CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE AND MEDICAID INNOVATION

Medicare Advantage (MA) and MDPP Webinar

September 25th, 2025

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Webinar Outline

Outline:

1. Overview of Medicare
2. MDPP Overview
3. MA Coverage of MDPP Services
4. Billing MA Plans for MDPP Services
5. Appealing MA Claim Denials
6. Helpful Resources
7. Glossary of Terms

Overview of Medicare

Original Medicare Overview

Original Medicare is a Fee-For-Service (FFS) plan that includes Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. People with Original Medicare can go to any doctor, supplier, hospital, or other facility that accepts Medicare and is accepting new patients or clients.

Part A helps pay for:

- Inpatient hospital care
- Inpatient care in a skilled nursing facility (SNF) after a covered hospital stay
- Hospice care

Part B helps pay for:

- Physician services
- Some preventive services (including MDPP)
- Home health for people without Part A
- Ambulance services
- Laboratory and diagnostic services
- Surgical suppliers
- Durable medical equipment, prosthetics, orthotics, and suppliers (DMEPOS)
- Hospital outpatient services

Part C/Medicare Advantage (MA) and Part D Overview

Part C is the Medicare Advantage (MA) plan which offers Part A and Part B coverage, and often extra benefits like vision or dental coverage. Part D is the Medicare drug plan which provides prescription drug coverage.

Part C (Medicare Advantage Plan)

- MA plans must cover all services that Part A and Part B cover, except hospice care
- MA plans also can offer other benefits beyond what Original Medicare would cover

Part D (Medicare Drug Plan)

- Insurance plans or private companies provide these services. Plans vary in cost and what drugs they cover
- Many MA plans include Medicare prescription drug coverage

Enrollment: MA vs Original Medicare

- The average Medicare beneficiary has 42 MA plans available to them, offering a wide range of choices in coverage and benefits.[1]
- In 2025, MA enrollment reached 34.1 million beneficiaries, covering 54% of all Medicare beneficiaries (62.8 million beneficiaries total), and is projected to grow to 64% by 2034.[2]
- As of 2025, 46% of eligible Medicare beneficiaries – are enrolled in Original Medicare.
- There have been 4,650 MA and 4,396 Original Medicare beneficiaries that have participated in MDPP between April 2018 and March 2024.[3]

Sources: 1) Medicare Advantage Plan Offerings (Kaiser Family Foundation [KFF]), **2)** Medicare Advantage Enrollment Trends (KFF) **3)** Evaluation of the Medicare Diabetes Prevention Program (MDPP)

Examples of Medicare Contractors

- **Medicare Advantage Organizations (MAOs)**
  - Private insurance companies contracted by CMS to administer Medicare benefits (Part C).
- **Medicare drug plan contractors**
  - Private companies approved by Medicare to offer prescription drug coverage (Part D).
- **Medicare Administrative Contractors (MACs)**
  - MACs are multistate, regional contractors responsible for administering both Part A and Part B claims. CMS uses MACs as the primary contact between organizations and the Original Medicare.

What do MACs do?

- **MACs oversee many activities including:**
  - Enrolling providers
  - Processing Original Medicare claims
  - Handling reimbursement services and auditing institutional provider cost reports
  - Handling redetermination requests (first-stage appeals process)
  - Answering questions on Original Medicare FFS billing and payment and enrollment applications, such as:
    - How can my organization correctly bill Original Medicare for Part B services?
    - Why was my organization's FFS claim denied?
    - What is the process for appealing denied FFS claims?
- **MACs are not available to help with MA claims**

Types of MA Plans

- **Health Maintenance Organization (HMO)**
  - An HMO requires enrollees to use doctors, specialists, and hospitals within its network (except for emergencies) to receive coverage.
- **Preferred Provider Organization (PPO)**
  - A PPO allows members to see both in-network and out-of-network providers, but out-of-network care usually costs more.
- **Private Fee-for-Service (PFFS) Plan**
  - A PFFS lets people see any Medicare-approved provider who agrees to the plan's payment terms; the plan, not Medicare, sets the costs and may offer extra benefits.
- **Medical Savings Account (MSA) Plan**
  - An MSA pairs a high-deductible health plan with a savings account for medical costs; once the deductible is met, the plan covers all Medicare Part A and B services, but doesn't cover prescription drugs.
- **Special Needs Plan (SNP)**
  - An SNP provides tailored benefits to people with specific conditions, low income, or institutional care needs, limiting membership to those who meet these criteria.

How MA Plans Work (1 of 2)

- MA plans offer Part A and Part B Medicare coverage, except hospice.
- Besides Part A and Part B coverage, MA plans **may** offer extra benefits such as vision, hearing, dental, and health and wellness programs. Many include drug coverage.
- MA plans generally have **provider networks**. People may have to see doctors in the plan's provider network or go to certain hospitals to get services. If they use providers who are not in the network (also called "out-of-network"), **they may have to pay part or the entire cost of the service**.
- MA plans are allowed to limit coverage to a network of providers as long as the services covered under Medicare, including MDPP services, are available under the MA plan.

How MA Plans Work (2 of 2)

- Some MA plans require enrollees to pay a monthly premium **in addition to the standard Part B premium paid to Medicare**. However, certain MA plans may cover all or part of the Part B premium, and the total cost will vary depending on the plan.

- An MA plan may also have a **yearly deductible or additional deductible** for some health services, as well as payment for each doctor's visit or service. The payment is considered a co-pay, which is a fixed amount paid each time beneficiaries receive a medical service.

- MA plan benefits may change from year to year. The plan sends an **Annual Notice of Change (ANOC)** to enrollees each fall with information about changes in premium, benefits, cost sharing, or service area effective starting January of the following year. If the MA plan includes prescription drug coverage, the ANOC will also detail any changes to those benefits.

Evidence of Coverage (EOC)

MA plans also send enrollees an **Evidence of Coverage (EOC)** each year (in either September or October) that gives details such as what benefits the plan will cover, how much the person will pay, and how to file an appeal. Many MA plans show in their EOC that MDPP is covered at no cost when using in-network providers, and may involve costs when services are received out-of-network.

Example EOC for an MA Beneficiary

MEDICAL BENEFITS		
	IN-NETWORK	**OUT-OF-NETWORK**
PREVENTIVE CARE		
This plan covers all Medicare preventive services including: - **Medicare Diabetes Prevention Program (MDPP)**	**$0** copay	**$0** copay or **50%** of the cost

MA Provider Selection

- Most MA Plans have provider networks that plan members must use for health care services. These providers of MA services **must have an agreement with CMS** allowing them to offer services under Original Medicare. **This includes preventive services, such as MDPP**.

- MA organizations have written policies and procedures when selecting and evaluating health care professionals to include in an MA plan's provider network. Certain health care professionals must undergo credentialing to join a provider network.

Note that credentialing is not required for out-of-network MDPP suppliers.

MDPP Overview

The Medicare Diabetes Prevention Program (MDPP)

Medicare Diabetes Prevention Program (MDPP) is a group-based preventive service targeting at-risk Medicare beneficiaries, using a CDC-approved National Diabetes Prevention Program curriculum.

HEALTHY EATING

PHYSICAL ACTIVITY

WEIGHT LOSS

- MDPP focuses on preventing the onset of type 2 diabetes through a combination of diet, physical activity, and behavior change strategies.
- MDPP suppliers' primary goal is to help Medicare beneficiaries achieve at least 5% weight loss.
- MDPP covers up to 1 year of interactive sessions delivered to groups of eligible beneficiaries.

MDPP vs. Diabetes Self-Management Training (DSMT)

Medicare Diabetes Prevention Program (MDPP)	Diabetes Self-Management Training (DSMT)
Designed to prevent type 2 diabetes in eligible Medicare beneficiaries with prediabetes	Aims to helps individuals manage existing diabetes and reduce complications
MDPP coaches must be trained in line with CDC DPRP's staffing and training standards, and no additional credentials are required	DSMT providers must meet the current National Standards for DSMES and should be accredited through a CMS certified Accrediting Organization and should be trained in diabetes care and education
Structured over 1 year, with 16 weekly core sessions followed by 6 monthly maintenance sessions	Typically includes 10 hours of initial training plus 2 hours of follow-up annually
Does not require a provider referral	Requires a provider referral
Covered by Medicare Part B at no cost to eligible beneficiaries, but costs may apply when using out-of-network MDPP suppliers	Covered by Medicare Part B but beneficiary may owe 20% coinsurance plus a deductible

Code of Federal Regulations (CFR) and Physician Fee Schedule (PFS) Rulemaking

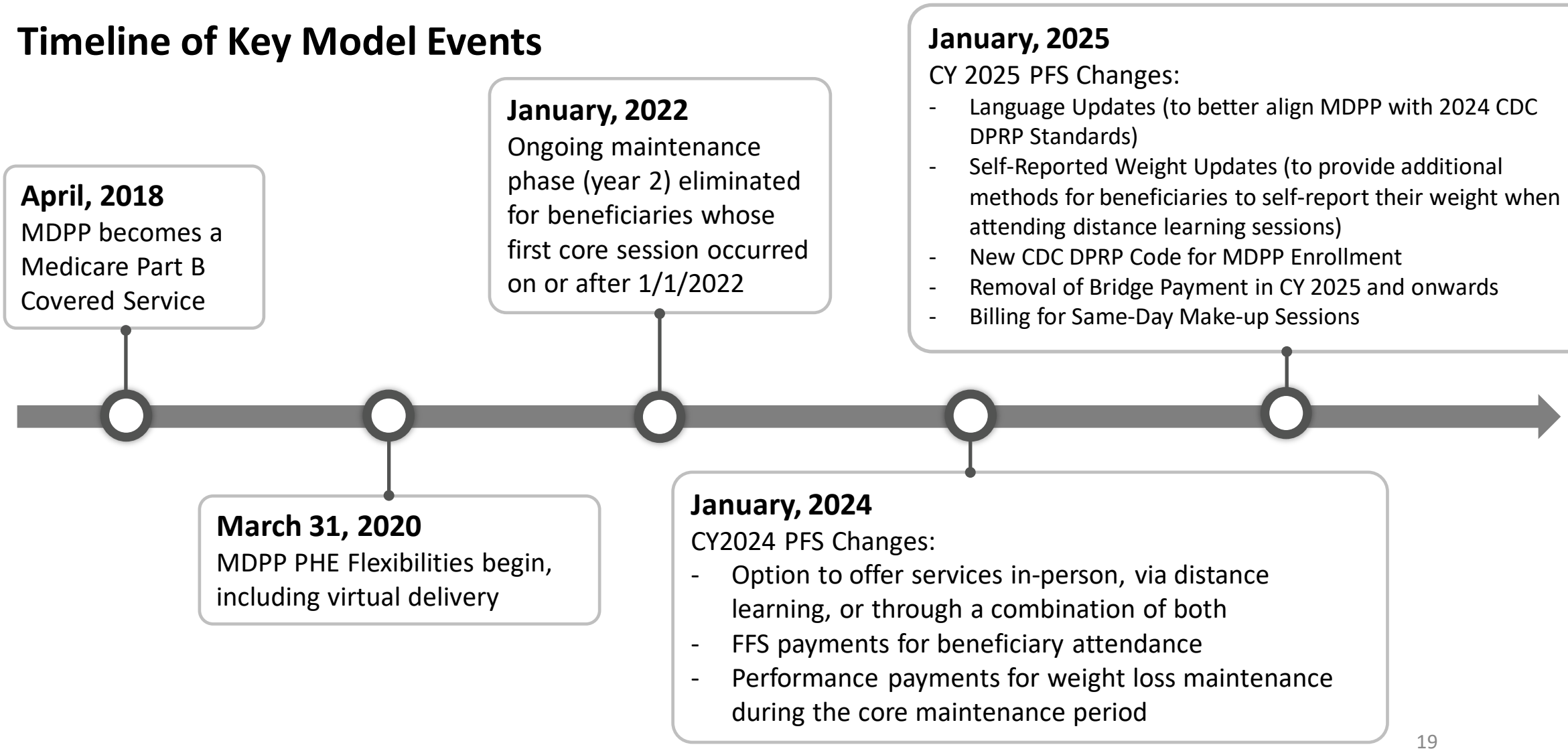
- The **Code of Federal Regulations (CFR)** contains official rules that implement laws like the Medicare statute. Most Medicare rules live in **42 CFR** – this governs coverage, payments, and provider requirements.

- CMS uses the CFR to set Medicare policies, including policies pertaining to MA and MDPP. Any changes to policy must go through a formal rulemaking process, which usually occurs once a year.

- CMS cannot require MA plans to contract with specific MDPP suppliers or set their payment terms as MDPP is limited by statute with respect to the Medicare Program and MA operations.

Changes to MDPP through PFS Rulemaking

Timeline of Key Model Events



MA and MDPP

MA Coverage of MDPP Services

- All Medicare health plans, including MA plans, are required to cover MDPP services for eligible beneficiaries.
- MA plans are allowed to limit coverage to a network of providers as long as the services covered under Medicare, including MDPP services, are available under the MA plan.
- MA plans must arrange for out-of-network access to care when in-network providers are unable to meet beneficiaries' needs.

Payment for MDPP Services

- CMS cannot require an MAO to contract with specific providers or require specific price or payment structures with in-network providers.
- MA plans must pay out-of-network providers the amount that would have been paid under Original Medicare when these providers furnish covered services to an MA beneficiary.

Preparing to Deliver MDPP Services to MA Beneficiaries (1 of 2)

Prior to the initiation of services with new Medicare beneficiaries, MDPP suppliers are advised to complete the following steps to ensure eligibility and minimize the risk of claim denials:

- Confirm the type of insurance the beneficiary has before initiating services by requesting and reviewing all medical insurance cards from the beneficiary
    - CMS Medicare cards include a unique, randomly assigned number called a Medicare Beneficiary Identifier (MBI). Information about whether people are enrolled in MA plans is not provided on their Medicare card.

For more information on beneficiary enrollment and guidance on verifying details for potential enrollees, please visit the *MDPP webpage* under *"MDPP Services and Standards".*

Preparing to Deliver MDPP Services to MA Beneficiaries (2 of 2)

- Gather details on the enrollee's eligibility for MDPP services, including:
  - Confirming that the enrollee has current coverage through an MA plan
  - Confirming beneficiary eligibility to MDPP
  - Determining whether the MA plan has previously covered MDPP services for the enrollee
  - Determining whether the Original Medicare has previously covered MDPP services for the enrollee
- Identify whether your organization (as the MDPP supplier) is in-network or out-of-network with the enrollee's MA plan

The once-per-lifetime limit applies equally to enrollees covered under Original Medicare as it does to enrollees covered under Medicare Advantage. To be eligible for coverage for MDPP services, an enrollee must not have previously received the set of MDPP services in his or her lifetime.

Billing MA Plans for MDPP Services

Billing MA for MDPP Services

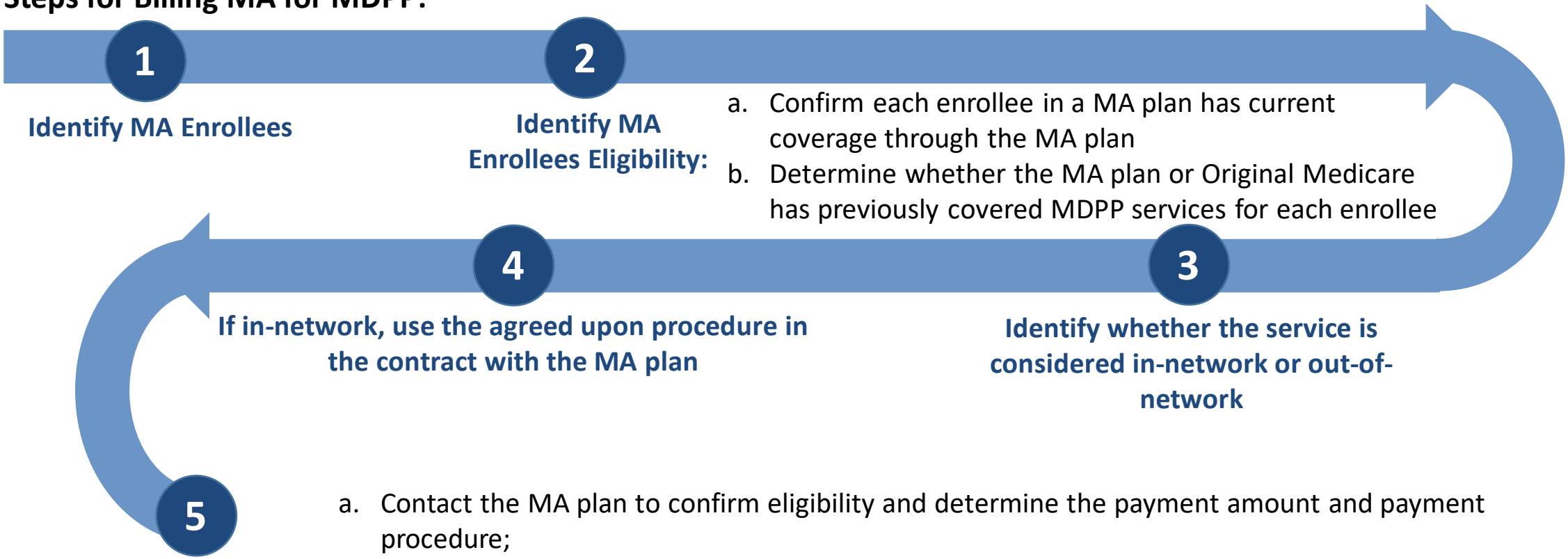
- If the beneficiary is in-network use the agreed upon procedure in the contract with the MA plan
- If the beneficiary is enrolled in an MA plan that the supplier does not have a contractual arrangement with (out-of-network), the supplier should:
  - Contact the MA plan to confirm eligibility and determine the claims and payment procedures;
  - Notify the enrollee they may be responsible for all or part of the cost of MDPP services and inform them that they can locate in-network suppliers by contacting their plan;
  - Bill the enrollee for the cost-sharing payment if applicable; and
  - Submit a request for payment to the MA plan using the procedure and payment amount determined when the MA plan was contacted

Out-of-Network Cost-Sharing

MA plans can impose beneficiary cost-sharing for MDPP services provided by an out-of-network supplier. However, cost-sharing is only allowed if the there is an in-network MDPP supplier that could be used.

MA Billing and Payment

Steps for Billing MA for MDPP:



Appealing MA Claim Denials

Denied MA Payments for MDPP Services

- An MA plan denial of a supplier's or an enrollee's request for a pre-service approval or payment is also known as an "**adverse organizational determination**."
- The MDPP supplier (in-network or out-of-network) should receive a **Remittance Advice** or similar notification with a specific reason for the denial and a description of the appeals process.
- If an MA plan denies a non-contracted MDPP supplier's request for pre-service approval or payment after services were provided, the MA plan must notify the non-contracted MDPP supplier of the reason for the denial and describe the appeals process. They must specify:
  - Right to request reconsideration within 60 days of the notification
  - Requirement to submit a Waiver of Liability form with any reconsideration request
  - Address for reconsideration request submission

A **Waiver of Liability** is a document where a healthcare supplier agrees not to bill a Medicare Advantage enrollee for a denied claim, ensuring the enrollee is not financially responsible regardless of the appeal outcome. It protects beneficiaries from costs not covered by their MA plan.

To find a model *Waiver of Liability* form go to the CMS Notices and Forms web page for Managed Care appeals and grievances.

Denial Notices

- A **Denial Notice** is a written communication from an MA plan informing an enrollee that a request for healthcare service or coverage has been denied, and explains the reason for denial.[4] They must be:
  - Specific to the enrollee
  - Specific to the situation
  - Clearly explain why the plan is denying coverage
  - Explain the next available steps

Source: 4) MA Denial Notice.

Common Reasons for MA Claim Denials

- One common reason for MA claim denials is MAOs stating that “prior authorization is required.”
  - This could relate to a problem with obtaining prediabetes blood test results, and suppliers should confirm all necessary medical documentation.
  - MDPP is a preventive service that requires no prior authorization and provider referrals are not required. This applies to both Original Medicare and Medicare Advantage.

- Another common reason for MA claim denials is an MAO stating that a registered dietitian, nutrition professional, physician, nurse practitioner, physician assistant, or clinical nurse specialist is required to administer or participate in the service.
  - Program requirements differ across CMS Preventive Services, including between MDPP and DSMT.

MA Appeals

- A non-contracted supplier or enrollee may appeal the denial to the MA plan by requesting a "**reconsideration**." The steps for a reconsideration should be provided with the adverse organizational determination.

- A non-contracted supplier may file a standard appeal for a denied claim only if the supplier submits a Waiver of Liability.

- Once the MA plan receives the reconsideration request, it must make its decision and notify the MDPP supplier or enrollee within **30 calendar days** of receipt of a pre-service request or within **60 calendar days** of receipt of a payment request. If the decision is unfavorable, in whole or in part, the MA plan must submit the case file and its decision for automatic review by the Part C Independent Review Entity (IRE).

Grievances and Reconsiderations Can be Miscategorized

- A grievance is an expression of dissatisfaction (other than an organization determination) by an enrollee with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers.

- Suppliers should instruct enrollees to not frame requests for appeals in a manner that may be confused as a grievance.

Enrollees may file grievances verbally or in writing within 60 calendar days from the incident date. Plans must notify the enrollee of their decision no later than 30 calendar days after getting the request and must address each issue in the grievance.

Helpful Resources

MDPP Supplier Support Center

- The purpose of the MDPP Supplier Support Center is to answer any MDPP policy-related questions from organizations, stakeholders and the general public.
- If your organization needs information or assistance with MDPP payment policy or the MA billing processes (such as determinations and appeals), you should submit your question to the MDPP Supplier Support Center by following the steps to start a new inquiry.

Suppliers should be prepared with specific information when submitting a question:

- Type of issue, such as repeated or intermittent denials for a specific reason (e.g., "prior authorization required" or "non-recognized provider")
- Dates of service, claim submission date, denial reason, appeal status and response
- Exact language from Remittance Advice or other notice accompanying a denial (including plan clarifications, if applicable)
- Plan name(s) and location(s) (e.g., city and state)

Additional MA Resources

Resource	Resource Location
Medicare Advantage Factsheet	https://www.cms.gov/priorities/innovation/files/fact-sheet/mdpp-ma-fs.pdf
Medicare Advantage Appeals Process	https://www.cms.gov/priorities/innovation/files/mdpp-ma-appeals-process.pdf
Medicare Part C Appeals Overview	https://www.cms.gov/medicare/appeals-grievances/managed-care-appeals-grievances/appeals-overview
Original Medicare vs. Medicare Advantage	https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage
Parts of Medicare	https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare
Medicare Advantage Plans	https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
About DSMES	https://www.cdc.gov/diabetes/education-support-programs/index.html
CDC DPRP's Staffing and Training Standards	https://www.cdc.gov/diabetes-prevention/php/program-provider/staffing-and-training.html

Summary

- MDPP is a covered Part B preventive service and MA plans must offer MDPP services to all eligible enrollees
- CFR dictates Medicare, Medicare Advantage, and MDPP rules and guidelines
- MA networks do not have to accept claims from non-contracted suppliers if they have sufficient coverage, either provided by themselves as recognized suppliers or recognized suppliers with which they are contracted
- MA plans are not required to contract with any given supplier
- Out-of-network services are subject to member co-payments
- MA plans must offer the opportunity to appeal adverse organizational determinations
  - Specific guidelines and requirements for appeals
- Common reasons for claim denials (billing and processing)
  - Eligibility for MDPP
  - Pre-authorization requirements
  - MDPP vs DSMT
  - Reconsiderations vs Grievances

Glossary of Terms

Glossary of Terms

Term	Description
Adverse Organizational Determination	An MA plan's denial of a supplier's or enrollee's request for a pre-service approval or payment.
Annual Notice of Change (ANOC)	An ANOC outlines any changes to a beneficiaries' coverage, costs, and other plan details that will be effective the following January.
Code of Federal Regulations (CFR)	The CFR contains official rules that implement laws like the Medicare statute.
Denial Notice	A Denial Notice is a written communication from an MA plan informing an enrollee that a request for healthcare service or coverage has been denied, either partially or in full, and explains the reason for denial.
Diabetes Self-Management Training (DSMT)	Diabetes Self-Management Training is an evidence-based standard of care program that incorporates the needs and goals of people with diabetes into a personalized plan that has proven to improve health outcomes.
Evidence of Coverage (EOC)	The EOC outlines the details of a beneficiaries' health coverage for the upcoming year, including costs, benefits, and how to access care.

Glossary of Terms

Term	Description
Grievances	A grievance is an expression of dissatisfaction (other than an organization determination) by an enrollee with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers.
Health Maintenance Organization (HMO)	An HMO requires enrollees to use doctors, specialists, and hospitals within its network (except for emergencies) to receive coverage.
Medicare Beneficiary Identifier (MBI)	An MBI is a unique, non-social security number-based identifier assigned to each Medicare recipient to protect their personal information.
Preferred Provider Organization (PPO)	A PPO allows members to see both in-network and out-of-network providers, but out-of-network care usually costs more.
Reconsiderations	A reconsideration is a review of the MA plan's initial decision by the MA plan itself.
Remittance Advice	A remittance advice provides a detailed explanation of a claim payment and reasons for denial, if any.
Waiver of Liability	A Waiver of Liability is a document where a healthcare supplier agrees not to bill a Medicare Advantage enrollee for a denied claim, ensuring the enrollee is not financially responsible regardless of the appeal outcome. It protects beneficiaries from costs not covered by their MA plan.

Questions for the CMS MDPP Team

Please contact the CMS MDPP Team with any further questions at the MDPP Supplier Support Center