

CONTENTS

- **What Are Medicare Advantage (MA) Plans?**
- **Who Can Join and When?**
- **MA Trial Right Special Election Period**
- **How MA Plans Work**
- **MA Costs**
- **Types of Medicare Advantage Plans**
- **Rights in All Medicare Plans**
- **Rights in Medicare Health Plans**
- **Appeals in Medicare Advantage**
- **Medicare Health Plan Fast Appeals Process**
- **Required Notices**
- **Disclosure of Plan Information**



What are Medicare Advantage (MA) Plans?

- Health plan options approved by Medicare
- Run by private companies
- Part of the Medicare program
 - Sometimes called “Part C”
- Available in many areas of the country
- Provide Medicare-covered benefits
 - May cover extra benefits, e.g.; vision or dental



Who Can Join?

- Eligibility requirements
 - Live in plan's service area
 - Entitled to Medicare Part A
 - Enrolled in Medicare Part B
 - Do not have End-Stage Renal Disease (ESRD) at enrollment
- To join an MA plan, a person must also
 - Agree to provide the necessary information to the plan
 - Agree to follow the plan's rules
 - Belong to only one Medicare Advantage plan at a time



When You Can Join or Switch MA Plans*

Initial Coverage Election Period	<ul style="list-style-type: none">▪ 7 month period begins 3 months before the month you turn 65<ul style="list-style-type: none">–Includes the month you turn 65–Ends 3 months after the month you turn 65

*Plan must be allowing new members to join.



ODI
Ohio Department
of Insurance

When You Can Join or Switch MA Plans*

Annual Election Period	October 15 – December 7 each year Coverage begins Jan. 1 of following year
Special Election Period	<ul style="list-style-type: none">▪ Move from the plan service area –and cannot stay in the plan▪ Plan leaves Medicare program▪ Other special situations

*Plan must be allowing new members to join.



ODI
Ohio Department
of Insurance

When You Can Join or Switch MA Plans

Annual Disenrollment Period

- Can leave an MA plan and switch to Original Medicare
- Between January 1–February 14
 - Coverage begins the first of the month after you switch
- If you make this change you also may join a Medicare Prescription Drug Plan to add drug coverage
 - Between January 1-February 14
 - Drug coverage begins the first of the month after the plan gets enrollment form



Medicare Advantage Trial Right Special Election Period

- People who join a MA plan for the **first time**
 - When first eligible for Medicare at age 65 or
 - Leave Original Medicare and drop Medigap policy
- Can disenroll from MA plan during first 12 months
 - Join Original Medicare
 - Have guaranteed issue for Medigap policy



How MA Plans Work

- You get Medicare-covered services through the plan
 - All Part A and Part B covered services
 - Some plans may provide additional benefits
- Most plans include prescription drug coverage
 - Part D
- You may have to go to network doctors or hospitals
- MA may be different than Original Medicare
 - Benefits and cost-sharing



How MA Plans Work

(continued)

- You are still in Medicare program
- You still have Medicare rights and protections
- If the plan leaves Medicare
 - You can join another MA plan
 - You can return to Original Medicare



ODI
Ohio Department
of Insurance

MA Costs

- Must still pay Part B premium
 - Some people may be eligible for state assistance
- May pay an additional monthly premium to plan
- You pay deductibles, coinsurance and copayments
 - Different from Original Medicare
 - Varies from plan to plan
 - Costs may be higher if you go out-of-network



Types of Medicare Advantage Plans

- Medicare Health Maintenance Organization (HMO)
- Medicare Preferred Provider Organization (PPO)
- Medicare Private Fee-for-Service (PFFS)
- Medicare Special Needs Plan (SNP)
- Point of Service Plan (POS)
- Medicare Medical Savings Account (MSA)



Medicare Health Maintenance Organization (HMO) Plan

Can you get your health care from any doctor or hospital?	No. You generally must get your care and services from doctors or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).
Are prescription drugs covered?	In most cases, yes. Ask the plan. If you want drug coverage, you must join an HMO Plan that offers prescription drug coverage.
Do you need to choose a primary care doctor?	In most cases, yes.
Do you need a referral to see a specialist?	In most cases, yes. Certain services like yearly screening mammograms don't require a referral.
What else do you need to know about this type of plan?	<ul style="list-style-type: none">▪ If your doctor leaves the plan, your plan will notify you. You can choose another doctor in the plan.▪ If you get health care outside the plan's network, you may have to pay the full cost.▪ It's important that you follow the plan's rules, like getting prior approval for a certain service when needed.



Medicare Preferred Provider Organization (PPO) Plan

Can you get your health care from any doctor or hospital?	Yes. PPOs have network doctors and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.
Are prescription drugs covered?	In most cases, yes. Ask the plan. If you want drug coverage, you must join a PPO Plan that offers prescription drug coverage.
Do you need to choose a primary care doctor?	No.
Do you need a referral to see a specialist?	No.
What else do you need to know about this type of plan?	<ul style="list-style-type: none">▪ There are two types of PPOs— Regional PPOs and Local PPOs.▪ Regional PPOs serve one of 26 regions set by Medicare.▪ Local PPOs serve the counties the PPO Plan chooses to include in its service area.



Medicare Private Fee-for-Service (PFFS) Plan

Can you get your health care from any doctor or hospital?	In some cases, yes. You can go to any Medicare-approved doctor or hospital that accepts the plan's payment terms and agrees to treat you. Not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members.
Are prescription drugs covered?	Sometimes. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan to get coverage.
Do you need to choose a primary care doctor?	No.
Do you need a referral to see a specialist?	No.



Medicare Private Fee-for-Service (PFFS) Plan

What else do you need to know about this type of plan?

- PFFS Plans aren't the same as Original Medicare or Medigap.
- The plan decides how much you pay for services.
- Some PFFS Plans contract with a network of providers who agree to always treat you even if you've never seen them before.
- If you join a PFFS Plan that has a network, you may pay more if you choose an out-of-network doctor, hospital, or other provider.
- Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before.
- For each service, make sure your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan's payment terms.
- In an emergency, doctors, hospitals, and other providers must treat you.



Medicare Special Needs (SNP) Plan

Can you get your health care from any doctor or hospital?	You generally must get your care and services from doctors or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).
Are prescription drugs covered?	Yes. All SNPs must provide Medicare prescription drug coverage (Part D).
Do you need to choose a primary care doctor?	Generally, yes.
Do you need a referral to see a specialist?	In most cases, yes. Certain services like yearly screening mammograms don't require a referral.



Medicare Special Needs (SNP) Plan

What do you need to know about this type of plan?

- A plan must limit plan membership to people in one of the following groups:
 - 1) People who live in certain institutions (like a nursing home) or who require nursing care at home, or
 - 2) People who are eligible for both Medicare and Medicaid, or
 - 3) People who have one or more specific chronic or disabling conditions (like diabetes, congestive heart failure, a mental health condition, or HIV/AIDS).
- Plans may further limit membership within these groups.
- Plans should coordinate the services and providers you need to help you stay healthy and follow your doctor's orders.
- If you have Medicare and Medicaid, your plan should make sure that all of the plan doctors or other health care providers you use accept Medicaid.
- If you live in an institution, make sure that plan doctors or other health care providers serve people where you live.



Other Medicare Advantage Plans

- Less common plans include:
 - Point-of-Service (POS) Plan
 - May allow some services out-of-network for a higher cost
 - Medical Savings Account (MSA) Plans
 - Combines a high deductible health plan with a bank account
 - Medicare deposits money into the account
 - You use the money to pay for your health care services



Other Medicare Plans

- Not Medicare Advantage, but still part of Medicare
- Some provide Part A and/or Part B coverage
- Some provide Part D coverage
- They include
 - Medicare Cost Plans
 - Demonstrations/Pilot Programs
 - Programs of All-inclusive Care for the Elderly (PACE)



Appeals in Medicare Advantage

- Plan must say in writing how to appeal if it:
 - Will not pay for a service
 - Does not allow a service
 - Stops or reduces a course of treatment
- Can ask for fast (expedited) decision
 - Plan must decide within 72 hours
- See plan's membership materials
 - Include instructions on how to file an appeal or grievance



Medicare Advantage Plan Fast Appeals Process

- Notice of Medicare Non-Coverage
 - Provider must deliver at least two days before Medicare-covered SNF, CORF, or HHA care will end
- If you think services are ending too soon
 - Contact your Ohio KePro (Ohio's QIO)
 - No later than noon the day before Medicare-covered services end to request a fast appeal
- Ohio KePro must notify you of its decision
 - By close of business of the day after it receives all necessary information



Required Notices

- Plan sponsors must provide notices after every
 - Adverse determination
 - Adverse appeal
- Include
 - Detailed explanation of why services denied
 - Information on next appeal level
 - Specific instructions



Disclosure of Plan Information for New and Renewing Members

- MA and PDPs must disclose plan information
 - At time of enrollment and at least annually
 - Required Annual Notice of Change/Evidence of Coverage
 - Comprehensive or Abridged Formulary
 - Pharmacy Directory
 - Provider Directory
 - Member ID card
 - only at the time of enrollment and as needed



Medicare Advantage Plans are sometimes called Medicare Part C.

- A) True
- B) False



To enroll in a Medicare Advantage Plan, a beneficiary must:

- A) have both Medicare part A and part B
- B) live in the plan's service area
- C) not have End Stage Renal Disease
- D) all of the above



Medicare Advantage Plans:

- A) supplement the original Medicare benefit
- B) are all managed care options with networks of doctors and hospitals
- C) are alternatives to the original Medicare programs
- D) are all available statewide



Medicare beneficiaries may enroll into a Medicare Advantage Plan during their:

- A) initial enrollment period
- B) special election periods
- C) annual coordinated election period
- D) all of the above



While you are enrolled in a Medicare Advantage Plan, you can change plans anytime during the year.

- A) True
- B) False



A provider can leave the network
anytime during the year in a Medicare
Advantage Plan.

- A) True
- B) False



Medicare Advantage Plans do not include Part D drug coverage.

- A) True
- B) False



Medicare Advantage Plans include all of the following except:

- A) HMOs
- B) PPOs
- C) PFFS
- D) CMOs



Medicare beneficiaries have the right to appeal any decision in a Medicare Advantage Plan.

- A) True
- B) False



Medicare Advantage plans sign how long of a contract with CMS in a given area?

- A) 1 month
- B) 3 years
- C) 1 year
- D) 5 years

