

Medicare Advantage (Part C) Plans

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Medicare Advantage Plans are another way for patients to get Medicare Part A (hospital insurance) and Part B (medical insurance) coverage. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by Medicare-approved private companies that must follow rules set by Medicare. Many Medicare Advantage Plans include drug coverage (Part D). In some cases, patients will need to use health care providers who participate in the plan’s network; however, many PPO plans provide coverage for out-of-network providers. These plans set a limit on what patients have to pay out-of-pocket each year for covered services. Patients must use the (red, white and blue) card from their Medicare Advantage Plan to get Medicare-covered services.¹ There is always coverage for emergency and urgent care.

Covered Services

Medicare Advantage plans may provide coverage for things original Medicare doesn't cover e.g., fitness programs (gym memberships or discounts), vision, hearing and dental services (routine check-ups or cleanings). Plans can also choose to cover even more benefits. For example, some plans may offer coverage for services like transportation to doctor visits, over-the-counter drugs, and services that promote your health and wellness. Plans can also tailor their benefit packages to offer these benefits to certain chronically-ill enrollees.² [Learn more about what Medicare Advantage Plans cover.](#)

Types of Medicare Advantage Plans

There are several different types of Medicare Advantage plans on the market including these most popular plans:

- Health maintenance organization (HMO) plans - These are typically closed panel plans meaning the patient needs to see a network provider in order to receive a benefit, except in the event of an emergency. Dentists are paid a capitated rate.
- Health maintenance organization (HMO) plus point of service (POS) plans – These are HMO plans that typically allow out-of-network benefits for dental coverage (if provided).
- Preferred provider organization (PPO) plans – These are indemnity plans where the insurance company has contracted with a network of dentists who have agreed to charge certain discounted fees for approved services. Benefits are available for patients to visit dentists not participating in the plan’s network. In addition, some MA plans may offer allowance plans as the dental option under a PPO plan. These plans typically pay a set dollar amount for covered procedures and patients can save money by visiting network providers.

¹ [Medicare Advantage Plans | Medicare](#)

² [Medicare Advantage Plans cover all Medicare services | Medicare](#)

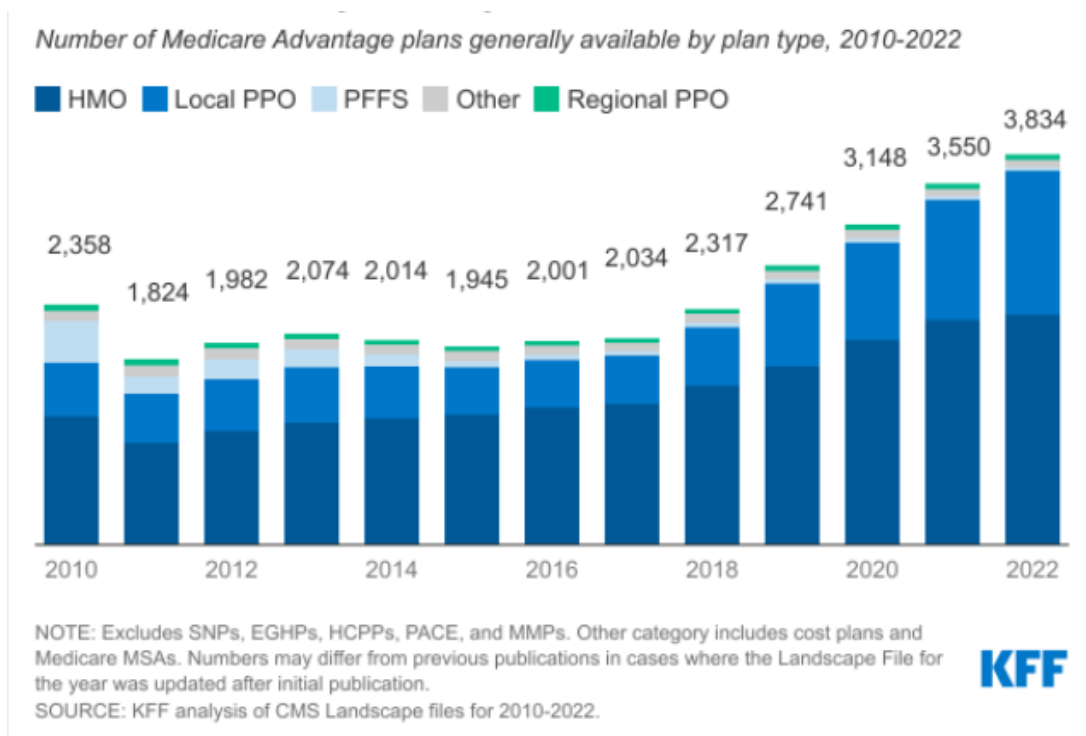
[How do I know if my patient has a Medicare Advantage plan?](#)

You will need to check the patient’s insurance identification card to determine if the patient has a Medicare Advantage plan. If this is not indicated on the ID card itself, you will need to call the 800-telephone number listed on the card to verify whether or not the patient has an MA plan. Although not always 100% accurate, your staff can ask the patient if he or she has an MA plan. This way if there is any doubt, it would behoove your office to call the plan to verify. Lastly, if the patient is over 65 years of age there is a greater chance that the patient may have an MA plan and once again, a call to the plan to verify is suggested.

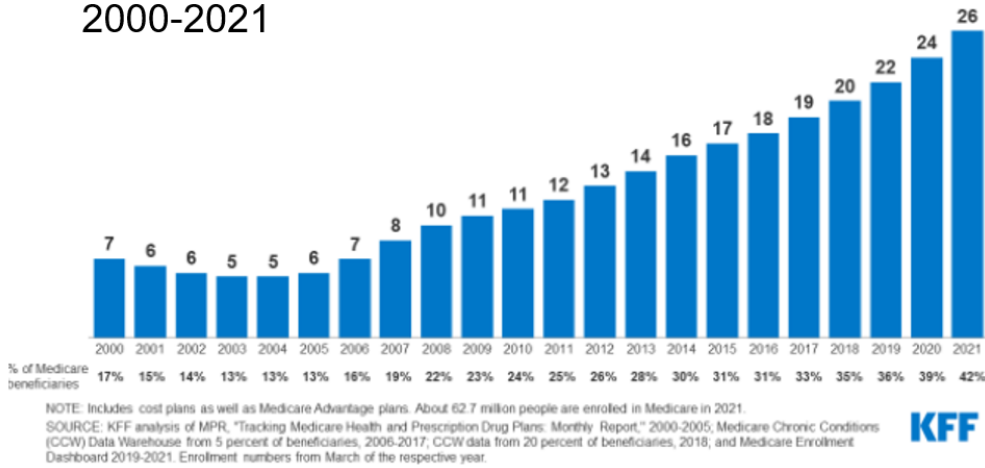
[How many Medicare Advantage plans are there and how many individuals are covered by Medicare Advantage plans?](#)

In 2022, according to the Kaiser Family Foundation (see charts below) there were **3,834** Medicare Advantage plans available nationwide for individual enrollment – an 8% increase (284 more plans) from 2021 and the largest number of plans available in more than a decade.

In 2021, approximately 26 million people had a Medicare Advantage plan and this market has continuously grown year after year. In fact, 42% of Medicare beneficiaries are now covered under MA plans. Compare this to 2000, where 7 million people had an MA plan which was 17% of the Medicare market at that time.



Total Medicare Advantage Enrollment 2000-2021



Commercial Plans and Medicare Advantage

Many commercial PPO plans include participation with their Medicare Advantage products. Some plans may send an addendum to the contract for your signature or require you to opt-out of the MA program should you choose not to participate. Still other plans may offer an exclusive provider organization (EPO) plan which requires patients to visit a network dentist in order to receive a benefit. Many commercial plans use the same network fee schedule for their commercial business as for their MA business.

Allowance plans are gaining popularity with MA plan options. These plans provide patients with a set dollar amount that the patient can use on any dental service (except cosmetic services). Out-of-network dentists can receive their full fees while network dentists are subject to the plan’s allowable fees.

If the plan also offers a separate dental health maintenance organization (DHMO) plan and the dentist wishes to participate in the MA DHMO plan, the dentist will need to sign a separate agreement with the DHMO plan.

View the archived webinar titled, [Medicare Advantage: What is Medicare Part C and how does it work with Dental Coverage?](#)

Coordination of Benefits

If your patient has Medicare and other health insurance (from a group health plan, retiree coverage or Medicaid), each type of coverage is called a payer. When there's more than one payer, [coordination of benefits rules](#) decide who pays first. The primary payer pays what it owes first, and then the rest is sent to the secondary payer (supplemental payer) to pay. In some rare cases, there may also be a third payer.

If there are questions about who pays first, call the Benefits Coordination and Recovery Center at 855-798-2627. Representatives are available Monday through Friday, 8:00 a.m. – 8:00 p.m. Eastern Time.

Listed below are some of the most common COB scenarios for patients aged 65 and older that have group health plan coverage based on their current employment status and this [link](#) will take you to multiple COB scenarios.

- If the employer has 20 or more employees, then the group health plan pays first and Medicare pays second.
- If the employer has less than 20 employees, the group health plan pays first, and Medicare pays second if both of these conditions apply:
 - the employer is part of a multi-employer or multiple employer group health plan
 - at least one of the other employers has 20 or more employees
- If the employer has less than 20 employees and isn't part of a multi-employer or multiple employer group health plan, then Medicare pays first and the group health plan pays second.³

If your patient has both Medicare and Medicaid coverage, Medicare will be primary over Medicaid.

Type of Insurance	Conditions	Primary	Secondary
65 years and older with employer plan	Fewer than 20 employees	Medicare	Employer Plan
65 years and older with employer plan	More than 20 employees	Employer Plan	Medicare
Retiree Plan	Not eligible for Medicare	Retiree	N/A
Retiree Plan	Eligible for Medicare	Medicare	Retiree Plan
Medicaid	Eligible for Medicare	Medicare	Medicaid

[The Appeals Process: Medicare Advantage \(Part C\)](#)

There are multiple levels in the Medicare Advantage Part C appeals process. The levels are:

1. [Level 1 Appeals: Medicare Advantage \(Part C\) | HHS.gov](#)
2. [Level 2 Appeals: Medicare Advantage \(Part C\) | HHS.gov](#)
3. [Level 3 Appeals \(OMHA\) | HHS.gov](#)
4. [Level 4 Appeals | HHS.gov](#)

³ <https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance>

5. [Level 5 Appeals | HHS.gov](#)⁴Waiver of Liability for Non-Contracted Providers

If the MA plan approves a request for payment from a non-contracted provider, the provider receives payment and a remittance advice/notice. If the MA plan denies a request for payment from a non-contracted provider, the MA plan must notify the non-contracted provider of the specific reason for the denial and provide a description of the appeals process. MA plans must deliver either a remittance advice/notice or other similar notification that states the non-contracted provider:

- Has the right to request a reconsideration of the MA plan's denial of payment
- Must submit a Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal. (MA plans must include the form as an enclosure or attachment and/or provide a direct link to the form)
- Has 60 calendar days from the remittance notification date to request a reconsideration
- Should include documentation, such as a copy of the original claim or remittance notification showing the denial, and must include any clinical records and other documentation that supports the provider's argument for reimbursement
- Return the request for reconsideration to the MA plan following the instructions provided by the plan on where to send the request⁵

⁴ [Level 1 Appeals: Medicare Advantage \(Part C\) | HHS.gov](#)

⁵ [Medicare Managed Care and Part D Appeals Guidance \(cms.gov\)](#)