

## 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 within the plan's service area where plan accepts enrollees
- Cannot have end-stage renal disease at time of enrollment (with certain exceptions)

### What Medicare options do I have in New York State?

- The Original Medicare Plan
- Original Medicare with a Supplemental Insurance Policy (Medigap)
- Medicare Advantage Plans (HMO, PPO, PFFS)
- Special Needs Programs (SNPs), PACE
- Medicare Medicaid Plan (MMP) - Fully Integrated Duals Advantage (FIDA) Program (NYC and Nassau County)

### How does someone choose an option?

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

### Medicare Advantage (MA) Star Ratings

- The star ratings system began in 2007 as a way for CMS and Medicare beneficiaries to assess MA health plans
- Medicare gives star ratings for health plan quality, with the top rating being five stars. Plans with the top ratings of four or five stars get extra money from the government to spend on medical benefits
- The measures target a broad array of clinical quality, customer satisfaction and other beneficiary experience areas. The stars rate things such as customer satisfaction and the quality of care the plan delivers.

### 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 and other medical services (outpatient)

### **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 providers are in the network
  - If the plan requires a member to use only network providers or allows members to use out-of-network providers also
  - If the beneficiary already has a primary care physician and/or sees other specialists, are those providers in the plan's network?
- 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)
- Are the Star ratings 3.5 or higher?
- Is the beneficiary entitled to other coverage, such as through the VA or TRICARE?

### **Can services be obtained outside the network?**

- Is the plan an HMO-POS, PPO or PFFS
- Is the service an emergency or urgent care
- Does the plan offer any travel services?

## **MORE MEDICARE HEALTH PLAN CHOICES**

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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/find-a-plan](http://www.medicare.gov/find-a-plan) . 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, 24 hours day/7 days a week.

## **ELIGIBILITY**

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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 or enroll in another plan offered by that company. In addition, a person with Medicare with ESRD already in an MA plan can enroll in another MA plan offered by the same organization; or with another organization if his or her original plan terminates its Medicare contract or reduces its service area. Also if an insurer offers both an employer group health plan and a Medicare Advantage plan, an employee suffering from ESRD may be able to be transfer into the Medicare Advantage plan.

**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 service 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. 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)
  - Medicare Medicaid FIDA Program (NYC and Nassau County)

**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 is responsible for the Medicare cost-sharing amounts.

**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 medical provider 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 is responsible for the Medicare cost-sharing amounts.

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 hospital 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 medical provider 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), Medicare Special Needs Plan (SNP), and FIDA Program.**

**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.

For those enrolling in a FIDA Program (NYC and Nassau County) there are no deductibles, premiums, or copayments/coinsurance. A FIDA plan will *not* cost more than what your client pays today for care. If your client has Medicaid with a “spend-down” or “excess income,” they will have to continue to pay the spend-down to the FIDA plan.



**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. Most Medicare Advantage Plans offer additional benefits not covered under the Original Medicare Plan such as dental care, eyeglasses, and hearing aids.



**Caution:** For hospital admissions, Medicare Advantage plan members may be subject to substantial cost-sharing, usually in the form of a daily co-payment for a limited number of days. Make sure to check the plan details regarding the hospital benefit.

**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.

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.

**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 may continue seeing the patient but this question should be asked before joining the plan.

**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.

Usually, a member will pay a higher amount if they use non-network providers; there may also be limits on the types of services covered out of network and prior authorization may be required. Check with the individual plan for details on the out-of-network coverage.

**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 does not have to get a referral to see a specialist.

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. Cost-sharing amounts will usually be lower when beneficiaries use network providers than when they use out-of-network providers. Premiums are usually more than HMO premiums, but less than premiums for Medicare Supplement Insurance.

**Note:** Some companies may offer a Regional PPO (RPPO) that serves the entire state of New York, rather than select counties. Currently, United Healthcare is the only company offering a RPPO in New York State. Other companies may 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 medical provider or hospital that accepts the plan's payment terms. PFFS plans also have networks of providers, and are very similar to PPO plans. No referrals are necessary.

And like other Medicare Advantage plans, the person with Medicare may receive extra benefits the Original Medicare Plan doesn't cover.

**Cost:** The monthly Part B premium, any monthly premium the Private Fee-for-Service plan charges, and an amount per visit or service.

**Providers:** Can go to any network provider or any Medicare-approved medical provider 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 also enroll in a separate 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. Any unused portion can be carried over to the next year. Once the deductible is met, the plan pays 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.

The medical savings account can be used to pay for non-Medicare covered medical expenses such as for dental, vision or hearing aids but only payments made for Medicare (Part A and Part B) covered expenses will also be credited toward the plan deductible.

**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) 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 enroll in a separate 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, and must live in the service area of a PACE organization.

**Note: PACE plans are not considered Medicare Advantage Plans**

**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](http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227) 24 hours day/7 days a week.

**Medicare Medicaid Plan (MMP) - Fully Integrated Dual Advantage (FIDA) Plan**

**Who is eligible for the FIDA program?**

Since FIDA builds upon the existing MLTC program, the vast majority of people enrolled in an MLTC plan are also eligible for a FIDA Plan. *In general*, individuals must:

- Reside in any of the New York City boroughs or Nassau county,
- Be 21 years or older, *and*
- Be entitled to Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Part D, and receiving full Medicaid benefits; *and*
- Require community-based long-term services and supports (LTSS) for more than 120 days per year or be eligible for but not already receiving facility-based or community-based LTSS (“New to Service”).

**When can individuals enroll in FIDA Plans?**

Generally, eligible individuals can enroll in FIDA Plans at any time. Those that are subject to passive enrollment will receive notices indicating the name of their FIDA Plan along with important information about the program and the phone number to call if they have questions or want to opt out.

**Is FIDA mandatory for dually eligible participants in New York State?**

No. FIDA is not mandatory for anyone in New York State. Individuals can opt out of FIDA at any time.

**If you join the FIDA program, you will:**

- **Get full Medicare and Medicaid coverage, long term care services, Part D and Medicaid drugs, and additional benefits from a single, integrated managed care plan.** In other words, FIDA covers all the benefits that you may receive through your managed long term care (MLTC) plan, Original Medicare or your Medicare Advantage plan, and your Part D plan.
- **Pay no deductibles, premiums, or copayments/coinsurance.** A FIDA plan will *not* cost you more than what you pay today for your care. (If you have Medicaid with a “spend-down” or “excess income,” you will have to continue to pay your spend-down to the FIDA plan.)
- **Be able to access specialists directly.** No need for provider referrals.
- **Have a dedicated person (“Care Manager”)** who can schedule doctor’s appointments, arrange transportation and help you get your medicine. (In most cases, you will keep your current care manager.)
- **Have your Medicare and Medicaid doctors and specialists on your care team.** They will spend time with you, your caregivers or anyone you trust to discuss the care you may need. In addition, they will have time to share their expert opinions with each other and coordinate your care.
- **Use one FIDA Plan phone number for all questions regarding your benefits.** You will no longer need to make separate calls to 1-800 Medicare, your Medicare health or drug plan, and your current Medicaid plan about your coverage.
- **Have the right to leave FIDA at any time and for any reason.** If you decide to do so, you will continue to receive all of your Medicaid long term care benefits through the MLTC program and all of your Medicare benefits through Original Medicare or a Medicare Advantage plan, and a Part D plan.

**MEDICARE ADVANTAGE (MA) ENROLLMENT PERIODS**

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

**Annual Coordinated Election Period (AEP)**

People with Medicare can enroll in a Medicare Advantage plan or switch their plan choice (either Medicare Advantage or Prescription Drug Plan) 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 (January 1 – February 14), 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 to disenroll from the plan 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 at age 65.

**5 STAR Special Enrollment Period**

You can switch to a Medicare Advantage Plan or Medicare Cost Plan or Medicare Advantage Plan with prescription drug coverage that has a 5 star for its overall rating from December 8 to November 30. You can only use this Special Enrollment Period once during this timeframe.

**IMPORTANT:** You may lose your prescription drug coverage if you move from a Medicare Advantage Plan that has drug coverage to a 5-star Medicare Advantage Plan that doesn't. You will have to wait until the next Open enrollment Period to get drug coverage and you may have to pay a late enrollment penalty. If your Medicare Advantage Plan includes prescription drug coverage and you join a Medicare Prescription Drug Plan, you'll be disenrolled from your Medicare Advantage Plan and returned to Original 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.

**IMPORTANT:** Enrollment in or switching to a different MA plan can only be done during the Annual Election Period (AEP) (October 15 – December 7). Disenrolling from a plan prior to the effective date of January 1 can be done up to December 31. After January 1 when the plan is in effect, disenrolling can be done during the Medicare Advantage Disenrollment Period (MADP) (January 1 – February 14) unless the beneficiary qualifies for a Special Enrollment Period (SEP).



**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 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 can send a signed request to the plan, but are not required to do so. The beneficiary could also call 1-800-MEDICARE (1-800-633-4227), 24 hours day/7 days a week, to disenroll when eligible.

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.

**Important:** 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. And if he or she enrolls into a stand-alone Part D plan (PDP), he or she will be automatically disenrolled from the MA plan (HMO or PPO) to Original Medicare.

## **WHAT TO CONSIDER BEFORE JOINING AN MA PLAN**

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Refer to the **www.medicare.gov** Web site or call 1-800-MEDICARE (1-800-633-4227), 24 hours day/7 days a week, for the most recent listing of Medicare Advantage (MA) plans in a county. If your client lives in a county served by more than one MA plan, they can compare benefits, costs and other features to find which plan best suits their needs at a price they can afford. (By using the Medicare Plan Finder section of the [www.medicare.gov/find-a-plan](http://www.medicare.gov/find-a-plan) Web site, counselors and people with Medicare can acquire the information needed.)

A person with Medicare should ask each MA plan for a copy of their Summary of Benefits and Evidence of Coverage. Beneficiaries should never rely on advertisements and should check the STAR ratings for any plan they are interested in. 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 when services are received.

**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. Most plans also offer limited coverage for 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 Plan Finder section of the [www.medicare.gov/find-a-plan](http://www.medicare.gov/find-a-plan) Web site, they may check their Medicare & You Handbook or call 1-800-MEDICARE, 24 hours day/7 days a week,

for a listing of county specific Medicare Advantage plans.

## **Additional Considerations for HMO Plan Members**

### **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.

### **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, Original Medicare will not pay for care outside the United States but Medicare

HMO plans may cover worldwide emergency care as an additional benefit. It is important to inquire about this before making travel arrangements to avoid unnecessary medical bills.

## **CHOOSING THE MEDICARE ADVANTAGE OPTION**

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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. For instance, most MA plans 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 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 instead because in most cases, they will 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 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 delay coverage for preexisting conditions. And a person with Medicare cannot be rejected because of their age or health status.

## **WHY JOIN A MEDICARE ADVANTAGE PLAN?**

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### **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.

### **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](http://www.medicare.gov) on the Web or one can call 1-800-MEDICARE. Callers can speak with a customer service representative at 1-800-MEDICAR(E) 24 hours a day, including weekends.

## QUALITY OF CARE

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Medicare Advantage plan quality comparison information is available in the Medicare Plan Finder section of the Medicare web site ([www.medicare.gov](http://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, IPRO, at 1-800-331-7767.

## APPEAL RIGHTS

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

**COVERED ITEMS AND SERVICES: COMPARING FIDA WITH MLTC, PACE, AND MAP PROGRAMS**

General Overview of Services	FIDA	MLTC	PACE	MAP
Medicare Part A and Part B services, such as: doctor office visits, specialty care, clinic visits, hospital stays, mental health services, X-ray and other radiology services, chiropractic care, ambulance services, etc.	✓		✓	✓
Medicare Part D brand-name and generic prescription drugs.	✓		✓	✓
Medicaid covered drugs (some covered drugs, including over-the-counter drugs).	✓	✓	✓	✓
All regular Medicaid services.	✓	✓	✓	✓
All long-term services and supports plus <i>many</i> additional supportive services to help the enrollee in his/her home that s/he cannot currently receive unless s/he is in the NHTD, Long Term Home Health Care Program (LTCHHP), or TBI Waiver program.	✓		✓*	
All Behavioral health services covered by Medicare and Medicaid <i>plus</i> additional services, including Mobile Mental Health Treatment, Crisis Intervention Services, Residential Addition Services, and Comprehensive Psychiatric Emergency Program services.	✓		✓**	
Supplemental benefits (for example, over-the-counter cards).	✓***			✓***
Care Manager is responsible for ensuring the enrollee gets what s/he needs, for example, making doctor’s appointments, arranging transportation, etc.	✓	✓	✓	✓
Comprehensive Care Management and a Care Team that works with the enrollee to get all the services s/he needs, even the services not usually covered by the plan (as long as they are medically necessary).	✓		✓	

\* Coverage of this/these service(s) is within the Plan’s discretion.

\*\* Some of the services.

\*\*\* Some of the plans.

Additional Services and Supports	FIDA	MLTC	PACE	MAP
<p><b>Adult Day Health Care Services</b>                      These services are provided to enrollees who are functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. The services include medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.</p>	✓	✓	✓	✓
<p><b>Community Integration Counseling</b>                      This service is for people who are having trouble learning how to live with their disability in the community. The service helps individuals to cope with altered abilities or skills and changes in their relation to significant others, to revise their long-term expectations, etc.</p>	✓			
<p><b>Community Transitional Services</b>                      These services help people who are transitioning from a nursing facility to living at home. They include the cost of moving furniture and other belongings; buying certain essentials items such as linens and dishes; security deposits, including broker's fee to obtain a lease on an apartment or home; set-up fees for deposits for utility (telephone, electricity, etc.).</p>	✓			
<p><b>Comprehensive Psychiatric Emergency Programs (CPEPs) Services</b>                      This includes a full range of psychiatric emergency services, 24 hours a day, 7 days a week.</p>	✓			
<p><b>Crisis Intervention Services</b>                      These services allow enrollees to discuss their issues with a mental health clinician and help them decide the best course of action. The services may be provided by phone or in person.</p>	✓			
<p><b>Home and Community Support Services (HCSS)</b>                      This is a combination of personal care services (ADLs and IADLs) with oversight / supervision services or oversight/supervision as a discrete service primarily at an enrollee's home. These services are provided to an enrollee who requires assistance with personal care services tasks and whose health and welfare in the community is at risk because oversight/supervision of the enrollee is required when no personal care task is being performed.</p>	✓		✓*	

Additional Services and Supports	FIDA	MLTC	PACE	MAP
<p><b>Home Maintenance Services</b>                      These services include household chores and services that are required to maintain an individual’s home environment in a sanitary, safe, and viable manner. The services are provided on two levels: 1) Light chores, for example, cleaning and/or washing of windows, walls, and ceilings; snow removal and/or yard work, etc. 2) Heavy-duty chores, for example, intensive cleaning/chore efforts.</p>	✓	✓*	✓*	✓*
<p><b>Home visits by Medical Personnel</b>                      Home visits by medical personnel, including physicians or physician extenders, such as nurse practitioners and physician assistants. This means doctors’ appointments at your home.</p>	✓		✓*	✓*
<p><b>Independent living Skills and Training</b>                      It is one-on-one training about self-care, medication management and other practical day-to-day skills. These services assist in recovering skills that have decreased as a result of the onset of the disability.</p>	✓		✓*	
<p><b>Medication Therapy Management (MTM)</b>                      These services are for enrollees who take medications for different medical conditions. They help enrollees and their providers make sure that enrollees’ medications are working to improve their health.</p>	✓	✓**	✓	✓**
<p><b>Mobile Mental Health Treatment</b>                      This service is available to enrollees who have a medical condition or disability that limits their ability to come into an office for regular outpatient therapy sessions.</p>	✓		✓*	

\* Coverage of this/these service(s) is within the Plan’s discretion.

\*\* Some of the services.

Additional Services and Supports	FIDA	MLTC	PACE	MAP
<p><b>Moving Assistance</b>                      These services help transport an enrollee’s possessions and furnishings when the enrollee must be moved from an inadequate or unsafe housing situation to a viable environment which more adequately meets the enrollee’s health and welfare needs and alleviates the risk of unwanted nursing home placement. The services may also be used when the enrollee is moving to a location where more natural supports will be available, and thus allows the enrollee to remain in the community in a supportive environment.</p>	✓	✓*	✓*	
<p><b>Medical Transportation</b>                      This service includes transportation to medical appointments.</p>	✓	✓	✓	✓
<p><b>Non-Medical Transportation</b>                      This service includes transportation to non-medical activities, such as religious services, community activities, supermarkets, etc.</p>	✓	✓*	✓*	✓*
<p><b>Palliative Care</b>                      These services help prevent or relieve pain and suffering and enhance the enrollee's quality of life. The services include family palliative care education, pain and symptom management, bereavement services, massage therapy, and expressive therapies.</p>	✓		✓	
<p><b>Peer-Delivered Services</b>                      These services are provided to individuals who are in the process of recovery from mental illness and substance abuse disorders.</p>	✓			
<p><b>Peer Mentoring</b>                      This service is for enrollees who have recently transitioned into the community from a nursing facility or during times of crisis. This is an individually designed service intended to improve the enrollee’s self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community. The service may include education, teaching, instruction, information sharing, and self-advocacy training.</p>	✓			

\* Coverage of this/these service(s) is within the Plan’s discretion.

Additional Services and Supports	FIDA	MLTC	PACE	MAP
<p><b>Personal Care</b>                      These services are for individuals who need some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support (for example, making and changing beds, light cleaning of the kitchen, bedroom and bathroom, preparing meals, bathing, dressing, grooming, toileting, feeding, etc.)</p>	✓	✓	✓	✓
<p><b>Positive Behavioral Interventions and Support Services</b>                      These services help decrease the intensity and/or frequency of the targeted behaviors and teach safer or more socially appropriate behaviors. These services may include: comprehensive assessment of the enrollee; development and implementation of a holistic structured behavioral treatment plan; training of family, natural supports, and other providers; regular reassessment of the effectiveness of the participant’s behavioral treatment plan.</p>	✓		✓*	
<p><b>Residential Addiction Services</b>                      These services are 24/7 structured treatment/recovery services in a residential setting provided by OASAS certified programs to persons recovering from substance use disorder. Certified residential programs may provide residential services corresponding to one or more of the following elements of the treatment/recovery process: stabilization; rehabilitation; reintegration in congregate or scatter-site settings.</p>	✓			
<p><b>Respite Services</b>                      These are individually designed services intended to provide scheduled relief to non-paid supports who provide primary care and support to an enrollee.</p>	✓	✓*	✓*	✓*
<p><b>Social Day Care</b>                      These services provide opportunities for individual socialization activities, including educational, craft, recreational and group events.</p>	✓	✓	✓	✓

- Coverage of this/these service(s) is within the Plan’s discretion.

Additional Services and Supports	FIDA	MLTC	PACE	MAP
<p><b>Structured Day Program Services</b>                      These services are designed to improve or maintain the enrollee’s skills and ability to live as independently as possible in the community. The services include but are not limited to: assessment; training and supervision to an individual with self-care; task completion; communication skills; interpersonal skills; problem-solving skills; sensory/motor skills; mobility; community transportation skills; reduction/elimination of maladaptive behaviors; money management skills; ability to maintain a household.</p>	✓		✓*	
<p><b>Substance Abuse Program Services</b>                      These services help enrollees manage addiction to opiates, such as heroin. These services help enrollees control the physical problems associated with opiate dependence and provide the opportunity for enrollees to make major lifestyle changes over time.</p>	✓		✓*	

\* Coverage of this/these service(s) is within the Plan’s discretion.

## Sources of Assistance

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

**1-800-MEDICAR(E)** **1-800-633-4227**

[www.medicare.gov](http://www.medicare.gov) 24 hours day/7 days a week

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

**Quality Improvement Organization (QIO)** (in NY) **1-800-331-7767**

**Island Peer Review Organization, Inc.**

1979 Marcus Avenue, 1st Floor

Lake Success, New York 11042

[www.ipro.org](http://www.ipro.org)

(out-of-state, call collect) **1-516-326-7767**

### Additional Resources

- *A Quick Look at Medicare*, CMS Publication #11514
  - <https://www.medicare.gov/Publications/Pubs/pdf/11514.pdf>
- *Your Guide to Medicare Private Fee-for-Service Plans*, CMS Publication #10144
  - <http://www.medicare.gov/Publications/Pubs/pdf/10144.pdf>
- *Your Guide to Medicare Special Needs Plans (SNPs)*, CMS Publication #11302
  - <http://www.medicare.gov/Publications/Pubs/pdf/11302.pdf>
- *Your Guide to Medicare Medical Savings Account Plans*, CMS Publication #11206
  - <http://www.medicare.gov/Publications/Pubs/pdf/11206.pdf>
- *Quick Facts About Programs of All-inclusive Care for the Elderly (PACE)* - CMS Publication #11341
  - <http://www.medicare.gov/publications/pubs/pdf/11341.pdf>

### FIDA Program Resources

- <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/New-York.html>
- The Memorandum of Understanding can be found at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NYMOU.pdf>
- Additional information on the ongoing development and implementation of the New York demonstration is available at: [http://www.health.ny.gov/health\\_care/medicaid/redesign/mrt\\_101.htm](http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm)
- NY Medicaid Choice at [1-800-600-3432](tel:1-800-600-3432), or visit [www.nymedicaidchoice.com](http://www.nymedicaidchoice.com).
- FIDA's Ombudsman Office – Independent Consumer Advocacy Network (ICAN) at [1-844-614-8800](tel:1-844-614-8800) or visit [www.icannys.org](http://www.icannys.org)

## 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 may be more predictable and more limited.*



**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.