

MEDICARE ADVANTAGE PLANS AND MEDICAID MANAGED CARE PLANS: MINIMUM LEVEL OF SERVICE

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MEDICARE ADVANTAGE PLANS AND MEDICAID MANAGED CARE PLANS: MINIMUM LEVEL OF SERVICE

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This White Paper summarizes the federal laws that address the minimum level of services that a (i) Medicare Advantage Plan (“MAP”) must provide to enrollees and (ii) Medicaid Managed Care Plan (“MMCP”) must provide to enrollees.

I. Medicare Advantage Plans

The statutes governing MAPs are found within Title XVIII, Part C of the Social Security Act (“Act”). Section 1852 of the Act governs the benefits that a MAP must offer to enrolled members. Specifically, a MAP must offer the “benefits under the original Medicare fee-for-service program option.”¹ In addition to the applicable statutes, CMS has codified regulations for MAPs. The regulations state that a MAP must *at minimum* provide enrollees “basic benefits” and may provide supplemental benefits to enrollees.²

Basic benefits are defined as “all items and services (other than hospice care or, beginning in 2021, coverage for organ acquisitions for kidney transplants) for which benefits are available under Parts A and B of Medicare, including telehealth benefits offered consistent with the requirements at § 422.135.”³ Basic benefits include Part B prescription drugs and durable medical equipment.⁴

Supplemental benefits consist of both mandatory and optional supplemental benefits. Mandatory supplemental benefits are services not covered by Medicare Part A, Part B or Part D and that an enrollee *must* purchase as part of a MAP.⁵ The enrollee is responsible for the costs of such benefits through premiums, cost sharing obligations, or rebates. The enrollee must cover the cost of optional supplemental benefits through an additional premium or cost-sharing. However, the enrollee may not utilize rebate dollars to cover the cost of optional supplemental benefits.⁶

In addition to supplemental benefits, a MAP may choose to offer Part D benefits.⁷ A MAP may not, however, “impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in original Medicare.”⁸

While a MAP must provide all medically necessary Part A and Part B covered items and services, there are limited exceptions⁹:

¹ 42 U.S.C. 1395w-22(a)(1)(A).

² 42 C.F.R. § 422.100 (a).

³ *Id.* § 422.100 (c)(1); 42 U.S.C. 1395w-22(a)(1)(B)(i).

⁴ *Medicare Managed Care Manual Ch. 4 – Benefits & Beneficiary Protections*, Cntrs. for Medicare & Medicaid Servs. § 10.3, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf> (last visited Nov. 21, 2021); 42 C.F.R. § 422.100(l).

⁵ *Id.*; 42 CFR § 422.102(2)(i)(A).

⁶ *Medicare Managed Care Manual Ch. 4, supra* note 4.

⁷ *Id.*

⁸ *Id.* at § 10.2

⁹ *Id.* at § 10.2.2.

- (a) Hospice: Original Medicare will cover the cost of hospice services if the enrollee has elected hospice while enrolled in a MAP.
- (b) Clinical Trials: An enrollee's costs of routine services are covered by original Medicare. The MAP will pay an enrollee the difference between original Medicare's cost-sharing obligation for qualifying clinical trial items and services and the MAP's "in-network cost-sharing for the same category of items and services."
- (c) Inpatient Hospital Stays: If an enrollee's MAP coverage takes effect after an inpatient stay begins, but prior to discharge from the stay, then original Medicare will cover the costs of the inpatient stay while the beneficiary is responsible for the cost-share.

A MAP must also provide payment for any of the following services, regardless of whether the provider or supplier maintains a contract with the MA organization¹⁰:

- (a) Ambulance services dispatched through 911 or its local equivalent as provided in § 422.113.
- (b) Emergency and urgently needed services as provided in § 422.113.
- (c) Maintenance and post-stabilization care services as provided in § 422.113.
- (d) Renal dialysis services provided while the enrollee was temporarily outside the plan's service area.
- (e) Services for which coverage has been denied by the MA organization and found (upon appeal under subpart M of this part) to be services the enrollee was entitled to have furnished, or paid for, by the MA organization.

II. Medicaid Managed Care Plans

Section 1932 of the Act provides State Medicaid programs the option to utilize Medicaid Managed Care Organizations ("MMCO") to assist with administering the state's Medicaid plan. A state may require Medicaid beneficiaries to enroll in the MMCO administered MMCP.¹¹ A contracted MMCO must provide MMCP enrollees the same services that would be available to the same individual if he or she were enrolled in the state's Medicaid plan.¹²

The minimum services required in a state Medicaid plan are set forth in 42 C.F.R. § 440.210 (required services for the categorically needy) and § 440.220 (required services for the medically needy). In sum, the mandatory benefits that a state plan must cover include¹³:

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services

¹⁰ 42 C.F.R. § 422.100(b).

¹¹ 42 U.S.C. 1396u-2(a)(1)(A)(i).

¹² 42 U.S.C. 1396b(m)(1)(A)(i)

¹³ *Mandatory & Optional Medicaid Benefits*, Medicaid.gov, <https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html> (last visited Nov. 21, 2021).

- Nursing Facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

A State may also choose to cover the following optional benefits¹⁴:

- Prescription Drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental Services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice
- Case management
- Services for Individuals Age 65 or Older in an Institution for Mental Disease
- Services in an intermediate care facility for Individuals with Intellectual Disability
- State Plan Home and Community Based Services- 1915(i)
- Self-Directed Personal Assistance Services- 1915(j)
- Community First Choice Option- 1915(k)
- TB Related Services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary
- Health Homes for Enrollees with Chronic Conditions – Section 1945

¹⁴ *Id.*

An MMCP must also provide coverage for emergency services “without regard to prior authorization or the emergency care provider’s contractual relationship with the organization or manager . . .” Emergency services are such services needed to evaluate or stabilize an emergency medical condition, which is defined as

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part.¹⁵

III. Summary

In short, MAPs must offer enrollees *at minimum* the “basic benefits” and may provide supplemental benefits to enrollees. An MMCP must at a minimum offer to its enrollees the mandatory benefits that state is required to offered in its state plan.

THIS WHITE PAPER DOES NOT CONSTITUTE LEGAL ADVICE. THIS WHITE PAPER WAS PREPARED ON A SPECIFIC DATE. THE LAW MAY HAVE CHANGED SINCE THIS WHITE PAPER WAS WRITTEN. BEFORE ACTING ON THE ISSUES DISCUSSED IN THIS WHITE PAPER, IT IS IMPORTANT THAT THE READER OBTAIN ADVICE FROM A HEALTH CARE ATTORNEY.

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¹⁵ 42 U.S.C. 1396u–2(b)(2).