Helping Older Persons With Legal & Long-Term Care Problems

MEDICARE HMOs and MEDICARE ADVANTAGE PLANS

1. What Are Medicare Advantage Plans?

A Medicare Advantage Plan (MAP), also known as Medicare Part C, is the name for some managed care provider options outside of the traditional Medicare Part A and Part B programs. A MAP is a type of Medicare health plan offered by a private company that contracts with Medicare. MAPs provide all of your Part A and Part B benefits. MAPs may offer extra coverage beyond what Part A and Part B cover, like vision, hearing, and dental. A MAP can charge different out of pocket costs and have different rules about how you get services than traditional Medicare. These rules can change each year. A Medicare beneficiary may choose to participate in a MAP instead of the traditional Medicare program. [1]

2. Does a Medicare beneficiary have to enroll in a MAP?

No. A Medicare beneficiary may elect to stay in the traditional Medicare Part A and Medicare Part B programs simply by not enrolling in any of the MAPs being offered. [2]

3. What are the options under a MAP?

(1) A Health Maintenance Organization (HMO) – a for-profit managed care organization that covers enrollees' medical services only if they use its network of providers. However**, Medicare HMOs are required to cover *emergency medical services*** even if non-network providers provided the care.

(2) Preferred Provider Organization (PPO) - this is a for-profit insurance plan that permits its members to go outside their network of health care providers and will still cover at least part of the cost of that provider's care. However, you pay less if you use health care providers in the network. The plan determines how much to reimburse for services provided and may charge a premium or have co-payments and deductibles, just like the Medicare HMOs.

(3) Private Fee-for-Service Plans (PFFS) – a for-profit plan that determines how much you pay doctors, other health care providers, and hospitals, and how much you pay when you get care. The plan may or may not have a network of health care providers or may be out-of-network.

(4) Special Needs Plans (SNP) – a for-profit plan that limits membership to people with specific diseases or characteristics. These plans tailor their benefits, provider choices, and drug formularies to best meet the specifics needs of the groups they serve.

(5) HMO Point of Service (HMOPOS) – An HMO plan that may allow you to get some services out-of-network for a higher cost.

(6) Medical Savings Account (MSA) – A plan that combines a high deductible for-profit health plan with a bank account. The plan deposits money into the account (usually less than the deductible). You can use the money to pay for your health care services during the year.

Careful attention must be paid to the different benefits and costs offered by each choice, and some choices are not available in all regions or states. [3]

4. Who can enroll in a MAP?

The beneficiary must usually be entitled to Part A and enrolled in Part B of the Medicare program. The beneficiary usually must live in the geographical area that the plan serves.. [4]

5. What is covered under each choice?

Most Medicare Advantage Plan organizations must provide the same medical care that would be available to a beneficiary under the traditional Medicare program. [5]

6. Does a beneficiary have a right to appeal a medical decision by a MAP organization or one of their providers?

Yes. A Medicare beneficiary has an absolute right to appeal a MAP organization's or one of their medical provider's actions or failure to act that denies, reduces or terminates medically necessary care or reimbursement for such care.

A request for reconsideration must be made within 60 calendar days of an organization's or their medical provider's notice of denial or their refusal to make a decision to provide needed health services. If on appeal the MAP organization upholds the denial, it must forward the appeal request and its file to an independent organization that will review whether the denial was proper. If this reconsideration results in a denial, then the beneficiary has a right to appeal to an Administrative Law Judge (ALJ) if the amount in controversy is $180 as of 2023. If the ALJ decision is adverse, the Medicare beneficiary may appeal that determination to the Medicare Appeals Council. An appeal of the Council's decision may be made to a federal district court if the amount in controversy is $1,850 as of 2023. [6]

7. What if I need a more immediate review of a decision?

A Medicare beneficiary has a **right to** request **an expedited decision if the usual time for a MAP organization to make a decision (14 days) could seriously jeopardize the life,**

health or the enrollee's ability to regain maximum function. *The expedited appeal request may be made either orally or in writing to the MAP organization or as directed by the MAP.*

In most cases, the MAP organization must issue a decision no later than 72 hours after receiving the request for an expedited decision.

If the MAP organization upholds its denial or termination, it then must submit a written explanation to the beneficiary within 3 calendar days. The written explanation must include information about the beneficiary's right to an expedited appeal the denial of the expedited grievance. If the expedited appeal denial is not changed, the Medicare beneficiary would have the same right to seek further appeal by following the steps and procedures described in Question 6. [7]

8. How much of your hospital stay will MAP organization pay?

Usually all MAPs will cover emergency hospitalizations and treatments. For other hospitalizations, how much the MAP will pay depends on the type of MAP plan a beneficiary has. Some MAPS require prior approval before a hospitalization, others may require a letter from your primary care physician, and others may require you only use the MAP's approved hospitals.

Your out of pocket cost will depend on your MAP's hospital deductible and co-payment policy for that year. For example, one MAP may charge $350 a day for each day of hospital care up to a maximum of $2500 per year, while another one may charge a flat $400 for each hospital stay in a calendar year. It is therefore crucial that the hospital deductible, co-payment and maximum co-payment policies be closely reviewed when selecting a MAP. [8]

9. What if my MAP organization wants me discharged from a hospital and says that I will have to pay for all additional care?

All hospitals must provide you with an Important Message from Medicare (IM) which tells you your hospital discharge appeal rights, as well as with an initial discharge notice if the hospital decides to discharge you. When you are advised of your planned date of discharge, either orally or in writing, if you think you are being asked to leave the hospital too soon, you have the right to appeal to your Quality Improvement Organization (QIO). The QIO is authorized by Medicare to provide a second opinion about your readiness to leave. You can appeal this proposed discharge by calling 1-800-633-4227 (1-800-MEDICARE) and asking for your local QIO's phone number. After calling your local QIO and appealing, you should then confirm your telephone appeal by writing to the QIO's office address.

If you appeal to the QIO by midnight of the same day you receive a Discharge Notice, you qualify for an expedited appeal, which then requires the QIO to make a determination within one calendar day of having received all pertinent information. By requesting an expedited appeal, you are not personally responsible for paying for the days you stay in the hospital during the QIO review, even if the QIO disagrees with your appeal. If you request an appeal after the midnight deadline, you may be held responsible for charges incurred after the date of discharge or as

otherwise stated by the QIO. You would have to pay any MAP organization's additional daily co-payments. [9]

10. What if a Medicare beneficiary decides that she no longer wants to be in the MAP organization?

Medicare beneficiaries already enrolled in a MAP can disenroll from the MAP and return to traditional Medicare or switch from one MAP to another by submitting the appropriate forms to their MAP organization or by calling 1-800-633-4227 during the open enrollment period of October 15 through December 7 and the open enrollment period of January 1 through March 31. Sometimes, depending on special circumstances, a beneficiary becomes eligible for a special enrollment period where they can make changes outside of the open enrollment periods. Call Medicare to see if you qualify for a special enrollment period. [10]

11. Where can I get help?

If you live in Hamilton, Clermont, Butler, Clinton or Warren County, **contact Pro Seniors for legal advice and representation** with your questions, denials or terminations of needed medical care.

If you live in Ohio but outside this five-county area, Pro Seniors can still provide free advice, information and referral services on denials**. For more information, call Pro Seniors' free Legal Hotline at (513) 345-4160 or (800) 488-6070.**

Pro Seniors' Legal Hotline for Older Ohioans provides free legal information and advice by toll-free telephone to all residents of Ohio age 60 or older. If you have a concern that cannot be resolved over the phone, then the hotline will try to match you with an attorney who will handle your problem at a fee you can afford.

In southwest Ohio, Pro Seniors' staff attorneys and long-term care ombudsmen handle matters that private attorneys do not, such as nursing facility, adult care facility, home care, Medicare, Medicaid, Social Security, protective services, insurance and landlord/tenant problems.

This pamphlet provides general information and not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Hotline or consult an attorney in elder law.

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Endnotes:

[1] 42 U.S.C. § 1395w-21 - 42 U.S.C. § 1395w-28 Part C Medicare+Choice Program; 42 C.F.R. § 422.1 et. al. Medicare Advantage Program https://www.hhs.gov/answers/medicare-and-medicaid/what-is-medicare-part-c/index.html

[2] 42 U.S.C. § 1395w-21(a)(1) Eligibility, election and enrollment; 42 C.F.R. § 422.66(c) Coordination of enrollment and disenrollment through MA organizations

[3] 42 C.F.R. § 422.4 Types of MA plans; 42 C.F.R. § 422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services; 42 U.S.C. § 1395w-28(b) Definitions; miscellaneous provisions; 42 U.S.C. § 1395dd ; Examination and treatment for emergency medical conditions and women in labor https://www.medicare.gov/sign-upchange-plans/types-of-medicare-health-plans/medicare-advantage-plans

[4] 42 C.F.R. § 422.50 Eligibility to elect an MA plan; 42 U.S.C. § 1395w-22(b) Benefits and beneficiary protections; 42 U.S.C. § 1395mm(c) Payments to health maintenance organizations and competitive medical plans; 42 C.F.R. § 422.66(d) Coordination of enrollment and disenrollment through MA organizations

[5] 42 U.S.C. § 1395w-22(a) Benefits and beneficiary protections; 42 U.S.C. § 1395mm(c) Payments to health maintenance organizations and competitive medical plans; 42 C.F.R. § 417.440(b) Entitlement to health care services from an HMO or CMP

[6] 42 U.S.C. § 1395w-22(g) Benefits and beneficiary protections; 42 C.F.R. § 476.71(a) QIO review requirements; 42 C.F.R. § 422.582(b) Request for a standard reconsideration; 42 C.F.R. § 422.592 Reconsideration by an independent entity; 42 C.F.R. § 422.600 Right to a hearing; 42 C.F.R. § 422.608 Medicare Appeals Council review; 42 C.F.R. § 422.612 Judicial review; https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart-.pdf

[7] 42 U.S.C. § 1395w-22(g)(3) Benefits and beneficiary protections; 42 C.F.R. § 417.600 Basis and scope; 42 C.F.R. § 422.570 Expediting certain organization determinations; 42 C.F.R. § 422.568; 42 C.F.R. § 422.572; 42 C.F.R. § 422.566; 42 C.F.R. § 422.584; 42 C.F.R. § 422.590; 42 C.F.R. § 422.590(d); 42 C.F.R. § 422.592(a); 42 C.F.R. § 422.600(a); 42 C.F.R. § 422.60; 42 C.F.R. § 422.612

[8] 42 U.S.C. § 1395w-22

[9] 42 U.S.C. § 1395cc(a)(1)(M); 42 C.F.R. § 482.30(d)(3); 42 C.F.R. § 411.404; 42 C.F.R. § 412.42; 42 C.F.R. § 417.440; 42 C.F.R. § 422.620; 42 C.F.R. § 422.622

[10] 42 U.S.C. §1395w-21; 42 C.F.R. § 422.66; 42 C.F.R. § 422.62