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IN FOCUS

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Medicare Coverage: Background and Resources

This In Focus provides an overview of Medicare coverage of services and items, coverage determination processes, and core resources on these topics for beneficiaries, health care providers, and policymakers.

Overview of Medicare

Medicare is a federal program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act to provide health insurance to individuals 65 and older, and it was expanded to include permanently disabled individuals under age 65 and certain other individuals. As of January 2025, there were 68.5 million Medicare beneficiaries.

Medicare has four distinct parts. Parts A, B, and D each cover different services, while Part C provides a private plan alternative for Parts A and B. Together, Parts A and B comprise "original" or "traditional" Medicare.

- Part A (Hospital Insurance, or HI) covers inpatient hospital services, skilled nursing care, hospice care, and some home health services.
- Part B (Supplementary Medical Insurance, or SMI) covers a range of medical services and supplies, including physician, outpatient hospital, some home health, durable medical equipment, some prescription drugs, and preventive services.
- Part C (Medicare Advantage, or MA) is an alternative to Parts A and B. Beneficiaries may choose to receive essentially all covered benefits through a private insurer under contract with Medicare. MA plans may offer additional benefits not covered under Parts A, B, or D, such as dental care and gym memberships. Most MA plans provide care through provider networks and may use utilization management (UM) techniques such as prior authorizations to ensure reasonable and necessary use.
- Part D is an optional outpatient prescription drug benefit offered through private organizations, either as a stand-alone benefit (PDP) or integrated with an MA plan (MA-PD). Part D plans may employ UM techniques.

Medicare Coverage

Medicare covers a broad range of items and services. For Medicare to cover, or pay for, an item or service, it generally must meet several criteria:

- it must be eligible for a Medicare benefit category (e.g., inpatient hospital care);
- it must not be statutorily excluded from coverage (e.g., cosmetic surgery and most dental care); and
- it must be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body part (Social Security Act [SSA] Section 1862(a)(1)(A); 42 U.S.C. §1395y(a)(1)(A)).

Additionally, Congress may grant explicit authority for an item or service that would not otherwise be covered under those criteria (e.g., preventive care). Coverage for Part D drugs is determined through separate formulary requirements.

Medicare Coverage Determinations

Many items and services covered by Medicare do not have an explicit coverage policy. If an item fits into a benefit category, has an existing billing code, and is prescribed by a physician, then it is generally paid for by Medicare. However, in other circumstances, policies may deny coverage all together or limit Medicare coverage to only those clinical circumstances under which items and services are reasonable and necessary. For example, Medicare covers power wheelchairs, but a power wheelchair is not considered reasonable and necessary for every beneficiary.

Determinations about which items and services are reasonable and necessary are made at either the national or local level. A national coverage determination (NCD) is a decision by the Secretary of Health and Human Services (HHS Secretary) that a particular item or service is reasonable and necessary, and therefore covered nationally by Medicare. In the absence of an NCD or in addition to an NCD, Medicare Administrative Contractors (MACs) may issue local coverage determinations (LCDs) to establish whether a particular item or service is reasonable and necessary, and therefore covered within the contractor's service area.

The NCD process was most recently described in 2013 (78 Federal Register 48164). While anyone can request the HHS Secretary to conduct an NCD, the HHS Secretary can also initiate one internally. Even prior to submitting an application, innovators are encouraged to contact the Centers for Medicare & Medicaid Services (CMS) to discuss their item and its potential benefit category and coverage, and to check for statutory exclusions.

Though MACs have broad discretion in setting local coverage determinations, CMS determines the process by which LCDs are developed. As with NCDs, anyone can submit an application to a MAC to conduct an LCD, or the MACs can initiate the process.

For both NCDs and LCDs, the process includes a review of the published scientific and medical literature, a review of local medical practice as evidenced by medical opinion from recognized authorities in the field, and opinions from medical associations and other health care experts. The processes include opportunities for public comment and a reconsideration process if, for example, there are concerns

that certain scientific evidence was not taken into account. NCDs, however, may also include a technology assessment or a review by the Medicare Evidence and Coverage Advisory Committee (MEDCAC). A technology assessment may be considered if, for example, evidence is extensive, or complex and conflicting. A MEDCAC referral may be considered if, for example, studies are flawed, do not address the Medicare population, or include technology that could have a large impact on the program or beneficiaries. The coverage policies specify the clinical circumstances under which an item or service is reasonable and necessary for aged and disabled beneficiaries, and thus covered by original Medicare, and MA plans.

If medical evidence is insufficient to determine reasonableness and necessity, the HHS Secretary may cover an item in the context of a clinical study while additional evidence is developed (NCD-Coverage with Evidence Development, or CED). This might be the case for very new items or services, or for new uses for existing items or services. In 2024, CMS updated CED guidance clarifying when it should be used, standards for clinical studies (encouraging fit-for-purpose studies, if applicable), and criteria for ending a CED.

In other cases, innovators may request that CMS provide feedback and guidance on research and how to establish sufficient evidence for Medicare coverage prior to an item being cleared or approved by the Food and Drug Administration (FDA) (Parallel Review, and Transitional Coverage of Emerging Technologies). These processes are intended to provide innovators with support and predictability while also hastening the Medicare coverage process. The Administration and Congress have also previously examined other methods of hastening Medicare coverage, such as deemed coverage of selected devices.

Medicare Coverage Resources

Information sources describing Medicare coverage are available, but they can be difficult to identify and navigate. This section highlights applicable sources for beneficiaries, as well as providers and policymakers. Individuals enrolled in MA or other health plans may have access to additional coverage and should consult their specific plan.

Resources for Beneficiaries

Each year, Medicare beneficiaries are mailed the *Medicare & You* handbook. The most recent handbook can be downloaded at any time, including in various formats and languages. The handbook includes an overview of Medicare options and a section entitled "Find out what Medicare covers."

The Medicare.gov website also outlines coverage, through its *Your Medicare Coverage* search portal and a browsable list. The *How do drug plans work?* page highlights prescription drug coverage.

Beneficiaries who would like help understanding their coverage can talk to someone via chat or phone, or seek local help through their State Health Insurance Assistance Program (SHIP), using the *Regional SHIP Location* tool.

Individuals enrolled in MA or other plans can refer to the basic coverage information outlined above, but they may also have access to additional coverage and should consult their specific plan.

Beneficiaries and providers interested in participating in a CED study can search for one through Clinicaltrials.gov.

Resources for Providers and Policymakers

Medicare providers and policymakers can use the basic beneficiary sources listed above, but for more detailed information, the *Medicare Coverage Center* compiles useful links, including those highlighted below.

The *Medicare Coverage Database* allows searches of NCDs, LCDs, and other support documents. Supporting documents may include coverage analyses or billing and coding guides. Users can search by keyword or code, and can limit by state. See *How to Use the Medicare Coverage Database* for tips.

The *Medicare Benefit Policy Manual*, updated throughout the year, is another organized topical guide to covered services. The *Medicare National Coverage Determinations (NCD) Manual* compiles the most recent NCDs available through the *Medicare Coverage Database*. CMS also issues an annual *Report to Congress on Medicare National Coverage Determinations*.

The Medicare Learning Network (MLN) publishes educational materials for health care providers, including detailed information on Medicare coverage topics.

Medicare Coverage Appeals

Beneficiaries who disagree with a coverage decision can file an appeal. Before filing, they can ask their provider or supplier for information to strengthen the appeal.

Sources for Beneficiaries

The appeals process differs based on the Medicare part. Beneficiaries can find part-specific information on the following web pages: Original Medicare, Medicare health plans, and Medicare drug plans.

The *Filing an Appeal* page on Medicare.gov includes forms and instructions to support beneficiaries. Beneficiaries can seek help in filing appeals through their SHIP or appoint a trusted family member or friend as a representative.

Information on fast appeals, which can be filed if beneficiaries believe their services are ending too soon or they are being discharged before they should, is available on the *Fast Appeals* webpage.

For more information about the Medicare program, see CRS Report R40425, *Medicare Primer*, and CRS In Focus IF10885, *Medicare Overview*.

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