1. Module 2: Part C and Other Medicare Health Plans
2. Navigation Instructions
3. Terms and Conditions

The training program is intended to provide guidance only in identifying factors for consideration in the basic rules and regulations governing coverage, eligibility, marketing, and enrollment for Medicare, Medicare supplement insurance, Medicare health plans, and Part D prescription drug plans and is not intended as legal advice. While all reasonable efforts have been made to ensure the accuracy of the information contained in this document, AHIP shall not be liable for reliance by any individual upon the contents of the training program.

4. Learning Objectives
    - After reviewing "Part 2: Medicare Health Plans" you will be able to:
        - Explain what types of Medicare health plans are available
        - Explain who is eligible for the different types of plans
        - Describe the different types of Special Needs Plans (SNPs)
        - Describe features of different Medicare health plan types
        - Describe the different types of benefits offered by Medicare Advantage plans
        - Explain how Medicare health plans work with prescription drug plans
        - Explain enrollee rights concerning their Medicare health plan

5. Training Roadmap: Module 2
    - Medicare Advantage Plans
    - MA Plan Types: Coordinated Care Plans
    - Special Needs Plans
    - MA Plan Types: Private Fee-for-Service (PFFS) Plans
    - MA Plan Types: Medical Savings Account (MSA) Plans
    - Medicare Advantage Employer/Union Plans
    - Medicare Advantage: Eligibility, Costs, and Benefits
    - Medicare Advantage and Prescription Drugs
    - Other Types of Medicare Health Plans
    - Enrollee Protections: Appeals and Grievances

6. Title Page: Medicare Advantage Plans

7. 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 (known as "basic benefits").

- Many also cover Part D prescription drug benefits (MA-PD plans).
- All MA plans have a maximum out-of-pocket limit (MOOP) for basic benefits.
- Many MA plans also offer additional benefits that Medicare does not cover, known as supplemental benefits.
- 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

8. Title Page: MA Plan Types Coordinated Care Plans

9. Coordinated Care HMOs: Network Coverage

- HMOs generally only cover services furnished by doctors and hospitals within the plan's network (known as participating providers). However, there are certain exceptions:
    - Emergency services furnished by out-of-network providers 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 furnished by out-of-network providers 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 or a covered procedure is not available or adequate through participating providers, the HMO plan will authorize out-of-network services at in-network cost-sharing.

10. Coordinated Care HMOs: PCPs, Referrals, and POS Options

- HMO enrollees may be required to select a primary care provider (PCP) from whom they will receive their routine outpatient care.
- HMO enrollees may be required to obtain a referral from their PCP for specialty care (like visits to a specialty physician) to be covered.
- Some HMOs offer a Point of Service (POS) option that allows enrollees to go to out-of-network doctors and hospitals for certain services without receiving prior approval.
    - 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 for services furnished by out-of-network providers than for services obtained from participating providers.

11. MA Plan Types Coordinated Care Plans – PPOs

Under a PPO, enrollees:

- may get care from any provider in the U.S. who accepts Medicare and the plan; they are not limited to network providers.
- usually pay higher cost-sharing amounts to receive services from an out-of-network provider than from a participating provider.
- do not need a referral or authorization to see an out-of-network provider or receive an out-of-network service but are encouraged to contact the plan to be sure the service they wish to obtain out-of-network is medically necessary and will be covered.
- may be required to get a referral or authorization to obtain certain in-network services or see certain in-network providers, but if they fail to do so, covered services service will still be paid for by their plan. They just have to pay the higher out-of-network cost sharing.

If a needed specialist or covered procedure is unavailable or inadequate in network to meet a beneficiary's needs, MA plans must cover out-of-network benefits at in-network cost sharing. Regional PPOs are PPOs that are offered throughout an entire region, made up of one or more states.

12. MA Plan Types Coordinated Care Plans – Special Needs Plans

- Special Needs Plans (SNPs) are a type of Medicare Advantage coordinated care plan (HMOs or PPOs) specially designed to serve a targeted subset of Medicare beneficiaries.
- In addition to meeting all other MA eligibility criteria, beneficiaries must also meet criteria specific to the type of SNP in which they wish to enroll.
- All SNPs must implement an evidence-based model of care with appropriate networks of providers and specialists designed to meet the specialized needs of the plan's targeted enrollees.
- All SNP plans include prescription drug coverage.
- SNPs generally offer a higher level of care coordination and case management to their target populations.

13. Title Page: Special Needs Plans

14. Special Needs Plan Types – C-SNPs

There are several types of Special Needs Plans:

- Chronic condition SNPs (C-SNPs) are SNPs that restrict enrollment to individuals with one or more severe or disabling chronic conditions, specified in CMS regulations.

- Those conditions include, but are not limited to:
    - diabetes,
    - stroke,
    - end stage renal disease
    - certain cardiovascular disorders,
    - cancer,
    - certain chronic lung disorders,
    - HIV,
    - dementia,
    - certain autoimmune disorders
    - chronic kidney disease,
    - chronic heart failure
    - certain mental health disorders,
    - drug or alcohol dependence, or
    - certain neurological disorders like epilepsy, multiple sclerosis, or Parkinson's disease.
- C-SNPs may focus on one severe or disabling chronic condition, or on a grouping specified by CMS of severe or disabling chronic conditions that represent multiple commonly co-morbid and clinically linked conditions.
- Each C-SNP will specify the condition or conditions necessary to be eligible to enroll.

The most common C-SNPs target cardiovascular disorders, chronic heart failure, and diabetes.

15. Special Needs Plan Types – I-SNPs and IE-SNPs

- 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 skilled nursing facility, a nursing facility (NF) as defined under Medicaid law, an intermediate care facility for individuals with intellectual and developmental disabilities, a long-term care hospital, an inpatient psychiatric facility, or certain other facilities specified by CMS.
- Institutional Equivalent (IE) SNPs enroll MA-eligible individuals who live in the community but require an institutional level of care (i.e., are determined by an impartial entity to need the level of services furnished by the types of facilities). MA plans may limit eligibility for enrollment in their IE-SNP to one or more assisted living facilities, in order to best implement their model of care.

16. D-SNPs: Who Is Eligible

- Dual-eligible SNPs (D-SNPs) enroll certain categories (as determined by each state) of individuals eligible for both Medicare and Medicaid (dual-eligible beneficiaries).
- Dual eligible beneficiaries are beneficiaries enrolled in Medicare Part A and/or Part B who receive full Medicaid benefits and/or Medicaid assistance with Medicare premiums or cost-sharing.
- The categories of dual eligibles include the following:
    - Qualified Medicare Beneficiaries (QMBs) -- Medicaid helps pay premiums, deductibles, coinsurance, and copayments for Part A, Part B, or both programs for these beneficiaries.
    - Specified Low-Income Medicare Beneficiaries (SLMBs): Medicaid helps pay Part B premiums for these beneficiaries.

- Qualifying Individuals (QIs): Medicaid helps pay Part B premiums for these beneficiaries.
  - Qualified Disabled Working Individuals (QDWIs) -- Medicaid pays the Part A premium for certain people under age 65 with disabilities who return to work. Medicaid may also cover medical costs that Medicare doesn't cover or partially covers (for example, nursing home care, personal care, and home- and community-based services). Beneficiaries' coverage can vary by state.
  - Dual-eligible individuals who are eligible for full Medicaid benefits are known as full-benefit dual eligible (FBDEs) or QMB-Plus.
- States may vary in determining their eligibility categories. Consequently, there may be state specific differences in the eligibility levels outlined.

17. D-SNPs: How Care Is Coordinated
    - D-SNPs coordinate the delivery of Medicare and Medicaid services for individuals eligible for such services.
    - D-SNPs may cover Medicaid services such as long-term services and supports and behavioral health for individuals eligible for such services.
    - There are different types of D-SNPs, including fully integrated dual-eligible (FIDE) SNPs, highly integrated dual-eligible (HIDE) SNPs, and coordination-only D-SNPs.

18. Types of D-SNPs – FIDE SNPs

- FIDE SNPs provide full benefit dual eligible individuals with access to Medicare and Medicaid benefits under a single organization that has both a Medicare Advantage and Medicaid managed care contract.
- FIDE SNP membership is limited to individuals who receive their Medicaid benefits through the MA organization or a parent or affiliate of the MA organization.
- FIDE SNPs cover primary care, acute care, Medicare cost-sharing, long-term services and supports (LTSS) (including coverage of nursing facility services for a period of at least 180 days during the plan year), behavioral health services, home health services, and medical supplies equipment and appliances.
- FIDE SNPs coordinate the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries.
- FIDE SNPS also coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement.

19. Types of D-SNPs – HIDE SNPs

- HIDE SNPs cover certain Medicaid benefits under a capitated contract between the State Medicaid agency and
    - the MA organization
    - the MA organization's parent organization, or an affiliate of the MA organization
    - or certain local nonprofit public benefit corporations that have a founding member that is the MA organization, the MA organization's parent organization, or another entity that is owned and controlled by its parent organization where that local nonprofit public benefit corporation is responsible for the delivery of physical, behavioral, and dental health services.
- HIDE SNPS cover all Medicare benefits and (to the extent enrollees are eligible for these benefits):
    - long-term services and support (including community based long term services and supports and some days of coverage of nursing facility services during the plan year), or
    - behavioral health services.

20. Types of D-SNPs – Coordination only D-SNPs

- Coordination-only D-SNPs (CO D-SNPs) are D-SNPs that do not qualify as HIDE or FIDE SNPs.
- CO D-SNPs have a CMS-approved contract with a state Medicaid agency that stipulates that, to coordinate Medicare and Medicaid-covered services between settings of care, the D-SNP notifies or arranges for another entity or entities to notify, the state Medicaid agency, individuals or entities designated by the state Medicaid agency, or both, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the state Medicaid agency.
- If the CO-D-SNP only enrolls partial-benefit dual eligibles (i.e., those not eligible for full Medicaid benefits) per the terms of its contract with the state, it is not required to meet the notification requirement when the MA organization also offers an integrated D-SNP with enrollment limited to FBDE individuals that is in the same state and service area and under the same parent organization.
- If the CO S-SNP enrolls full benefit dually eligible beneficiaries, such full benefit dually eligible beneficiaries cannot be enrolled in a Medicaid managed care organization that is owned and controlled by an entity other than the MA organization, its parent organization, or an entity that shares a parent organization with the MA organization.

21. D-SNPs – Exclusively Aligned Enrollment

Exclusively aligned enrollment is where a State limits eligibility to enroll in a D-SNP to full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization (MCO) contract held by either:

- the D-SNP organization,
- the D-SNP's parent organization, or
- another entity that is owned and controlled by the D-SNP's parent organization.

22. D-SNPs – Applicable Integrated Plans: Eligibility

- Applicable Integrated Plans are:
  - FIDE or HIDE SNPs with exclusively aligned enrollment and the MCOs through which their members receive Medicaid benefits.
    - All Fide SNPs and their affiliated MCOs are applicable integrated plans.
    - HIDE SNPs and their affiliated MCOs may be applicable integrated plans if they have exclusively aligned enrollment.

23. D-SNPs – Applicable Integrated Plans: Contracting and Coverage

- Applicable Integrated Plans are:
  - A D-SNP and affiliated MCO where the D-SNP's enrollment is limited to beneficiaries enrolled in an MCO and
    - the MA organization, the MA organization's parent organization, or another entity that is owned and controlled by its parent organization has a capitated contract with either a Medicaid agency or an MCO; and
    - through the capitated contract, Medicaid benefits including primary care and acute care, including Medicare cost-sharing and at a minimum, one of the following: home health services, medical supplies, equipment, and appliances, or nursing facility services are covered for the enrollees.
      - For example, a CO D-SNP and affiliated MCO can be an applicable integrated plan where the CO D-SNP holds a contract with a separate MCO to cover all capitated managed care benefits in the state and the separate MCO holds the contract with the state for those benefits. Applicable Integrated Plans are required to have unified appeals and grievances processes for Medicare and Medicaid benefits that simplify the grievance and appeals steps for their dual eligible enrollees and require the plan to continue benefits pending an appeal decision.

24. Title Page: MA Plan Types: Private Fee-for-Service (PFFS) Plans

25. MA Plan Types: Private Fee-for-Service (PFFS) Plans (1 of 2)

- PFFS are MA plans under which enrollees are not limited to receiving services from a network of plan providers. PFFS Plan enrollees 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.
- PFFS plans pay providers on a fee-for-service basis and do not put them at financial risk.
- PFFS plans do not require prior authorization, prior notification, or referrals as a condition of coverage.
- Some PFFS plans contract with 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 receiving services that they are a PFFS plan member (typically by showing their membership card), so that non-network providers can decide whether to accept the plan's terms and conditions.

26. MA Plan Types: Private Fee-for-Service (PFFS) Plans (2 of 2)

- Non-network providers that accept Original Medicare may choose not to accept PFFS plan enrollees. Therefore, an enrollee needs to confirm that their provider of choice will accept a PFFS plan before enrolling in one.
- PFFS plans may decide to allow network and non-network providers to balance bill their members up to 15 percent of the amount of the plan's payment to the provider. If a PFFS plan prohibits this balance billing, providers may only charge the member the plan-allowed cost-sharing amount. PFFS plans may choose to offer Part D benefits but are not required to do so.

27. Title Page – MA Plan Types: Medicare Savings Account Plans

28. MA Plan Types: Medical Savings Account (MSA) Plans: Overview

- A Medicare MSA is a high-deductible Medicare Advantage plan that is combined with a special medical savings account.
    - Medicare contributes money to the beneficiary's medical savings account to assist with paying for Medicare-covered services during the deductible phase.
    - The amount of the contribution varies by plan.
    - Money left in the account at the end of the year stays there. If the beneficiary remains enrolled in the plan the following year, Medicare will add any new deposits.
- If an MSA enrollee uses all the funds in their medical savings account, they must pay out-of-pocket until they reach their deductible.
- After the annual deductible is met, the plan pays 100% for covered services.
    - The maximum allowable deductible for MSA plans in 2026 is $18,100. However, most MSAs will have a substantially lower deductible.

29. MA Plan Types: MSA Plans

- There is no premium for an MSA.
- MSA plans cover Part A and Part B benefits, but beneficiaries must continue paying their Part B premium.
- 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.
- MSA enrollees may receive covered services from any Medicare-approved provider in the U.S. if the provider chooses to accept their plan.
- 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.

30. Title Page: Medicare Advantage Employer/Union Plans

31. Employer/Union Plans

- Employers and unions may offer their retirees and their dependents:
    - Medicare Advantage individual plans (plans available to any beneficiary). These plans are listed on Medicare.gov.
    - Medicare Advantage plans that are only available to individuals based on their employer, known as **Employer Group Waiver Plans or EGWPs**.
    - A Medicare Advantage plan offered through a direct contract between the employer or union and CMS, known as a direct contract plan.
- Employers with less than 20 employees (as calculated under Medicare secondary payor rules) may be able to offer Medicare Advantage plans to their active employees and their dependents.
- Any size employer can offer Medicare Advantage plans to its retirees and their dependents.
- EGWP and direct contract plans are different from other Medicare Advantage plans because eligibility to enroll is limited to certain active employees, retirees, and their dependents, and because a variety of regulatory requirements are waived as they apply to the plans.

32. Title Page: Medicare Advantage Plans – Eligibility, Costs, and Benefits

33. 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.
    - Entitlement to Part A means that the beneficiary is either eligible and signed up for premium-free Part A or paying the premium (or having the premium paid on their behalf) for Part A.
- 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, they should only enroll in MA-PD plans with a visitor/traveler benefit.)
- MA plans must generally enroll any eligible beneficiary who applies regardless of health status.
    - Special needs plans only enroll beneficiaries within their targeted populations.

34. Medicare Advantage Eligibility: EGWPs

- Employer group waiver plans (EGWPs) or direct contract plans may only enroll Medicare beneficiaries who are 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 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.

EGWPs Examples

An association of employers, such as school boards, may offer its former employees an EGWP plan. Employers can also form associations specifically to provide retirees with health coverage.

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

35. MSAs: Special Eligibility Rules

MSAs are not available to all beneficiaries. The following individuals are ***not*** eligible to enroll in an MSA:

- An individual who receives health benefits that cover all or part of the annual deductible under the MA MSA plan. Examples include but are not limited to, primary health care coverage other than Medicare, disease-specific policies, certain supplemental insurance policies, and retirement health benefits.
- An individual who is enrolled in a Federal Employee Health Benefits plan or is eligible for health care benefits through the Veteran's Administration.
- Dual eligibles entitled to coverage of Medicare cost-sharing under Medicaid.
- An individual who cannot provide assurances that they will reside in the United States for at least 183 days during the year for which the election is effective.
- An individual who has already elected hospice.

36. Medicare Advantage Plans: Premiums and Cost-Sharing

- 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.
- 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 out-of-pocket 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, $30 for each visit to a primary care provider, or $500 for each hospital inpatient stay.
    - Coinsurance: A percentage of the cost of the service the member must pay. For example, 20% of the cost of durable medical equipment.

37. Maximum Out-of-Pocket Limits

- All Medicare Advantage plans must have a "maximum out-of-pocket" limit (known as the "MOOP") for Part A and Part B benefits. 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.
    - Each plan's MOOP will be specified in its summary of benefits and its evidence of coverage.
- For 2027, the maximum MOOP limit for Medicare Advantage coordinated care plans and private fee-for-service plans is $9,850, although most plans will have lower limits. PPOs must also have an aggregate MOOP for network and non-network providers of $14,800 in 2027. Again, it is likely that many will have lower limits.
- MSAs have a deductible that members must pay, then the plan pays 100% for covered services.

38. Cost-Sharing for Qualified Medicare Beneficiaries (QMBs)
QMBs are a type of dual-eligible beneficiary. Special cost-sharing rules apply to QMBs enrolled in any type of MA plan:

- QMBs do not have to pay more cost-sharing than any minimal copayment that would apply under Medicaid, regardless of what the plan requires for other enrollees.
- All providers (whether or not they are Medicaid participating, or in-network) are prohibited by law from billing QMBs for any Medicare cost-sharing amounts, including the amounts under their MA plan. Providers who balance bill are subject to sanctions.

Case Study
Mr. Walsh is a Qualified Medicare Beneficiary (QMB) who is enrolled in a MA PPO. Mr. Walsh goes to an out-of-network cardiologist. The plan cost-sharing for the visit is $80. However, the doctor may only collect from Mr. Walsh any minimal cost-sharing allowable under the state Medicaid program, which in Mr. Walsh's case is $2.00. His doctor may bill the state for the cost-sharing, but the hold harmless obligation applies regardless of whether or how much of the cost-sharing the state pays.

39. Part C: Medicare Advantage Plan Benefits

- All Medicare Advantage (MA) plans must cover all Part A and Part B benefits.
- MA plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in Original Medicare.
- Most MA plans also cover part of the Original Medicare cost-sharing for Part A and Part B benefits.
- MA plans may also cover extra benefits not covered by Original Medicare (known as "supplemental benefits"), such as:
    - Vision services, including vision exams for contacts and eyeglasses
    - Hearing aids
    - Routine dental services, such as teeth cleaning
- Supplemental benefits may be optional or mandatory.
    - Mandatory supplemental benefits are embedded in the Medicare Advantage plan and must be purchased as part of the plan. They can include reductions in cost-sharing for benefits covered under Original Medicare.
    - Optional supplemental benefits may be added to an MA plan at the option of the beneficiary.

40. Special Supplemental Benefits Depending on Chronic Health Condition
Medicare Advantage plans may offer supplemental benefits targeted to individuals with certain chronic health conditions, such as diabetes, heart failure, COPD, or other conditions, which are not available to members of the same plan without the specified condition. There are two categories of such benefits: (1) those that are primarily health-related and (2) those that are not (the latter generally address social determinants of health and are known as Special Supplemental Benefits for the Chronically Ill, or SSBCI).

- Primarily health-related benefits for chronically ill enrollees may include items such as decreased cost-sharing for certain services, or supplemental benefits (e.g., at-home palliative care or transportation to medical appointments).

- SSBCI may include items such as groceries, meals beyond a limited basis, pest control, and non-medical transportation.

Consequently, it is useful for agents to know if their clients have conditions that may qualify them for these types of benefits if they are available in the clients' area.

41. Medicare Advantage Plans – Utilization Management

- Medicare Advantage plans may implement mechanisms to promote the appropriate utilization of covered services. These mechanisms are known as "utilization management."
- Such mechanisms include requiring a referral or prior authorization to obtain a service.
    - PPOs may not require prior authorization for out-of-network services.
    - PFFS plans may not require prior authorization.
    - Non-network MSAs may not require prior authorization.
- Authorizations must be valid for as long as medically necessary to avoid disruptions in care.
- 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.
- When an enrollee enrolls in an MA plan after starting a course of treatment, there is a minimum 90-day transition period during which the MA organization may not disrupt or require authorization for the active course of treatment, even if they are receiving the services from a non-network provider.
    - An active course of treatment can include a scheduled surgery.

42. Title Page - Medicare Advantage and Prescription Drugs

43. MA & Prescription Drugs

- An organization offering coordinated care MA plans (HMOs or PPOs) 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.
- If a beneficiary enrolls in an MA coordinated care plan (HMO, PPO) that does not include Part D coverage, the beneficiary <u>cannot</u> join a stand-alone Prescription Drug Plan (PDP). If the beneficiary wants to remain enrolled with the organization offering their MA plan, they must choose an MA-PD offered by the organization.
    - Enrollees in certain Employer/Union retiree group plans may have different options.

44. Title Page – Other types of Medicare Health Plans

45. Other Types of Medicare Health Plans: Overview

There are other types of Medicare health plans, which are NOT Part C or Medicare Advantage plans. The other types of Medicare health plans include:

- Medicare Cost Plans
- Programs of All-Inclusive Care for the Elderly (PACE) plans
- Other Demonstration Plans
  - Other Medicare health plan demonstrations include state-specific demonstrations such as the Minnesota Senior Health Care Options (MSHO) program.

46. Medicare Cost Plans

Medicare Cost Plans are Medicare health plans that are not Medicare Advantage (Part C) plans and are not Original Medicare. Medicare cost plans are sometimes referred to section 1876 cost plans.

Medicare 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.

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 2026 they were offered in 11 states including some counties in Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin, and Wyoming.

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

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

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 Part B premiums and any plan premium.

47. PACE Plans

Programs of All-Inclusive Care for the Elderly (PACE):

- are Medicare plans for frail, elderly beneficiaries who are certified as needing a nursing home level of care but still living in the community (i.e., not in a nursing home).
- are available in most states but tend to have small service areas and thus may only be available in a few counties.

- offer an adult day health center, where enrollees can get health care, meals, and other services.
- include comprehensive medical and social service delivery systems using an interdisciplinary team approach in the adult day health center, supplemented by in-home and referral services.

Eligibility for PACE: Participants must be:

- age 55 or older.
- reside in the PACE organization's service area.
- be certified as eligible for nursing home care by their state.
- be able to live safely in a community setting at the time of enrollment.

Under a PACE Plan:

- There's no deductible or copayment for any drug, service, or care approved by the PACE team of health care professionals.
- Beneficiaries with Medicaid pay no premiums.
- Beneficiaries with only Medicare pay a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Part D (in addition to the Part B premium).

More information on PACE visit Program of All-Inclusive Care for the Elderly (PACE) | CMS or click here: https://www.npaonline.org/#:~:text=Find%20a%20PACE%20Program,PACE%20program%20near%20you%20today!

48. Title Page-Enrollee Protections Appeals and Grievances

49. Enrollee Protections
Enrollees of a Medicare Advantage plan, Medicare Cost plan, or PACE 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.
- get a review (appeal) of adverse decisions about health care payment, coverage of services, or prescription drug coverage.

50. Enrollee Protections: Grievances
The grievance process is used for complaints about the operations of a plan or its network providers.

- 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/my/medicare-complaint
- Medicare Advantage, Medicare Cost, and Medicare Prescription Drug Plans must also provide a link on their websites to the Medicare.gov website where the enrollee can enter a complaint.

51. Enrollee Protections: Coverage Decisions

- Coverage decisions are determinations made by a Medicare health plan concerning whether medical care or prescription drugs are, or will be, covered and the beneficiary's share of the cost for the care or drugs.
- Examples of times when an enrollee may need a coverage decision include:
    - To get prior authorization for a provider to furnish a service.
    - To obtain coverage for certain items or services, such as the type or level of services the enrollee thinks should be furnished.
    - To obtain payment for urgently needed services the enrollee received when they were temporarily out of the area.
    - To continue a service that the enrollee believes is medically necessary.
    - To obtain coverage for a prescription drug.
    - To ask for an exception from a plan's formulary requirements (including step therapy requirements) or tiering structure for prescription drugs.

52. Enrollee Protections: Prior Authorization

- An enrollee has a right to ask for prior authorization even when it is not required in order to find out if a service will be covered by the plan.
- An MA organization or Medicare Cost Plan must generally make a prior authorization decision in seven days (or within 72 hours for drugs). In certain instances when the standard timeframe could endanger the enrollee's health, the decision must be made more quickly.
- MA organizations must post on their websites the following information about prior authorization requests:
    - The list of services that require prior authorization;
    - Beginning in 2027, the percentage of prior authorization requests the MA organization approved and denied; and
    - Beginning in 2027, the average and median amount of time it took to make a prior authorization decision.

53. Enrollee Protections: Appeals Basics

The appeals process is used to ask for a reconsideration of the plan's coverage or payment decisions.

- If an enrollee disagrees with the coverage decision, they, or in some cases their physician, can appeal the decision.
    - Physicians can appeal prior authorization denials on behalf of their patients.
- An appeal is a formal way to ask the plan to review or change a coverage decision.
- An appeal can be filed if:
    - an enrollee believes a Medicare health plan did not pay for or authorize a service that should be covered. Where the plan did not pay, the enrollee must be financially liable in order to appeal.
    - an enrollee believes an authorized service such as 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.

54. Enrollee Protections: Appeals Process

- Medicare health plans must provide enrollees with a written description of the appeal process.
- Medicare health plans must include on their websites written procedures for filing an appeal or grievance along with phone number(s) for receiving oral requests (requests for payment must be in writing); mailing address for written requests; and links to any forms created by the plan for appeals and grievances.
- 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 about coverage of a drug.
    - require network pharmacies to provide enrollees with a printed notice with the plan's toll-free number and website for requesting a coverage determination concerning a drug.
- Beginning in 2027, MA organizations must post on their websites the percentage of prior authorization requests that were approved and denied after an appeal.
- D-SNPs that are part of Applicable Integrated Plans must offer processes for grievances, coverage decisions, and appeals that integrate beneficiaries' rights under Medicare and Medicaid.

55. Sources of Additional Information

- Medicare & You Handbook
  https://www.medicare.gov/medicare-and-you
- Detailed information on Medicare Advantage plan requirements
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending
- Information on Medicare Advantage enrollment and eligibility
  https://www.cms.gov/files/document/cy-2024-ma-enrollment-and-disenrollment-guidance.pdfhttps://www.cms.gov/files/document/cy-2026-cd-enrollment-and-disenrollment-guidance.pdf