes in your entry, you can contact CRISP directly with your NPI and telephone number, by emailing providersearch@crisphealth.org or calling 1-877-952-7477 during business hours.

59. ***How does the Affordable Care Act affect substance use services for Qualified Medicare Beneficiaries (QMB) and/or Specified Low-Income Medicare Beneficiaries (SLMB)?***

Medicare beneficiaries who also qualify for full Medicaid benefits are considered "dual eligibles." For individuals over sixty-five (65) or disabled to be dually eligible for full Medicaid, their incomes must not exceed $350 per month for a single person; there is also an asset limit of $2,500. If an individual is not eligible for full Medicaid because of these strict income and asset rules, there are two "Medicare Savings Programs" available to Medicare beneficiaries with limited incomes.

QMB is available to individuals who receive Medicare and have incomes under 100% of the Federal Poverty Level (FPL). Under QMB, Medicaid pays for Part A and B premiums, deductibles, copayments, and coinsurance. QMB will cover cost-sharing for Medicare-covered substance use disorder services but does not cover methadone maintenance treatment, because it is not currently a Medicare-covered service. For an individual to be eligible for QMB, his or her monthly income must be below 100% of the FPL (approximately $993 for an individual and $1,331 for couples).

SLMB, the second Medicare Savings Program, is available to Medicare beneficiaries with incomes between 100% and 120% of the FPL. Under SLMB, Medicaid only pays for Medicare Part B premiums. Therefore, individuals with SLMB are responsible for out-of-pocket costs related to Medicare, including substance use disorder treatment services. For an individual to be eligible for SLMB, their monthly income must be greater than 100% of the FPL but less than 120% of the FPL (approximately $1,187 for an individual) and $1,593 for couples).

For more information about how the Affordable Care Act affects Medicare, see Part II-C, starting on page 18.

B. Veterans' Issues

60. ***Which veterans are eligible to receive Veterans Administration (VA) health care benefits? Are reservists and those who are not on active duty eligible for VA health coverage?***

Veterans who have served in the active military, naval or air force service and have left service under any condition other than a dishonorable discharge may qualify for VA health care benefits. Most veterans who enlisted after September 7, 1980 or entered active duty after October 16, 1981, must have served 24 continuous months or the full term for which they were called to active duty to be eligible for health care through the VA. Veterans who were discharged for a disability incurred or worsened in the line of duty, or discharged for a hardship, may still be eligible for benefits even if they served for less than this time period.

Current and former members of the Reserves or National Guard who were called to active duty by a federal order and completed the full period for which they were called or ordered to active duty may be eligible for VA health care benefits. Reservists who were called to duty to train, as opposed to active duty, will not be eligible for VA health care benefits.

If you are enrolled in VA health care, you don't need to take additional steps to meet the health care law coverage standards. The health care law does not change VA health benefits or Veterans' out-of-pocket costs. The open enrollment period does not affect veterans. If you are a veteran and not enrolled in VA health care, you can apply at any time.

The Department of Veterans Affairs recommends that all veterans should apply to determine their eligibility for health care benefits because the standards vary by individual circumstances. The Veterans Health Benefit Guide provides helpful information and is available at http://www.va.gov/healthbenefits/vhbg/IB-10-465_veterans_health_benefits_guide_508.pdf. You may call 1-877-222-VETS (8387) to obtain enrollment information.

61. ***Are Veterans Administration (VA) benefits counted as income for the determination of income eligibility for Medicaid or Qualified Health Plans?***

Individuals who have retired from the military and receive retirement pay based on age or length of service must report that income as a pension.

Veterans' benefits that are administered by the Department of Veterans Affairs (VA) are not taxable as income for purposes of the modified adjusted gross income (MAGI) determination for Medicaid and Qualified Health Plans (QHPs). The following benefits paid to veterans or their families are not considered income:

- Education, training, and living allowances;
- Disability compensation and pension payments for disabilities;
- Grants for homes designed for wheelchair living;
- Grants for motor vehicles for veterans who lost their sight or the use of their limbs;
- Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death;
- Interest on insurance dividends left on deposit with the VA;
- Benefits under a dependent-care assistance program;
- The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001;
- Payments made under the compensated work therapy program; or
- Any bonus payment by a state or political subdivision because of service in a combat zone.

C. Coverage Before and After Incarceration

62. ***Can a person who is incarcerated pending disposition of the charges keep his insurance coverage?***

An individual who is incarcerated pending the disposition of charges may keep his coverage if he is enrolled in a Qualified Health Plan (QHP), and a Medicaid enrollee may also retain Medicaid eligibility until the end of his certification period. Different rules apply depending upon whether the individual is enrolled in a QHP or Medicaid.

Individuals who are enrolled in a QHP at the time of incarceration remain eligible for and enrolled in the QHP prior to the disposition of their charges. He or she must continue to pay the insurance policy premiums to prevent disenrollment by the insurance carrier. An incarcerated individual will only lose eligibility when found guilty of the charges and sentenced to incarceration. After serving the sentence, an individual will be eligible to apply for a QHP upon release.

A Medicaid enrollee who is incarcerated pending disposition of the charges is considered an "inmate" of a public institution and not eligible for Medicaid. The Maryland Department of Human Resources and Department of Public Safety and Correctional Services have implemented rules that allow a Medicaid enrollee who is incarcerated to retain his Medicaid eligibility status through the end of his certification period. This status allows an incarcerated individual to receive inpatient services covered by Medicaid at a hospital, nursing facility, or juvenile psychiatric facility. In addition, individuals who do not have an active Medicaid status while incarcerated may

be certified for Medicaid for purposes of receiving inpatient services in these health care facilities. These individuals are covered under the Medicaid fee-for-service program rather than through a Managed Care Organization (MCO). Upon release from jail or prison, an individual whose Medicaid status remains active will not be required to re-enroll in Medicaid but will be covered again through his MCO.

63. ***How does a person who was released from jail or prison after the end of the Open Enrollment Period enroll in insurance coverage?***

Individuals who are released from jail or prison after the end of the enrollment period may enroll in either Medicaid or a Qualified Health Plan (QHP) upon release, even if the open enrollment period has ended. Individuals who are eligible for Medicaid may enroll at any time during the year (For more information about enrolling after the end of Open Enrollment, see Question 53). You can apply online at www.marylandhealthconnection.gov or in person by going to a local Department of Social Services.

Individuals who do not qualify for Medicaid are eligible for a Special Enrollment Period (SEP), at which time they may purchase a QHP and, depending on their income, get a discount on their premium and reductions in out-of-pocket expenses. Individuals who return to the community from jail or prison are eligible for special enrollment for several reasons. First, they are eligible to purchase a Qualified Health Plan because they have made a permanent move to a new geographic location – from jail to the community – and are newly eligible for a QHP. Second, they have likely experienced changes in their individual or household income based on their release that will make them eligible for a QHP and possibly premium discounts and cost-sharing reductions.

Some correctional facilities will assist individuals apply for Medicaid or other insurance coverage at the time of their release. In addition, consumer assistance is available in the community from HealthCare Access Maryland (HCAM), the Navigator entity for Baltimore City, Baltimore County and Anne Arundel County, at 1-877-223-5201 or http://www.healthcareaccessmaryland.org.

64. ***Does someone who is incarcerated lose their Medicare coverage while incarcerated?***

Medicare does not pay for health services provided to people who are in custody, including people who are under arrest, incarcerated in jail or prison, or required to live in a halfway house. Eligibility for these benefits does not terminate when a person enters custody, however. Each Part of Medicare is treated differently when a beneficiary is incarcerated.

Medicare Part A (hospital and skilled nursing care) does not terminate during incarceration. Except for the small group of people who must pay a premium to participate in Part A, this coverage will simply resume when a beneficiary is released.

Medicare Part B (outpatient care) does not automatically terminate during incarceration, but all Part B beneficiaries are required to pay premiums directly to Medicare, through a deduction in their Social Security retirement or disability benefits, or through a Medicare Savings Program provided by their state Medicaid agency. When a person is convicted of a felony and is incarcerated in jail or prison, Social Security will stop paying cash retirement and disability benefits, which also stops deductions for premium payments. Inmates in jail or prison, including those who are awaiting pretrial adjudication, are also ineligible for Medicare Savings Programs. Therefore, a person can only continue to have Part B coverage if he pays Part B premiums directly.

Since Part B will not pay for care during a period of incarceration, even if a beneficiary continues to pay premiums, many people will not choose to continue paying for Part B. If a beneficiary knows that he will not continue to pay Part B premiums, he can contact the Social Security Administration to withdraw from Part B.

When the person is released, he can re-enroll in Part B, but only during Open Enrollment. Open Enrollment for Part B is January 1 – March 31, but coverage will not begin until July 1 of that year. In other words, a person who is released in July 2014 cannot reapply for Part B until January 1, 2015, and will not actually have Part B coverage again until July 1, 2015. Therefore, a person who will be in jail for a relatively short time may decide to continue to pay premiums rather than encountering a long coverage gap upon release. If a person reapplies for Part B coverage after a long period of incarceration, he will pay a "late enrollment penalty." This penalty is a surcharge that is added to the base Part B premium, and is equivalent to 10% of the Part B premium for each full 12-month period when the person was eligible for Part B but was not covered. For example, if a beneficiary does not pay Part B premiums during a 36-month sentence, he will pay 30% more for Part B coverage every month after he is released.

If a Medicare beneficiary is eligible for Medicaid coverage when she is released, including full Medicaid or a Medicare Savings Program like Qualified Medicare Beneficiaries (QMB) or Specified Low-Income Medicare Beneficiaries (SLMB) she can enroll in Part B without waiting for Open Enrollment and without incurring any late enrollment penalties. Therefore, a Medicare beneficiary should be carefully screened for eligibility for other health coverage after release. Full Medicaid coverage, QMB, or SLMB can prevent lengthy waiting periods and serious financial penalties. (For more information about Medicare and Medicaid, see Questions 39 and 40).

Part D (prescription coverage) will terminate during incarceration. Unlike Part B, however, being released from jail or prison qualifies a beneficiary for a Special Enrollment Period for Part D or for a Medicare Advantage plan (HMO-style plan that provides Part A, B, and D benefits through a private plan). This means that the beneficiary will have two months after she is released from incarceration to apply for Part D coverage or a Medicare Advantage Plan. Beneficiaries can call 1-800-Medicare or go to www.medicare.gov to shop for and enroll in a Part D plan.