SHIBA

Senior Health Insurance Benefits Assistance

Section 4

Medicare Advantage Plans

SHIBA Volunteer Training Program, July 2008

Section 4, Medicare Advantage Plans

Introduction to Medicare MAs

Learning objectives

On completion of this section, the SHIBA volunteer trainee will be able to:

- define Medicare Advantage (MA) plans.
- compare MAs and traditional Medicare supplement insurance.
- identify who is and who is not a good candidate for enrollment in a Medicare Advantage plan.
- describe the eligibility, enrollment, and disenrollment rules of MAs.
- know the rules for MAs' coverage of emergencies and urgent care.

The Balanced Budget Act of 1997 allowed for a new range of options for filling the gaps in Medicare coverage. Under this program, called **Medicare+Choice (M+C)** or **Medicare Part C**, a health insurance plan can contract with Medicare and receive a fixed monthly payment for each enrolled beneficiary. The Medicare Prescription Drug Improvement and Modernization Act of 2003 improved on M+C by increasing benefits and improving payments to providers. Also, the name changed from M+C to **Medicare Advantage (MA).**

Medicare Advantage includes:

- expanded plan choices with regional Preferred Provider Organization plans (PPOs). Regional PPOs will help ensure that all people with Medicare have multiple choices for Medicare health coverage, no matter where they live.
- prescription drug coverage, optional under Medicare Part D.
- new preventive benefits.
- a tax-free savings account (Health Savings Account) plan that earmarks money for health care expenses, with money not spent gaining interest tax-free, just like an IRA. Special provisions apply.

What are Medicare Advantage plans?

Medicare Advantage plans combine the functions of both health insurance and health services in one organization. They offer, on a pre-paid basis, medical and preventive services through a network of designated hospitals, doctors, and other providers. They offer integrated health delivery systems, coordinate individual care and records, and handle most of the paperwork.

Medicare Advantage plans contract with Medicare to provide a full range of Medicare-covered services to enrollees on a prepaid basis. Many of these managed care plans provide additional services, which are not covered by Medicare. Typically, MA enrollees have access to a range of preventive health services that other Medicare beneficiaries do not.

In 2006, new regional plans were available to everyone with Medicare in the region they serve. Other plans can decide, with Medicare's approval, to be open to everyone with Medicare in a state, or be open only in certain counties or parts of counties.

Medicare vs. Medicare Advantage

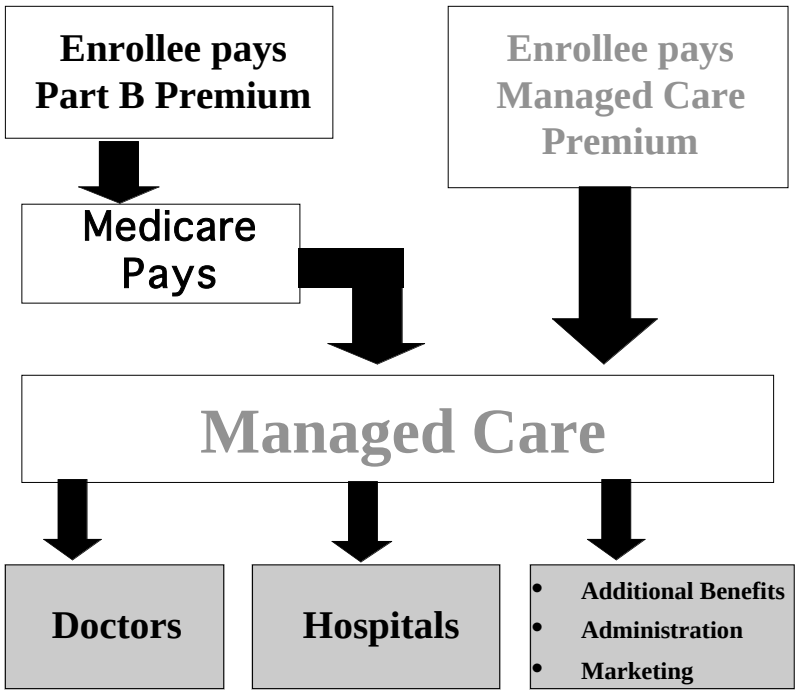
Medicare does not pay 100% of health care expenses. What Medicare covers and doesn't cover was discussed in previous sections. The charges Medicare does not pay include deductibles, co-payments, and services not covered by Medicare. Medicare bases its payments on Medicare's approved amount. Also, some important expenses like routine checkups are not covered.

Consumers can plan for these uncovered expenses by:

- purchasing a traditional Medicare supplement (Medigap) policy.
- enrolling in an employer-provided retirement health plan.
- paying the charges out-of-pocket.
- enrolling in a Medicare Advantage plan.

Medicare MAs

Medicare prepays a monthly amount to the MA plan to cover the enrollee's Medicare-covered care. Enrollees usually pay the plan a fixed monthly premium for health services that are added to Medicare coverage. Enrollees continue to pay their Part B premiums directly to Medicare. Co-payments may be required for some services.



In return, the MA delivers all Medicare-covered care and covers the enrollee's Medicare deductibles and coinsurance. The MA must provide Medicare-covered services, but may also provide additional services, which may include preventive health care, prescription drugs, dental care, hearing aids, and eyeglasses. Generally, there are no bills or claim forms as long as the enrollees use plan doctors or are referred for care.

(In contrast, Medicare supplement insurance companies – Medigaps – have no such relationship with health care providers. While enrollees do not receive coordinated or managed care, they can choose health care providers without reducing the plan's benefits. The Medicare supplement policy pays its benefits based on how much the doctor charges and what portion of those charges Medicare approves.)

How do MAs control costs?

Under the Original-Medicare-with-Medigap-supplement system, Medicare grew increasingly costly. Because patients may choose any licensed physician and any hospital, health care provider, or facility that accepts Medicare, there is no control on how much care patients receive. Until Congress began to limit the amount providers could charge under Medicare, there was little control over costs under the Original-Medicare-with-Medigap-supplement system. **Medicare Advantage plans are part of the Centers for Medicare & Medicaid Services' effort to control health care costs.**

Medicare Advantage plans usually cover more than Medicare itself does, and they usually cost less than Medigap plans. MAs are able to provide more benefits for a smaller premium, due to their utilization controls, provider contracts, and lower administrative costs.

Utilization controls

Instead of paying for care *after* it is received, MAs may review an enrollee's care to assure it is appropriate *before* it is provided. Most MAs based in Oregon require enrollees to select a primary care physician (PCP). PCPs coordinate patient care. A patient must get a referral from their PCP before receiving specialist care or care from a non-plan provider. Many MAs have **utilization review** teams that work to assure that patient care is appropriate, medically necessary, and cost-effective. Prior authorization is required for elective surgeries.

Provider contracts

MAs contract with providers and hospitals in a specific geographic area in order to obtain the most favorable rates for services. Often these contracts reflect substantial discounts on the rates providers would charge a fee-for-service client. Providers are willing to accept a lower rate of reimbursement for the guarantee of a larger volume of patients.

Administration

Fees are negotiated with physicians and hospitals, reducing billing costs and problems. Also, because the MA providers are not required to bill Medicare and then patients' supplemental insurance companies, the cost to administer MAs is lower.

Risk plans

Under a "risk" plan, members are *locked in to using only plan providers*. If a member uses a doctor who is not a plan provider without prior approval, the member will be responsible for all of the charges. The exceptions are for emergencies and urgently needed care or when a specific condition is pre-authorized outside the plan to a specific medical provider.

Medicare pays the MA a fixed amount for each member. This amount is equal to approximately 95%of what Medicare would pay if the member were not enrolled in an MA. The MA will not receive any more money from Medicare if their expenses exceed the 95% rate. Moreover, the MA receives this payment for each enrollee on a prospective basis whether or not services are actually obtained. Most MA plans in Oregon are "risk" plans.

Cost plans

Members of a "cost" MA *may use health care providers outside the plan*; however, non-plan provider bills go to Medicare and are subject to Medicare's payments and coverage limits. For example, if a member used an MA provider, the MA would cover 100% of the service costs (less any co-payment that may apply). If the enrollee chose a non-plan provider, Medicare would pay for 80% of the Medicare-approved amount. The enrollee would owe 20% of the approved amount, and possibly doctor's charges beyond the approved charge, not to exceed 115% of the Medicare approved amount.

Cost MAs also get a payment from Medicare, adjusted to reflect the actual costs of benefits provided, unlike the flat rate for a risk contract. In Oregon, Regence HMO Preferred Choice 65 is the only "cost" plan at this time.

Other MA plans

Group Practice MAs (e.g. Kaiser Permanente) have one or more staffed health care facilities. Primary care doctors and specialists work out of these facilities. Enrollees must go to these facilities for their health care.

Individual Practice MAs (e.g. large clinic) contract with large clinic/private practice doctors in a variety of locations through the MA's service area. Enrollees can choose a plan physician in a more convenient location if travel to a Group Practice MA is impractical.

Managed Care Basics

Medicare Advantage is the broad name for plans that contract with the Centers for Medicare and Medicaid Services (CMS) and includes a variety of different managed care and fee-for-service organizations. In Medicare Advantage plans (also called Medicare Health plans) the government pays a fixed amount of money to a health plan to provide all medically necessary treatment covered by Medicare. Generally, plan members must obtain services from health care providers who are part of the plan. The MA functions as both the insurer and health care provider. Most Medicare beneficiaries can choose to receive benefits through the original Medicare fee-for-service program, or through one of the following plan types:

- Coordinated care plans (or MAs) including:
  - Health Maintenance Organizations (HMO)
  - Provider Sponsored Organizations (PSO)
  - Preferred Provider Organizations (PPO)
- Religious fraternal benefit society plans (SMCO)
- Private fee-for-service plans (PFFS)
- Health Maintenance Organizations with Point of Service (POS) option

MAs and MAPDs

In Oregon, most HMOs and PPOs include prescription drug (Part D) coverage in their managed care package; one PFFS plan offers the drug option. With few exceptions, MA plans that offer Part D coverage also make available the same health plans without the drug component because beneficiary participation in drug plans is voluntary.

Important: Any Medicare Advantage enrollee who does elect drug coverage *must take the MA's plan, if it has one*. Enrolling in other drug coverage (such as a stand-alone PDP) will result in automatic disenrollment from the MA plan.

For more on Medicare Part D, see Section 5 of this training series.

Eligibility for managed care

A Medicare beneficiary is eligible to enroll in a Medicare MA if he or she:

- Is enrolled in Medicare A and B,
- Lives in the MA service area,
- Does not have end-stage renal disease (ESRD) and
- Pays Part B premiums, MA premiums and co-payments.

Where to enroll

Beneficiaries may call the Medicare Advantage plan to enroll or enroll at www.medicare.gov.

Candidates for MA enrollment

As a SHIBA volunteer, you may often be asked to make recommendations about what type of insurance your clients should buy. You cannot make recommendations; however, you may give clients some basic guidelines about who is an appropriate MA member and who is not. The clients' decisions often come down to their personal preferences and lifestyles. An MA is ideal for clients who:

- Prefer a less expensive alternative to a Medigap policy.
- Prefer no insurance paperwork.
- Have a pre-existing condition for which a waiting period may be a hardship.
- Appreciate a coordinated system of care through an MA's primary care physician.

Advantages of MAs

- Affordable premiums
- Small co-payments
- Little or no paperwork
- Extra benefits (e.g. routine eye exams and eyeglasses)

Disadvantages of MAs

- MAs may limit the enrollee's choice of physicians. Individuals who like to self-refer to specialists for medical care will have to make some changes in how they access care if they join an MA.
- Medicare beneficiaries who do extended travel and use non-emergency services while away may not be good candidates for an MA. Absence from an MA's service area for six months or longer is reason for involuntary disenrollment.
- In some cases, traditional standardized Medicare supplements offer benefits that better meet a client's needs.
- Individuals who do not live in the MA service area cannot enroll in an MA.
- MAs must accept all applicants who have Medicare and who live in the plan's service area, except those who have end-stage kidney disease (ESRD).

Choosing a Medicare Advantage plan

SHIBA volunteers should encourage prospective MA enrollees to study the publication *The Guide to Medigap, Medicare Advantage & Prescription Drug Coverage*. It provides information about the benefits, service areas, and participating hospitals. **Oregon Insurance Complaints,** a publication from the Oregon Insurance Division, may help consumers make informed choices about MAs. (MAs have their own procedures for appeals and grievances, so many complaints do not come to the Insurance Division).

Note: Volunteers should encourage beneficiaries to review the plan's marketing materials carefully.

Volunteers can also encourage clients to ask the following questions of MAs:

- What are the qualifications of the doctors on the plan? Does the MA have doctors specializing in surgery, eye care, mental health, etc.?
- What is the physician staff turnover rate?
- What control does the enrollee have over the choice of physician?
- What benefits are covered?
- What are the enrollee's co-payment responsibilities?
- How many available primary care doctors does the plan have?
- What is the procedure for switching doctors?
- What restrictions apply to emergency/urgent care out of the network area?
- What is the waiting time for appointments?
- Which hospitals and skilled nursing facilities are used by the MA?
- What do other enrollees think of the plan?

How to enroll in managed care

- Medicare.gov: Enroll online. Beneficiaries can do this by themselves or with the help of a family member or SHIBA volunteer.
- Contact the plan directly.

Medicare Advantage election periods

***Annual Election Period* (AEP) for Medicare Advantage plans**

Each year, from November 15 through December 31, people with Medicare can make their Medicare Advantage election for the following year. The change generally is effective the following January 1, unless you enroll in November and specify a December 1 effective date. During this period the MA plan must accept new members, unless the plan has reached its limit on Medicare enrollees.

This period from **November 15 to December 31** is the time when just about any change you could dream of can be made.

- You can go from an MA to Original Medicare, or vice versa.
- Pick up Part D for those who do not have it, or drop Part D.
- Change from Original Medicare with a PDP to an MAPD.

This is **the key time when the maximum amount of choice** is available to individuals.

***Special Election Period* (SEP) for Medicare Advantage plans**

An SEP* is a period of time to change MA plans, to return to original Medicare, or to join a Medigap plan, all under certain situations. These situations include: you make a permanent move outside your MA's service area, the MA plan breaks its contract with you or does not renew its contract with Centers for Medicare & Medicaid Services (CMS) or other exceptional conditions determined by CMS.

This **Special **E**lection **P**eriod for Medicare Advantage Plans – SEP – is different from **Medicare's** Special Enrollment Period – also an "SEP" – which deals with people who wait to enroll in Medicare Part B because they are covered under a group health plan.*

Open Enrollment Period (OEP) for Medicare Advantage plans

The period from January 1 to March 31 is a limited choice event. You may change only from like to like, e.g., MA to MA, MAPD to MAPD, Original Medicare only to MA only, Original-Medicare-with-PDP to MAPD, etc. You cannot add or subtract from your coverage extent. If you have it, you keep it. If you don't have it, you can't get it during this period.

Coverage is effective the first day of the month after the month the MA organization receives a completed enrollment application.

For people new to Medicare eligibility

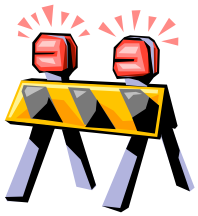
When beneficiaries first become eligible for Medicare, they may join a Medicare Advantage plan during the seven-month period that starts three months before the month of their 65th birthday (or their 24th month of cash disability payments), and ends three months after that month.

Coverage is effective the first day of the month of entitlement to Medicare Parts A and B – or – the first of the month after the month the election was made if that was after entitlement has occurred.

Disenrollment from MA plans

Once enrolled, members of plans are committed to maintain their membership with their MA or MAPD and may not leave it until the election periods explained above: during the AEP (Nov. 15-Dec. 31) they may make changes of every type; during the OEP (Jan. 1-Mar. 31) they may make one change to another plan, but may not change their drug option.

Switching from one MA or MAPD plan to another causes automatic disenrollment from the first plan. When a beneficiary cancels a plan, the disenrollment must be *in writing*. MA plans do not accept disenrollment by phone.



Caution: Special rules may apply if the member chooses to disenroll from an MA and return to a supplemental insurance policy or an employer's insurance policy. See Guaranteed Issue (GI) situations in *Section 3 – Insurance to Supplement Medicare.*

It takes one to two months for the system to be updated with the disenrollment information. Fee-for-service claims for beneficiaries enrolled in risk MAs will be rejected by Medicare until the system is updated. CMS recommends that beneficiaries who have recently disenrolled from an MA wait to file their fee-for-service claims until their disenrollment is confirmed.

Note: As with any replacement policy, consumers should make sure they have replacement coverage before dropping their old plan.

Involuntary disenrollment

MAs have the right to disenroll members under the following conditions:

- Failure to pay premium or other fees for which the enrollee is responsible.
- Enrollee's absence from geographic service area of longer than 6 months (cost contract 90 days.)
- Death of the enrollee.
- The end of the enrollee's entitlement to Medicare Part B.
- Enrollee commits fraud or permits his or her membership card to be abused.
- Termination of the Medicare Advantage contract by CMS or the MA. (Enrollees will receive 60 days notice).
- Enrollee's own abusive, unruly, or uncooperative behavior (subject to CMS review).

Medicare Advantage options

Health Maintenance Organizations (HMOs)

HMOs are a form of managed care that has been around since 1985. Usually the beneficiary picks a *primary care physician* (PCP) who serves as a *gatekeeper*. The PCP provides basic health care services and may refer for specialty care. Generally, patients only have coverage for care if they use providers that are part of the plan's network. Some plans also offer other benefits that traditional Medicare doesn't provide, including prescription drug coverage, vision care, and hearing aids. However, these benefits may change from year to year.

Costs

When Medicare beneficiaries enroll in a Medicare coordinated care plan, they continue to pay the Part B premium, and Medicare makes a monthly payment to the Medicare Advantage plan (HMO). Most plans also charge the enrollee a monthly premium. The plan may have its own deductibles and co-payments, but there are no Medicare deductibles or coinsurance. The plan provides all Medicare services and may provide some additional services such as physical examinations or eyeglasses. These plans generally cost less because they stress prevention and early detection. They are required to provide quality care and are reviewed by Quality Improvement Organizations (QIOs).

Advantages

- Allows individuals to budget for health care expenses.
- Emphasizes prevention, early detection, routine care, and wellness programs.
- Limits out-of-pocket expenses.
- No Medicare or insurer claim forms.

- No waiting periods for pre-existing conditions.
- Enhanced benefit packages, reduced premiums, or both.
- Physicians and facilities are subject to federal quality assurance requirements.

Limitations

- Limited access to nonmember providers.
- Limited choice of physicians and hospitals.
- Coverage outside the service area is lacking.
- Must have referral from PCP.
- Physicians can terminate contract.
- Plan benefits determination board can refuse to cover a procedure your PCP may have recommended.

Point of Service (POS) HMO option

Some managed care plans offer a POS option for additional cost. Under this option, it is possible to see providers outside the network, and the plan may cover part of the cost. Usually these services will require a deductible and a high coinsurance. If a beneficiary uses out-of-network services often, a POS policy may be more expensive than a traditional Medicare-with-Medigap-supplement policy.

Provider Sponsored Organization (PSO)

These plans are very similar to HMO's, but are run by doctors and hospitals. Medicare pays a monthly amount to the plan on behalf of the beneficiary. The beneficiary pays Part B premiums directly to Medicare and a monthly premium to the PSO. There may be co-payments and/or deductibles for some services. The PSO will provide all medically necessary treatment covered by Medicare.

Advantages

- Physicians make decisions about patient care independent of the plan.
- No claim forms or bills for the patient.
- Small co-payments.
- No waiting periods for pre-existing conditions.

Limitations

- Except for emergency or urgent care, patients must use the plan's providers or pay the full cost for care received outside the plan.
- Services of specialists are not covered without a physician referral.
- Coverage outside of service area is lacking.
- Enrollees must live in plan's service area.

Preferred Provider Organization (PPO)

A PPO is a network of providers who contract to provide services. *Enrollees may receive care outside the network, but have to pay more for this.* Medicare prepays a monthly amount to the PPO on behalf of the beneficiary. The beneficiary pays Part B premiums to Medicare and a premium to the PPO. In return, the PPO provides all medically necessary Medicare-covered care.

The plan may have its own deductibles and co-payments, but there are no Medicare deductibles or coinsurance. For example, the beneficiary may have to spend $100 annually before the plan will start paying its share. It may also pay 90% of the approved amount for a preferred provider's service but only 60% for services from non-preferred providers.

Advantages

- Unlike an HMO, a PPO allows use of Medicare benefits outside the plan.
- There is usually no requirement to select a Primary Care Physician.
- It may be possible to see specialists without a referral.
- Seeing preferred providers can reduce out-of-pocket expenses.

Limitations

- While care from a non-participating provider will be covered, it will cost more.
- A PPO, its Medicare contract, or the provider contracts may be cancelled.

Religious/Fraternal Organization plan

Organizations such as churches or associations may contract with the providers for health care services in a managed care setting. Enrollment must be open to all members of the group sponsoring the plan and the plan may be limited to a certain geographic area. The advantages and limitations are the same as Medicare MAs.

Other Medicare Advantage options

Medicare Private Fee-For-Service plan (PFFS)

Under a PFFS, an insurance company provides a plan that not only pays for Medicare-covered services, but also supplemental coverage. This is essentially a combination of traditional fee-for-service coverage and Medicare supplement coverage. These plans are very different from HMO's, PSOs, and PPOs.

Advantages/limitations, or possible disadvantages

- Like original Medicare, it is possible to use almost any doctor or health care provider as long as the provider is willing to bill the plan.
- The plan may cover extras not covered by Medicare or Medicare supplements such as alternative providers or prescription drugs.
- Plans without prescription drug coverage allow members to enroll in a stand-along prescription drug plan of their choice.
- *A PFFS plan can set its monthly premium as high as it wants, and out-of-pocket costs are likely to be high.*
- *It may be difficult for beneficiaries to budget for health care expenses under this option because they'll have to pay out-of-pocket to fill gaps in coverage.*

- *Benefit packages will not be standardized*, so it will be important to compare policies carefully.
- *Billings and claims paperwork may have to be handled by the beneficiary.*
- *Plans may have waiting periods for pre-existing conditions.*
- *The plan is not required to have a quality assurance program.*
- *There are no limits on what providers can charge for services.*
- *Some beneficiaries – End-Stage Renal Disease and hospice patients, Medicaid recipients, and federal retirees – are not eligible.*

Medicare Advantage Consumer Concerns

Like the traditional options for supplementing Medicare, any method will have advantages and limitations, and no option will be right for everyone. Consumers should read the plan's marketing materials carefully and understand benefits and out-of-pocket costs. Also, not all options will be available in all areas of Oregon, not all options will be available immediately, and some may change over time.

When comparing Medicare Advantage plans, consumers should keep the following points in mind:

- Provider restrictions— For those who like to self-refer, traditional Medicare with a supplemental policy may be the best option.
- Possibly high out-of-pocket costs—Read plan's marketing materials carefully.
- Limited prescription coverage.
- For those likely to need routine health care services when away from home, traditional Medicare with a Medigap supplement may be a good choice.

Consumer protections in Medicare managed care

- Care must be available 24 hours per day, seven days a week.
- Enrollees must have direct access to specialists.
- There must be a process for evaluating persons with complex or serious medical conditions.
- The plan must have a grievance and appeal procedure. Appeals of denials must be handled in 14 days for plan determination, 30 days for reconsideration and 72 hours for expedited urgent care.
- *Prudent layperson standard applies to coverage for emergency treatment.*
- The plan cannot charge more than a $50 co-payment for ER services.

Marketing

CMS regulates the marketing practices of MAs in order to ensure that all eligible beneficiaries enjoy the same access to enrollment. Medicare MAs must:

- Offer the plan to all eligible Medicare beneficiaries.
- Have at least one open enrollment period each year (unless plan is full).
- Publicize the enrollment availability throughout the entire geographic service area.
- Use only CMS-approved marketing materials.
- Accept enrollees on a first-come, first-served basis.

MAs must also allow beneficiaries to make an informed choice by communicating plan restrictions and membership rules. They are also prohibited from engaging in the following:

- Discriminatory marketing practices that tend to enroll people who are, or are perceived to be, in better health (e.g., new Medicare beneficiaries, or affluent beneficiaries).

- Distributing misleading or confusing materials about the plan, or materials that misrepresent CMS.
- Making claims that CMS endorses or recommends the specific MA.
- Using official US Government or Medicare-endorsed envelopes or marketing materials.
- Using the terms “Medicare substitute” or “instead of Medicare,” (implying that enrollees are no longer entitled to Medicare).
- Identifying a plan agent as a representative of Medicare or the federal government, rather than as a sales representative for the plan, who gains from sales.
- Making inaccurate statements about the fee-for-service system.
- Overstating the plan’s coverage.
- Implying that the coverage is perpetual.
- Making gifts or payments to encourage enrollment.
- Uninvited door-to-door solicitation.

CMS discourages MAs from using plan providers (e.g., doctors) to market plans because doctors may not be fully aware of plan benefits and costs. When physicians market plans, beneficiaries may be confused about when the doctor is providing medical services and when the doctor is an agent of the MA. Also, the marketing of plans by doctors increases the chance of discrimination in favor of healthier beneficiaries.

Emergencies, urgent care, and referrals

MAs generally will not pay for services received from non-plan providers nor for services received outside the plan’s service area. MAs do make exceptions to this rule for emergencies, urgent care, and referrals.

Emergencies

All MAs pay for services of a non-plan provider if the enrollee is injured or has a sudden illness and cannot reach a plan provider. CMS's guidelines define emergencies as services that "appear to be needed immediately to prevent the death of the enrollee or serious impairment of his or her health." Care after an emergency may not be covered if received from a non-plan provider. The enrollee should notify the MA of his or her situation and allow the MA to arrange for needed care after the emergency passes.

Urgent care

MAs will pay for medical emergencies or urgently needed care while enrollees are out of the MA service area; however, they will not pay for routine care or care that could have been planned in advance. Members of cost MAs may use non-plan providers who will then bill Medicare. According to CMS, "Urgently needed services are covered services which an enrollee requires in order to prevent a serious deterioration in his or her health while he or she is absent from the geographic area."

CMS regulates how MAs reimburse expenses related to emergencies. MAs may not:

- Require prior authorization for emergencies or urgent care.
- Require that emergencies and urgent care be received within a certain period of time from the onset of the condition.
- Use words such as *life-threatening* or *bona fide* in the definition of emergency or urgent care.
- Deny payment because an enrollee failed to notify the MA of emergency or urgent care services within a specified period of time.

Referrals

Most MAs require enrollees to select a primary care physician who coordinates all health care. Unless a doctor refers the enrollee to a specialist, most MAs will not pay for the specialist's care.

Complaints and appeals

Medicare Advantage plans must provide an appeals process for claims denials and for concerns about quality of care. The appeals process applies to complaints or disputes about coverage. The MA must inform each enrollee of his or her right to appeal at the time it makes its initial decision. For more on the appeals process please refer to Section 6 (Appeals) of your SHIBA Volunteer Training Manual.

Grievances

The MA grievance procedure applies to complaints that are not appeals. They can relate to any of the following:

- Coverage for optional benefits (such as prescriptions and eyeglasses).
- Waiting time for services.
- Physician behavior (rudeness, inattentiveness).
- Involuntary disenrollment.

MAs must do the following:

- Respond in a timely fashion to grievances.
- Take appropriate action on grievances, including full investigations.
- Notify all involved of the investigation's outcome.
- Provide all enrollees with information about how to file a grievance, the difference between an appeal and a grievance, and of grievance time limits.

Quality of care

If an MA enrollee is dissatisfied with the quality of care provided by an MA, the enrollee should follow the MA's grievance procedure. The enrollee may also file a complaint with the Quality Improvement Organization. In Oregon, call or write:

Acumentra
2020 SW 4th, Suite 520
Portland OR 97205
1-800-633-4227 (which is 1-800-Medicare)
****for SHIBA volunteers only*** – Acumentra's Medicare helpline: **1-800-344-4354**
Web site: www.medicare.gov

Enrollees may also file complaints about claim denials and enrollment or disenrollment issues with the Insurance Division by calling or writing:

Department of Consumer & Business Services
Insurance Division-2
PO Box 14480
Salem OR 97309-0405
(503) 947-7984 or 1-888-877-4894
Web site: www.oregoninsurance.org

Glossary

Capitation: A set dollar amount, which varies by county, that Medicare will pay a managed care plan to cover the cost of health care services for one person.

Centers for Medicare & Medicaid Services (CMS): (Was Health Care Financing Administration (HCFA). CMS is the agency responsible for administering Medicare. CMS is a branch of the federal government.

Coordinated care: MAs are often called *coordinated care* plans, referring to the way MAs manage health care costs, control use of health care services, and assure that all care received is necessary and medically appropriate.

Co-payment and coinsurance: A co-payment is the means by which an MA shares some health care costs with enrollees. A co-payment is a flat fee (such as $10 per office visit) while coinsurance is usually a percentage of charges (the dollar amount can vary dramatically).

Cost MA: Cost MAs get a payment from Medicare for each enrollee. This payment is adjusted to reflect the actual costs of the benefits, unlike the flat rate of a *risk* contract.

Health Maintenance Organization (HMO): A managed care organization that provides a wide variety of health care services to enrolled members through participating providers in a specific geographic area.

HMO-with-risk contract: A managed care organization/health-maintenance organization is under contract with CMS to provide services in a limited geographic area to enrolled participants who must use plan providers only. Unless the enrollee gets prior approval from the plan, the enrollee has to pay all charges for non-plan services.

HMO-with-Point-Of-Service (POS) option: With a POS option, a member may use a provider who is not part of the HMO network and the plan will pay a portion of the cost. The HMO may limit the total it will pay under the POS option during a year and may allow a member to go outside the network only for specific medical conditions.

Indemnity benefit: A fixed dollar amount paid to the individual for a covered service, without regard to the actual cost.

Medicare Advantage: Private companies contract with CMS. Medicare pays approved managed care plans to cover the services under Part A and Part B, usually combined with other supplemental services.

Medicare Cost plan (cost HMO): A cost HMO is not a Medicare Advantage plan, although it is a managed care plan and is included in listings of MAs. Cost plans have stricter rules than other managed care organizations. Cost HMOs are under contract with and get a payment from Medicare for the actual costs of the benefits, unlike a risk contract, under which Medicare pays a flat rate to the company for each enrollee, regardless of the cost of services. The enrollee pays a premium, coinsurances, and in some cases, deductibles set by the plan. The enrollee must live in the plan's geographic area and must choose a primary-care physician who contracts with the plan. Enrollees may use health-care providers outside the plan but charges will be subject to Medicare's payment limits. Members will then be responsible for the same deductibles and coinsurance as if Original Medicare covered them.

Medicare supplement policy: An insurance policy designed to pay for health care expenses not paid for by the Medicare program. Sometimes called *Medigap* plans because they can pay all or part of these uncovered expenses. See *Oregon Guide to Medigap, Medicare Advantage & Prescription Drug Coverage* for a detailed description of the plans available in the state.

Notice of initial determination: The form in which MAs deny claims for services.

Open Enrollment Period (OEP): A period during which MAs must accept all eligible applicants.

Preferred Provider Organization (PPO): PPO's are like HMO's, except that when you go to a doctor who is not in the PPO network, the plan pays a percentage of the cost. It may be easier under a PPO to see a doctor or other health-care provider not in the network, but you may pay more for the convenience.

Primary Care Physician (PCP): Most MAs require consumers to select a PCP. The PCP coordinates the consumer's care to assure that appropriate and cost-effective treatment is provided.

Private Fee-For-Service (PFFS) plan: A private insurance program under contract with CMS that charges enrollees a premium, deductibles, and co-pays. The plan must offer basic Medicare-covered services and may offer "extras" such as emergency medical coverage in a foreign country. Beneficiaries may see the provider of their choice and providers must furnish services under the terms of the plan.

Provider-Sponsored Organization (PSO): This plan is under contract with CMS and provides services in a limited geographic area. The plan charges a premium and co-pays. The participating doctors and hospitals control the PSO and they assume the financial risk.

Qualified Medicare Beneficiary (QMB): A program established by Congress to help low-income individuals pay their Medicare premium, deductibles, and coinsurance. For eligibility criteria, contact the local Senior and Persons with Disabilities Office.

Quality Improvement Organization (QIO): A group of practicing doctors and other health care professionals under contract to Medicare to review the care provided to Medicare patients. In Oregon, the QIO is Acumentra.

Risk MA: Medicare pays the MA a fixed amount for each member. This amount is equal to 95 percent of what Medicare would pay if the enrollee were not in an MA plan. The MA will not get any more money from Medicare even if the expenses exceed the 95 percent rate.

Social Health Maintenance Organization (SHMO): An innovative pre-paid program integrating medical, social, and long-term-care services. Beneficiaries may pay premiums, co-pays, and deductibles and must use the plan's network of providers within a limited geographical area.

Specified Low Income Medicare (SLMB): A program established by Congress to help low-income individuals pay the Medicare premium. For eligibility criteria, contact the local Senior and Persons with Disabilities Office.

Utilization review: A review of health care services by the QIO or hospital to assure that the services are appropriate.

Appendix A – Medicare & MA Comparison

Differences between Traditional Medicare and Medicare Advantage Options		
Traditional Medicare		**Medicare Advantage Options**
Government's role *Centers for Medicare and Medicaid Services* ***(CMS)***	CMS pays doctors and other health care providers for your health care.	CMS pays private health plans to provide your health care. *The plan expects that what CMS pays it will more than cover the cost of your care.*
How care is paid	CMS pays for each service you receive.	CMS pays a fixed monthly amount to the health plan to provide all your health care, no matter what the actual amount of services you need.
Financial incentives	Providers have no financial incentive to control costs.	The health plan has a financial incentive to control costs.
Out-of-pocket costs	If you only have Medicare you may have high out-of-pocket costs. You can limit your costs with: • Medigap insurance, or • Retiree health insurance	In Medicare HMOs, PPOs, or PSOs, you have low out-of- pocket costs as long as you use the plan's doctors. In Medicare PFFS plans, you can have high out-of-pocket costs, depending on services needed.
Additional benefits	CMS does not pay for: • Dental care • Vision Care • Hearing Aids	Other Medicare options may provide additional benefits: • Vision care • Hearing Aids • Dental