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FACT SHEET
KNOWLEDGE • RESOURCES • TRAINING

Original Medicare vs. Medicare Advantage

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

What's Changed?

Updated payment rules for patients enrolled in Medicare Advantage Organizations (page 3)

Substantive content changes are in dark red.

People with Medicare can get their health coverage through Original Medicare or a Medicare Advantage (MA) plan. This fact sheet describes what you, as a provider, need to know about how different coverage affects:

- Seeing patients
- Processing claims
- Filing appeals

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the CMS Office of Minority Health:

- Health Equity Technical Assistance Program
- Disparities Impact Statement

Seeing Patients

Original Medicare

If a patient has coverage through Original Medicare, and you accept assignment, you can treat a patient without a referral. Submit the claim directly to Medicare. By accepting assignment, you agree to charge the patient only the Medicare deductible and coinsurance amount. Ask your patient if they have Supplemental Insurance (Medigap) to help pay out-of-pocket costs, like the deductible and coinsurance. You'll usually wait for Medicare and Supplemental Insurance to pay its share before asking a patient to pay their share.

MA Plans

If a patient has coverage through an MA plan, like an HMO, they'll generally need to see providers who participate in their plan's network. Some plans, like a PPO, allow patients to get non-emergency or non-urgent care out of network, but they'll pay a higher cost.

For MA plan patients, check with the MA plan for information on eligibility, coverage, and payment. Each plan can have different patient out-of-pocket costs and specific rules for getting and billing for services. You must follow the plan's terms and conditions for payment.

If you don't participate in a plan's network, let the patient know and explain how this affects their cost. You can also refer patients to their plan for a list of participating providers.

MA plans provide all Part A and Part B benefits excluding some costs associated with Medicare clinical trials, hospice services, and, for a temporary time, some new benefits that come from legislation or national coverage determinations. If a patient is getting hospice care or getting care in a clinical trial, Original Medicare will usually cover these costs.

Federally Qualified Health Centers (FQHCs) contracting with MA organizations (MAOs) get at least the same amount they would have gotten for the same service under the FQHC prospective payment system. If the MAO contract rate is lower than the amount Original Medicare would otherwise pay for FQHC services, FQHCs contracting with MAOs will get a wrap-around payment from Medicare to cover the difference.

Under the Value-Based Insurance Design (VBID) Model, participating MAOs are responsible for all Original Medicare services, including hospice care. MAOs will incorporate the current Medicare hospice benefit into MAO-covered benefits. MAOs must also offer palliative care services outside the hospice benefit for enrollees with serious illness and through in-network providers, provide individualized transitional concurrent care services.

Home Health: If patients enroll in an MA plan during the 30-day period that includes all home health services, CMS will proportionately adjust the 30-day period payment with a partial payment adjustment since the patient is receiving coverage under MA. Starting with the effective date of enrollment, the MA plan will get a capitation payment for covered services.

In cases where a home health agency knows in advance that a patient will become enrolled in an MAO as of a certain date, submit a claim for the shortened period before the MAO enrollment date and code the claim with patient status 06.

DMEPOS: If a patient is enrolled in an MA plan, they need to use the plan's approved suppliers to get DMEPOS items.

Most MA plans offer coverage for things Original Medicare doesn't cover, like fitness programs and some vision, hearing, and dental services. MA plans may offer supplemental mental health benefits to address coping with life changes, conflict resolution, or grief counseling, offered as individual or group sessions. Check with the MA plan.

Processing Claims

Original Medicare

Medicare Administrative Contractors (MACs) process Original Medicare claims. After a MAC processes a claim, they'll send you a remittance advice that explains how the MAC processed the claim, indicates if forwarded to second coverage, and what to do if you have questions. The patient will get a Medicare Summary Notice (MSN) stating the MAC paid or denied the claim.

MA Plans

MA plans process all claims through their own claims and payment procedures.

Like with Original Medicare, the MA plan will send you a remittance advice after they process a claim. The patient will get an Explanation of Benefits (EOB) stating the plan paid or denied their claim.

Filing Appeals

People with coverage through Original Medicare or an MA plan have the right to file an appeal if they disagree with a coverage or payment decision. You may be able to file an appeal on behalf of your patient. You can also help your patients by providing any information and documentation that could help your patient's appeal.

Original Medicare

- Read the Medicare Parts A & B Appeals Process booklet
- Visit Original Medicare Appeals

MA Plans

- Visit Medicare Managed Care Appeals & Grievances
- Get more information about MA organization determinations, appeals, and grievances in the Parts C & D Enrollee Grievances, Organization, Coverage Determinations, and Appeals Guidance

Resources

- Beneficiaries Dually Eligible for Medicare & Medicaid booklet
- Internet-Only Manuals
- Local Coverage Determinations
- MA Plan Directory
- Medicare Coverage Database
- Medicare Managed Care Manual