Medicaid Medicare

What is Medicare?

Medicare is the federal health insurance program for people who are sixty-five or older, certain younger people with disabilities, and people with end-stage renal disease.

There are four “Parts” to Medicare: Part A, Part B, Medicare Advantage Plans, and Part D.

Part A covers inpatient care in a hospital, skilled nursing facility care, nursing home care, hospice care, and home health care. Most people do not have to pay a premium to get Part A benefits. You are eligible for “premium-free” Part A Medicare if you already get retirement benefits from Social Security or the Railroad Retirement Board, you are eligible to get social security or Railroad benefits but haven’t filed for them yet, or you or your spouse had Medicare-covered government employment. If you do not qualify for premium-free Part A, you can purchase it and pay monthly premiums based on how much you have paid in federal Medicare taxes over a period of time. Usually, if you choose to buy Part A, you must also have Medicare Part B and pay monthly premiums on both Part A and Part B.

Part B covers medically necessary services and preventative services. This would include things like clinical research, ambulance services, durable medical equipment, inpatient and outpatient mental health, and limited outpatient prescription drugs. If you choose to have Medicare Part B, your premium will be automatically taken out of your benefit payment if you receive benefits from Social Security, the Railroad Retirement Board, or the Office of Personnel Management. If you do not receive any of these benefits, then you will get a bill.

“Original Medicare” includes Medicare Part A and Part B. A Medicare Advantage Plan (previously known as Part C) includes a “bundle” of Medicare Part A, Medicare Part B, usually Medicare prescription drug, and sometimes includes extra coverage for things like vision, hearing, and dental. The cost of Medicare Advantage Plans varies by plan. Medicare Advantage Plans provide coverage through private insurance companies that are approved by Medicare.

Part D helps cover the cost of prescription drugs. The cost of the Part D monthly premium varies by your income. Like Medicare Advantage Plans, Part D is also run by private insurance companies approved by Medicare.

How do I sign up for Medicare?

If you currently get benefits from Social Security, you will automatically get Medicare Part A and Part B when you turn 65 and don't need to sign up. Three months before you turn 65, you will receive a packet from Medicare detailing what further actions you need to take.

If you do not already receive benefits from Social Security, you will not get Medicare automatically. You need to sign up to get Medicare Part A and Part B. There is a seven month Initial Enrollment Period to sign up for Part A and Part B when you're first eligible for Medicare. This period starts three months before the month you turn 65 and ends three months after the month you turn 65. If you wait until the month after you turn 65, there may be a gap in your coverage under Part B. If you do not sign up for Part B when you are initially eligible, you will likely need to pay a late enrollment penalty.

If you don't sign up during the initial enrollment period, there are a couple other options for signing up. You can sign up during the General Enrollment Period between January 1 and March 31 each year if you are not eligible for a Special Enrollment Period. If you sign up during the General Enrollment Period, your coverage will not start until July 1 of that year and you may have to pay a higher premium for Part A and Part B. The other option for signing up after your Initial Enrollment Period has passed is to sign up during a Special Enrollment Period. If you are covered under a group health plan based on your current employment, there is an 8 month Special Enrollment Period if you or your spouse is working and you're covered by a group health plan through the employer or union based on that work. The Special Enrollment Period starts the month after the employment ends or the month after the group health plan insurance based on current employment ends, whichever comes first.

A Medicare Savings Program can help you pay Medicare expenses through the state's Medicaid program. There are income and resources limits to determine if you would qualify for this program.

More information on Medicare can be found at Medicare.gov.

What is Medicaid?

Medicaid provides health coverage to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities, and is funded through federal and state governments. Medicaid acts as an insurance company and pays for medical services like going to the doctor, hospital, dentist, optometrist, and chiropractor. As of April 2020, there were over 116,000 South Dakotans eligible for Medicaid services including over 78,000 children.

Most Medicaid recipients are required to have a primary care provider. In most cases, a referral from your primary care provider is required for a visit to specialty and hospital services. You can choose your primary care provider from a list provided by Medicaid. You may change your primary care provider at any time, but you must notify Medicare of the change and reason for the change.

Most medical services are covered under Medicaid, but some services are not. You are responsible for paying for these non-covered services. If you receive a medical bill, you should not ignore it. If you think a mistake has been made and you should not have been given a bill, you should call the provider and Medicaid to get it sorted out. If you did not provide your Medicaid recipient ID card to the provider or the service was not covered under Medicaid, you will be responsible for paying the bill. Some services are provided under a cost-sharing system where you need to pay for part of the medical bill and Medicaid will pay the rest.

What does Medicaid cover?

There are three basic kinds of health coverage that Medicaid covers: physical health, behavioral health, and dental. To be covered by Medicaid, the services must be medically necessary and be provided by an enrolled Medicaid provider. Physical health includes the following:

- Chiropractic – this includes only manual manipulations of the spine.
- Community Health Worker – Medicaid recipients with a chronic condition or are at risk for a chronic condition may be eligible for a community health worker to help navigate the health system and promote healthy living.
- Diabetes Education – 10 hours of diabetes self-management education is covered when the patient is first diagnosed and two hours of follow-up education each year.

- Dietician and Nutritionist – Limited services from dieticians and nutritionists are covered for select conditions.
- Family Planning – Family planning services such as office visits, testing and treatment for STDs, birth control, and sterilization are covered by Medicaid.
- Home Health – nursing and therapy services while recovering from an illness or injury are covered when ordered by a doctor.
- Hospice – Hospice services for terminally ill individuals are covered when ordered by a doctor.
- Hospital – Inpatient and outpatient hospital services are covered. Self-administered drugs are not covered.
- Medical Equipment and Supplies – Medical equipment that is reusable and needed due to an illness or injury, such as wheelchairs, walkers, and crutches, are covered with a certificate of medical necessity from a doctor. Medical supplies, which are disposable health care items required for a medical condition are also covered. Some items are not considered medical equipment and are therefore not covered by Medicaid. This includes exercise equipment, protective outerwear, air conditioners, humidifiers, dehumidifiers, heaters, and furnaces.
- Nursing Home – Nursing home services for people who cannot be safely cared for at home are covered. This coverage includes room and board, nursing care, therapy care, and meals.
- Personal Care – Personal care such as bathing, toileting and assistance with medication is covered through a care plan based on an evaluation.
- Medical and Surgical Services – Most medical and surgical services performed by a doctor are covered. This includes routine examinations, drugs given at the doctor’s office, x-rays, and lab tests needed for diagnosis and treatment.
- Podiatry – Podiatrist office visits, blood sugar checks, tests to check for a foot infection and limited surgical procedures are covered by Medicaid.
- Prescription Drugs – Most prescription drugs are covered, but some require prior authorization. Most prescriptions are limited to a 30-day supply at a time. Most over-the-counter medications and products are not covered.
- Vision – Vision services including exams, lenses, and frames are covered. Contact lenses are covered only when medically necessary.

Behavioral Health includes mental health and substance use disorder. Medicaid covers up to 40 hours per year of therapy for mental illnesses. Community mental health center services are also covered. Treatment for substance use disorder is also

covered and includes screenings and assessments and outpatient and inpatient treatment.

Dental services covered under Medicaid are slightly different between children and adults. Both are covered for two exams and cleanings per year among other benefits. Adult coverage is limited to $1,000 each year and anything over that limit must be paid out of pocket.

Medicaid covers transportation for Medicaid recipients to medical appointments. Mileage is reimbursed if the provider you are seeing is more than 150 miles from your residence. The mileage is reimbursed only for the distance between the cities and not travel within either city. Lodging and meals are reimbursable when the provider is over 150 miles from the recipient's residence. A Non-Emergency Medical Travel Reimbursement Form must be filled out within and submitted within six months of the services being provided. Community transportation and secure medical transportation between your home and a medical provider may also be covered. Transportation by ambulance is only covered for life threatening emergencies.

If you believe you have been wronged by Medicaid or a medical provider, you may file a grievance in writing or by phone and the grievance will be investigated. You may appeal the decision made by the state or your provider. You may also request a fair hearing with a hearing officer and someone from DSS.

To apply for Medicaid and for more information, visit https://dss.sd.gov/medicaid/.

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Health

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