

TYPES OF PLANS

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- Medicare Medical Savings Accounts (MSAs)
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- Employer/Union Sponsored Group Plans for Retirees

INTRODUCTION

In order to receive health coverage through a Medicare Advantage (MA) plan, beneficiaries need to enroll in an available plan. While all MA plans are set up under the Medicare Part C program, the law allows plan sponsors to take very different approaches to structures for coverage, provider networks, and payment. Even so, most MA plans fall into three basic groups: Coordinated Care Plans (CCPs), Private Fee-for-Service (PFFS) plans, and Medicare Medical Savings Account (MSA) plans. Among Coordinated Care Plans, plan sponsors offer five types of plans. These are Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Provider Sponsored Organizations (PSOs), Cost plans, and Special Needs Plans. PACE plans are the only types of MA plan that do not fall into the three basic groups of plans. This section provides in-depth descriptions of the different MA plans available across the country.

Medicare Advantage plans are offered in a specific geographical area, with exceptions for some employer/union sponsored MA plans that have retirees living in different areas. Generally, beneficiaries must live within a plan's service area to be considered eligible for enrollment in the MA plan. A service area may be as small as one county or as large as multiple MA regions. Within an MA plan's service area, the plan must provide all enrollees an identical package of benefits with an identical cost-sharing structure.



For more information on choosing and enrolling in a MA plan, see Eligibility for Enrollment section on page 17 .



For more information about service areas, see Coverage of Benefits and Access to Services on page 35 .

COORDINATED CARE PLANS (CCPs)

Coordinated Care Plans (CCPs) are a health care delivery and payment system that uses a network of health care providers to deliver and coordinate covered health services. Each year CMS establishes contract requirements that approved plans must meet. CMS lists these requirements in an annual Call Letter for applications that it sends to potential MA plan sponsors. Plan sponsors' applications must show that they have met certain CMS-established conditions for CCPs, which include access and availability, service area, and quality criteria. CCPs typically control costs through utilization management tools – for example, by requiring referrals to certain providers or health services and using a cost structure that creates incentives to receive some services over others. Coordinated Care Plans include the following types of plans:

- Health Maintenance Organizations (HMOs)
- Cost Plans
- Preferred Provider Organizations (PPOs)
- Provider Sponsored Organizations (PSOs)
- Special Needs Plans (SNPs)

Health Maintenance Organizations (HMOs)

Health Maintenance Organizations (HMOs) are a type of Coordinated Care Plan (CCP) that operates through a network of health care providers. HMOs contract with hospitals, physicians, laboratories, and other providers to create their provider networks. Plans may offer incentives to network providers to help in the effort to contain costs or to meet certain quality of care standards. Most HMOs require people who enroll in the plan to choose a primary care provider (PCP). The PCP is often a physician who is expected to act as a gatekeeper to health care services. HMO plan members, or “enrollees,” generally must contact their PCP to obtain referrals to see specialists or to receive some services, such as expensive diagnostic procedures. Many HMOs also require prior approval for elective surgeries and post-acute care admissions, for example, to rehabilitation hospitals. HMOs cannot, however, require enrollees to obtain referrals for emergency medical care or urgently needed care, though most plans expect enrollees to contact the plan within a certain time frame after receiving such care. Each HMO can have different provider networks and different rules for referrals and prior approval, so it is important to understand the specifics of a plan before enrolling in one.

In HMO plans, enrollees usually must obtain health care services through network providers. The HMO will not cover services that plan enrollees obtain when they see physicians or go to hospitals or other providers outside of the network (except for necessary emergency or urgent care). Some HMO plans have developed a more lenient approach, called a Point of Service (POS) benefit option. The HMO-POS benefit allows enrollees to obtain certain health care services without following the plan's standard network or prior authorization rules. Often, services obtained through the POS benefit will cost an enrollee more than services provided according to the standard rules. HMO plans with a POS benefit may limit the POS portion of the benefit to specific services or to a fixed dollar benefit amount. As with all MA plans, it is important to understand the POS benefit, if offered, before enrolling in an HMO plan.

Emergency Care and Urgent Care

Emergency care includes care for unforeseen illnesses and injuries that most people would consider a serious medical condition. Urgent care includes medically necessary services required for unforeseen illnesses and injuries which require professional attention to prevent serious harm or permanent damage (e.g., suspected heart attack, fracture of a limb, excessive bleeding). HMO plans may or may not offer Medicare Part D drug coverage through the HMO, although most do. Enrollees in HMO plans with no Medicare drug coverage (MA-only) may not enroll in a stand-alone Prescription Drug Plan (PDP). Enrollees who select an HMO plan with Medicare drug coverage (MA-PD) must accept the drug coverage portion of the plan.

Note:

Some beneficiaries, including those with creditable coverage, may not want or need Medicare Part D drug coverage. These beneficiaries might be interested in an MA-only HMO plan

Cost Plans

Cost plans are a type of Coordinated Care Plan (usually an HMO) available in certain areas of the country. Many of them pre-dated the creation of Medicare+Choice and Medicare Advantage programs. As of July 2009, there were only 22 Cost plan contracts nationwide (see Kaiser Family Foundation, *Tracking Medicare Health and Prescription Drug Plans Monthly Report* (August 2009), available online at http://www.kff.org/medicare/advantagetrackingreport_archive.cfm), and CMS no longer offers new Cost plan contracts to MA organizations. These plans differ greatly from other MA plans. Unlike other MA plans, Cost plan enrollees need not be enrolled in both Medicare Parts A and B, but can be Part B-only beneficiaries. Further, beneficiaries may enroll in a Cost plan at any time the plan is accepting new enrollees, and enrollees may leave the Cost plan at any time to return to Original Medicare.



For more information about enrollment in all MA plans, see Eligibility for Enrollment on page 17.

Enrollees in a Cost plan are entitled to all Part A and Part B-covered services (or all Part B-covered services if an enrollee only has Part B), whether the plan provides the services directly or through arrangements made by the plan. The Cost plan will not cover services obtained by plan enrollees who see physicians or providers outside of the network (except for necessary emergency or urgent care). However, enrollees in Cost plans who get routine services outside of the plan's network without a referral will have coverage under Original Medicare for any Medicare-covered services. In these instances, Cost plan enrollees are responsible for Original Medicare's deductibles and coinsurance charges.

Cost plans may or may not offer Medicare Part D drug coverage. Unlike in many MA plans, enrollees in Cost plans without Medicare drug coverage (MA-only) may enroll in a stand-alone Prescription Drug Plan (PDP).

Preferred Provider Organizations (PPOs)

Preferred Provider Organizations (PPOs) are a type of Coordinated Care Plan that operates through a network of health care providers. Unlike HMOs, PPOs generally pay for out-of-network care. Also, they do not require enrollees to choose a primary care provider (PCP) nor do they require referrals to see specialists or receive certain types of health services. Enrollees in PPOs usually pay lower cost-sharing amounts for services provided by the PPO's network of "preferred" health care providers. Even in routine circumstances, PPOs provide coverage for services received out-of-network, but cost-sharing (deductibles and copayments) is generally higher for out-of-network care.

A Regional Preferred Provider Organization (RPPO) is a type of PPO plan that offers coverage throughout any of the 26 CMS-established MA regions. These plans are the result of the government's effort to expand and support Coordinated Care Plans even in rural areas. RPPO plans may even be offered across more than one MA region. By contrast, other PPOs (local PPOs) provide a benefit package to a service area of only one or more counties. RPPOs offer a number of incentives and changes from local PPOs, including a standard benefit package (that includes a set premium) across the region, an annual out-of-pocket limit, or "cap," on enrollee out-of-pocket cost-sharing, and a combined Part A and Part B deductible. Furthermore, the health care provider network of RPPOs is spread throughout the MA region, providing access to more health care providers across a broader area than local PPOs and most HMOs.

Note: *Annual Out-of-Pocket Limits: Some local PPOs may have a limit on enrollee out-of-pocket cost-sharing, but it is not a requirement. In contrast, all RPPOs are required to provide this beneficiary protection, established by the MMA of 2003.*

PPO plans may or may not offer Medicare drug coverage. Enrollees in PPO plans without Medicare drug coverage (MA-only) may not enroll in a stand-alone Prescription Drug Plan (PDP). Enrollees who select a PPO plan with Medicare drug coverage (MA-PD) must accept the drug coverage portion of the plan.

Note: Some beneficiaries, including those with creditable coverage, may not want or need Medicare Part D drug coverage. These beneficiaries might be interested in an MA-only PPO plan.

Provider Sponsored Organizations (PSOs)

Provider Sponsored Organizations (PSOs) are a type of Coordinated Care Plan (usually a PPO) that are organized and managed by a provider or provider group. PSO plans offer Medicare-covered services directly through the provider or provider group. Medicare pays these plans to coordinate services for enrollees in the PSO plan. To obtain a contract with CMS, each PSO must satisfactorily demonstrate that it is capable of delivering a range of services, with a substantial portion being delivered directly through the provider or the provider group that operates the PSO. PSO plans are uncommon.

Special Needs Plans (SNPs)

Special Needs Plans (SNPs) are a type of Coordinated Care Plan (HMO or PPO) that exclusively provides coverage for beneficiaries with special medical needs or health care situations. A SNP may serve one of the following three subgroups of Medicare beneficiaries:

- Institutionalized individuals
 - Those residing in or expected to reside for 90 days or longer in a long-term care facility (including skilled nursing facility (SNF), nursing facility (NF), intermediate care facility (ICF), or inpatient psychiatric facility)
 - Those living in the community but requiring an equivalent level of care (LOC) to those residing in a long-term care facility
- Dual-eligible individuals
 - Those entitled to Medical Assistance under a state plan under Title XIX (Medicaid)
 - Some SNPs may enroll all or a portion of dual-eligible beneficiaries, including those with Medicaid and those in Medicare Savings Programs (including Qualified Medicare Beneficiary (QMB only), QMB+, Specified Low-Income Medicare Beneficiary (SLMB only), SLMB+, Qualifying Individual (QI), Qualified Disabled and Working Individual (QDWI))
- Individuals with a chronic or disabling condition
 - Effective in 2010, these plans must be designed to serve 15 severe and chronic conditions:
 - Chronic alcohol and other drug dependence
 - Autoimmune disorders – including polyarteritis nodosa, polymyalgia rheumatica, polymyositis, rheumatoid arthritis, and systemic lupus erythematosus
 - Cancer excluding pre-cancer conditions

- Cardiovascular disorders – including cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorder
 - Chronic heart failure
 - Dementia
 - Diabetes mellitus
 - End-stage liver disease
 - End-stage renal disease (ESRD) requiring dialysis
 - Severe hematologic blood disorders – including aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease (excluding sickle-cell trait), and chronic venous thromboembolic disorder
 - HIV/AIDS
 - Chronic lung disorders – including asthma, chronic bronchitis, emphysema, pulmonary fibrosis, and pulmonary hypertension
 - Chronic and disabling mental health conditions – including bipolar disorders, major depressive disorders, paranoid disorder, schizophrenia, and schizoaffective disorder
 - Neurologic disorders – including amyotrophic lateral sclerosis (ALS), epilepsy, extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington’s disease, multiple sclerosis, parkinson’s disease, polyneuropathy, spinal stenosis, and stroke-related neurologic deficit
 - Stroke
- SNPs also must apply one of the following structures:
- The plan may target one chronic condition from the list of approved chronic conditions (see above).
 - The plan may target a group of commonly co-morbid and clinically linked chronic conditions from a list of approved common multi-condition groupings in which the eligible beneficiary has at least one condition. The groupings include diabetes mellitus and chronic heart failure; chronic heart failure and cardiovascular disorders; diabetes mellitus and cardiovascular disorders; diabetes mellitus, chronic heart failure, and cardiovascular disorders; and stroke and cardiovascular disorders.
 - The plan may target a plan-designed grouping of multiple chronic conditions from the list of approved chronic conditions (see pages 9-10) in which the eligible beneficiary has all conditions
- Special Needs Plans must offer Medicare Part D drug coverage.

Note: SNP plans must verify the special condition of beneficiaries prior to their enrollment in the plan.

SNPs are authorized through 2010. While CMS requires all SNPs to submit a model of care that meets certain expectations to assist the target population, the agency does not describe any specific requirements that an organization must meet when it applies to be a SNP.

CMS requires that SNPs use models of care that demonstrate the following:

- Goals and objectives specific to the plan’s special needs beneficiaries
- Comprehensive risk assessment using a risk assessment tool
- A specialized provider network
- Care coordination
- A service delivery system that includes treatment protocols and out-of-network specialists
- A communication and accountability system
- SNP training for network providers
- Performance measurement and improvement activities

Each type of SNP has additional requirements. SNPs for institutionalized individuals (I-SNPs) must verify that those beneficiaries who live in the community actually require an institutional level of care (LOC) prior to enrollment. There are two tools to assess institutional LOC: a state assessment tool and an evaluation by an impartial group. Beneficiaries who qualify using both tools are known as “institutionalized-equivalent” individuals and may, therefore, enroll in an I-SNP.

Effective January 1, 2010, SNPs for dual-eligible individuals (D-SNPs) must contract with each state Medicaid agency in which the D-SNP operates. This requirement only applies to plans that are new to an area and plans that expand their service area. The contracts will determine how the D-SNPs provide benefits (or arrange for benefits to be provided) for enrollees in the plans. More information about state contracts with D-SNPs is available online at http://www.cms.hhs.gov/SpecialNeedsPlans/05_StateResourceCenter.asp.

Effective January 1, 2010, SNPs for individuals with certain chronic conditions (C-SNPs) must limit enrollment according to one of the above-mentioned structures. The C-SNP must verify from all potential enrollees’ providers that the individuals indeed have the diagnosis in question. Instead of pre-enrollment direct-provider contact, the C-SNP may choose to use a CMS-approved qualification assessment tool followed by confirmation directly with the treating physician.



While Medicare rules generally do not allow Medicare beneficiaries with end-stage renal disease (ESRD) to join MA plans, CMS has the ability to waive the ESRD enrollment exclusion for Special Needs Plans. Some SNPs may seek CMS approval to enroll beneficiaries with ESRD in 2010.

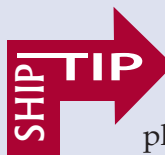
PRIVATE FEE-FOR-SERVICE (PFFS) PLANS

Private Fee-for-Service (PFFS) Plans are a type of Medicare Advantage (MA) plan that is very different from Coordinated Care Plans. PFFS plans resemble Original Medicare in that the plans pay providers for each service they deliver to plan enrollees. They are also similar in that enrollees are not limited to a network of health care providers and do not need referrals to see a specialist. And PFFS plan service areas are nationwide – not limited to an MA region or to a county as with Coordinated Care Plans. On the other hand, unlike Original Medicare, PFFS plans set their own payment rates for health care providers. Thus, enrollees may see any provider who agrees to accept the plan’s payment terms. But CMS does not require providers to accept these terms. Because of this, it is critical to know that any Medicare provider, including physicians, home health agencies, and equipment suppliers, **may choose to accept, or not accept, the terms of the PFFS plan each time a patient visits the provider.** This means that enrollees cannot trust that their preferred doctors and hospitals will remain PFFS providers even if they received covered services through these providers previously.

Some PFFS plans are developing networks of providers to prevent this problem. Under a network model, a PFFS plan enrollee will know which providers accept the plan’s terms. Even with a network, however, enrollees may still choose to see a willing provider out-of-network. In these cases the PFFS plan may charge an enrollee more to see an out-of-network provider than one in the network. A plan’s terms may also allow providers to balance-bill beneficiaries up to 15 percent of the plan’s payment rate, in the same way that Medicare providers that do not accept assignment may do. Because many of these plans do not follow the provider network model, PFFS plans are often found in rural regions of the country.

Starting in 2011, non-employer/non-union PFFS plans that are operating in areas with more than one MA network-based plan must meet the access standards of other MA network-based plans. In other words, if there are two or more network-based MA plans in the service area, a PFFS plan must also have a network of providers and must use contracts with these providers. The plans’ providers will no longer be allowed to accept a plan’s terms on a case-by-case basis. Also beginning in 2011, all employer/union PFFS plans must use contracts with providers and can no longer deem providers into plans.

Private Fee-for-Service plans may or may not offer Medicare drug coverage through the PFFS. Unlike many other types of MA plans, enrollees in PFFS plans without Medicare drug coverage (PFFS-only) may enroll in a stand-alone Prescription Drug Plan (PDP).



When counseling, it is critical to remind beneficiaries that PFFS plans require providers to agree to the terms of the plan each and every time a service is delivered. Otherwise, the plan may not pay for the service. A physician may accept the plan’s terms this week, but may choose to not accept the same plan’s terms for an appointment next month. Beneficiaries should be aware of this situation and be sure to discuss it with their providers before they join the plan.

EXAMPLE Nancy is currently enrolled in a PFFS plan. She is scheduled for surgery. The hospital performing the surgery has a contract with the PFFS plan. Her PFFS plan lets contracting providers “balance bill” (charge 15% over the plan’s payment amount) for services. Nancy has a 20% coinsurance for all inpatient services. For this surgery, her PFFS plan’s payment amount is \$10,000. Nancy has a 20% coinsurance for this service, so she must pay \$2,000. Because her plan allows balance billing, Nancy is charged an additional 15% of the \$10,000 payment rate for this service, equaling, \$1,500. She owes a total of \$3,500 to the hospital for her surgery. To avoid these additional costs, beneficiaries should ask the PFFS plan if they allow providers to balance bill.

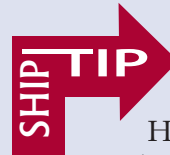
MEDICARE MEDICAL SAVINGS ACCOUNTS (MSAs)

Medicare Medical Savings Account (MSA) plans are a type of Medicare Advantage plan that combines a high-deductible health insurance plan with a special savings account. These plans are similar to Health Savings Account (HSA) plans sold in the private market. The MSA plan deposits a set amount of money into the special savings account at the beginning of each plan year. Enrollees in MSA plans use the money in the savings account to pay for qualified health expenses up to a deductible amount. Once enrollees have reached the plan’s deductible, the health plan portion of the MSA will pay 100 percent of all Medicare Parts A and Part B covered services for the rest of the year.

While the savings account deposit may be used to pay (tax-free) for any qualified medical expenses, only Medicare Part A and Part B covered services count towards the plan’s deductible. The savings account may be used to pay for any expense, though only money used to pay for qualified medical expenses may be tax-free. Any amount of the savings account used to pay for other expenses will be subject to a high tax penalty.

Any amount (including any interest accrued) that remains in the special savings account at the end of the year can roll over to following years. If an MSA plan enrollee leaves a plan for any reason during the plan year (including in the event of death), the enrollee must pay back to the plan a portion of the deposit.

Medicare MSAs may not offer Medicare drug coverage through the MSA plan. Unlike most MA plans, enrollees in MSA plans may enroll in a stand-alone Prescription Drug Plan (PDP).



Tip 1: The savings account may be an interest-bearing account.

However, enrollees in MSA plans are not allowed to add any additional money to the savings account.

Tip 2: When counseling beneficiaries on MSA plans, it is important to emphasize that the savings account may be used to purchase items other than qualified medical expenses. However, any amount spent on other items (i.e., not qualified medical expenses) does not count towards the MSA plan’s deductible and is subject to a high tax penalty.

PROGRAMS FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

The Program for All-Inclusive Care for the Elderly (PACE) is a model that provides community-based medical, psychosocial, long-term care, and chronic care to frail older adults. An interdisciplinary team manages participants' care to keep them out of nursing homes as long as possible by providing adult day center and home-based care services.

To qualify for PACE services, an individual must be age 55 or older, certified by the state to need nursing home care, have the ability to live in the community safely and live within a PACE service area. PACE programs receive monthly Medicare and Medicaid capitation payments for each qualifying participant, and those who are not eligible for these benefits must privately pay the capitation amount. Capitation allows PACE programs to provide a variety of services, even some that Medicare or Medicaid may not typically cover, through a determined monthly payment for each individual.

PACE delivers most of its services from a day health center which members attend several times a week. The day health center provides primary medical care, physical, occupational and recreational therapies, personal care, social services, and transportation to and from the center. Home-based services often supplement the center-based services.

EMPLOYER/UNION SPONSORED GROUP PLANS FOR RETIREES

Medicare allows employers and unions that sponsor group health plans to contract with Medicare Advantage plan sponsors or directly with CMS to offer group MA plans to their retirees, spouses and dependents. Employers or unions that decide to work with an MA plan sponsor have two contractual options: they can offer individual membership in MA plans that are open both to individuals in the plan's service area and to members of the retiree group, or they can offer a customized plan that is open only to members of the retiree group. Group MA plans must comply with all Medicare Advantage and/or Part D requirements unless CMS specifically waives or modifies them.

Because the federal government pays all MA plans, both group and individual, under the same payment rules, some employers have reduced their costs for health benefits by moving their retirees from group insurance plans that complement Original Medicare to group MA plans. In June 2008, nearly 1.7 million Medicare beneficiaries were enrolled in group MA plans, almost double the number in 2006. (See Kaiser Family Foundation,

Note: CMS commonly waives service area and enrollment period rules for MA group plans that normally apply to other MA plans. For example, MA group plans can set their own enrollment period dates. They do not have to use Medicare's annual coordinated election period from November 15 to December 31.

The Emerging Role of Group Medicare Private-Fee-for-Service Plans, December 2008, available online at <http://www.kff.org/medicare/7841.cfm>.) Employer/union sponsored group MA plans may or may not offer Part D prescription drug coverage. MA group plans may take the form of most of the MA plans described above, including Cost plans and MSAs. Typically, though, the group plans are one of these three types of MA plans:

- Local Health Maintenance Organizations (HMOs)
- Local Preferred Provider Organizations (PPOs)
- Private-Fee-for-Service (PFFS) plans

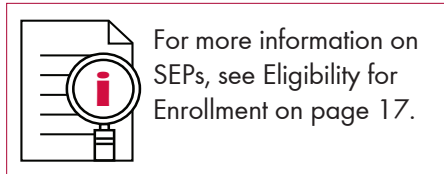
Enrollment and Eligibility

A Medicare beneficiary's ability to enroll in a group MA plan is based on receiving "employment-based" health coverage from an employer/union plan sponsor that has a contract with an MA plan sponsor to provide coverage or with CMS to provide coverage directly for its Medicare eligible group members. Membership in State Pharmacy Assistance Programs (SPAP) or coverage obtained through a professional association or another type of group association would not make a person eligible for an MA group plan.

A CMS waiver allows employer/union sponsored group MA plans to enroll members who have end-stage renal disease (ESRD). Another waiver allows MA plan sponsors to develop group plans for retirees who have Medicare Part B only, including those who worked for some state and local governments and are not entitled to Medicare Part A because their employers did not deduct FICA taxes.

Enrollment Periods

CMS does not require retiree group MA plans to comply with the annual coordinated election period (AEP) that is in effect for other MA and Part D plans. Group MA plans, however, must accept valid disenrollment requests at any time.



Retiree group plans members are eligible for the Special Enrollment Periods (SEPs) that are available to all Medicare beneficiaries. The SEPs apply to beneficiaries who disenroll from a retiree group MA plan in order to enroll in an individual MA plan not sponsored by an employer or union.

Group PFFS Plans

A CMS waiver allows MA plan sponsors to offer national PFFS plans to employer and union groups whose retirees are spread throughout the country. In other words, CMS's service area restrictions do not apply to group PFFS plans as they currently do to MA group HMO and PPO plans. By removing a major administrative barrier, the CMS waiver opened the door to rapid growth in group PFFS plans. In 2006, only 32,890 retirees belonged to group PFFS plans. In 2008, the number had grown to more than 600,000 nationally.

Starting in 2011, group PFFS plans must establish contracted provider networks to ensure that all plan members have access to care. Until then, it is important for SHIP counselors to keep in mind that any provider, including physicians, home health agencies, diagnostic facilities, and equipment suppliers, may choose to accept, *or not accept*, the group PFFS plan's terms each time a patient visits, just as with any other PFFS plan.