1. Module 2: Part C and Other Medicare Health Plans

2. Navigation Instructions

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4. Learning Objectives

- After reviewing "Part 2: Medicare Health Plans" you will be able to:
    - Explain what types of Medicare health plans are available
    - Explain who is eligible for the different types of plans
    - Understand the role of Special Needs Plans (SNPs) in delivering care
    - Describe features of different Medicare health plan types
    - Describe key issues for beneficiaries eligible for both Medicare and Medicaid
    - Explain how Medicare health plans work with prescription drug plans

5. Training Roadmap: Module 2

- Medicare Advantage Plans
- MA Plan Types: Coordinated Care Plans
- Special Needs Plans
- MA Plan Types: Private Fee-for-Service (PFFS) Plans
- MA Plan Types: Medical Savings Account (MSA) Plans
- Medicare Advantage Employer/Union Plans
- Medicare Advantage: Eligibility, Costs, and Benefits
- Medicare Advantage Plans and Dual Eligible Beneficiaries
- Medicare Advantage and Prescription Drugs
- Other Type of Medicare Health Plans
- Enrollee Protections: Appeals and Grievances

6. Title Page: Medicare Advantage Plans

7. Part C: Medicare Advantage Plans: Overview

Under the Medicare Advantage (MA) program, known as Medicare Part C, private companies offer health plans that cover all Medicare Part A and Part B benefits.

- Many also cover Part D prescription drug benefits (MA-PD plans)
- All MA plans have a maximum out-of-pocket limit (MOOP) for basic benefits
- Many MA plans also offer additional benefits that Medicare does not cover
- The types of Medicare Advantage (MA) plans are:
    - Coordinated Care Plans. These plans have a network of preferred providers and include:
        - Health Maintenance Organizations (HMOs), some have a point-of-service (POS) benefit that allows beneficiaries to go out-of-network subject to limitations
        - Preferred Provider Organizations (PPOs), which may be local or regional
    - Private Fee-for-Service (PFFS) Plans
    - Medical Savings Account (MSA) Plans

8. Title Page: MA Plan Types Coordinated Care Plans

9. MA Plan Types Coordinated Care Plans – HMOs

HMO enrollees must generally only use doctors and hospitals within the plan's network (known as participating providers) for services to be covered. However, there are certain exceptions:

- Emergency services received outside of the plan network are covered.
- When the enrollee is temporarily absent from the plan's service area, dialysis services are covered outside of the network.
- Urgently needed services received outside of the plan network are covered when the enrollee is temporarily outside of the service area or in rare circumstances when the network is not available.
- If a needed specialist or a covered procedure is not available through the network, the plan will authorize out-of-network services.

10. MA Plan Types Coordinated Care Plans – HMOs (continued)

- HMO enrollees may need to select a primary care doctor and may need a referral for specialty care.
- Some HMOs offer a Point of Service (POS) option that allows enrollees to go to non-plan doctors and hospitals without receiving prior approval for certain services.
    - Unlike a PPO, an HMO-POS plan may limit the services available out of network or may put a dollar cap on the amount of out-of-network coverage.
    - Cost-sharing is generally higher than for services obtained from network providers.

11. MA Plan Types Coordinated Care Plans – PPOs

Under a PPO, enrollees:

- may get care from any provider in the U.S. who accepts Medicare; they are not limited to network providers.
- do not need a referral to see an out-of-network provider but are encouraged to contact the plan to be sure the service they wish to obtain out-of-network is medically necessary and will be covered.
- usually pay higher cost-sharing amounts than they would pay in-network if they see an out-of-network provider.

Regional PPOs are PPOs that are offered throughout an entire region, made up of one or more states.

12. MA Plan Types Coordinated Care Plans – Special Needs Plans

- Special Needs Plans (SNPs) are a type of Medicare Advantage coordinated care plan (HMOs or PPOs) that are specially designed to serve a subset of Medicare beneficiaries.
- In addition to meeting all other MA eligibility criteria, beneficiaries must also meet criteria specific to the type of SNP in which they wish to enroll.
- All SNP plans include prescription drug coverage.

13. Title Page: Special Needs Plans

14. Special Needs Plans –Types (1 of 2)

There are several types of Special Needs Plans

- Chronic condition SNPs (C-SNPs) are SNPs that restrict enrollment to individuals with certain chronic or disabling chronic conditions, such as diabetes, heart failure, cancer, lung conditions, HIV, or certain other conditions.
    - Each C-SNP will specify the condition or conditions necessary to be eligible to enroll.
- Dual eligible SNPs (D-SNPs) enroll beneficiaries who are entitled to both Medicare and medical assistance from a State plan under Medicaid.
    - A subset of D-SNPs, fully Integrated Dual Eligible (FIDE) SNPs, provide dual-eligible enrollees access to Medicare and Medicaid benefits under a single managed care organization.

15. Special Needs Plans –Types (2 of 2)

- Institutional SNPs (I-SNPs) are SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility (NF) as defined under Medicaid law, an intermediate care facility for the individuals with intellectual and developmental disabilities, a long-term care hospital, an inpatient psychiatric facility, or certain other facilities specified by CMS.
- Institutional Equivalent (IE) SNPs enroll MA eligible individuals who live in the community but require an institutional level of care (i.e., are determined by an impartial entity to need the level of services furnished by the types of facilities listed above). Eligibility for an IE-SNP may be limited to certain Assisted Living Facilities.

16. Title Page: MA Plan Types: Private Fee-for-Service (PFFS) Plans

17. MA Plan Types: Private Fee-for-Service (PFFS) Plans (1 of 2)

- Individuals enrolled in PFFS plans may receive covered services from any provider in the U.S. who is eligible to provide Medicare services and agrees to accept the plan’s terms and conditions of payment. They are not limited to a network of plan providers.
- Some PFFS plans contract with providers. If the PFFS plan has a network, enrollees may pay more if they see out-of-network providers.
- Except for emergencies, enrollees must inform providers before receiving services that they are a PFFS plan member, so the non-network providers can decide whether to accept the plan’s terms and conditions.
- Non-network providers that accept Original Medicare may choose not to accept PFFS plan enrollees. Therefore, an enrollee needs to confirm that their provider of choice will accept a PFFS plan before enrolling in one.

18. MA Plan Types: Private Fee-for-Service Plans (2 of 2)

- Providers are prohibited from charging a PFFS enrollee more than the cost-sharing specified in the PFFS plan's terms and conditions of payment.
    - Cost-sharing may include balance billing up to 15% of the Medicare rate only if allowed in the plan's terms and conditions of payment.
        - Balance billing happens when a doctor is eligible to accept Medicare but is not a Medicare "participating" provider under Original Medicare. Under Original Medicare, these non-participating providers are allowed to balance bill beneficiaries up to 15% over the Medicare payment amount.
        - PFFS plans may choose whether or not to allow non-participating providers to balance bill their members.
- PFFS plans may choose to offer Part D benefits but are not required to do so.

19. Title Page – MA Plan Types: Medicare Savings Account Plans

20. MA Plan Types: Medical Savings Account (MSA) Plans

- A Medicare MSA is a high-deductible health plan which is combined with a savings account used to pay for health care expenses during the deductible phase.
    - Medicare contributes money to the beneficiary's savings account to assist with paying for health care expenses during the deductible phase.
- The deductible applies even in the case of preventive services that have no member cost-sharing under other plans. If the member is in the deductible phase, they must pay for these services.
- MSA enrollees pay for health care expenses from the savings account and then, if they use all the funds in the savings account, out-of-pocket.
- After the annual deductible is met, the plan pays 100% for covered services.
    - The maximum allowable deductible for MSA plans in 2023 is $15,750. However, most MSAs will have a substantially lower deductible.

21. MA Plan Types: MSA Plans, continued

- MSAs cover Part A and Part B benefits after the deductible
- MSAs do NOT cover, Part D Medicare prescription drug benefits
    - MSA enrollees must enroll in a stand-alone PDP if they want prescription drug benefits
- MSA enrollees may receive covered services from any Medicare approved provider in the U.S. if the provider chooses to accept their plan.
- MSAs may not have a network or may have a full or partial network of providers.
- All non-network providers must accept the same amount that Original Medicare would pay them as payment in full. This is the amount the enrollee will pay the provider before the deductible is met.
- In 2023, MA MSA plans were only available in 36 states and the District of Columbia.

22. Title Page: Medicare Advantage Employer/Union Plans

23. Employer/Union Plans

- Employers and unions may offer their retirees and their dependents:
  - Medicare Advantage individual plans (plans open to the public).
  - Medicare Advantage plans that are only available to individuals based on their employer, known as **Employer Group Waiver Plans or EGWPs**.
  - A Medicare Advantage plan through a direct contract between the employer or union and CMS, known as a direct contract plan.
- Employers with less than 20 employees (as calculated under Medicare secondary payor rules) may be able to offer Medicare Advantage plans to their active employees and their dependents.
- Any size employer can offer Medicare Advantage plans to its retirees and their dependents.

24. MA Plan Types – Employer Group Waiver Plans

- Employer Group Waiver Plans (EGWPs) can be any type of Medicare Advantage Plan (HMO, PPO, PFFS, or MSA).
- These plans are different than other Medicare Advantage plans because eligibility to enroll is limited and because a variety of regulatory requirements are waived as they apply to EGWPs. For example, certain marketing and enrollment requirements do not apply to EGWPs. We discuss these waivers in the subsequent modules of this training.

25. Title Page: Medicare Advantage Plans – Eligibility, Costs, and Benefits

26. Medicare Advantage Eligibility

To be eligible to enroll in a Medicare Advantage plan:

  - A beneficiary must be entitled to Part A ***and*** enrolled in Part B.
  - The beneficiary must permanently live in the MA plan's service area. (If a beneficiary spends six months or more outside of the plan's service area, they should only enroll in MA-PD plans with a visitor/traveler benefit.)
  - Be a U.S. citizen or lawfully present in the United States on or before the enrollment effective date. (CMS makes this determination.)
- MA plans must enroll any eligible beneficiary who applies regardless of health status.
  - Certain special needs plans (SNPs) known as chronic condition SNPs (C-SNPs) can limit enrollment to beneficiaries with certain chronic conditions, such as diabetes, chronic heart failure, end-stage renal disease, cancer, HIV, or other specified conditions.
- MA MSA plans, Special Needs Plans, and Employer Group Waiver Plans have additional eligibility requirements.

27. MSAs: Special Eligibility Rules

The following individuals are ***not*** eligible to enroll in an MSA:

- An individual who receives health benefits that cover all or part of the annual deductible under the MA MSA plan. Examples include, but are not limited to, primary health care coverage other than Medicare, Medicare hospice, certain supplemental insurance policies, and retirement health benefits.
- An individual who is enrolled in a Federal Employee Health Benefits plan or is eligible for health care benefits through the Veteran's Administration.
- Dual eligibles entitled to coverage of Medicare cost-sharing under Medicaid.
- An individual who cannot provide assurances that they will reside in the United States for at least 183 days during the year for which the election is effective.
- An individual who has already elected hospice.

28. EGWPs and Direct Contract Employer Plans: Special Eligibility Requirements

- Employer group waiver plans (EGWPs) or direct contract plans may only enroll Medicare beneficiaries who are active employees or retirees of the employer or union offering the plan and their dependents.
    - A beneficiary's enrollment in an EGWP must be based on receiving "employment-based" health coverage from an employer/union group health plan sponsor.
    - Coverage obtained through a professional or another type of group association would not make a beneficiary eligible for an EGWP, except to the extent that the coverage obtained through the association can properly be characterized as "employment-based" group health plan coverage.

29. Medicare Advantage Plans: Premiums

Medicare Advantage Plans may charge a premium. If the plan charges a premium, beneficiaries must generally continue paying their Part B premium in addition to paying the monthly plan premium to remain enrolled.

30. Medicare Advantage Plans: Cost-Sharing

- Medicare Advantage plans may also require their members to pay for a portion of the covered services they receive. This is known as member cost-sharing. There are several potential types of cost-sharing:
    - Deductible: A set amount the member must pay for covered services before the health plan begins paying for those services.
    - Copayment: A fixed dollar amount per service the member must pay. For example, $20 for each visit to a primary care provider, or $30 for each visit to a specialist.
    - Coinsurance: A percentage of the cost of the service the member must pay. For example, 20 percent of the cost of durable medical equipment.

31. Maximum Out-of-Pocket Limits

- All Medicare Advantage plans must have a "maximum out-of-pocket" limit (known as the "MOOP") for Part A and Part B benefits. That is, once the member pays a specified amount of cost-sharing, the health plan covers 100% of covered medical services. Each year CMS specifies a mandatory MOOP, which health plans cannot exceed, although they may have a lower MOOP.
  - Each plan's MOOP will be specified in its summary of benefits and its evidence of coverage.
- For 2024, the maximum MOOP limit for Medicare Advantage coordinated care plans and private fee-for-service plans is $8,850, although most plans will have lower limits. PPOs must also have an aggregate MOOP for network and non-network providers of $13,300 in 2024. Again, it is likely that many will have lower limits.

32. Part C: Medicare Advantage Plan Benefits

- All Medicare Advantage (MA) plans must cover all Part A and Part B benefits.
- Most Medicare Advantage plans also cover part of the Original Medicare cost-sharing for Part A and Part B benefits.
- Medicare Advantage plans may also cover extra benefits not covered by Original Medicare, such as:
  - Additional days of hospitalization
  - Skilled nursing and rehabilitative services without a prior 3-day inpatient hospital stay
  - Vision Services, including glasses
  - Hearing Aids
  - Routine Dental Services
  - Fitness (such as gym membership or Silver Sneakers)
  - Meals related to a medical condition or after a hospitalization
  - Worldwide Urgently Needed and Emergency Services
  - Non-emergency transportation

33. Special Benefits Depending on Chronic Health Condition

Medicare Advantage plans may offer special benefits for individuals with certain chronic health conditions, such as diabetes, heart failure, COPD, or other conditions, that are not available to members of the same plan without the specified condition. There are two categories of such benefits: (1) those that are primarily health related and (2) those that are not (the latter generally address social determinants of health and are known as Special Supplemental Benefits for the Chronically Ill, or SSBCI).

- Primarily health related benefits for chronically ill enrollees may include items such as: decreased cost sharing for certain services, or supplemental benefits such as at-home palliative care or transportation to medical appointments.
- SSBCI may include items such as: groceries, meals beyond a limited basis, pest control, and non-medical transportation.

Consequently, it is useful for agents to know if their clients have conditions that may qualify them for these types of benefits if they are available in the clients' area.

34. Medicare Advantage Plans – Utilization Management

Medicare Advantage plans may implement mechanisms to manage the utilization of covered services that do not apply under Original Medicare.

Such mechanisms include requiring a referral or prior authorization to obtain a service.

Plans may also implement step therapy requirements for Part B or Part D drugs. Step therapy is when a plan requires a beneficiary to try less expensive options before "stepping up" to drugs that cost more.

35. Title Page-Medicare Advantage Plans and Dual Eligible Beneficiaries

36. MA Plans and Dual Eligible Beneficiaries (1 of 3)

- Beneficiaries who qualify for both Medicare and Medicaid are considered "dual eligible" individuals. Dual eligible beneficiaries include beneficiaries enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits and/or assistance with Medicare premiums or cost-sharing.
- The Medicaid programs that help beneficiaries pay for premiums or cost-sharing are also known as "Medicare Savings Programs." These programs generally fall under 4 categories:
    - The Qualified Medicare Beneficiary (QMB) program:
        - helps pay premiums, deductibles, coinsurance, and copayments for Part A, Part B, or both programs.
    - The Specified Low-Income Medicare Beneficiary (SLMB) program:
        - helps pay Part B premiums.
    - The Qualifying Individual (QI) program:
        - helps pay Part B premiums.
    - The Qualified Disabled Working Individual (QDWI) program:
        - pays the Part A premium for certain disabled and working beneficiaries.

37. MA Plans and Dual Eligible Beneficiaries (2 of 3)

Qualified Medicare Beneficiaries (QMBs) fall into two categories:

- QMB only – those beneficiaries who just receive assistance paying for their Medicare premiums and cost-sharing.
- QMB plus – those beneficiaries who are also eligible for full Medicaid benefits.

Special rules apply to all QMBs:

- When a QMB enrolls in an MA plan, the beneficiary does not have to pay more cost-sharing than any minimal copayment that would apply under Medicaid.
- All providers (whether or not they are Medicaid participating, or in-network) are prohibited by law from balance billing QMBs for any Medicare cost-sharing amounts. Providers who balance bill are subject to sanctions.

Individuals that fall into other categories of Medicare Saving Programs may also be eligible for full Medicaid benefits. Such individuals, along with QMB plus individuals, are known as full-benefit dual eligible (FBDEs).

38. MA Plans and Dual Eligible Beneficiaries, (3 of 3)

- Dual eligible beneficiaries may enroll in any type of MA plan except an MA MSA.
- Some MA plans, known as **dual eligible Special Needs Plans (D-SNPs)**, are tailored to dual eligible individuals, depending on the category (i.e., QMB, QMB-Plus, SLMB, etc.) to which they belong.

- Issues that are important to dual eligible beneficiaries considering MA enrollment include:
    - Whether the beneficiary is eligible for medical benefits covered under Medicaid. Medicaid may cover items and services not covered by Medicare, but Medicaid will only pay for those items and services if they are furnished by Medicaid participating providers. (Note, however, that even providers NOT participating in Medicaid must hold beneficiaries harmless for the cost sharing for Medicare covered benefits.)
    - Whether the beneficiary will need help to find providers who accept both Medicare and Medicaid to obtain any Medicaid benefits.

39. Case Study

Mr. Walsh is a Qualified Medicare Beneficiary (QMB). He enrolls in a Medicare Advantage HMO. Mr. Walsh goes to his primary care doctor to receive a Medicare covered service. The normal copayment is $25.00. The doctor may only collect from Mr. Walsh any minimal cost sharing allowable under the state Medicaid program which in Mr. Walsh's case is $2.00 for his physician visit. His doctor may bill the state for the cost sharing, but the hold harmless obligation applies regardless of whether or how much of the cost sharing the state pays.

40. Title Page - Medicare Advantage and Prescription Drugs

41. MA & Prescription Drugs

- An organization offering coordinated care MA plans must offer at least one MA plan with prescription drug coverage (known as an MA-PD plan) in every service area.
- MA PFFS plans have the option of offering prescription drug coverage but are not required to do so.
    - An individual enrolled in an MA PFFS plan that does not include a Part D benefit may enroll in a PDP, even if under the same MA contract, the organization offers another PFFS plan that includes a Part D benefit.
- MA MSA plans are prohibited from offering prescription drug coverage. If an MSA member wants prescription drug coverage, the member must enroll in a stand-alone PDP.

42. MA & Prescription Drugs, continued

- If a beneficiary enrolls in an MA plan that includes Part D prescription drug coverage (an MA-PD plan), the beneficiary can only receive Part D drug coverage through that plan.
- If a beneficiary enrolls in an MA plan that is an HMO or PPO plan that does not include Part D coverage, the beneficiary cannot join a stand-alone Prescription Drug Plan (PDP).
  - Enrollees in certain Employer/Union retiree group plans may have different options.

43. Title Page – Other types of Medicare Health Plans

44. Other Types of Medicare Health Plans

There are other types of Medicare health plans, which are NOT Part C or Medicare Advantage plans. The other types of Medicare health plans include:

  - Medicare Cost Plans
  - Programs of All-Inclusive Care for the Elderly (PACE) plans
  - Medicare-Medicaid Plans (MMPs)
  - Other Demonstration Plans
    - Other Medicare health plan demonstrations include state-specific demonstrations such as the Minnesota Senior Health Care Options (MSHO) program.

45. Medicare Cost Plans

Medicare Cost Plans are Medicare health plans that are not Medicare Advantage (Part C) plans and are not Original Medicare.

Cost plan enrollees can choose to receive Medicare-covered services:

- Under the plan's benefits by going to plan network providers
  - The plan's cost-sharing applies when the enrollee gets services from network providers.
- Under Original Medicare by going to non-network providers.
  - Original Medicare cost-sharing applies when the enrollee gets services from non-network providers. This amount is generally higher than the plan cost-sharing.

46. Medicare Cost Plans, continued

Medicare Cost Plans:

- may offer Part D prescription drug coverage as an optional benefit but are not required to do so.
- may offer other optional supplemental benefits.
- are available only in certain areas in the United States. In 2023 they were offered in 11 states including some counties in Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin, and Wyoming.

An individual may enroll in a cost plan and a PDP.

- This applies regardless of whether the cost plan offers Part D coverage.

47. Medicare Cost Plans: Eligibility and Premiums

The following individuals are eligible to enroll in a Medicare cost plan:

- Those with Medicare Parts A and Part B; or
- Those with only Part B. Enrollees with Part B only will not have Part A coverage under the plan unless they purchase it. The plan may adjust the enrollee premium for individuals with Part B only.

Premiums:

- Enrollees must pay their Part B premiums and any plan premium.

48. PACE Plans

Programs of All-Inclusive Care for the Elderly (PACE):

- are Medicare plans for frail, elderly beneficiaries certified as needing a nursing home level of care but still living in the community (i.e., not in a nursing home).
- are available in most states but tend to have small service areas, and thus may only be available in a few counties.
- offer an adult day health center, where enrollees can get care, meals and other services.
- include comprehensive medical and social service delivery systems using an interdisciplinary team approach in the adult day health center, supplemented by in-home and referral services.

49. PACE Plans, continued

Eligibility for PACE: Participants must be

- age 55 or older.
- reside in the PACE organization's service area.
- be certified as eligible for nursing home care by their state.
- be able to live safely in a community setting at the time of enrollment.

Under a PACE Plan:

- there's no deductible or copayment for any drug, service, or care approved by the PACE team of health care professionals.
- Beneficiaries with Medicaid pay no premiums.
- Beneficiaries with only Medicare pay a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Part D (in addition to the Part B premium).

50. Medicare-Medicaid Plans (MMPs)

Medicare-Medicaid Plans (MMPs):

   - are established under demonstration authority; and
   - are available only in certain counties in Rhode Island, South Carolina, Texas, California, Illinois, Massachusetts, Michigan, New York, and Ohio.

- Only certain individuals eligible for both Medicare and Medicaid may enroll in MMPs.
   - Eligibility varies by state.
- MMPs financially integrate and provide both Medicare and Medicaid benefits.
   - In some states, MMPs may offer additional benefits.
- All MMPs include Part D benefits.
- MMPs are NOT Medicare Advantage plans.

51. Title Page-Enrollee Protections Appeals and Grievances

52. Enrollee Protections

Enrollees of a Medicare Advantage plan, Medicare Cost plan, PACE plan or MMP have a right to:

- file complaints (sometimes called grievances), including complaints about the quality of their care.
- get a decision about health care payment or services, or prescription drug coverage.
- get a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.

53. Enrollee Protections: Grievances

The grievance process is used for complaints about the operations of a plan or its network providers.

- Enrollees or their representatives may file a grievance if they experience problems with their health care services such as timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
- Grievance issues also may include complaints that a covered health service, procedure, or item furnished during a course of treatment did not meet accepted standards for the delivery of health care.
- An enrollee or their representative may make the complaint orally, in writing, or via a CMS website at https://www.medicare.gov/MedicareComplaintForm/home.aspx.
- Plans must also provide a link to the Medicare.gov website where the enrollee can enter a complaint.

54. Grievance Example

Mr. Russell went to his in-network primary care doctor for his welcome to Medicare visit after he had enrolled in an MA HMO. His doctor spent only 5 minutes with him, which Mr. Russell felt was not long enough to get the services available to him under that benefit. He called his MA plan to complain. The customer service representative assisted him in filing a grievance. The plan investigated his complaint and responded to Mr. Russell.

55. Enrollee Protections: Coverage Decisions

- Coverage decisions are determinations made by a Medicare health plan concerning whether medical care or prescription drugs are covered, how they are covered, and the beneficiary's share of the cost.
- Examples of times when an enrollee may need a coverage decision include:
    - To get prior authorization for a provider to furnish a service.
    - To obtain payment for certain items or services, such as the type or level of services the enrollee thinks should be furnished.
    - To obtain payment for services when the enrollee is temporarily out of the area.
    - To continue a service that the enrollee believes is medically necessary.
    - To obtain payment for a prescription drug.
    - To ask for an exception from a plan's formulary requirements (including step therapy requirements) or tiering structure for prescription drugs.
- An enrollee has a right to ask for prior authorization even when it is not required to find out if a service will be covered by the plan.

56. Enrollee Protections: Appeals

The appeals process is used to ask for a review of the plan's coverage or payment decisions.

- If an enrollee is not satisfied with the coverage decision, they, or in some cases their physician, can appeal the decision.
    - Physicians can appeal prior authorization denials on behalf of their patients.
- An appeal is a formal way to ask the plan to review or change a coverage decision.
- An appeal can also be filed if:
    - an enrollee believes a Medicare health plan did not pay for or authorize a service that should be covered. Where the plan did not pay, the enrollee must be financially liable in order to appeal.
    - an enrollee believes an authorized service such as a hospitalization or home health care is ending too soon.
    - an enrollee believes a plan has not authorized or paid for a Part D prescription drug that should be covered.

57. Enrollee Protections: Appeals, continued

- Medicare health plans must provide enrollees with a written description of the appeal process.
- Medicare health plans offering a Part D benefit must:
    - provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a coverage determination or appeal a decision about coverage of a drug.
    - require network pharmacies to provide enrollees with a printed notice with the plan's toll-free number and website for requesting a coverage determination concerning a drug.

58. Sources of Additional Information

- Medicare & You Handbook
  https://www.medicare.gov/medicare-and-you
- Detailed information on Medicare Advantage plan requirements
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending
- Information on Medicare Advantage enrollment and eligibility
  https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf