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

2. Navigation Instructions

3. Terms and Conditions

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
  - Describe the different types of Special Needs Plans (SNPs)
  - Describe features of different Medicare health plan types
  - Describe the different types of benefits offered by Medicare Advantage plans
  - Explain how Medicare health plans work with prescription drug plans
  - Explain enrollee rights concerning their Medicare health plan

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 and Prescription Drugs
- Other Types 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, known as supplemental benefits.
- 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

- HMOs generally only cover services furnished by doctors and hospitals within the plan's network (known as participating providers). However, there are certain exceptions:
    - Emergency services furnished by out-of-network providers 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 furnished by out-of-network providers 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 participating providers, the HMO plan will authorize out-of-network services.

10. MA Plan Types Coordinated Care Plans – HMOs

- HMO enrollees may be required to select a primary care provider (PCP) from whom they will receive their day-to-day outpatient care.
- HMO enrollees may be required to obtain a referral from their PCP for specialty care (like visits to a specialty physician) to be covered.
- Some HMOs offer a Point of Service (POS) option that allows enrollees to go to out-of-network 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 for services furnished by out-of-network providers than for services obtained from participating 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 and the plan; they are not limited to network providers.
- usually pay higher cost-sharing amounts to receive services from an out-of-network provider than from a participating provider.
- do not need a referral or authorization to see an out-of-network provider or receive an out-of-network service 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.
- may be required to get a referral or authorization to obtain certain in-network services or see certain in-network providers, but if they fail to do so, covered services service will still be paid for by their plan. They just have to pay the higher out-of-network cost sharing.

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) specially designed to serve a targeted 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 SNPs must implement an evidence-based model of care with appropriate networks of providers and specialists designed to meet the specialized needs of the plan's targeted enrollees.
- All SNP plans include prescription drug coverage.

13. Title Page: Special Needs Plans

14. Special Needs Plans Types – C-SNPs

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, specified in CMS regulations. Those conditions include, but are not limited to diabetes, stroke, certain cardiovascular disorders, cancer, certain chronic lung disorders, HIV, dementia, chronic kidney disease, certain mental health disorders, drug or alcohol dependence, or certain neurological disorders like epilepsy or Parkinson’s disease.

- C-SNPs may focus on one severe or disabling chronic condition, or on a grouping specified by CMS of severe or disabling chronic conditions that represent multiple commonly co-morbid and clinically linked conditions.
- Each C-SNP will specify the condition or conditions necessary to be eligible to enroll.

15. Special Needs Plans Types – I-SNPs and IE-SNPs

- 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. Special Needs Plans Types D-SNPs

- Dual-eligible SNPs (D-SNPs) enroll certain categories (as determined by each state) of individuals eligible for both Medicare and Medicaid (dual-eligible beneficiaries).
- Dual eligible beneficiaries include beneficiaries enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits and/or Medicaid assistance with Medicare premiums or cost-sharing.
- The categories of dual eligibles include the following:
    - Qualified Medicare Beneficiaries (QMBs) -- Medicaid helps pay premiums, deductibles, coinsurance, and copayments for Part A, Part B, or both programs for these beneficiaries.
    - Specified Low-Income Medicare Beneficiaries (SLMBs): Medicaid helps pay Part B premiums for these beneficiaries.
    - Qualifying Individuals (QIs): Medicaid helps pay Part B premiums for these beneficiaries.
        - Qualified Disabled Working Individuals (QDWIs) -- Medicaid pays the Part A premium for certain people under age 65 with disabilities who return to work. Medicaid may also cover medical costs that Medicare doesn't cover or partially covers (for example, nursing home care, personal care, and home- and community-based services). Beneficiaries' coverage can vary by state.
- Dual-eligible individuals may also be eligible for full Medicaid benefits. Such individuals are known as full-benefit dual eligible (FBDEs) or QMB-Plus.

17. Types of D-SNPs – FIDE SNPs

- There are different types of D-SNPs, including fully integrated dual-eligible (FIDE) SNPs, highly integrated dual-eligible (HIDE) SNPs, and coordination-only D-SNPs. FIDE SNPs provide FBDE individuals with access to Medicare and Medicaid benefits under a single organization that has both a Medicare Advantage and Medicaid managed care contract. FIDE SNP membership is limited to individuals who receive their Medicaid benefits through the organization or a parent or affiliate of the organization.
- FIDE SNPs cover primary care, acute care, Medicare cost-sharing, long-term services and supports (LTSS) (including coverage of nursing facility services for a period of at least 180 days during the plan year), behavioral health services, home health services, and medical supplies equipment and appliances.
- FIDE SNPs coordinate the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries.
- FIDE SNPS also coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement.
- All FIDE SNPs qualify as "applicable integrated plans," but not all applicable integrated plans are FIDE SNPs.

18. Types of D-SNPs – HIDE SNPs and Coordination only D-SNPs

- HIDE SNPs cover certain Medicaid benefits under a capitated contract between the State Medicaid agency and the MA organization, the MA organization's parent organization, or an affiliate of the MAO or certain local nonprofit public benefit corporations that have a founding member that is the MAO, the MAO's parent organization, or another entity that is owned and controlled by its parent organization where that local nonprofit public benefit corporation is responsible for the delivery of physical, behavioral, and dental health services.
- HIDE SNPS cover all Medicare benefits and (to the extent enrollees are eligible for these benefits) community long-term services and support (including some days of coverage of nursing facility services during the plan year), or behavioral health services. HIDE SNPs **may** also qualify as applicable integrated plans if they meet the relevant conditions.
- Coordination-only D-SNPs are D-SNPs that do not qualify as HIDE or FIDE SNPs. CO D-SNPs have a CMS-approved contract with a state Medicaid agency that stipulates that, to coordinate Medicare and Medicaid-covered services between settings of care, the D-SNP notifies or arranges for another entity or entities to notify, the state Medicaid agency, individuals or entities designated by the state Medicaid agency, or both, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the state Medicaid agency. If the CO-D-SNP only enrolls partial-benefit-only dual eligibles (i.e., those not eligible for full Medicaid benefits) per the terms of its contract with the state, it is not required to meet the notification requirement when the MA organization also offers an integrated D-SNP with enrollment limited to FBDE individuals that is in the same state and service area and under the same parent organization.

19. D-SNPs – Applicable Integrated Plans

- Applicable Integrated Plans are certain D-SNPs and entities with a Medicaid managed care organization contract with the state (MCO) that work together to coordinate Medicare and Medicaid benefits furnished to FBDE enrollees, where the state requires D-SNP enrollment to be limited to individuals enrolled in both the MCO and D-SNP. Applicable Integrated Plans include, but are not limited to:
    - All FIDE SNPS
    - HIDE SNPs that under state policy may only enroll FBDE individuals whose Medicaid benefits are covered under an MCO contract with the State and either: the MA organization offering the D-SNP, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization.

Applicable Integrated Plans are required to have unified appeals and grievances processes for Medicare and Medicaid benefits that simplify the grievance and appeals steps for their dual eligible enrollees and require the plan to continue benefits pending an appeal decision.

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

21. 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 receiving services from 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 (typically by showing their membership card), so that 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.

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

- Non-network 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 for out-of-network services 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.

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

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

- A Medicare MSA is a high-deductible Medicare Advantage plan that is combined with a special medical savings account.
    - Medicare contributes money to the beneficiary's medical savings account to assist with paying for Medicare-covered services during the deductible phase.
    - The amount of the contribution varies by plan.
    - Money left in the account at the end of the year stays there. If the beneficiary remains enrolled in the plan the following year, Medicare will add any new deposits.
- If an MSA enrollee uses all the funds in their medical savings account, they must pay out-of-pocket until they reach their deductible.
- After the annual deductible is met, the plan pays 100% for covered services.
    - The maximum allowable deductible for MSA plans in 2025 is $16,350. However, most MSAs will have a substantially lower deductible.

25. MA Plan Types: MSA Plans

- There is no premium for an MSA.
- MSA plans cover Part A and Part B benefits, but beneficiaries must continue paying their Part B premium.
- 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.

26. MSA Example

Mr. Johnson recently enrolled in an MSA from Original Medicare. He was surprised to receive a statement from the plan indicating he had financial responsibility for the screening colonoscopy services he received two weeks prior. He called the plan and said he was confused because most preventive benefits have zero cost-sharing under Original Medicare. The plan explained that under an MSA, beneficiaries must pay out-of-pocket for even preventive care services if they have not yet reached the annual deductible.

27. Title Page: Medicare Advantage Employer/Union Plans

28. Employer/Union Plans

- Employers and unions may offer their retirees and their dependents:
    - Medicare Advantage individual plans (plans available to any beneficiary).
    - 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 offered 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.
- EGWP and direct contract plans are different from other Medicare Advantage plans because eligibility to enroll is limited to certain active employees, retirees, and their dependents, and because a variety of regulatory requirements are waived as they apply to the plans.

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

30. 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.
    - Entitlement to Part A means that the beneficiary is either eligible and signed up for premium-free Part A or paying the premium (or having the premium paid on their behalf) for Part A.
- 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 generally enroll any eligible beneficiary who applies regardless of health status.
    - Special needs plans only enroll beneficiaries within their targeted populations.

31. Medicare Advantage Eligibility: EGWPs

- 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.
    - 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 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.

EGWPs Examples

An association of employers, such as school boards, may offer its former employees an EGWP plan. Employers can also form associations specifically to provide retirees with health coverage.

A professional association, such as a lawyer's association, may not offer an EGWP because membership in the association is based on profession, not the individual's employer or former employer.

32. 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.

33. Medicare Advantage Plans: Premiums and Cost-Sharing

- 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.
- 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 $400 for each hospital inpatient stay.

- Coinsurance: A percentage of the cost of the service the member must pay. For example, 20% of the cost of durable medical equipment.

34. 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 2026, the maximum MOOP limit for Medicare Advantage coordinated care plans and private fee-for-service plans is $9,250, although most plans will have lower limits. PPOs must also have an aggregate MOOP for network and non-network providers of $13,900 in 2026. Again, it is likely that many will have lower limits.
- MSAs have a deductible that members must pay, then the plan pays 100% for covered services.

35. Cost-Sharing for Qualified Medicare Beneficiaries (QMBs)

QMBs are a type of dual-eligible beneficiary. Special cost-sharing rules apply to QMBs enrolled in any type of MA plan:

- QMBs do not have to pay more cost-sharing than any minimal copayment that would apply under Medicaid, regardless of what the plan requires for other enrollees.
- 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, including the amounts under their MA plan. Providers who balance bill are subject to sanctions.

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.

36. Part C: Medicare Advantage Plan Benefits

- All Medicare Advantage (MA) plans must cover all Part A and Part B benefits.
- MA plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in original Medicare.
- 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 (known as "supplemental benefits"), such as:
    - Vision Services, including glasses
    - Hearing Aids
    - Routine Dental Services
- Supplemental benefits may be optional or mandatory.
    - Mandatory supplemental benefits are embedded in the Medicare Advantage plan and must be purchased as part of the plan. They can include reductions in cost-sharing for benefits covered under Original Medicare.
    - Optional supplemental benefits may be added to an MA plan at the option of the beneficiary.
- Beginning in 2026, Medicare Advantage plans are required to send members a mid-year notice of any supplemental benefits they have not yet accessed.

37. Special Supplemental Benefits Depending on Chronic Health Condition

Medicare Advantage plans may offer supplemental benefits targeted to 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 (e.g., 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.

38. Medicare Advantage Plans – Utilization Management

- Medicare Advantage plans may implement mechanisms to promote the appropriate utilization of covered services. These mechanisms are known as “utilization management.”
- Such mechanisms include requiring a referral or prior authorization to obtain a service.
    - PPOs may not require prior authorization for out-of-network services.
    - PFFS plans may not require prior authorization.
    - Non-network MSAs may not require prior authorization.
- 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.
- When an enrollee has enrolled in an MA plan after starting a course of treatment, there is a minimum 90-day transition period during which the MA organization may not disrupt or require reauthorization for the active course of treatment for new plan enrollees, even if they are receiving the services from a non-network provider.

39. Title Page - Medicare Advantage and Prescription Drugs

40. 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.
- 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). If the beneficiary wants to remain enrolled with the organization offering their MA plan, they must choose an MA-PD offered by the organization.
    - Enrollees in certain Employer/Union retiree group plans may have different options.

41. Title Page – Other types of Medicare Health Plans

42. 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
- Other Demonstration Plans
  - Other Medicare health plan demonstrations include state-specific demonstrations such as the Minnesota Senior Health Care Options (MSHO) program.

43. 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.

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 2025 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.

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.

44. 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 health 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.

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).

45. Title Page-Enrollee Protections Appeals and Grievances

46. Enrollee Protections

Enrollees of a Medicare Advantage plan, Medicare Cost plan, or PACE plan 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.

47. 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/my/medicare-complaint
- Medicare Advantage, Medicare Cost, and Medicare Prescription Drug Plans must also provide a link on their websites to the Medicare.gov website where the enrollee can enter a complaint.

48. 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 urgently needed services the enrollee received when they were 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.

49. 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.

50. Enrollee Protections: Appeals

- Medicare health plans must provide enrollees with a written description of the appeal process.
- Medicare health plans must include on their websites written procedures for filing and appeal or grievance along with phone number(s) for receiving oral requests; mailing address for written requests; and links to any forms created by the plan for appeals and grievances.
- 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.

51. 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/cy-2024-ma-enrollment-and-disenrollment-guidance.pdf