Medicare Utilization Review Version

SUPPLEMENTAL OUTLINE
Medicare Advantage

A. Medicare Part C

1. Medicare Part C is an alternative to traditional fee-for-service Medicare Part A and B. Private insurance companies offer Part C in the form of Medicare Advantage (MA) plans. <Medicare.gov, "Your Medicare coverage choices" website>

2. MA plans may be Coordinated Care Plans (CCPs), Medical Savings Account (MSA) plans, and Private Fee-for-Service (PFFS) Plans. <*Medicare Managed Care Manual,* Chapter 1 § 20.1>

    a. Coordinated Care Plans may take the form of Health Maintenance Organizations (HMOs) that use a network of providers and a primary care provider gatekeeper, Local and Regional Preferred Provider Organizations (PPOs), and Special Needs Plans (SNPs) for institutionalized beneficiaries (I-SNPs), dual eligible beneficiaries (D-SNPs) and beneficiaries with a severe or disabling chronic condition (C-SNPs).

3. MA plans must cover as basic benefits all services traditional Medicare covers, except hospice care, applying coverage criteria that are no more restrictive than traditional Medicare coverage criteria. <42 *C.F.R.* 422.101(a); see also 88 *Fed. Reg.* 22185-200>

    a. Traditional Medicare covers hospice care for beneficiaries covered by MA Plans, except plans participating in the Value-Based Insurance Design Model with the Hospice Benefit Component. <Medicare.gov, "What Medicare health plans cover" website; cms.gov, "VBID Model Hospice Benefit Component Overview">

    Link: Medicare Advantage Value Based Insurance Design – Hospice Model under Medicare-Related Sites - General

b. When interpreting traditional Medicare coverage criteria for prior authorization, case management, or claim payment for basic benefits, MA plans must comply with:

    i. National Coverage Determinations (NCDs);

    ii. Local Coverage Determinations (LCDs) in the geographic area in which services are covered under the MA plan; and

    iii. Other general coverage and benefit conditions in traditional Medicare laws, including criteria for determining whether an item or service is a benefit such as:

        a) Inpatient requirements in 42 *C.F.R.* 412.3 (e.g., the two-midnight rule, inpatient only list, and case-by-case admissions);

        b) Requirements for SNF and HH services under 42 *C.F.R.* Part 409 (e.g., level of care requirements or definition of and need for skilled services),

            1) Except, MA plans may cover post hospital SNF care without a prior qualifying stay; and

        c) Inpatient Rehabilitation Facility (IRF) coverage requirements in 42 *C.F.R.* 412.622 (a)(3). <42 *C.F.R.* 422.101(b) and (c)(2); see also 88 *Fed. Reg.* 22185-200>

c. Examples of coverage determinations that would not comply with the above requirements include:

    i. Restricting access to a Medicare covered item or service unless another item or service is furnished first, if not specifically required in NCD or LCD (e.g., an x-ray prior to authorizing an MRI otherwise covered under an LCD that does not require a prior x-ray) <88 *Fed. Reg.* 22188>; or

    ii. Denying ordered care based on considerations other than failure to meet coverage criteria, when care can be delivered in more than one setting or provider type (e.g., denying covered SNF care ordered by the attending physician and redirecting the patient to home health care). <88 *Fed. Reg.* 22190>

d. When coverage criteria are not fully established by Medicare statutes, regulations, NCDs, or LCDs, MA plans may establish internal coverage criteria. <42 *C.F.R.* 422.101(b)(6)>

4. MA plans may cover additional services not covered under traditional Medicare as supplemental benefits if they are primarily health related and are not for comfort, cosmetic, or for daily maintenance. <*Medicare Managed Care Manual,* Chapter 4 § 30.1>

    a. Examples of supplemental benefits include

        i. Vision, hearing, dental, or preventative services not covered by Medicare <*Medicare Managed Care Manual* Chapter 4 § 30.2>;

        ii. Bathroom safety devices, fitness benefits, health and nutritional education and weight management programs, meals on a temporary basis after surgery or for a chronic condition, over the counter supplements and drugs, remote access technology such as a nurse hotline, and transportation services. <*Medicare Managed Care Manual,* Chapter 4 § 30.3>; and

        iii. Services furnished by a different type of provider or in a different setting than basic benefits (i.e., as covered under traditional Medicare). <88 *Fed*. *Reg*. 22186-7, 22192, 22195>

    b. MA Plans may make beneficiaries aware of treatment options and settings under their supplemental benefits or encourage specific treatment options as part of the plan's coordination and management of the care. <88 *Fed*. *Reg*. 22195>

5. MA plans pay hospitals according to their contract with the hospital or, if they are not contracted with the hospital, they must generally pay the hospital at least the traditional Medicare payment rate. <*MA Payment Guide for Out of Network Payments, 4/15/2015 Update*>

    a. Medicare publishes a very helpful guide for payments by MA plans to out of network providers on their "Provider Payment Dispute Resolution for Non-Contracted Providers" website.

    Link: Medicare Advantage Out of Network Payment Guide under Medicare-Related Sites - General