Module 2-Medicare Health Plans

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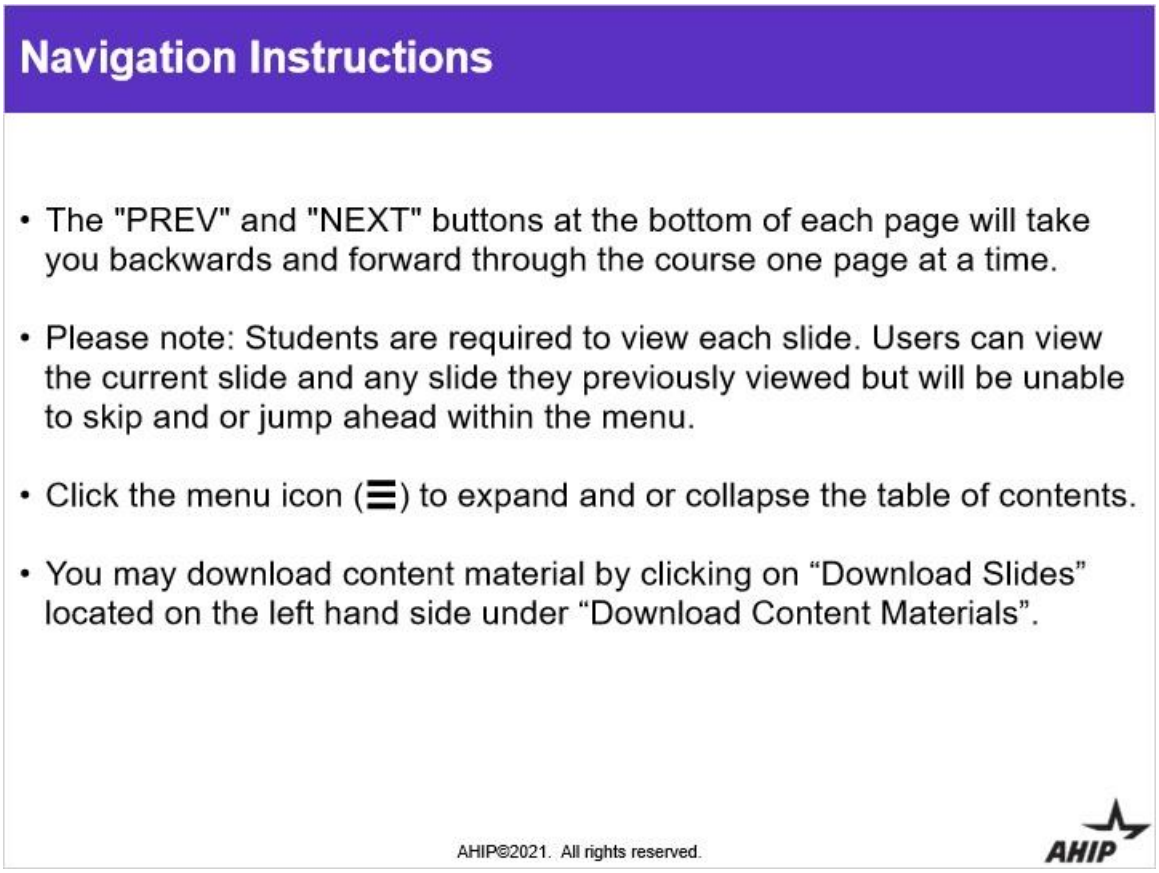
1.1 Part C and other Medicare Health Plans

1.2 Navigation Instructions



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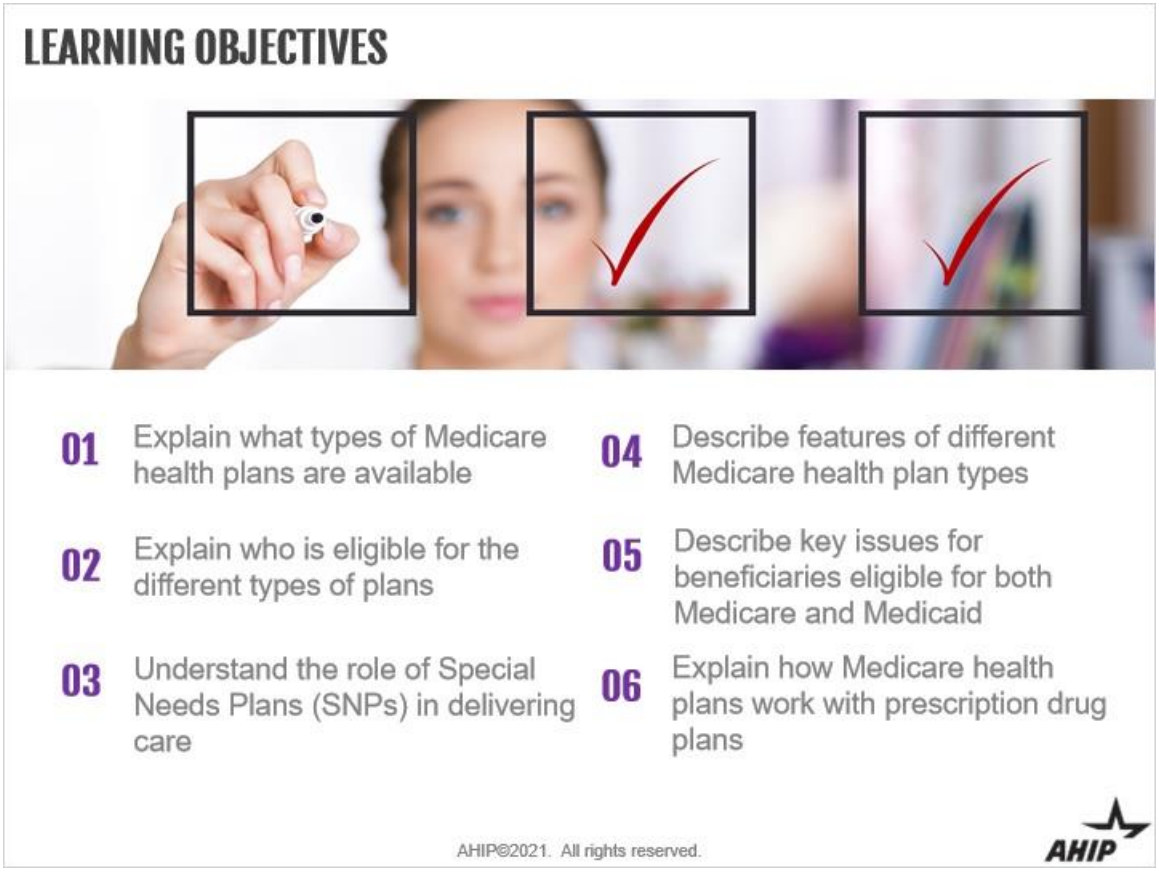
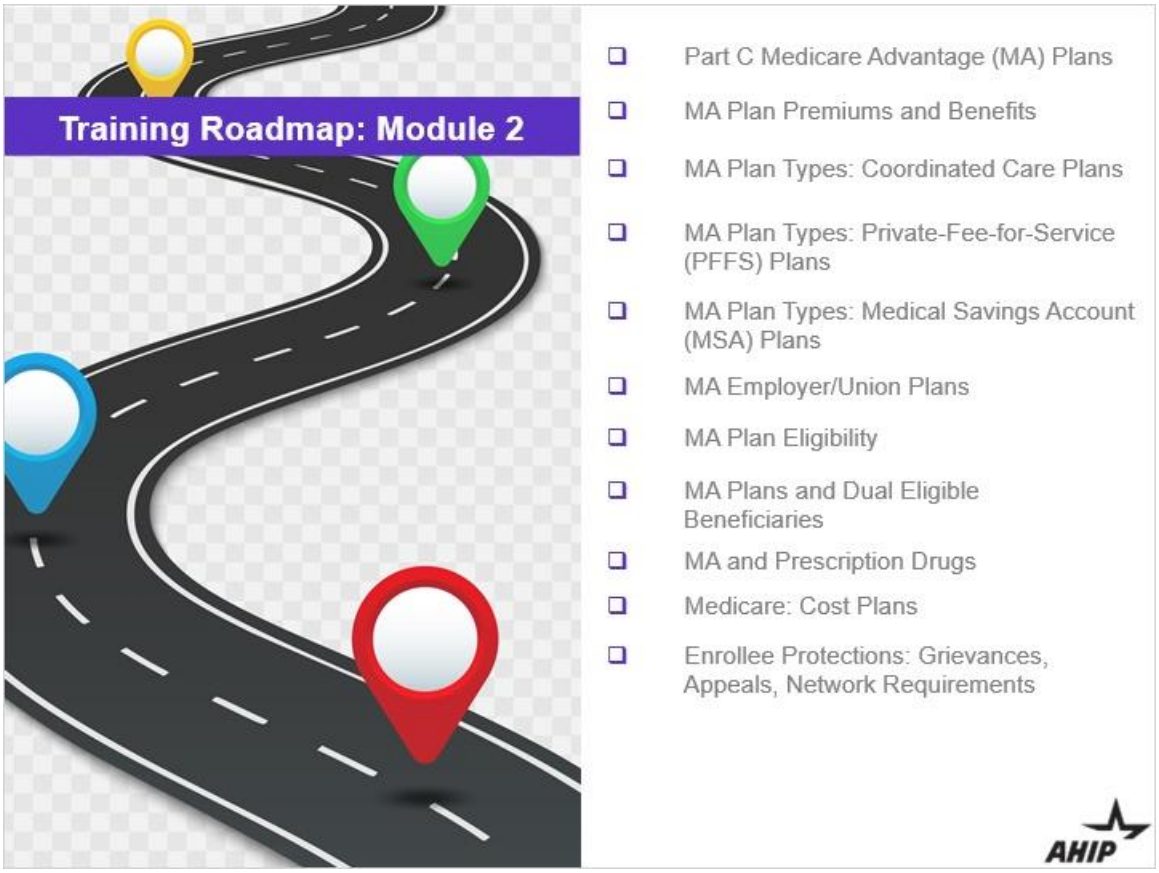
1.4 LEARNING OBJECTIVES



1.5 Training Roadmap: Part 2



1.6 Part C: Medicare Advantage Plans Overview

Part C: Medicare Advantage Plans Overview

Under the Medicare Advantage (MA) program, known as Medicare Part C, private companies offer health plans that cover all Medicare Part A and Part B benefits.

- Many also cover Part D prescription drug benefits (MA-PD plans).
- All MA plans have a maximum out-of-pocket limit.
- Many MA plans also offer additional benefits that Medicare does not cover.
- The types of Medicare Advantage (MA) plans are:
  - Coordinated Care Plans. These plans have a network of preferred providers and include:
    - Health Maintenance Organizations (HMOs), some have a point-of-service (POS) benefit that allows beneficiaries to go out-of-network subject to limitations.
    - Preferred Provider Organizations (PPOs), which may be local or regional.
  - Private Fee-for-Service (PFFS) Plans
  - Medical Savings Account (MSA) Plans

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1.7 Medicare Advantage Plans: Premiums

Medicare Advantage Plans: Premiums

Medicare Advantage Plans may charge a premium. If the plan charges a premium, beneficiaries must generally continue paying their Part B premium in addition to paying the monthly plan premium to remain enrolled.

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1.8 Medicare Advantage Plans: Cost-Sharing

Medicare Advantage Plans: Cost-Sharing

- Medicare Advantage plans may also require their members to pay for a portion of the covered services they receive. This is known as member cost-sharing. There are several potential types of cost-sharing:
  - Deductible: A set amount the member must pay for covered services before the health plan begins paying for those services.
  - Copayment: A fixed dollar amount per service the member must pay. For example, $10 for each primary care visit.
  - Coinsurance: A percentage of the cost of the service the member must pay.
- All Medicare Advantage plans must have a "maximum out-of-pocket" limit (known as the "MOOP"). That is, once the member pays a specified amount of cost-sharing, the health plan covers 100% of covered medical services. Each year CMS specifies a mandatory MOOP, which health plans cannot exceed, although they may have a lower MOOP.

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1.9 Part C: Medicare Advantage Plan Benefits

Part C: Medicare Advantage Plan Benefits

- All Medicare Advantage (MA) plans must cover all Part A and Part B benefits.
- Most Medicare Advantage plans also cover all or a part of the Original Medicare cost-sharing for Part A and Part B benefits.
- Medicare Advantage plans may also cover extra benefits not covered by Original Medicare, such as:
  - Additional days of hospitalization
  - Skilled nursing and rehabilitative services without a prior 3-day inpatient hospital stay
  - Vision Services
  - Hearing Aids
  - Routine Dental Services and/or Dentures
  - Annual Physical Exams*
  - In-Home Safety Assessments and fall prevention devices
  - Worldwide Urgently Needed and Emergency Services
  - Over the Counter Drugs

* An annual physical is different from the annual wellness visit covered under Medicare, which does not include a physical exam.

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1.10 Special Benefits Depending on Chronic Health Condition

Special Benefits Depending on Chronic Health Condition

Medicare Advantage plans may offer special benefits for individuals with chronic health conditions, such as diabetes, heart failure, or other conditions. Those benefits may include supplemental benefits or decreased cost-sharing not available to members in the same plan without the specified chronic condition.

AHIP

1.11 Medicare Advantage Plan- Utilization Management

Medicare Advantage Plan- Utilization Management

Medicare Advantage plans may implement mechanisms to manage the utilization of covered services that do not apply under Original Medicare.

Such mechanisms include requiring a referral or prior authorization to obtain a service.

Plans may also implement step therapy requirements for Part B or Part D drugs. Step therapy is when a plan requires a beneficiary to try less expensive options before "stepping up" to drugs that cost more.

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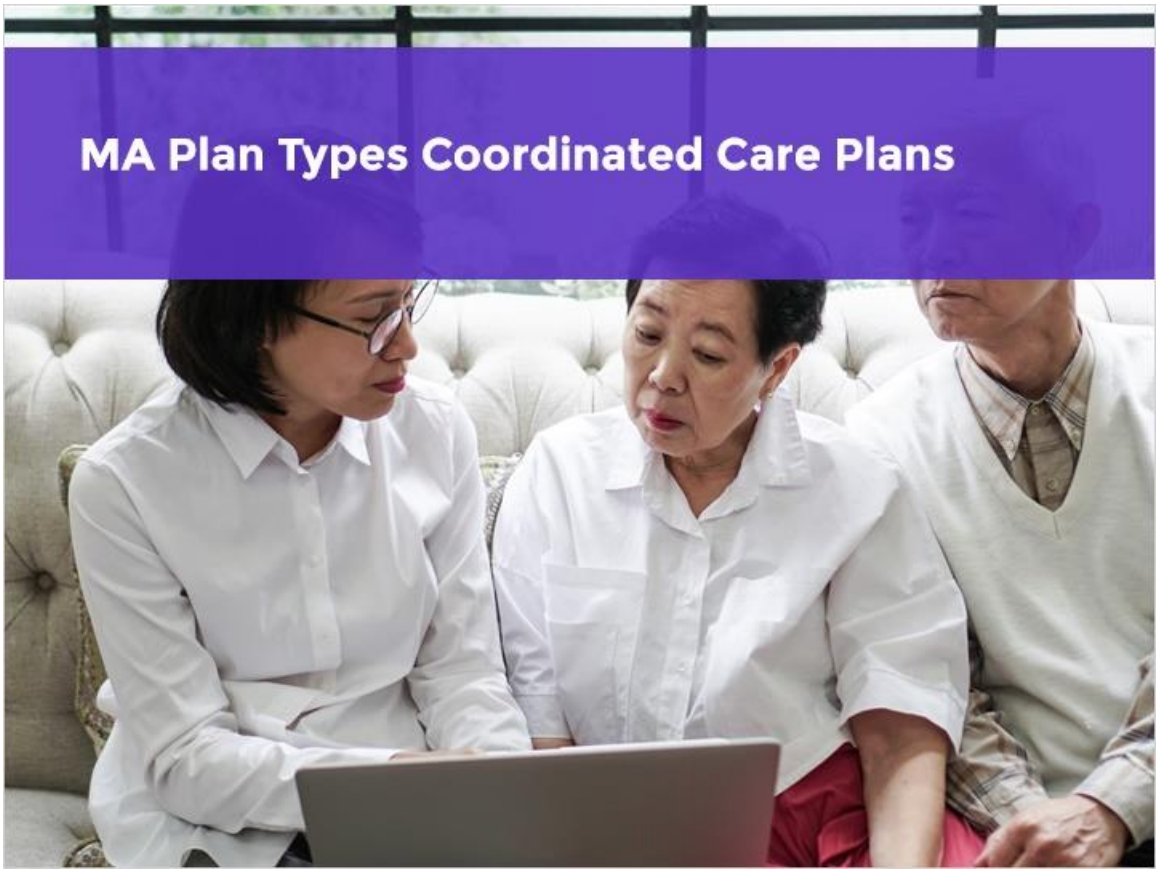
1.12 MA Plan Types Coordinated Care Plans



1.13 MA Plan Types Coordinated Care Plans - HMOs

MA Plan Types Coordinated Care Plans - HMOs

- HMO enrollees must generally use doctors and hospitals within the plan's network (known as participating providers) for services to be covered. However, there are certain exceptions:
  - Emergency services received outside of the plan network are covered.
  - When the enrollee is temporarily absent from the plan's service area, dialysis services are covered outside of the network.
  - Urgently needed services received outside of the plan network are covered when the enrollee is temporarily outside of the service area or in rare circumstances when the network is not available.
  - If a needed specialist of a covered procedure is not available through the network, the plan will authorize out-of-network services.
- HMOs must have a maximum limit on member out-of-pocket costs (MOOP) of not greater than $7,550 in 2021. Many plans have lower limits.

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1.14 MA Plan Types Coordinated Care Plans - HMOs, continued

MA Plan Types Coordinated Care Plans - HMOs, continued

- HMO enrollees may need to select a primary care doctor and may need a referral for specialty care.
- If an HMO enrollee needs a type of specialist who is not in the plan's network, the plan will arrange for care outside of the network.
- Some HMOs offer a Point of Service (POS) option that allows enrollees to go to non-plan doctors and hospitals generally without receiving prior approval for certain services.
  - Unlike a PPO, an HMO-POS plan may limit the services available out of network or may put a dollar cap on the amount of out-of-network coverage.
  - Cost-sharing is generally higher than for services obtained from network providers.

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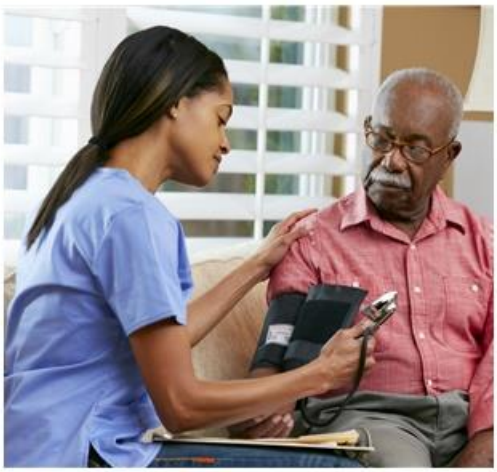
1.15 MA Plan Types Coordinated Care Plans - PPOs

MA Plan Types Coordinated Care Plans - PPOs

PPO enrollees:

- may get care from any provider in the U.S. who accepts Medicare.
- do not need a referral to see an out-of-network provider but are encouraged to contact the plan to be sure the service is medically necessary and will be covered.
- usually pay higher cost-sharing amounts if they see an out-of-network provider.



- PPOs must have a maximum limit on member out-of-pocket costs for network providers of not greater than $7,550 in 2021. They must also have an aggregate MOOP for network and non-network providers of $11,300 in 2021.
- Regional PPOs are PPOs that serve an entire region, made up of one or more states.

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1.16 MA Plan Types Coordinated Care Plans – Special Needs Plans

MA Plan Types Coordinated Care Plans – Special Needs Plans

- Special Needs Plans are a type of Medicare Advantage coordinated care plans (HMOs or PPOs) specially designed to serve a subset of Medicare beneficiaries.
- All SNP plans include prescription drug coverage.
- There are several types of Special Needs Plans (SNPs):
  - Chronic condition (known as C-SNPs)
  - Dual eligible (known as D-SNPs)
  - Institutional (known as I-SNPs)
  - Institutional equivalent (known as IE-SNPs)

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1.17 Medicare Advantage Eligibility: SNP Description (1 of 2)

Medicare Advantage Eligibility: SNP Description (1 of 2)

- Chronic condition SNPs (C-SNPs) are SNPs that restrict enrollment to individuals with certain or disabling chronic conditions, such as diabetes, heart failure, cancer, lung conditions, HIV, or certain other conditions.
  - Each C-SNP will specify the condition or conditions necessary to be eligible to enroll.
- Dual eligible SNPs (D-SNPs) enroll beneficiaries who are entitled to both Medicare and medical assistance from a State plan under Medicaid.
  - A subset of D-SNPs, fully Integrated Dual Eligible (FIDE) SNPs, provide dual-eligible enrollees access to Medicare and Medicaid benefits under a single managed care organization.

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1.18 Medicare Advantage Eligibility: SNP Description (2 of 2)

Medicare Advantage Eligibility: SNP Description (2 of 2)

- Institutional SNPs (I-SNPs) are SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility, a LTC nursing facility (NF), an intermediate care facility for the for individuals with intellectual and developmental disabilities, a long-term care hospital, an inpatient psychiatric facility, or certain other facilities specified by CMS.
- IE SNPs enroll MA eligible individuals who live in the community but require an institutional level of care. Eligibility for an IE-SNP may be limited to certain Assisted Living Facilities.

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1.19 MA Plan Types: Private Fee-for-Service (PFFS) Plans

1.20 MA Plan Types: Private Fee-for-Service (PFFS) Plans

MA Plan Types: Private Fee-for-Service (PFFS) Plans

- Individuals enrolled in PFFS plans may receive covered services from any provider in the U.S. who is eligible to provide Medicare services and agrees to accept the plan's terms and conditions of payment.
- Some PFFS plans contract with network providers. If the PFFS plan has a network, enrollees may pay more if they see out-of-network providers.
- Except for emergencies, enrollees must inform providers before they receive services that they are a PFFS plan member, so the non-network providers can decide whether to accept the plan's terms and conditions.
- Non-network providers that accept Original Medicare may choose not to accept PFFS plan enrollees.

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1.21 MA Plan Types: Private Fee-for-Service Plans (2 of 3)

MA Plan Types: Private Fee-for-Service Plans (2 of 3)

Example:

Mr. Young is interested in switching to a PFFS plan because his primary care physician (PCP) no longer participates in his HMO. His PCP is not in the PFFS plan's network. Mr. Young should call his PCP before he enrolls to make sure she is willing to see patients enrolled in the PFFS plan.

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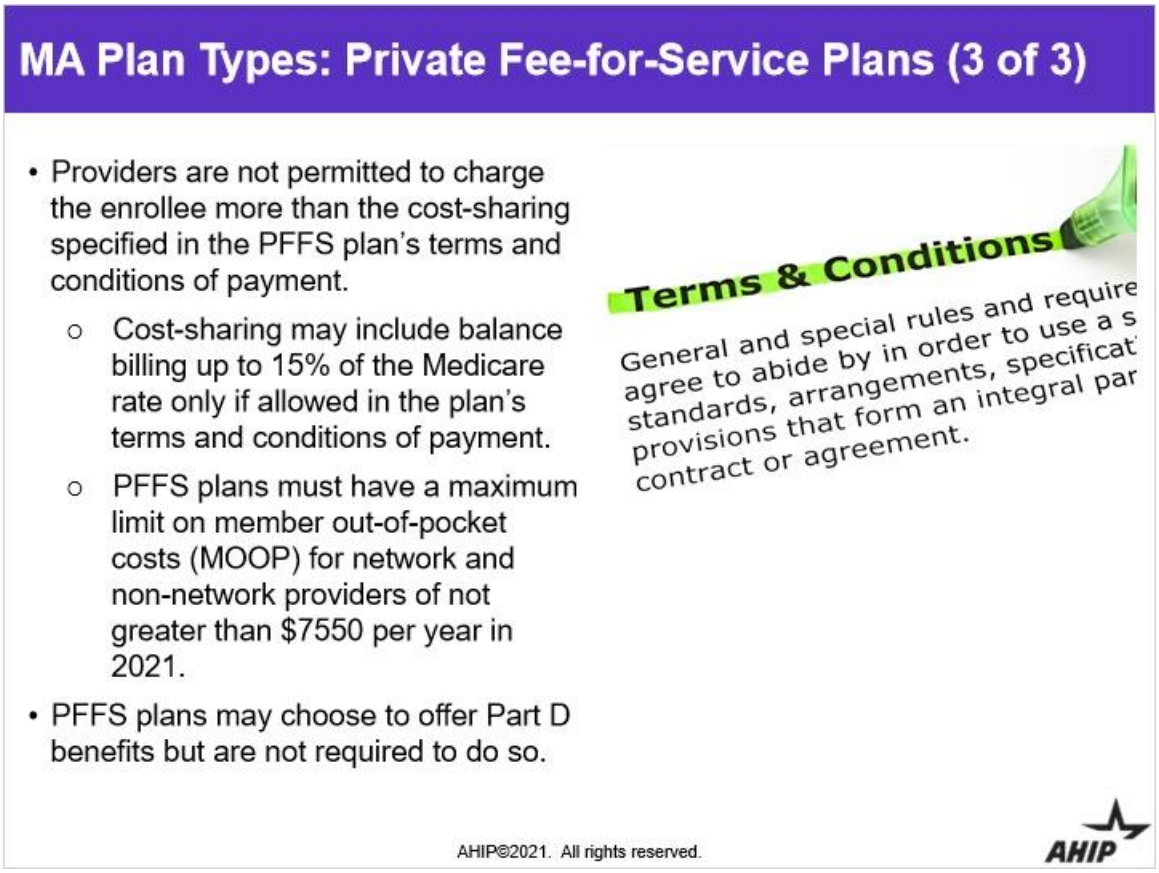
1.22 MA Plan Types: Private Fee-for-Service Plans (3 of 3)



1.23 MA Plan Types: Medicare Savings Account Plans

1.24 MA Plan Types: Medical Savings Account (MSA) Plans

MA Plan Types: Medical Savings Account (MSA) Plans

- A Medicare MSA is a high deductible health plan which is combined with a savings account used to pay for health care expenses not covered under the health plan.
  - Medicare contributes to the beneficiary's savings account.
- MSA enrollees pay for health care expenses from the savings account and then out-of-pocket until the annual deductible is met, after which the plan pays 100% for covered services.
  - The maximum deductible for MSA plans in 2021 is $14,150.
- MSAs cover Part A and Part B benefits after the deductible.
- MSAs do NOT cover, Part D Medicare prescription drug benefits.
  - MSA enrollees must enroll in a stand-alone PDP if they want prescription drug benefits.
- Enrollees pay their Part B premium and any premium for supplemental benefits.

AHIP

1.25 MA Plan Types: MSA Plans, continued

MA Plan Types: MSA Plans, continued

- Enrollees may receive covered services from any Medicare approved provider in the U.S.
- MSAs may not have a network or may have a full or partial network of providers.
- All non-network providers must accept the same amount that Original Medicare would pay them as payment in full. This is the amount the enrollee will pay the provider before the deductible is met.
- In 2021, MA MSA plans were available in all 50 states and the District of Columbia.

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1.26 Medicare Advantage Employer/Union Plans

1.27 Employer/Union Plans

Employer/Union Plans

- Employers and unions may offer their retirees and their dependents:
  - Medicare Advantage individual plans (plans open to the public).
  - Medicare Advantage plans only available to individuals based on their employer, known as Employer Group Waiver Plans or EGWPs.
  - A Medicare Advantage plan through a direct contract between the employer or union and CMS, known as a direct contract plan.
- Employers with less than 20 employees may be able to offer Medicare Advantage plans to their active employees and their dependents.
- Active employees of employers with at least 20 employees must retain their non-Medicare group health plan because Medicare is secondary for them.

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1.28 Medicare Advantage Eligibility

1.29 Medicare Advantage Eligibility

Medicare Advantage Eligibility

To be eligible to enroll in a Medicare Advantage plan:

- A beneficiary must be entitled to Part A ***and*** enrolled in Part B.
- The beneficiary must permanently live in the MA plan's service area. (If a beneficiary spends six months or more outside of the plan's service area, he or she should only enroll in MA-PD plans with a visitor/traveler benefit.)
- Be a U.S. citizen or lawfully present in the United States on or before the enrollment effective date. (CMS makes this determination.)

- Certain MA plans including MA MSA plans, Special Needs Plans, and Employer Group Waiver Plans have additional eligibility requirements.
- Note that a beneficiary must generally continue to pay his/her Part B premium to remain enrolled in Part B and eligible for enrollment in the Medicare Advantage plan.

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1.30 Medicare Advantage Eligibility, continued

Medicare Advantage Eligibility, continued

MA plans must enroll any eligible beneficiary who applies regardless of health status.

- Beginning in 2021, beneficiaries with ESRD became eligible to enroll in Medicare Advantage plans as long as they met other eligibility requirements.
- Certain special needs plans (SNPs) known as chronic condition SNPS or C-SNPs can limit enrollment to beneficiaries with certain chronic conditions.

AHIP

1.31 Medicare Advantage Eligibility: SNPs

Medicare Advantage Eligibility: SNPs

Special Needs Plans (SNPs) must limit enrollment to beneficiaries who meet specified plan eligibility criteria (e.g., beneficiaries who are dual eligible, have specified chronic conditions (which may include ESRD), or reside in institutions or live in the community, but require an institutional level of care.)

AHIP

1.32 Medicare Advantage Eligibility: EGWPs

Medicare Advantage Eligibility: EGWPs

- Employer group waiver plans (EGWPs) or Employer/Union plans may only enroll Medicare beneficiaries who active employees or retirees of the employer or union offering the plan.
  - A beneficiary's enrollment in an EGWP must be based on receiving "employment-based" health coverage from an employer/union group health plan sponsor.
  - Coverage obtained through a professional or another type of group association would not make a beneficiary eligible for an EGWP, except to the extent that the coverage obtained through the association can properly be characterized as "employment-based" group health plan coverage.

AHIP

1.33 Medicare Advantage Eligibility: EGWPs Example

Medicare Advantage Eligibility: EGWPs Example

An association of employers, such as school boards, may offer their former employees an EGWP plan. Employers may form associations for purposes of offering their retirees health coverage.

A professional association, such as a lawyer's association, may not offer an EGWP because membership in the association is based on profession, not the individuals' employer or former employer.

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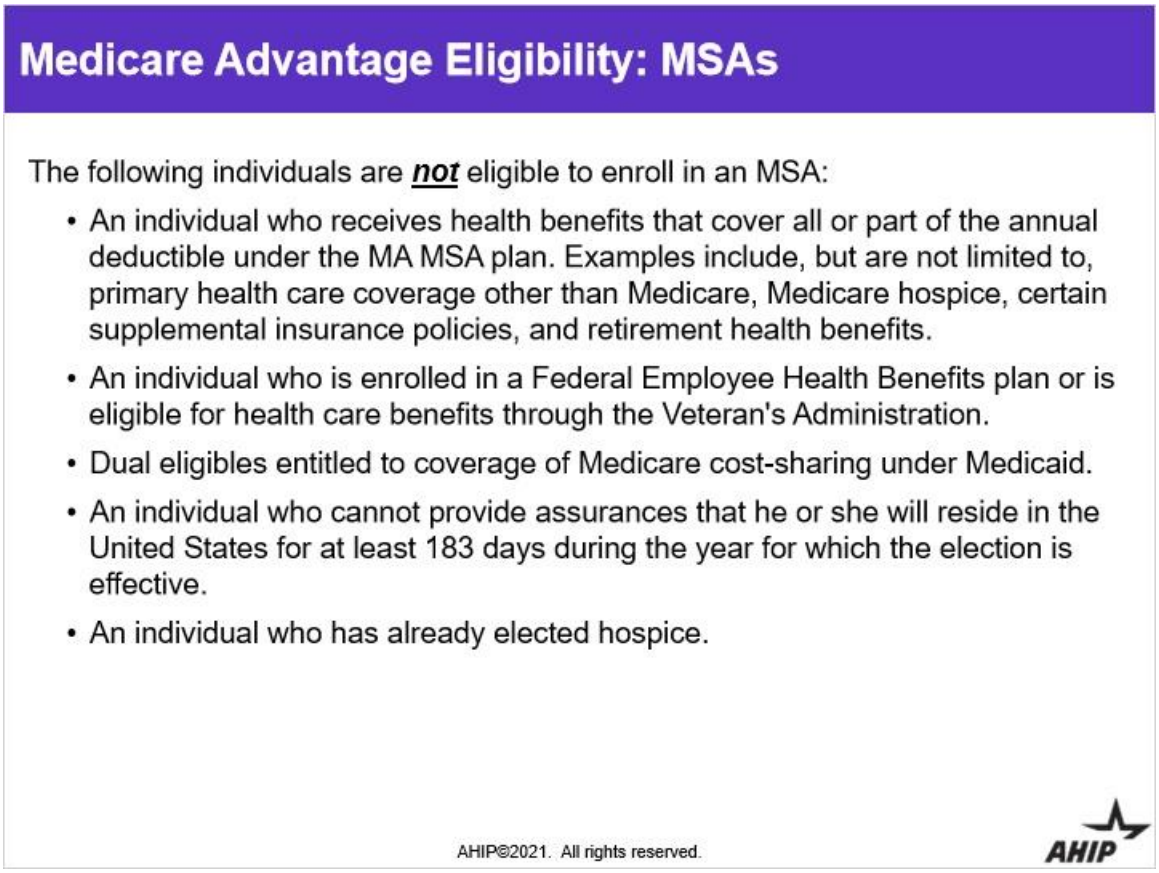
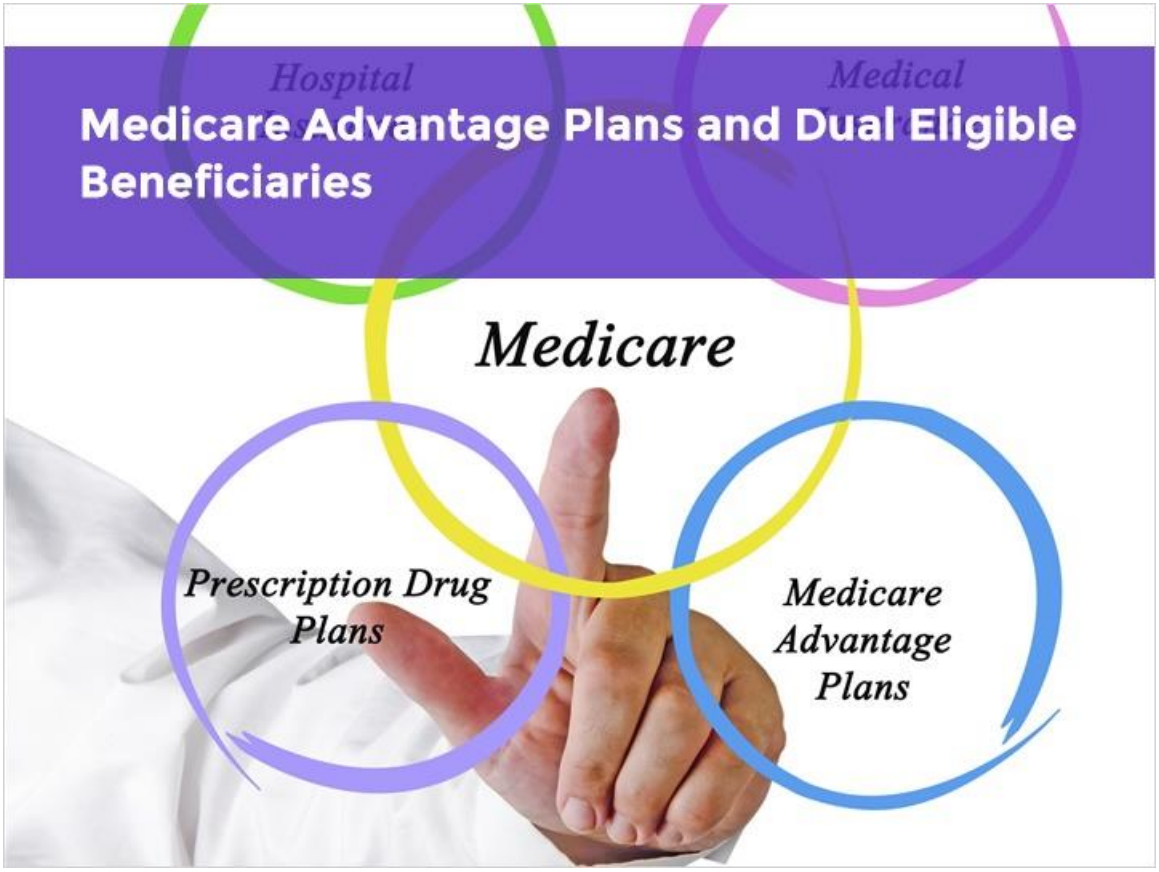
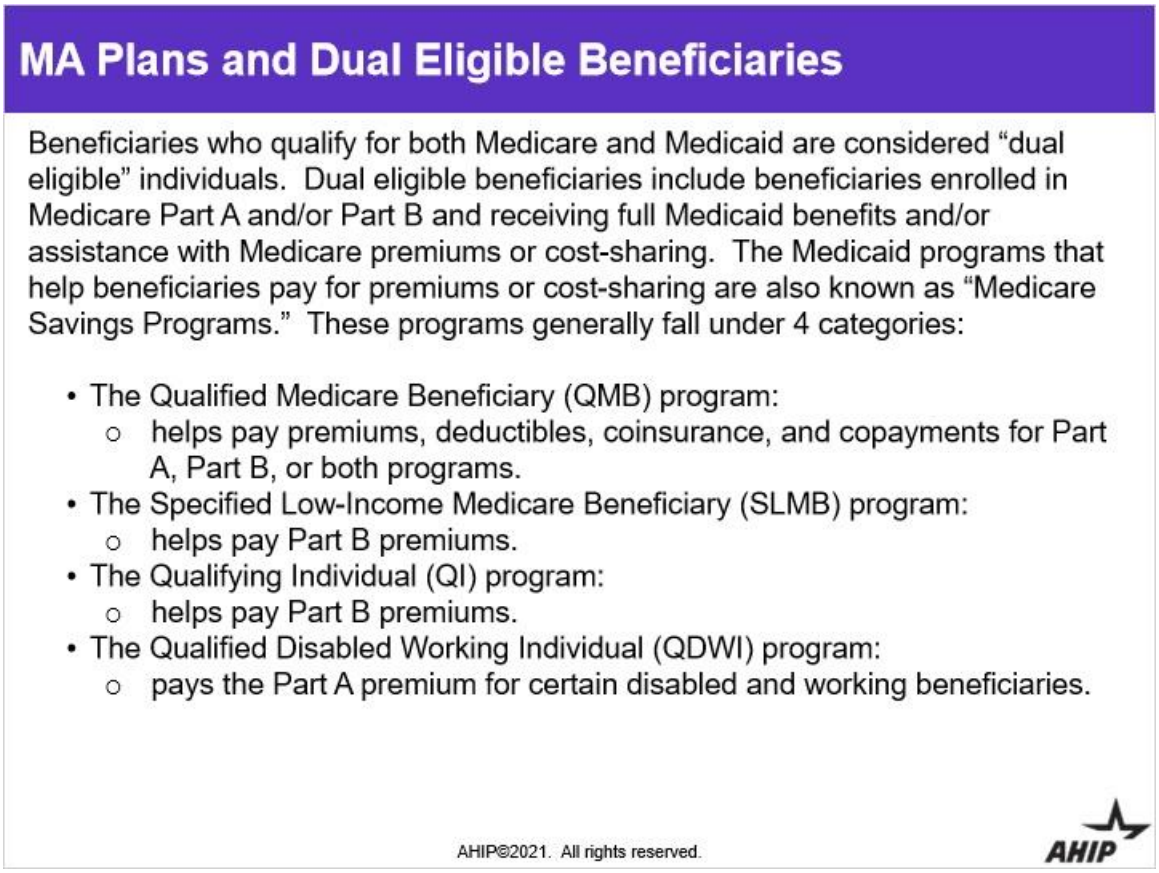
1.34 Medicare Advantage Eligibility: MSAs



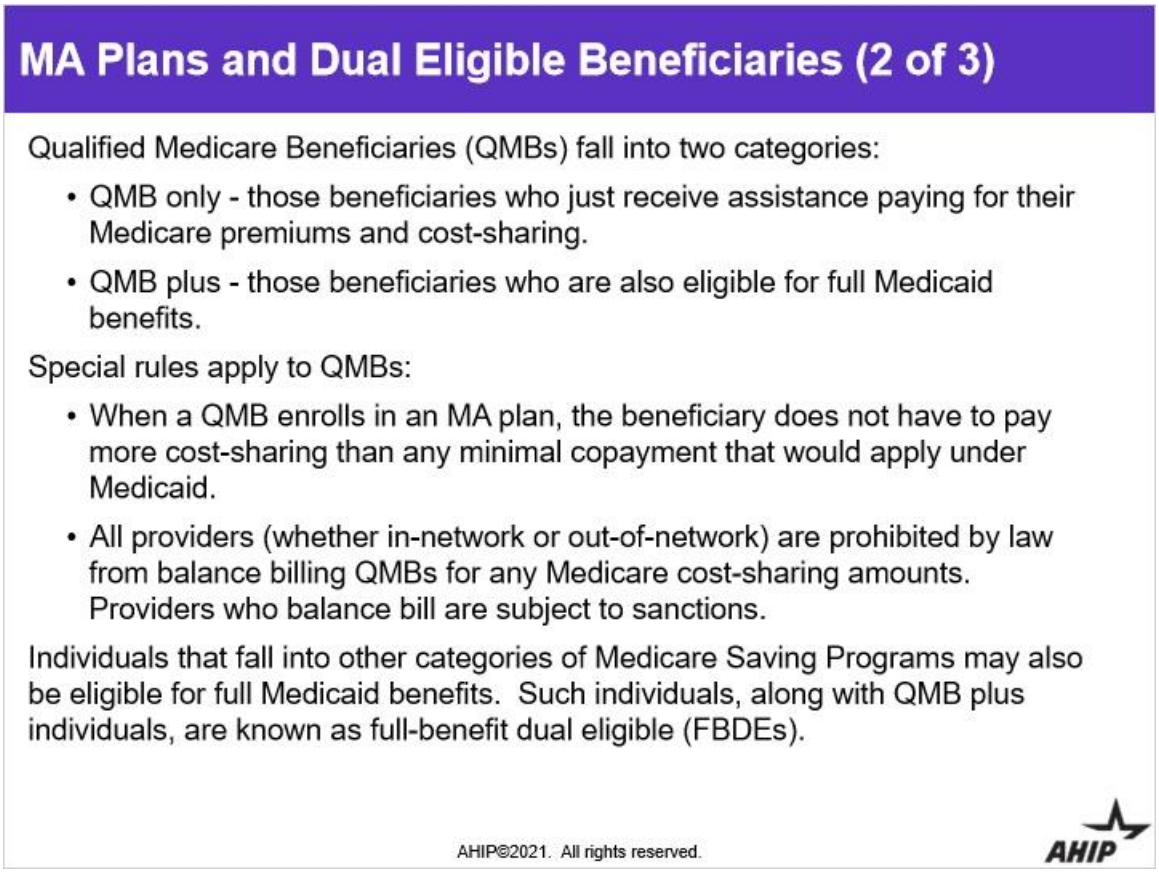
1.35 Medicare Advantage Plans and Dual Eligible Beneficiaries



1.36 MA Plans and Dual Eligible Beneficiaries



1.37 MA Plans and Dual Eligible Beneficiaries (2 of 3)



1.38 MA Plans and Dual Eligible Beneficiaries (3 of 3)

MA Plans and Dual Eligible Beneficiaries (3 of 3)

- Dual eligible beneficiaries may enroll in any type of MA plan except an MA MSA.
- Some MA plans, known as **dual eligible Special Needs Plans (D-SNPs)**, are tailored to dual eligible individuals, depending on the category to which they belong.
- Issues that are important to dual eligible beneficiaries considering MA enrollment include:
  - Whether the beneficiary is eligible for medical benefits under Medicaid. Medicaid may provide additional items and services as covered benefits, but Medicaid will only pay for those items and services if they are furnished by Medicaid participating providers.
  - Whether the beneficiary will need help to find providers who accept both Medicare and Medicaid.

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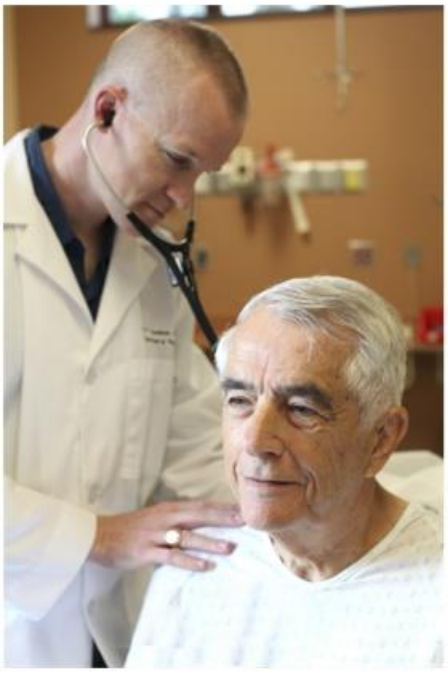
1.39 Case Study

Case Study

Mr. Walsh is a Qualified Medicare Beneficiary (QMB). He enrolls in a Medicare Advantage HMO. Mr. Walsh goes to his primary care doctor to receive a Medicare covered service. The normal copayment is $25.00. The doctor may only collect from Mr. Walsh any minimal cost sharing allowable under the state Medicaid program.



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1.40 Medicare Advantage and Prescription Drugs

1.41 MA & Prescription Drugs

MA & Prescription Drugs

- An organization offering coordinated care MA plans must offer at least one MA plan with prescription drug coverage (known as an MA-PD plan) in every service area.
- MA PFFS plans have the option of offering prescription drug coverage but are not required to do so.
    - An individual enrolled in an MA PFFS plan that does not include a Part D benefit may enroll in a PDP, even if under the same MA contract, the organization offers another PFFS plan that includes a Part D benefit.
- MA MSA plans are prohibited from offering prescription drug coverage. If an MSA member wants prescription drug coverage, the member must enroll in a stand-alone PDP.

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1.42 MA & Prescription Drugs, continued

MA & Prescription Drugs, continued

- If a beneficiary enrolls in an MA plan that includes Part D prescription drug coverage (an MA-PD plan), the beneficiary can only receive Part D drug coverage through that plan.
- If a beneficiary enrolls in an MA plan that is an HMO or PPO plan that does not include Part D coverage, the beneficiary cannot join a stand-alone Prescription Drug Plan (PDP).
    - Enrollees in certain Employer/ Union retiree group plans may have different options.

AHIP

1.43 MA & Prescription Drugs, Example

MA & Prescription Drugs, Example

Examples:

Mr. Page is enrolled in a MA PPO. He did not choose Part D coverage through the PPO. Now he wishes to enroll in a stand-alone PDP. Mr. Page cannot enroll in a PDP because he can only get Part D coverage through his PPO.

Ms. Smith is enrolled in a PDP. She wishes to enroll in an MA MSA plan. Ms. Smith can remain enrolled in her PDP because MSA plans do not offer Part D coverage.

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1.44 Medicare: Cost Plans

1.45 Medicare Cost Plans

Medicare Cost Plans

Medicare Cost Plans are Medicare health plans that are not Medicare Advantage plans, not Part C plans, and are not Original Medicare.

Medicare Cost Plans:

- May offer Part D prescription drug coverage as an optional benefit but are not required to do so.
- May offer other optional supplemental benefits.
- Are available only in certain areas in the United States. In 2021 they were offered in some counties in Kansas, Minnesota, North Dakota, South Dakota, Colorado, Illinois, Wisconsin, Iowa, and Nebraska.

An individual may enroll in a cost plan and a PDP.

- This applies regardless of whether the cost plan offers Part D coverage.

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1.46 Medicare Cost Plans: Network and Out-of-Network Care

Medicare Cost Plans: Network and Out-of-Network Care

Cost plan enrollees can choose to receive Medicare-covered services:

- Under the plan's benefits by going to plan network providers
  - The plan's cost-sharing applies when the enrollee gets services from network providers.
- Under Original Medicare by going to non-network providers
  - Original Medicare cost-sharing applies when the enrollee gets services from non-network providers. This amount is generally higher than the plan cost-sharing.

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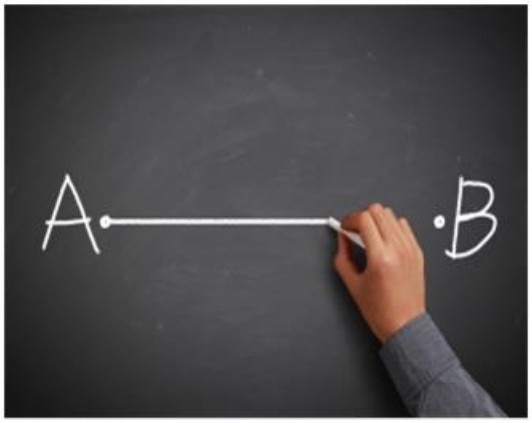
1.47 Medicare Cost Plans, Eligibility, and Premiums

Medicare Cost Plans, Eligibility, and Premiums

The following individuals are eligible to enroll in a Medicare cost plan:

- Those with Medicare Parts A and Part B; or
- Those with only Part B. Enrollees with Part B only will not have Part A coverage under the plan unless they purchase it. The plan may adjust the enrollee premium for individuals with Part B only.



Premiums:

- Enrollees must pay their Part B premiums and any plan premium.

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1.48 Enrollee Protections Appeals and Grievances

1.49 Enrollee Protections

Enrollee Protections

Enrollees of a Medicare Advantage plan or Medicare Cost Plan have a right to:

- File complaints (sometimes called grievances), including complaints about the quality of their care;
- Get a decision about health care payment or services, or prescription drug coverage; and
- Get a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.

AHIP

1.50 Enrollee Protections: Complaints, Coverage Decisions, Appeals

Enrollee Protections: Complaints, Coverage Decisions, Appeals

- Medicare health plan enrollees have two main processes to address concerns or disagreements with their plan.
  - The grievance process is used for complaints about the operations of a plan or its network providers.
  - The appeals process is used to ask for a review of the plan's coverage or payment decisions.

AHIP

1.51 Enrollee Protections: Grievances

Enrollee Protections: Grievances

- Enrollees or their representatives may file a grievance if they experience problems with their health care services such as timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
- Grievance issues also may include complaints that a covered health service, procedure, or item furnished during a course of treatment did not meet accepted standards for the delivery of health care.
- An enrollee or their representative may make the complaint orally, in writing, or via a CMS website at https://www.medicare.gov/MedicareComplaintForm/home.aspx.
- Plans must provide a link to the Medicare.gov website where the enrollee can enter a complaint.

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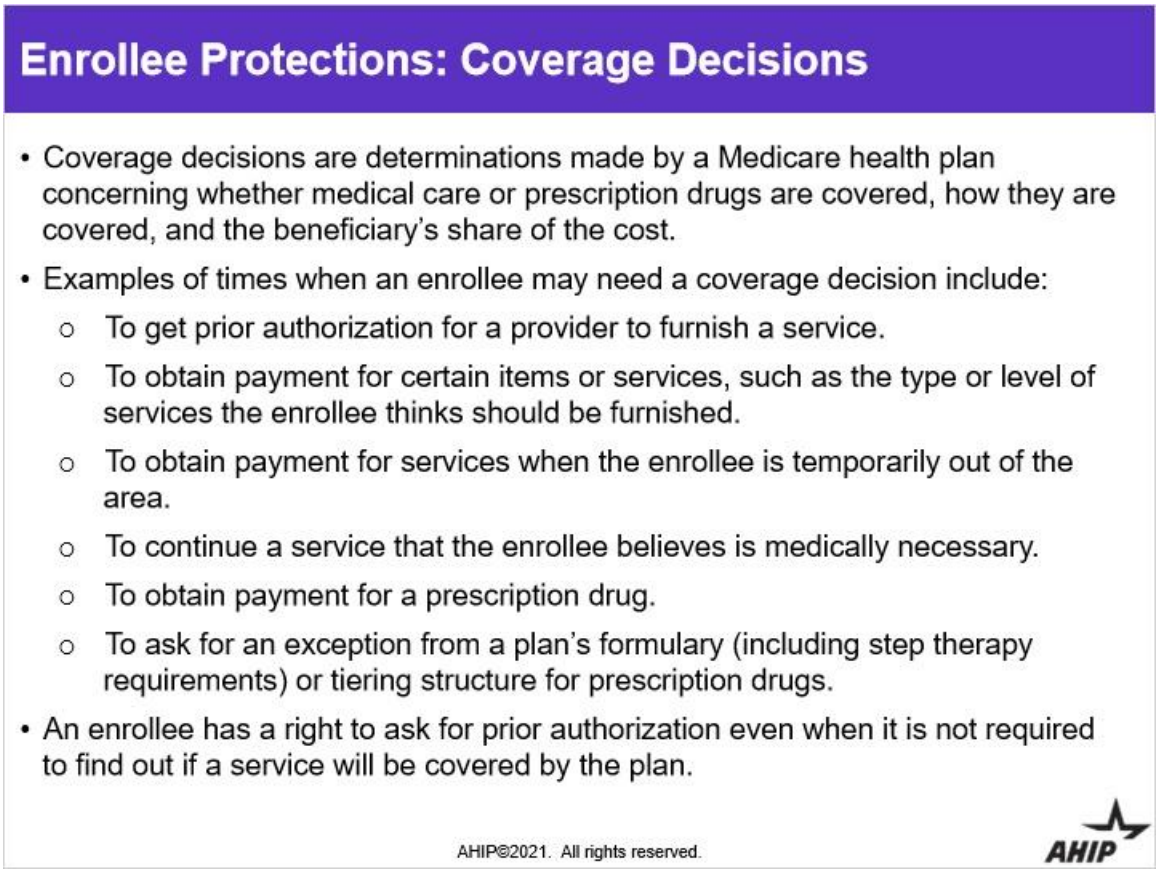
1.52 Enrollee Protections: Coverage Decisions



1.53 Enrollee Protections: Appeals

Enrollee Protections: Appeals

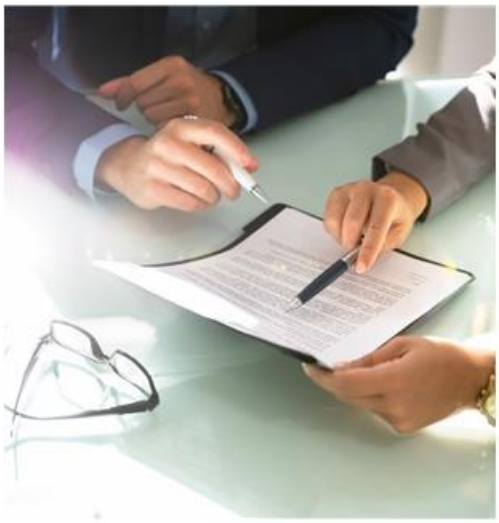
- If an enrollee is not satisfied with the coverage decision, he/she or in some cases his/her physician can appeal the decision.
- An appeal is a formal way to ask the plan to review or change a coverage decision.
- An appeal can also be filed if:
  - an enrollee believes a Medicare health plan did not pay for or authorize a service that should be covered.
  - an enrollee believes an authorized service such as a hospitalization or home health care is ending too soon.
  - an enrollee believes a plan has not authorized or paid for a Part D prescription drug that should be covered.

AHIP

1.54 Enrollee Protections: Appeals, continued

Enrollee Protections: Appeals, continued

- Medicare health plans must provide enrollees with a written description of the appeal process.
- To file an appeal, enrollees should look at their plan materials or call their plan.
- Medicare Health Plans offering a Part D benefit must:
  - provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a coverage determination or appeal a decision.
  - require network pharmacies to provide enrollees with a printed notice with the plan's toll-free number and website for requesting a coverage determination.



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1.55 Enrollee Protections Network Requirements and Other Enrollee Rights

1.56 Enrollee Protections: Network Requirements

Enrollee Protections: Network Requirements

Enrollees of a plan have a right to:

- Select and/or change their primary care provider without interference from the plan. However, network restrictions may apply.
- Have access to doctors, specialists, and hospitals:
  - Enrollees in Cost Plans, HMOs, PPOs, network-based PFFS plans, and SNPs must have access to provider networks that include enough doctors, specialists, and hospitals to provide all covered services necessary to meet enrollee needs within reasonable travel time.
  - Exception - In limited circumstances, PPOs that serve regions established by CMS (Regional PPOs) may offer services through non-network providers at the in-network enrollee cost-sharing level.
- Get emergency care when and where they need it.

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1.57 Enrollee Protections: Network Requirements, continued

Enrollee Protections: Network Requirements, continued

Enrollees of a plan that offers Part D benefits have a right to:

- have access to covered Part D drugs through network pharmacies.
- have access to plan networks that include retail, specialty, and home infusion pharmacies to provide convenient access to covered drugs.
  - Exception: PFFS plans may provide access to covered drugs through a network or by covering the drugs at any pharmacy.
- have convenient access to network long term care pharmacies if the enrollee resides in a long-term care facility.
- have convenient access to Indian Health Service, Tribal, and urban Indian organization (I/T/U) pharmacies, if enrollees are American Indians or Alaska Natives (AI/AN).

AHIP

1.58 Enrollee Protections: Other Enrollee Rights

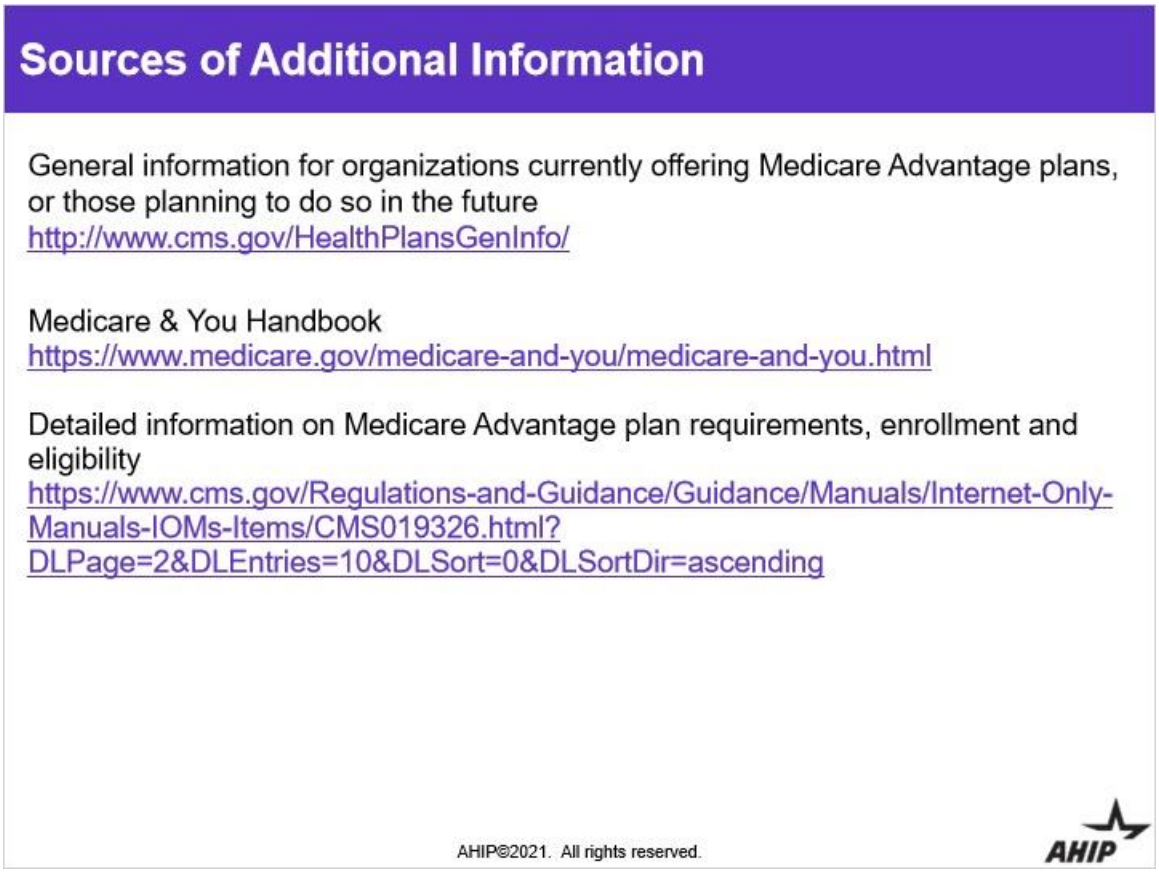
Enrollee Protections: Other Enrollee Rights

Enrollees of a plan have a right to:

- be protected from discrimination.
- learn about all their treatment choices and participate in treatment decisions.
- know how their doctors are paid.
- have personal and health information kept private.
- obtain a treatment plan.

AHIP

1.59 Sources of Additional Information



1.60 THANK YOU