Follow-Up Questions & Answers from the Medicare & End Stage Renal Disease Webinar

Does the 10 years of work history [to qualify for Medicare] have to be immediately before the onset of ESRD? What if they worked 10 years but it was 10 years before the onset of ESRD?

No, the 10 years of working history could have occurred at any point in the individual’s working life—it does not have to occur directly prior to the onset of ESRD. The 10 years of working history can also be a current or former spouse’s working history. In the case of children (persons under 21 and certain persons aged 22-25), a parent’s work history will qualify them for ESRD Medicare coverage.

Note that 10 years of work history is not the only way to qualify. If the beneficiary does not have 10 years of work history, they still may qualify with fewer quarters of work. For more information, see [http://policy.ssa.gov/poms.nsf/lnx/0600801201](http://policy.ssa.gov/poms.nsf/lnx/0600801201).

Do the work records of foster parents count for a child’s eligibility for ESRD Medicare?

Based on our reading of the Social Security Administration’s Programs and Operations Manual (SSA POMS), a child must use the working history of their natural legitimate or legally adoptive parents. Therefore, a foster child who has not been adopted or is not in the process of being adopted by a family must use the working history of their parent whose legal guardianship rights have been terminated. If this situation applies to your client, you should confirm this answer with your local SSA office and get answers in writing.

For more information, see:

- [https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801201#c](https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801201#c)
- [https://secure.ssa.gov/apps10/poms.nsf/lnx/0200306006](https://secure.ssa.gov/apps10/poms.nsf/lnx/0200306006)
- [https://secure.ssa.gov/apps10/poms.nsf/lnx/0200306001#b](https://secure.ssa.gov/apps10/poms.nsf/lnx/0200306001#b)
- **GN 00306.001 Determining Status as Child; C. Policy - Status of Child; 2. Which State Law Applies; c. Change of Domicile; 6. Termination of NH’s Parental Rights:** When the NH’s parental rights with respect to a child have been terminated, and the child has not been adopted by someone else, the child does not necessarily lose inheritance rights with respect to the NH under State law. This issue is relevant to initial entitlements or reentitlements; termination of parental rights and/or loss of inheritance rights are not terminating events for child’s benefits. In the absence of a legal precedent opinion, the adjudicator should submit the case to the RCC per GN 01010.815 ff. (See GN 00306.165 ff. if someone other than the NH adopted the child during the NH’s lifetime.)
Just to clarify, is the person eligible for Medicare effective the month they begin TRAINING for home dialysis or just the month they actually BEGIN home dialysis?

If your client needs dialysis and starts a self-dialysis training program, Medicare begins the first day of the first month of the training program. Find out more at: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=1743.

So if a person does not have employer group health coverage, then the person has Medicare as primary, and only pays 20% (or whatever the cost-sharing amount is for services)?

Yes, exactly right. If Medicare is the only insurance available to the individual (i.e., they do not have any type of current or former employer coverage from their own or their spouse’s work), Medicare is the primary insurer for that person throughout their ESRD treatment. The 30-month coordination period would not apply in this case.

Can you give an example of a circumstance under which someone would decide NOT to enroll in ESRD Medicare?

If the person has comprehensive insurance from a current or former employer, that person would often delay ESRD Medicare enrollment. Many people pay premiums for employer coverage and see paying Medicare premiums in addition to their existing insurance premiums as paying for insurance that may not give them much in addition to their employer coverage. This is a fine course of action as long as

1. that person delays BOTH Medicare Part A and Medicare Part B, and
2. that person takes BOTH Medicare Part A and Medicare Part B before their 30-month coordination period ends.

The main consequence to delaying Medicare coverage during the 30-month coordination period is that immunosuppressant drugs are covered by Part D rather than Part B, which can mean higher cost-sharing.

How do pharmacies know whether to bill Part B or Part D for an immunosuppressant ESRD drug?

Almost all pharmacists will bill Part D first for oral medications purchased at the pharmacy counter. Many patients will know it is a Part B covered drug and will tell the pharmacist to bill Medicare Part B rather than Part D. However, not all patients will be able to verbalize this, so most drug plans have
prior authorization processes in place for their immunosuppressant drug coverage. The prior authorization processes ask the pharmacists to bill the patient’s Part B first before billing Part D or asks the prescriber to assert it is a Part D-covered drug. Depending on the plan, the pharmacist may be asked to provide a Part B denial of the medication or receive a phone call from the patient’s provider stating the immunosuppressant drugs are Part D rather than Part B covered before the Part D plan will pay. On the other hand, some Part D plans will not require any information and will simply pay for the drug.


20.2.2 - Part D Sponsor Due Diligence in Prior Authorization of Part B Versus Part D Coverage Determination: Part D sponsors may apply prior authorization to establish appropriate payment under Part B or Part D, even if the beneficiary is currently taking the drug. In Part B versus Part D situations, CMS expects Part D sponsors will work aggressively to eliminate any interruptions of current therapy.

Assuming a Part D plan does not cover all of the immunosuppressant drugs, can the redetermination process be used to get the drugs that not covered?

Yes, the redetermination process can be used for immunosuppressant drugs not covered by a Part D plan. HOWEVER, remember that immunosuppressant drugs are a Protected Class drug. This means all or substantially all immunosuppressant drugs must be covered by every Part D plan-making it unlikely that a beneficiary’s drug would not be on their plan’s formulary.


30.2.5 - Protected Classes (Rev. 10, Issued: 02-19-10, Effective/Implementation Date: 03-01-10) Part D sponsor formularies must include all or substantially all drugs in the immunosuppressant (for prophylaxis of organ transplant rejection), antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes. CMS instituted this policy because it was necessary to ensure that Medicare beneficiaries reliant upon these drugs would not be substantially discouraged from enrolling in certain Part D plans, as well as to mitigate the risks and complications associated with an interruption of therapy for these vulnerable populations. Formularies must include substantially all drugs in these six categories that are FDA approved by the last CMS specified HPMS formulary upload date for the upcoming contract year. New drugs or newly approved uses for drugs within the six classes that come onto the market after the CMS specified formulary upload date will be subject to an expedited P&T committee review. The expedited review process requires P&T committees to make a decision within 90 days, rather than the normal 180-day requirement. At the end of the 90 day period, these drugs must be added to Part D plan
formularies. “Substantially all” in this context means that all drugs and unique dosage forms in these categories are expected to be included in sponsor formularies, with the following exceptions: multi-source brands of the identical molecular structure; extended release products when the immediate-release product is included; products that have the same active ingredient or moiety; and dosage forms that do not provide a unique route of administration (e.g., tablets and capsules versus tablets and transdermals).

Part D sponsors may not implement prior authorization or step therapy requirements that are intended to steer beneficiaries to preferred alternatives within these classes for enrollees who are currently taking a drug. This prohibition applies to those beneficiaries already enrolled in the plan as well as new enrollees who were actively taking drugs in any of the six classes of clinical concern prior to enrollment into the plan. If a sponsor cannot determine at the point of sale that an enrollee is not currently taking a drug (e.g., new enrollee filling a prescription for the first time), sponsors shall treat such enrollees as currently taking the drug.

Since someone might have a Qualified Health Plan (QHP) for a family, if the family member with ESRD joins Medicare, how does the subsidy work for the household? Where do we send the family for detailed counseling? SHIPs don’t have marketplace expertise.

Subsidies for QHPs will stop when this person enrolls in ESRD Medicare. Before then, they are eligible for the subsidies to continue. In other words, “An individual may be eligible for the health care Premium Tax Credit if he or she is not eligible for minimum essential coverage, as outlined in the IRS Notice 2013-41 at the following web link: http://www.irs.gov/pub/irs-drop/n-13-41.pdf. However, individuals will lose their eligibility for the health care Premium Tax Credit when coverage in Medicare Part A begins.” Quote taken from Section B, Question 3 of the Medicare & Marketplaces Master FAQ from CMS: http://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_6-11-15.pdf

The above applies specifically to the Medicare beneficiary; for more information on how the family’s QHP subsidies will be affected, the Navigator who helped them purchase the plan should be contacted.

So, what is the "discrete period of time" for ESRD Medicare? If someone is on dialysis for 10 years, would they still need to switch to Original Medicare if they are under 65 and on ESRD Medicare?

If a person only has ESRD-related Medicare and then becomes eligible for Medicare for another reason (age or disability), they should enroll into age/disability related Medicare in addition to their ESRD Medicare. This is because 3 years after a successful transplant or 12 months after the
beneficiary stops receiving dialysis treatments, their ESRD Medicare will stop. They must be sure to enroll into age or disability-related Medicare to continue their Medicare coverage after this time.

I have a 70-year-old client with Medicare A & B but not D with ESRD. She was turned down for a transplant list because of no D. If B covers the immunosuppressant drugs, how can she be turned down?

Since this is not a Medicare-related question, there is nothing in the Medicare manuals or guidance that allows or does not allow hospitals to turn down a patient due to insufficient insurance coverage. According to UNOS & OPTN bylaws (http://www.transplantliving.org/before-the-transplant/about-organ-allocation/policies/), there are many factors that inform whether a person is a good transplant candidate, namely how likely it is they will reject the organ. Taking all necessary medications and managing all illnesses in addition to ESRD are key to avoiding organ rejection in the eyes of the reviewing body. Immunosuppressant drugs are not the only drugs needed after a transplant, and most drugs other than immunosuppressant drugs would not be covered by Part B. The transplant facility may want to ensure that the person has coverage for medications to treat other health conditions—since managing other health conditions is essential in avoiding rejection. Again, these are observations based on a review of transplant by-laws and ethics, but for a more robust answer the hospital’s transplant review committee will need to be contacted and provide guidance as to why the client needs Part D.

Does the client have any way of obtaining Part D outside of enrollment periods, i.e., is she eligible for Extra Help? A State Pharmaceutical Assistance Program?

Will the employer pay first if the person is ELIGIBLE for Medicare and not ENROLLED in Medicare?

Generally not if the 30-month coordination period has elapsed. The 30-month coordination period applies even if a person is eligible for but not enrolled in Medicare. This means that if an individual delayed Medicare enrollment because of employer coverage, Medicare switches from secondary to primary coverage after 30 months of eligibility have elapsed. This can leave the beneficiary in a vulnerable place, since Medicare has become their primary insurer even though they do not have it yet. This usually results in denials from employer coverage. If the beneficiary delayed both Part A and Part B, they can enroll into both parts of Medicare at any time—but if they took Part A and delayed Part B, they will have to wait until the next General Enrollment Period (January 1- March 31 of each year) to enroll. Learn more at: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=1747
When you become eligible for ESRD Medicare, your employer group health plan will pay first and Medicare will pay second. This is called the 30-month coordination period. The 30-month coordination period begins when you are first eligible for Medicare based on ESRD, even if you haven’t signed up for it yet. For example, if Mr. X begins dialysis at a facility in September of 2011, he is eligible for Medicare the first day of the fourth month he gets dialysis, which is December 1, 2011. Mr. X does not enroll in Medicare until June, 2012. His 30-month coordination period still began on December 1, 2011.

The 30-month coordination period applies to current employer insurance, retiree insurance and COBRA. They all pay first and Medicare pays second. After the 30-month coordination period, Medicare will pay first for all Medicare-covered services and your employer group health plan will pay second.

If you do not have any insurance but Medicare, Medicare pays primary on all claims as soon as you enroll.