MODULE 5: MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

Objectives

Below are the topics covered in Module 5, Medicare Advantage (MA) Health Plan Options. This module will help to ensure that HIICAP counselors will attain an understanding of all the options available to the person with Medicare and give the counselors the tools to assist their clients in making wise independent choices.

At the end of this module are the Study Guide Test and Answer Key.

What are the requirements needed to become eligible for one of the Medicare Advantage health plan choices?

- Must have Medicare Part A **and** Medicare Part B
- Must live in the plan area where plan accepts enrollees
- Cannot have end-stage renal disease at time of enrollment (also see page 5-2)

What Medicare options do I have in New York State?

- The Original Medicare Plan
- Original Medicare with a Supplemental Insurance Policy
- Medicare Advantage Plans (HMO, PPO, PFFS, etc.)

How does someone choose an option?

- Comparing different Medicare Advantage plans in their area
- Choosing a primary care physician (specific to HMO plans)

Why join a Medicare Advantage (MA) plan?

- MA plans may offer benefits not available in Original Medicare, such as dental care, hearing aids, and eyeglasses
- Predictable copayments for doctor visits

What should be considered before joining a MA plan?

- What is the plan premium and other out-of-pocket costs
- What additional services are offered
- What doctors are in the network
  - If the plan requires a member to use only network doctors or allows members to use out-of-network doctors also
- Does the MA plan include prescription drug coverage (Part D)?
  - Are your drugs on the formulary?
- Lock-in provision (When a member can switch their MA plan choice)

Can services be obtained outside the network?

- In an emergency or if urgent care is needed
- Does the HMO have a Point of Service (POS) option

MORE MEDICARE HEALTH PLAN CHOICES

There are a few different ways to get health care coverage with Medicare. No matter what your client decides, they are still in the Medicare Program. All Medicare health plans must provide all Medicare-covered services. However, all Medicare health plan choices may not be available in your client's area. For the most current list of Medicare health plan choices, check the Medicare & You Handbook, or look on the Internet at www.medicare.gov. A local library or senior center may be able to help your client get information on their computers, or call 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048

ELIGIBILITY

To be eligible for one of the Medicare health plan choices:

- **A person with Medicare must have Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare.** If your client is not sure if they have Part A and Part B, look at their Medicare card (red, white and blue card). It will show "Hospital Insurance (Part A)" and/or "Medical Insurance (Part B)" on the lower left corner of the card. Your client can also visit their local Social Security Administration (SSA) office, or call SSA at 1-800-772-1213.
- **A person with End-Stage Renal Disease (ESRD) cannot join a Medicare Advantage (MA) plan.** (ESRD is permanent kidney failure that requires dialysis or a transplant.) However, ESRD beneficiaries currently in a Medicare health plan will be able to remain in the plan they are in. In addition, a person with Medicare with ESRD already in an MA plan can enroll in another MA plan if his or her original plan terminates its Medicare contract or reduces its service area.

  Note: Following a successful kidney transplant, beneficiaries are still eligible for Medicare for 36 months. And within this time, during an available enrollment period, they may join a Medicare Advantage plan (with medical documentation of the transplant).
- **A person with Medicare must live in the area of a health plan.** The service area is the geographic area where the plan accepts enrollees. For plans that require a person with Medicare to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll a member if they move out of the plan's service area. If your client is disenrolled, they are automatically covered under the Original Medicare Plan (the traditional pay-per-visit arrangement). A person with Medicare may be able to join a Medicare health plan in their new area if one is available.

Consumer Tip: If your client is happy with the way they get health care now, they don't have to do anything. If they do nothing, they will continue to receive their Medicare health care in the same way they always have.

MEDICARE OPTIONS

- **The Original Medicare Plan**
- **The Original Medicare Plan with a Medicare Supplement/Medigap Policy**
- **Medicare Advantage (MA) Plans:**
  - Health Maintenance Organization (HMO)
  - HMOs with Point of Service Option (HMO-POS)
  - Preferred Provider Organization (PPO)
  - Private Fee-for-Service (PFFS) Plan
  - Medicare Medical Savings Account (MSA)
  - Medicare Special Needs Plan (SNP)

Note: Currently, all of the Medicare Advantage plan choices are available in New York State, but not all plan types are available in each county.

Original Medicare Plan

The Original Medicare plan is the traditional system, run by the federal government, which covers Part A and Part B services. Medicare pays its share of the bill and the person with Medicare pays the balance.

Cost: The monthly Part B premium, Part A and Part B deductibles, and the coinsurance. *(Refer to* Modules 3 and 4 for more information.)

Providers: Any doctor or hospital that accepts Medicare.

Extra Benefits: One receives all the Medicare Part A and Part B covered services, but no extra benefits.

Original Medicare Plan with a Medicare Supplement/Medigap Policy

The Original Medicare Plan is the traditional system that covers Part A and Part B services. Medicare pays its share of the bill, and the person with Medicare pays the balance. A person with Medicare may purchase one of ten standard Medicare Supplement (Medigap) plans available in New York State for extra benefits. These policies pay for many of the out-of-pocket costs under Original Medicare.

Cost: The monthly Part B premium and an additional monthly premium for the Medicare Supplement/Medigap policy. All policies cover Medicare's coinsurance amounts and most pay for Medicare's Part A deductible. The premium varies by region and insurer. New York State is a community rated state; therefore, everyone in the same region of the state pays the same premium for the exact same policy sold by the same insurer.

Providers: Any doctor or hospital that accepts Medicare.

Extra Benefits: A person with Medicare receives all Medicare Part A and Part B covered services. Medigap plans generally do not provide any extra benefits. However, most Medicare Supplement/Medigap Policies also cover emergency care received outside of the United States which Original Medicare does not.

Refer to Module 7 for more information on Medicare Supplement/Medigap insurance

Medicare Advantage (MA) Plans

A Medicare Advantage Plan (except for Medicare Medical Savings Account plans) involves a group of doctors, hospitals and other health care providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. Medicare Advantage Plans include **Health Maintenance Organization (HMO), Health Maintenance Organization with Point of Service Option (HMO-POS), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS), Medicare Medical Savings Account (MSA) and Medicare Special Needs Plan (SNP).**

Cost: The monthly Part B premium. Some plans charge an extra monthly premium. Your client may also pay the plan a co-payment per visit or service. With an HMO, your client will be responsible for all charges if they go out-of-network except for emergency services, urgent care, and out-of-area dialysis.

Caution: Medicare Supplement/Medigap Policies do NOT work with Medicare Advantage Plans.

Providers: The choice of doctors and hospitals varies by the type of Medicare Advantage Plan. HMO plans are typically more restrictive; however, under a PPO plan, a person with Medicare may use doctors and hospitals outside of the plan's network for an additional cost.

Extra Benefits: The person with Medicare receives all the Medicare Part A and Part B covered services. Many Medicare Advantage Plans offer additional benefits not covered under the Original Medicare Plan such as dental care, eyeglasses, and hearing aids.

Health Maintenance Organization (HMO)

An **HMO** should offer comprehensive health insurance, with fixed costs and little or no paperwork. However, there are some considerations that need to be mentioned. The plan may require members to get referrals from a primary care physician in order to see a specialist in their network. They may also change coverage and/or premiums annually and there may be additional costs such as hospital and skilled nursing facility co-payments, as well as prior authorization (approval) requirements for certain services.

Caution: For hospital admissions, HMO plan members may be subject to a substantial co-payment per admission or even a daily co-payment. Make sure to check the plan details regarding the hospital benefit.

Also, providers can choose to no longer participate with an HMO plan during the year. And even participating providers may decide at any point that they are not accepting new patients under the Medicare HMO plan.

It is important to read information carefully, particularly the rules about access to providers, out-of-network costs and premiums.

Also, there is a lock-in provision, which means that most beneficiaries can only switch plans during certain times in each calendar year, with exceptions such as if a beneficiary moves out of the plan's service area.

HMO with Point of Service Option (HMO-POS)

An HMO with a Point of Service option, or **HMO-POS**, is an HMO where a member may receive some services outside of the plan's network of providers without being referred by their primary care physician (PCP).

Usually, a member will pay a higher amount if they use non-network providers; there may also be some limits set on specialties, number of visits, and amounts. A member may be able to use non-network providers only for specific conditions.

Preferred Provider Organization (PPO)

A PPO must have a network of providers so that enrollees can get all services within the plan. The main difference between a PPO and an HMO is that PPO enrollees are not required to use only network providers. Also, with a PPO, a member usually does not have to get a referral to see a specialist. PPOs also generally have a wider choice of providers and more generous coverage for those who choose to go to someone outside the network. Medicare beneficiaries can see any Medicare provider, but it usually costs less to see providers in the plan's network.

Medicare Advantage plans, including PPOs, must offer all of Medicare's required benefits. They may also offer additional benefits, such as dental, eyeglasses or hearing aids.

PPOs have networks of preferred providers (hospitals, physicians and other providers) who provide all of the basic Medicare benefits, like Medicare HMOs. In addition, unlike HMOs, PPOs provide some coverage for services provided outside of their network. Co-payments and deductibles will usually be lower when beneficiaries use network providers than when they use out-of-network providers. Each PPO is unique. Each PPO offers its own set of benefits and has its own cost-sharing requirements and monthly premiums as well. Premiums are usually more than HMO premiums, but less than premiums for Medicare Supplement Insurance.

Note: United Health Care offers a Regional PPO that serves the entire state of New York, rather than select counties. Several other companies offer PPO plans in only certain counties of the state.

Caution: People with Medicare who are enrolled in an HMO, HMO-POS, or PPO plan who want Part D drug coverage must get it through the same plan. They cannot purchase a separate stand-alone Part D plan (PDP). Doing so would cause them to be disenrolled from their Medicare Advantage plan.

Private Fee-for-Service Plan (PFFS)

Under a PFFS plan, a person with Medicare may go to any Medicare-approved doctor or hospital that accepts the plan's payment terms.

PFFS plans also have networks of providers, and are very similar to PPO plans.

The person with Medicare may have extra benefits the Original Medicare Plan doesn't cover. No referrals are necessary.

Cost: The monthly Part B premium, any monthly premium the Private Fee-for-Service Plan charges, and an amount per visit or service. The person with Medicare will be responsible for paying whatever the plan doesn't cover.

Providers*:* Can go to any network provider or any Medicare-approved doctor or hospital that accepts the PFFS plan.

Extra Benefits*:* Receive all Medicare Part A and Part B covered services. PFFS plans may offer additional benefits the Original Medicare Plan doesn't cover.

Caution: PFFS plan members should check to make sure their doctors, hospitals, and other providers will agree to treat them under the plan and that they will accept the PFFS plan's payment terms.

Note: Prescription drug coverage (Part D) may be included in the PFFS plan. But if the PFFS plan does not include drug coverage, a person with Medicare can join a stand-alone Medicare Prescription Drug Plan (PDP).

Medicare Medical Savings Account (MSA)

Medicare MSA plans combine a high deductible Medicare Advantage plan with a medical savings account. The plan deposits an amount annually into an account which can be used for medical expenses including the deductible. Any unused portion can be carried over to the next year. Once the deductible is met, the plan may pay 100% of covered expenses or there may be a coinsurance until the maximum out of pocket is met and then the plan will pay 100% of covered expenses.

Preventive services may not be subject to the deductible and coinsurance. MSA plans do not have a provider network. MSA plan members can use any Medicare-approved provider.

Note: Beneficiaries can only enroll or disenroll from an MSA plan from October 15 – December 7 each year (or when first Medicare eligible). Also, beneficiaries with other health insurance coverage (including Medicaid) which could cover the MSA plan deductible would not be eligible to join an MSA.

Note: Prescription drug coverage (Part D) is not included in the MSA plan. A person with Medicare in an MSA plan would need to join a stand-alone Medicare Prescription Drug Plan (PDP) in order to have drug coverage under Medicare.

Medicare Special Needs Plan (SNP)

A Medicare SNP is a type of Medicare Advantage plan that is only available for certain Medicare beneficiaries such as those with both Medicare and Medicaid (or enrolled in a Medicare Savings Program), institutionalized beneficiaries or those with certain chronic conditions. Special Needs Plans may offer more focused and specialized health care as well as better coordination of care for these beneficiaries than other types of Medicare Advantage plans, and SNPs all include Part D drug coverage.

Programs of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare program for older adults and people over age 55 living with disabilities. This program provides community-based care and services to people who otherwise need nursing home level of care. PACE provides all the care and services covered by Medicare and Medicaid, as well as additional care and services not covered by either program. You can have either Medicare or Medicaid or both to join PACE.

Where Beneficiaries Can Go if They Need Help

If your client needs help or more answers about their health insurance, they may contact their local Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. Trained staff or volunteer health insurance counselors can provide information about one's health insurance and help to collect benefits.

HIICAP counselors cannot endorse a particular Medicare Advantage (MA) plan, but can help clients get information needed to decide if an MA plan meets their needs.

Detailed information on Medicare Advantage options is available at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227).

MEDICARE ADVANTAGE (MA) ENROLLMENT PERIODS

Initial Coverage Election Period (ICEP)

The ICEP is the period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan. This period begins three months immediately before the individual's first entitlement to BOTH Medicare Part A and Part B and ends on the later of:

- The last day of the month preceding entitlement to both Part A and Part B or
- The last day of the individual's Part B initial enrollment period

Annual Coordinated Election Period (AEP)

People with Medicare can enroll in a Medicare Advantage plan or switch their plan choice during the Annual Coordinated Election Period, which runs every year from October 15 to December 7. Any election made during this period will be effective the following January 1.

Medicare Advantage Disenrollment Period (MADP)

During the MADP, beneficiaries on a Medicare Advantage plan (with or without Part D) have one opportunity to switch to Original Medicare. The change would be effective the first of the following month (either February or March 1). The MADP also allows beneficiaries in this situation to sign up for a stand-alone Part D plan (PDP), even if their former MA plan did not include Part D drug coverage.

Note: Unlike other types of MA plans, beneficiaries on an MSA plan cannot use the Medicare Advantage Disenrollment Period (January 1 – February 14) to disenroll from the plan back to Original Medicare.

Special Election Period (SEP)

Special Election Periods (SEP) are exceptions where people with Medicare may be able to enroll, disenroll or switch their Medicare Advantage plan outside of the other enrollment periods. An SEP may be available for a number of different reasons including for a change in residence or loss of an employer/retiree plan, or for people with Medicare who enroll in a MA plan when first eligible for Medicare.

SEP65

People with Medicare who elect an MA plan (other than an MSA plan) during the Initial Enrollment Period (IEP) for Part B surrounding their 65th birthday have an SEP. This "SEP65" allows the individual to disenroll from this MA plan and elect Original Medicare any time during the 12-month period that begins on the effective date of coverage in the MA plan.

What if a person with Medicare no longer wants to be in an MA plan?

If the person with Medicare wants to disenroll from an MA plan, they need to send a signed request to the plan, visit their local Social Security or Railroad Retirement Board office, or call 1-800-MEDICARE (1-800-633-4227). 1-800-MEDICARE can also disenroll a person from an MA plan and return them to Original Medicare.

When a person with Medicare returns to Original Medicare, it may be advisable to purchase Medicare Supplement (Medigap) insurance and a Medicare Part D plan.

Note: If a MA plan member joins a different MA plan, he or she will automatically be disenrolled from the first MA plan upon enrollment in the new MA plan.

IMPORTANT: A request for disenrollment from an MA plan can only be done during the Annual Election Period (AEP) (October 15 – December 7) or during the Medicare Advantage Disenrollment Period (MADP) (January 1 – February 14) unless the beneficiary qualifies for a Special Enrollment Period (SEP). See above for details.

Caution: Simply not paying your MA plan premium does not guarantee that the beneficiary will be disenrolled from the MA plan and returned to Original Medicare.

WHAT TO CONSIDER BEFORE JOINING AN MA PLAN

Refer to the **www.medicare.gov** Web site or call 1-800-MEDICARE (1-800-633-4227) for the most recent listing of Medicare Advantage (MA) plans in an area. If your client lives in an area served by more than one MA plan, they can compare benefits, costs and other features to find which best suits their needs at a price they can afford. (By using the Medicare Compare section of the www.medicare.gov Web site, counselors and people with Medicare can acquire the information needed.)

First, a person with Medicare should ask each MA plan for a copy of their Benefit Summary and/or plan booklets. Beneficiaries should never rely on advertisements. The client needs to learn about their rights and the nature and extent of coverage. After the information is reviewed, one should ask:

Cost: What is the MA plan's monthly plan premium? What co-payment(s) will I have to pay?

A person with Medicare will have to continue to pay their Medicare Part B premium. Some MA plans charge a premium in addition to the Medicare Part B premium, while others do not. MA plans usually charge a co-payment or co-insurance when services are received. Some plans have low option and high option plans. This means a member can choose between a basic benefits package, and one that covers additional services for an additional premium.

Additional Services: Does the MA plan offer services in addition to those covered under Original Medicare?

All MA plans must provide the same basic health benefit package available under Original Medicare. Some plans also offer additional coverage such as dental care, hearing aids and eyeglasses. (Most MA plans also offer Medicare Part D (Medicare Prescription Drug Coverage) to their members. *See Module 6 for details.*) Find out by asking about additional services: What benefits are available for preventive care; routine physical; vision care; dental; hearing; home care; chiropractic; foot care; nursing home; house calls; mental health services.

Reference: If the counselor or person with Medicare does not have access to the Internet to view the Medicare Compare section of the www.medicare.gov Web site, they may check their Medicare & You Handbook or call 1-800-MEDICARE for a listing of county specific Medicare Advantage plans.

CHOOSING THE MEDICARE ADVANTAGE OPTION

Medicare Advantage (MA) plans provide all Medicare-covered services and receive payment directly from Medicare for the care a person with Medicare needs. MA plans also provide additional benefits. All MA plans offer preventive care, and may offer limited coverage for dental care, hearing aids and eyeglasses.

If a person with Medicare joins a Medicare HMO plan, they must obtain services from the health care professionals and facilities that are part of the HMO plan network except for emergency or urgently needed care, or out-of area dialysis care. The person with Medicare selects a primary care physician (PCP) from those affiliated or under contract with the HMO plan. That doctor coordinates your client's care by providing health care and arranging for them to see other providers when necessary.

If your client enrolls in any type of Medicare Advantage (MA) plan, they must continue to pay their Part B monthly premium. This is the premium that is withheld from their monthly Social Security check. Your client may also have to pay small co-payments when they see a provider and a monthly premium to the MA plan. In return, the MA plan provides your client with all Medicare hospital and medical benefits.

A person with Medicare will not need a Medigap policy if they join a Medicare Advantage plan since they will not be able to collect on the Medigap policy benefits. If your client already has a Medigap policy to supplement their fee-for-service Medicare coverage and they decide to join a Medicare Advantage plan, they should be advised to discontinue their Medigap policy, because it is not needed.

Caution: Please note that if your client has a retiree plan, they should be very cautious about giving it up to join a Medicare Advantage plan because they will probably not be able to get this retiree plan benefit back again.

Who can enroll in a Medicare Advantage plan?

Most Medicare beneficiaries are eligible to enroll. A person with Medicare can enroll in a Medicare Advantage plan which has a Medicare contract if they:

- live in the plan's service area
- are enrolled in both Medicare Part A and Part B
- do not have End-Stage Renal Disease (ESRD) before they join

Medicare Advantage (MA) plans cannot screen a person with Medicare's application to find out whether they are healthy or delay coverage for preexisting conditions. A person with Medicare cannot be rejected because of poor health.

WHY JOIN A MEDICARE ADVANTAGE PLAN?

More Benefits

Medicare Advantage (MA) plans offer benefits that are not available under Medicare's fee-for-service program. For example, MA plans may offer limited coverage for dental care, hearing aids, and eyeglasses.

Predictable Payments and Lower Costs

Medicare Advantage (MA) plans minimize out-of-pocket payments and have predictable co-payment amounts. These features may give a person with Medicare more control over their health care costs.

ALL Medicare Advantage plans must have Maximum Out of Pocket (MOOP) amounts for all Part A and B covered services, not to exceed $6,700 (HMO) and $10,000 (PPO), including $6,700 in-network. Although these are the highest amounts that plans may have, many MA plans have a much lower MOOP. (MOOP does NOT include the plan premium, any cost-sharing for extra benefits not covered by Medicare and any Part D drug cost-sharing.) Once a beneficiary has reached the MOOP, Part A and B covered services are provided at 100%.

Note: MA plans must provide all in-network preventive services that are covered at zero cost-sharing under Original Medicare at zero cost-sharing. This means no deductible and no co-pay.

People with Medicare enrolled in a Medicare Advantage plan also do not need Medigap insurance, since MA plans provide all or most of the benefits provided by Medicare and a Medigap policy.

Note: In New York State if a person with Medicare enrolls in an MA plan and later returns to Original Medicare, they will be able to buy a Medigap insurance policy regardless of age or health status at any time. However, there could be a pre-existing condition waiting period if there is more than a 63-day lapse in coverage.

Less Paperwork

Another advantage is that a member usually does not have to fill out claim forms for services provided. They simply show their membership card, pay the required co-payment and receive services. A member does not have to complete any paperwork, nor do they receive Medicare Summary Notice (MSN) forms.

The only exception is if a member pays out-of-pocket for **emergency** or **urgently needed** care. Then they may have to send a claim form and other information to the MA plan for payment or reimbursement.

No Assignment Problems

If a person with Medicare joins a Medicare Advantage plan, they do not have to worry about finding a doctor who accepts Medicare assignment. However, they may have problems finding in-network doctors.

Preventive Care

Medicare Advantage plans may emphasize preventive care, such as mammograms, flu shots, diabetes and hypertension screening. This may help a person stay healthy longer. Early detection may prevent major health problems.

Educational Services

Medicare Advantage plans often provide ongoing health education classes and information to encourage healthier lifestyles.

Tool to Help with Decision-Making

The Medicare Plan Finder can help make health plan choices. This service is on www.medicare.gov on the Web or one can call 1-800-MEDICARE and ask about the Medicare Plan Finder. Callers can speak with a customer service representative at 1-800-MEDICAR(E) 24 hours a day, including weekends.

MEDICARE RISK CONTRACTS

Risk Contracts

HMOs with risk contracts provide all Medicare-covered services and may provide benefits not covered by fee-for-service Medicare. If a member's HMO has a Medicare risk contract, they must receive all their health care either from the HMO or from a provider the HMO referred them to for their care to be covered. The only exception is in an emergency or urgently needed care situation and out-of-area dialysis care.

Neither Medicare nor the HMO will pay for non-emergency services a member receives from providers outside the HMO network. Before a person with Medicare joins, be sure they get a list with the names and addresses of the HMO providers.

HMOs with risk contracts are allowed to offer another benefit, called a Point-of-Service (POS) benefit, to Medicare enrollees. Under the POS option, the plan permits them to receive certain services outside the plan's provider network and the HMO will pay a percentage of the charges. In return for this flexibility, the member must pay a portion of the cost. Usually, the member can expect to pay at least 20 percent of the bill.

Since all risk plans will offer different services and have different rules under the POS benefit, it is very important to review the information about the POS benefit carefully. A risk contract is so named because the plan assumes the financial risk. Medicare pays the plan a fixed amount for each enrollee, regardless of how much it costs the plan to provide health care to that enrollee.

Types of HMOs

There are different types of HMOs. Group and staff model HMOs have their own medical centers. In these HMOs a member can receive medical care, including laboratory, X-ray and sometimes even pharmacy services, in one place. Other types of HMOs, such as Independent Practice Associations (IPAs), provide medical services through private practice physicians who give members care in their own offices.

Facility and Operation

If the HMO has its own facility it is a good idea for your client to arrange for a tour to see if it meets their needs. They may wish to ask some of the following questions:

- Where is the service area?
- Where do they go for care?
- Can they get to the center easily?
- Is there access for the disabled? Ample parking?
- Is the center clean?
- What are the hours?
- What is the center's phone number?
- What is the procedure for after hours care?
- Where do they go for emergencies?
  Individuals should call their PCP or Center within 48 hours or as soon as possible after an emergency to obtain the necessary referrals.
- Is the staff friendly and helpful?
- Is it easy to schedule appointments?
- Do they have to wait long to see their doctor?
- What hospitals and skilled nursing facilities does the plan use?
- What languages are spoken at the facility?

Staff

What physician and other health care providers are affiliated with the HMO? Where are they located? Does the plan have its own specialists? Do they have geriatric specialists? Can a member choose a primary care physician? Or easily change physicians? Are affiliated or contracting primary care physicians accepting new patients?

The written material from the HMO should include a list of physicians and other providers within the HMO network. Most plans allow a member to select a primary care doctor from those affiliated with the plan. Most will let them change physicians from among the plan's primary care doctors.

IMPORTANT: If a member wants to use a particular primary care doctor, check to see if he or she is accepting new patients in the plan. The doctor may be participating in the HMO but not accepting new patients in that plan. If the beneficiary is an existing patient of the doctor in the HMO, the doctor will typically continue seeing the patient even if his or her panel is closed. This question should be asked before joining the plan.

Care outside the HMO network

What if a member wants to receive health care services outside the HMO, or wants to get a second opinion outside the HMO, or needs to see a specialist that does not contract with the HMO?

Neither the HMO nor Medicare will cover care outside the HMO network except for: emergency or urgently needed care, or if their primary care physician refers them to someone outside the network, or for out-of-area dialysis care. In addition, HMOs need to cover out-of-network specialist care if they do not have an in-network specialist. However, a referral from the primary care physician and prior authorization from the HMO is still required.

Some risk plans have a Point of Service (POS) benefit option, which allows a member to receive some health services outside the plan. Since each POS has different coverage and rules, they will need to get detailed information about the POS option from the plan.

Emergency Care

What is a medical emergency? How do members get emergency care if they are in a Medicare HMO Plan?

Emergency Medical Condition is defined as a "medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual (or in the case of a pregnant woman, the health of the unborn child)
2. Serious impairment to bodily functions
3. Serious dysfunction of any body organ or part"

HMOs are required to provide access to emergency and urgently needed care services 24 hours a day, 7 days a week. The plan must pay for emergency care and cannot require prior authorization for emergency care received from any provider. A person with Medicare can receive emergency care anywhere in the United States. When a beneficiary receives emergency care, the doctor or hospital that provides the service should bill their HMO. If the beneficiary receives the bill, they should send it to the HMO and keep a copy for their own record.

Following a medical emergency, the HMO must also pay for necessary care before the condition is stable enough for the beneficiary to return to their plan's provider. If their condition lets them return to the plan's service area, they will need to get follow-up care from their Medicare HMO plan provider.

A beneficiary (family member or friend) should let their plan know of emergencies as soon as medically possible. If what the beneficiary believed was an emergency turns out not to be, the plan must still pay. A member should always appeal a denial of payment for emergency services. *(Refer to Claims and Appeals Module 10.)*

What is "urgently needed care?" How does a member get urgently needed care if in a Medicare HMO Plan?

Urgently needed services are defined as covered services provided when a beneficiary is temporarily absent from the HMO's service area, (or, under unusual and extraordinary circumstances, provided when the beneficiary is in the service area but their contracting medical provider is temporarily unavailable or inaccessible) and when such services are medically necessary and immediately required:

1. As a result of an unforeseen illness, injury, or condition; and
2. It is not reasonable given the circumstances to obtain the services through the Contracting Medical Provider.

Care outside the United States

Under what conditions will the HMO pay for health care if a member is traveling outside the United States? Generally, Medicare will not pay for care outside the United States. A member can purchase **special insurance** for the time they will be outside of the United States and most Medigap plans provide coverage for foreign travel emergencies. However, **some** Medicare-contracting HMOs cover worldwide emergency care as an additional benefit. It is important to inquire about this before making travel arrangements to avoid unnecessary medical bills.

Treatment procedures

Do physicians have to receive permission from the HMO before referring a member to a specialist, admitting a beneficiary to a hospital, or other types of treatments? Under what circumstances can a member use a specialist or other health care professional outside the HMO?

QUALITY OF CARE

Medicare Advantage plan quality comparison information is now available in the Medicare Options Compare section of the Medicare web site (www.medicare.gov). Plans receive an overall rating of 1 (poor) to 5 (excellent) stars. If you want more detail, you can see the actual numbers or percentages that go into each of 5 different categories that make up these overall ratings. These categories include:

- Staying healthy: screenings, tests, and vaccines: Includes whether members got various screening tests, a yearly flu shot, and other check-ups that help them stay healthy.
- Managing chronic (long-term) conditions: Includes how often members with different conditions got certain tests and treatments that help them manage their condition.
- Member experience with the health plan: Includes ratings of member satisfaction with the plan.

- Member complaints, problems getting services, and improvement in the health plan's performance: Includes how often Medicare found problems with the plan and how often members filed complaints against the plan and choose to leave the plan. Includes how much the plan's performance has improved (if at all) over the last two years.
- Health plan customer service: Includes how well the plan handles calls from members, makes decisions about member appeals for health coverage, and handles new enrollment requests in a timely way.

People with Medicare may also wish to check with the New York State Department of Financial Services at **1-800-342-3736** to see if complaints have been filed against the health insurer that offers the Medicare Advantage plan.

Note: Complaints about the quality of care received from providers should be directed to the Quality Improvement Organization (QIO) in New York State, the Island Peer Review Organization (IPRO), at 1-800-331-7767.

APPEAL RIGHTS

Refer to Module 10 (Medicare Claims and Appeals) for information on appealing a denial of coverage for services provided to Medicare Advantage plan members.

Sources of Assistance

NYS OFA HIICAP Hotline **1-800-701-0501**

1-800-MEDICAR(E) **1-800-633-4227**
www.medicare.gov

NYS Office for the Aging Senior Hotline **1-800-342-9871**

Independent Review Entity (IRE) **1-585-425-5210**
MAXIMUS Federal Services **Fax: 1-585-425-5292**
www.medicareappeal.com

Centers for Medicare & Medicaid Services (CMS), Region 2
Division of Medicare - Managed Care Unit
www.cms.gov

Quality Improvement Organization (QIO) **(in NY) 1-800-331-7767**
Island Peer Review Organization, Inc.
1979 Marcus Avenue, 1st Floor **(out-of-state, call collect) 1-516-326-7767**
Lake Success, New York 11042
www.ipro.org

Additional Resources

- *Your Guide to Medicare's Preferred Provider Organization (PPO) Plans*, CMS Publication #11152, September 2008
- *Your Guide to Medicare Private Fee-for-Service Plans*, CMS Publication #10144, September 2007
    - http://www.medicare.gov/Publications/Pubs/pdf/10144.pdf
- *Your Guide to Medicare Special Needs Plans (SNPs)*, CMS Publication #11302, November 2011
    - http://www.medicare.gov/Publications/Pubs/pdf/11302.pdf
- *Your Guide to Medicare Medical Savings Account Plans*, CMS Publication #11206, May 2012
    - http://www.medicare.gov/Publications/Pubs/pdf/11206.pdf
- *Quick Facts About Programs of All-inclusive Care for the Elderly (PACE)* - CMS Publication #11341, January 2011
    - http://www.medicare.gov/publications/pubs/pdf/11341.pdf

STUDY GUIDE MODULE 5: MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

1. MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

Read your *HIICAP Notebook* to learn about all of the Medicare Advantage Options.

What do all Medicare Health Plans have in common?

2. WHY JOIN A MEDICARE ADVANTAGE (MA) PLAN?

In summary: Consider what you have learned in this Medicare Advantage Module:

- No matter what your client decides, they are still in the Medicare program.
- All Medicare Health Plans **must** provide all Medicare covered services.
- To be eligible for any of the Medicare Advantage (MA) plan choices, a person with Medicare must have Medicare Part A **and** Part B, must not have End-Stage Renal Disease (ESRD) and must live in the service area of the MA plan.
- Not all of the Medicare Advantage Health Plan Choices are available in all areas.
- People with Medicare must be advised of when they can enroll in a Medicare Advantage plan, or switch to Original Medicare or another MA plan.
- If your client is happy with the way they get health care now, they do not have to do anything. Your client will continue to receive their Medicare health care in the same way they always did.

ANSWER KEY MODULE 5: MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

1. MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

Read your *HIICAP Notebook* to learn about all of the Medicare Advantage Options.

What do all Medicare Health Plans have in common?

All Medicare Health Plans must provide all Medicare covered services.

2. WHY JOIN A MEDICARE ADVANTAGE (MA) PLAN?

Because a person with Medicare may receive extra benefits that Original Medicare does not offer such as dental benefits, hearing aids, eyeglasses and more. With an MA plan, a person with Medicare does not need a Medicare Supplement/Medigap plan and their payments are more predictable.

In summary: Consider what you have learned in this Medicare Advantage Module:

- No matter what your client decides, they are still in the Medicare Program.
- All Medicare Health Plans **must** provide all Medicare covered services.
- To be eligible for any of the Medicare Advantage (MA) plan choices, a person with Medicare must have Medicare Part A **and** Part B, must not have End-Stage Renal Disease (ESRD) and must live in the service area of the MA plan.
- **Not** all of the Medicare Advantage Health Plan Choices are available in all areas.
- People with Medicare must be advised of when they can enroll in a Medicare Advantage plan, or switch to Original Medicare or another MA plan.
- If your client is happy with the way they get health care now, they do not have to do anything. Your client will continue to receive their Medicare health care in the same way they always did.