



Module 11: Medicare Advantage Plans and Other Medicare Plans

 **National Medicare
TRAINING PROGRAM**

...helping people with Medicare make
informed health care decisions



Centers for Medicare & Medicaid Services
National Train-the-Trainer Workshop Instructor Information Sheet
Module 11: Medicare Advantage (MA) Plans and Other Medicare Plans

Module Description

Medicare Advantage Plans, also known as Part C, provide Medicare-covered benefits to members, and sometimes offer extra benefits that Original Medicare doesn't cover, such as vision or dental services. This module provides a comprehensive overview of Medicare Advantage Plans, and other types of Medicare health plans, including who can join, when to join, how the plans work, and what you pay. This module also has a detailed lesson on marketing guidelines – the ways health plans may, and may not, market their plans.

These up-to-date materials are ready-to-use. They are designed for people who are familiar with the Medicare program, and would like to have prepared information for their presentations. Where applicable, updates from recent legislation are included.

The following sections are included in this module:

Slides	Topics
2-3	Session Objectives and Lessons
4-5	Overview
6-12	Eligibility/Enrollment Requirements
13-17	How MA Plans Work
18-27	Types of MA Plans
28-32	Other Medicare Plans
33-41	Rights, Protections and Appeals
42-61	Medicare Marketing Guidelines
62	Resources

Objectives

- Define Medicare Advantage (MA) Plans
- Explain eligibility requirements and enrollment
- Define how MA Plans work
- Identify types of MA Plans
- Identify other Medicare Plans
- Recognize rights and protections including appeals
- Understand Medicare marketing guidelines

Target Audience

This module is designed for presentation to trainers and other information givers. It is suitable for presentation to groups of beneficiaries.

Handouts

Slides 8 - 11 and 37 are provided as full page handouts in the Appendix of this workbook. You may want to refer to these during your training if you provide copies of the workbooks to attendees. Or, you may wish to make copies of the handouts and distribute them as learning aids.

Time Considerations

The module consists of 63 PowerPoint slides with corresponding speaker's notes. It can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers.

References

- To learn about the Medicare Advantage plans in your area, and the services they cover, visit www.medicare.gov
- For detailed information on the Medicare Part C Appeals Process, please visit www.medicare.gov and select CMS Pub. #11312, Medicare Advantage Plans and Medicare Cost Plans: How to File a Complaint (Grievance or Appeal) CMS product number 11312




Module 11, *Medicare Advantage Plans & Other Medicare Plans*, explains Medicare health plan options other than Original Medicare.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and Pre-existing Condition Insurance Plans. The information in this module was correct as of April 2012.

To check for updates on health care reform, visit www.healthcare.gov/.

To check for an updated version of this training module, visit <http://www.cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/Training-Library.html> on the web.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.



Session Objectives

- This session will help you to
 - Define Medicare Advantage (MA) Plans
 - Explain eligibility requirements and enrollment
 - Define how MA Plans work
 - Identify types of MA Plans
 - Identify other Medicare Plans
 - Recognize rights, protections, and appeals
 - Understand Medicare Marketing Guidelines (MMG)

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Medicare Advantage Plans and Other Medicare Plans

2

This session will help you to

- Define Medicare Advantage (MA) Plans
- Explain eligibility requirements and enrollment
- Define how MA Plans work
- Identify types of MA Plans
- Identify other Medicare Plans
- Recognize rights, protections, and appeals
- Understand Medicare Marketing Guidelines (MMG)




Lessons

1. Medicare Advantage (MA) Plan Overview
2. Eligibility and Enrollment Requirements
3. How MA Plans Work
4. Types of MA Plans
5. Other Medicare Plans
6. Rights, Protections, and Appeals
7. Medicare Marketing Guidelines (MMG)
8. Resources for More Information

04/02/2012 Medicare Advantage Plans and Other Medicare Plans 3

This module includes lessons on:

1. Medicare Advantage (MA) Plan Overview
2. Eligibility and Enrollment Requirements
3. How MA Plans Work
4. Types of MA Plans
5. Other Medicare Plans
6. Rights, Protections, and Appeals
7. Medicare Marketing Guidelines (MMG)
8. Resources for More Information



1. Overview

- Medicare Advantage (MA) Plan Overview

04/02/2012 Medicare Advantage Plans and Other Medicare Plans 4

This brief lesson gives you the basic information on Medicare Advantage (MA) Plans.

What is a Medicare Advantage Plan?

- Health plan options
 - Approved by Medicare
 - Run by private companies
- Part of the Medicare program
- Sometimes called “Part C”
- Available across the country
- Provide Medicare-covered benefits
 - May cover extra benefits

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Medicare Advantage Plans and Other Medicare Plans

5

Medicare Advantage (MA) Plans are health plan options that are approved by Medicare and are run by private companies. They are part of the Medicare program and are sometimes called “Part C.”

Medicare Advantage Plans are offered in many areas of the country by private companies that sign a contract with Medicare. Medicare pays these private plans for their members' expected health care.

Medicare Advantage Plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Medicare doesn't cover, such as extra vision or dental services. The plan may have special rules that its members need to follow.



2. Eligibility and Enrollment Requirements

- Who can join
- When you can join or switch
 - Initial Enrollment Period (IEP)
 - Medicare Open Enrollment Period (OEP)
 - Special Enrollment Periods (SEP)
 - 5-Star Special Enrollment Period
- When you can leave a Medicare Advantage Plan

04/02/2012 Medicare Advantage Plans and Other Medicare Plans 6

Lesson 2, *Eligibility and Enrollment Requirements*, provides information on

- Who can join
- When you can you join or switch
 - Initial Enrollment Period (IEP)
 - Medicare Open Enrollment Period (OEP)
 - Special Enrollment Periods (SEP)
 - 5-Star Special Enrollment Period
- When you can leave a Medicare Advantage Plan

Who Can Join?

- Eligibility requirements
 - Live in plan service area
 - Entitled to Medicare Part A (Hospital Insurance)
 - Enrolled in Medicare Part B (Medical Insurance)
 - No End-Stage Renal Disease (ESRD) at enrollment
 - Some exceptions
- To join you must also
 - Provide necessary information to the plan
 - Follow the plan rules
 - Belong to one plan at a time

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Medicare Advantage Plans and Other Medicare Plans

7

Medicare Advantage (MA) Plans are available to most people with Medicare. To be eligible to join a Medicare Advantage Plan, you must live in the plan's geographic service area, and be entitled to Medicare Part A (Hospital), and enrolled in Medicare Part B (Medical Insurance).

People with End-Stage Renal Disease (ESRD) usually can't join an MA Plan or other Medicare plan. However, there are some exceptions. For example, an individual who develops ESRD while enrolled in an MA Plan may continue to be enrolled in the MA Plan, and some Medicare Advantage Special Needs Plans accept people with ESRD. A person who receives a kidney transplant and no longer requires a regular course of dialysis treatment is not considered to have ESRD for purposes of MA eligibility.

To join an MA Plan, you must also:

- Agree to provide the necessary information to the plan,
- Agree to follow the plan's rules, and
- Belong to only one Medicare Advantage Plan at a time.

To find out what Medicare Advantage Plans are available in your area, visit www.medicare.gov and click on "Compare Drug and Health Plans," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

More information on the enrollment exceptions for people with ESRD can be found in Section 20.2 of the Medicare Advantage enrollment and disenrollment guidance available at www.cms.gov/MedicareMangCareEligEnrol/.

When You Can Join or Switch MA Plans*	
Initial Enrollment Period (IEP)	<ul style="list-style-type: none"> ▪ 7 month period begins 3 months before the month you turn 65 <ul style="list-style-type: none"> • Includes the month you turn 65 • Ends 3 months after the month you turn 65
Medicare Open Enrollment Period “Open Enrollment”	<ul style="list-style-type: none"> ▪ Oct 15 – Dec 7 ▪ Coverage begins Jan 1
<p>*Plan must be allowing new members to join</p>	
<p>04/02/2012 Medicare Advantage Plans and Other Medicare Plans 8</p>	

You can join a Medicare Advantage Plan

- When you first become eligible for Medicare, i.e., during your Initial Enrollment Period (IEP), which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B, or
- The Medicare Open Enrollment Period (OEP), or
- In certain special situations that provide a Special Enrollment Period (SEP).

You can only join one Medicare Advantage Plan at a time, and enrollment in a plan is generally for a calendar year.

You can switch to another Medicare Advantage Plan or to Original Medicare during the Open Enrollment Period, also known as “Annual Enrollment.” This period runs from October 15 - December 7 each year, with coverage starting January 1.

For more information about when you can join or switch MA Plans, see Section 3204 of the Affordable Care Act.

NOTE: This chart is provided as a handout in the corresponding workbook (see Appendix A).

When You Can Join or Switch MA Plans*	
Special Enrollment Period (SEP)	<ul style="list-style-type: none"> ▪ Move from plan service area ▪ Plan leaves Medicare program ▪ Other special situations
<p>*Plan must be allowing new members to join</p>	
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You may be able to join or switch plans under special circumstances that grant a Special Enrollment Period (SEP). For example, if you move out of the plan’s service area, or if the plan decides to leave the Medicare program or reduce its service area at the end of the year. In these cases, there are special rules that allow for enrollment in a different Medicare Advantage Plan, or Original Medicare and a Medigap policy.

For more information about when you can join or switch MA Plans, see Section 3204 of the Affordable Care Act.

NOTE: This chart is provided as a handout in the corresponding workbook (see Appendix A).

When You Can Leave MA Plans	
Jan 1 – Feb 14	<ul style="list-style-type: none"> ▪ Can leave MA Plan ▪ Switch to Original Medicare ▪ Coverage begins first day of month after switch ▪ May join Part D Plan <ul style="list-style-type: none"> • Drug coverage begins first day of month after plan gets enrollment • May not join another MA Plan during this period
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If you belong to a Medicare Advantage (MA) Plan, you can switch to Original Medicare from January 1 – February 14. If you go back to Original Medicare during this time, plan coverage will take effect on the first day of the calendar month following the date on which the election or change was made.

To disenroll from an MA Plan and return to Original Medicare during this period, you can:

- Make a request directly to the MA organization
- Call 1-800-MEDICARE
- Enroll in a Medicare Prescription Drug Plan (PDP) also known as a Part D Plan (enrolling in a Part D plan disenrolls you from a MA-PD only)

If you make this change you may also join a PDP to add drug coverage. Coverage begins the first of the month after the plan gets the enrollment form.

NOTE: This chart is provided as a handout in the corresponding workbook (see Appendix A).

Special Enrollment Period Trial Rights

- People who join an MA Plan for the first time
 - When first eligible at 65 or
 - Leave Original Medicare and drop Medigap policy
- Can disenroll during first 12 months
 - Enroll in Original Medicare
 - Have guaranteed issue for Medigap

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Medicare Advantage Plans and Other Medicare Plans

12

There are special trial rights for a Special Enrollment Period (SEP) available when you join a Medicare Advantage Plan for the first time. You can drop your MA Plan and enroll in Original Medicare anytime within the first 12 months of your Medicare Advantage Plan coverage. You are eligible for this trial right if you either:

- Joined an MA plan when first eligible for Medicare at age 65, or
- Were in Original Medicare, enrolled in an MA Plan for the first time, and dropped a Medigap policy.

The trial right allows you to disenroll from the MA plan during the first 12 months to join Original Medicare. You also have a guaranteed issue opportunity to purchase a Medigap (Medicare supplement insurance) policy.



3. How Medicare Advantage Plans Work

- How Medicare Advantage (MA) Works
- MA Plan Costs
- Recent Changes

04/02/2012

Medicare Advantage Plans and Other Medicare Plans

13

Lesson 3, *How Medicare Advantage Plans Work*, provides information on

- How Medicare Advantage Works
- Medicare Advantage Plan Costs
- Recent Changes

How Medicare Advantage Plans Work

- Receive services through the plan
 - All Part A and Part B covered services
 - Some plans may provide additional benefits
- Most plans include prescription drug coverage
- You may have to visit network doctors/hospitals
- May differ from Original Medicare
 - Benefits
 - Cost-sharing

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Medicare Advantage Plans and Other Medicare Plans

14

In most Medicare Advantage (MA) Plans, you receive all Part A and B Medicare covered services through that plan. Some MA Plans provide additional benefits. Many plans also include Medicare prescription drug coverage. This is Medicare Part D coverage.

Medicare pays for your care every month to these private health plans whether you use services or not.

In some plans, like HMOs, you may only be able to see certain doctors or go to certain hospitals.

Benefits and cost-sharing in a Medicare Advantage Plan may be different than in Original Medicare.

How Medicare Advantage Plans Work

- You are still in Medicare program
- You still have Medicare rights and protections
- If the plan leaves Medicare
 - You can join another Medicare Advantage Plan, or
 - You can return to Original Medicare

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Medicare Advantage Plans and Other Medicare Plans

15

It's important to note that when you join a Medicare Advantage Plan or other Medicare plan you

- Are still in the Medicare program
- Still have Medicare rights and protections, and
- If the plan decides to stop participating in Medicare, you will have to join another Medicare health plan or return to Original Medicare.

Medicare Advantage Costs

- Must still pay the Part B premium
 - A few plans may pay all or part for you
 - State assistance for some
- May pay plan an additional monthly premium
- You pay deductibles, coinsurance, and copayments
 - Different from Original Medicare
 - Varies from plan to plan
 - Costs may be higher if out-of-network

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16

If you join a Medicare Advantage Plan you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2012 is \$99.90.

- A few plans may pay all or part of the Part B premium for you
 - Some people may be eligible for state assistance
 - You may pay an additional monthly premium to plan
- You pay deductibles, coinsurance and copayments
 - Different from Original Medicare
 - Varies from plan to plan
 - Your costs may be higher if you go out of network

Medicare Advantage – Recent Changes

- Plans can't charge more than Original Medicare
 - Chemotherapy
 - Dialysis
 - Skilled nursing facility care
 - Certain other services
- Plans must limit out-of-pocket costs
- Participants in approved clinical research study
 - Costs may be lower
 - Plan may cover some costs

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Medicare Advantage Plans and Other Medicare Plans

17

Let's discuss some of the things that changed in 2011:


Medicare Advantage Plans can't charge more than Original Medicare, (Affordable Care Act Section 3202), for certain services, (e.g., chemotherapy, dialysis, and skilled nursing facility care).

Medicare Advantage Plans must limit your out-of-pocket costs for Part A and Part B covered services, (Affordable Care Act Section 3202).

If you are accepted as a participant in an approved clinical research study

- Your costs may be lower
- Some of your costs may be covered by your plan

For more on Part A and Part B covered services, see Affordable Care Act Sections 2101 and 3202.



4. Types of Medicare Advantage Plans

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Private Fee-for-Service (PFFS)
- Special Needs Plan (SNP)
- HMO Point-of-Service Plan (HMOPOS)
- Medicare Medical Savings Account (MSA)

04/02/2012 Medicare Advantage Plans and Other Medicare Plans 18

Lesson 4, *Types of Medicare Advantage Plans*, provides information on the six main types of MA Plans. They are:

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Private Fee-for-Service (PFFS)
- Special Needs Plan (SNP)
- HMO Point-of-Service Plan (HMOPOS)
- Medicare Medical Savings Account (MSA)

Medicare Health Maintenance Organization (HMO) Plan	
Can you get your health care from any doctor or hospital?	No. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (POS) option.
Are prescription drugs covered?	In most cases, yes. Ask the plan. If you want Medicare drug coverage, you must join an HMO Plan that offers prescription drug coverage.
Do you need to choose a primary care doctor?	In most cases, yes.
Do you need a referral to see a specialist?	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.
What else do you need to know about this type of plan?	<ul style="list-style-type: none"> ▪ If your doctor or other health care provider leaves the plan, your plan will notify you and you can choose another plan doctor ▪ If you get health care outside the plan's network, you may have to pay the full cost. ▪ It's important that you follow the plan's rules, like getting prior approval for a certain service when needed.
04/02/2012	Medicare Advantage Plans and Other Medicare Plans 19

In a Medicare Health Maintenance Organization (HMO) Plan you generally must get your care and services from doctors or hospitals in the plan's network, (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called a HMO with a POS option.

In most cases, prescription drugs are covered. Ask the plan. If you want drug coverage, you must join a HMO Plan that offers prescription drug coverage.

In most cases, you need to choose a primary care doctor and will have to get a referral to see a specialist. Certain services like yearly screening mammograms don't require a referral.

If your doctor leaves the plan, your plan will notify you and you can choose another doctor in the plan.

If you get care outside the plan network, you may have to pay the full cost.

It's important that you follow the plan rules, like getting prior approval for a certain service when needed.

Medicare Advantage Plans can vary. Read individual plan materials carefully to make sure you understand the plan rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.

Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1 -877-486-2048.

NOTE: Information in this chart, and those on the following slides are from the 2012 *Medicare & You* handbook, CMS Pub. # 10050. It can be viewed at <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>.

Medicare Preferred Provider Organization (PPO) Plan	
Can you get your health care from any doctor or hospital?	In most cases, yes. PPOs have network doctors, other health care providers, and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.
Are prescription drugs covered?	In most cases, yes. Ask the plan. If you want Medicare drug coverage, you must join a PPO Plan that offers prescription drug coverage.
Do you need to choose a primary care doctor?	No.
Do you need a referral to see a specialist?	In most cases, no.
What else do you need to know about this type of plan?	<ul style="list-style-type: none"> ▪ There are two types of PPOs: Regional PPOs and Local PPOs. ▪ If your doctor or other health care provider leaves the plan, your plan will notify you. You can choose another doctor in the plan. ▪ If you get health care outside the plan's network, you may have to pay the full cost.
04/02/2012	Medicare Advantage Plans and Other Medicare Plans
	20

In a Medicare Preferred Provider Organization (PPO) Plan you have PPO network doctors and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.

In most cases, prescription drugs are covered. Ask the plan. If you want drug coverage, you must join a PPO Plan that offers prescription drug coverage.

You do not need to choose a primary care doctor and do not have to get a referral to see a specialist.

There are two types—Regional PPOs and Local PPOs.

- A regional PPO serves one of 26 regions set by Medicare
 - May appeal to beneficiaries who seek treatment in a state other than their state of residence.
 - May appeal to beneficiaries who spend a large portion of the year in a state other than their state of residence each year (e.g. Snowbirds)
- Local PPOs serve the counties the PPO Plan chooses to include in its service area. Local PPOs have mandatory limits on out-of-pocket costs that are set by Medicare.

Medicare Advantage Plans can vary. Read individual plan materials carefully to make sure you understand the plan rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.

Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.

Medicare Private Fee-for-Service (PFFS) Plan	
Can you get your health care from any doctor or hospital?	In some cases, yes. You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. Not all providers will. If you join a PFFS Plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can also choose an out-of-network doctor, hospital, or other provider, who accepts the plan's terms, but you may pay more.
Are prescription drugs covered?	Sometimes. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan (Part D) to get coverage.
Do you need to choose a primary care doctor?	No.
Do you need a referral to see a specialist?	No.
<small>04/02/2012</small>	<small>Medicare Advantage Plans and Other Medicare Plans</small>

In a Medicare Private-Fee-for-Service (PFFS) Plan **you can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you.** Not all providers will. If you join a PFFS Plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can also choose an out-of-network doctor, hospital, or other provider, who accepts the plan's terms, but you may pay more. Prescription drugs are sometimes covered. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare prescription drug plan to get coverage.

You don't need to choose a primary care doctor and you don't have to get a referral to see a specialist.

Medicare Private Fee-for-Service (PFFS) Plan

What else do you need to know about this type of plan?

- PFFS Plans aren't the same as Original Medicare or Medigap.
- The plan decides how much you must pay for services.
- Some PFFS Plans contract with a network of providers who agree to always treat you even if you've never seen them before.
- Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before.
- For each service you get, make sure your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan's payment terms.
- In an emergency, doctors, hospitals, and other providers must treat you.

04/02/2012

Medicare Advantage Plans and Other Medicare Plans

22

Other things you need to know about Medicare PFFS Plans include:

- PFFS Plans aren't the same as Original Medicare or Medigap.
- The plan decides how much you must pay for services.
- Some PFFS Plans contract with a network of providers who agree to always treat you even if you've never seen them before.
- Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before.
- For each service you get, make sure your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan's payment terms.
- In an emergency, doctors, hospitals, and other providers must treat you.

Medicare Advantage Plans can vary. Read individual plan materials carefully to make sure you understand the plan's rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.

Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.

PFFS Access Requirements

- Employer PFFS Plans must meet access requirements
- Plans may meet access requirements
 - Through a contracted network of providers
- Where two or more network-based MA Plan options exist
 - Non-employer PFFS plans must meet access requirements through contracts with providers

04/02/2012

Medicare Advantage Plans and Other Medicare Plans

23

The Medicare Improvements for Patients and Providers Act (MIPPA) required that beginning in 2011 all employer Private-Fee-for-Service plans must meet Medicare access requirements through contracts with providers. Access requirements are in place to make sure that beneficiaries have access to a sufficient number of providers in their area who are willing to treat them.

Access requirements

- Non-employer PFFS Plans operating in network areas must establish contracts with a sufficient number of providers across service categories in order to operate. Network areas are those in which at least two network-based plans are operating with enrollment for a given plan year.
- Employer/union sponsored PFFS Plans are required to establish contracts with a sufficient number of providers across service categories in their services areas.

Employer and non-employer PFFS plans may meet access requirements through a contracted network of providers that meets CMS requirements, or by paying no less than the Original Medicare payment rate and having providers deemed to be contracted as provided under providers accepting the plans' terms and conditions of payment, on a patient-by-patient and visit-by-visit basis. This process is also known as deeming.

Additionally, all non-employer PFFS Plans must meet Medicare access requirements through contracts with providers if two or more network-based MA Plan options exist.

Medicare Special Needs Plans (SNPs)	
Can you get your health care from any doctor or hospital?	You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).
Are prescription drugs covered?	Yes. All SNPs must provide Medicare prescription drug coverage (Part D).
Do you need to choose a primary care doctor?	Generally, yes.
Do you need a referral to see a specialist?	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.
04/02/2012	Medicare Advantage Plans and Other Medicare Plans
	24

Medicare Special Needs Plans (SNPs) are Medicare Advantage Plans designed to provide focused care management, special expertise of the plan's providers, and benefits tailored to enrollee conditions.

You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network, (except emergency care, out-of-area urgent care, or out-of-area dialysis).

All SNPs must provide Medicare Part D coverage.

You generally do need to choose a primary care doctor.

In most cases, you do need a referral to see a specialist. Certain services, like yearly screening mammograms, don't require a referral.

Medicare SNPs	
What do you need to know about this type of plan?	<ul style="list-style-type: none"> ▪ A plan must limit plan membership to people in one of the following groups: <ul style="list-style-type: none"> • Those living in certain institutions • Those eligible for both Medicare and Medicaid • Those with one or more specific chronic or disabling conditions ▪ Plan may further limit membership ▪ Plan should coordinate your needed services and providers ▪ Plan should make sure plan providers you use accept Medicaid if you have Medicare and Medicaid ▪ Plan should make sure plan providers serve people where you live if you live in an institution
04/02/2012	Medicare Advantage Plans and Other Medicare Plans
25	

Other things you need to know about Medicare Special Needs Plans (SNPs) include:

- A plan must limit plan membership to people in one of the following groups:
 - 1) People who live in certain institutions, (like a nursing home), or who require nursing care at home, or
 - 2) People who are eligible for both Medicare and Medicaid, or
 - 3) People who have one or more specific chronic or disabling conditions like diabetes, congestive heart failure, a mental health condition, or HIV/AIDS.
- Plans may further limit membership within these groups.
- Plans should coordinate the services and providers you need to help you stay healthy and follow your doctor's orders.
- If you have Medicare and Medicaid, your plan should make sure that all of the plan doctors or other health care providers you use accept Medicaid.
- If you live in an institution, make sure that plan doctors or other health care providers serve people where you live.

Medicare Advantage Plans can vary. Read individual plan materials carefully to make sure you understand the plan's rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.

Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.

Less Common Medicare Advantage Plans

- HMO Point of Service (HMOPOS) Plan
 - May allow out-of-network services
- Medical Savings Account (MSA) Plans
 - Combine high deductible plan with bank account
 - Medicare deposits money into account
 - Use money to pay for services

04/02/2012

Medicare Advantage Plans and Other Medicare Plans

26

Other, less common types of Medicare Advantage Plans include

- HMO Point of Service (HMOPOS) Plans—A plan that may allow you to get some services out-of-network for a higher cost.
- Medical Savings Account (MSA) Plans—A plan that combines a high deductible health plan with a bank account. Medicare deposits money into the account, and you use the money to pay for your health care services.

For more information about MSAs, visit www.medicare.gov/Publications/Pubs/pdf/11206.pdf to view the booklet, “Your Guide to Medicare Medical Savings Account Plans.” You can also call 1-800-MEDICARE (1-800-633-4227) to have a copy mailed to you. TTY users should call 1-877-486-2048.

Medicare Advantage Plan Networks

- Some types of MA plans have provider networks
- Plans may change networks mid-year
 - Must notify beneficiaries who see affected providers
 - 30 days prior to termination
 - Must maintain adequate access to services
 - Must protect beneficiaries from interruptions in medical care
- Mid-year network changes are not basis for SEP

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Medicare Advantage Plans and Other Medicare Plans

27

Network-based Medicare Advantage (MA) plans (e.g., HMO's, PPO's and PFFS plans with networks) can make changes to their network of contracted providers at any time during the year. It is important to note that CMS has safeguards in place to ensure that Medicare beneficiaries are protected from medical care interruptions.

- As an example, CMS requires plans to maintain continuity of care for impacted enrollees by ensuring continuous access to medically necessary services, without interruption, should a Medicare beneficiary's medical condition require it.


When MA plans make changes to their networks, CMS also requires that they maintain adequate access to all medically necessary Medicare Parts A and B services through their remaining provider network. If the remaining network does not meet Medicare access and availability standards, plans must add new providers necessary to meet CMS's access requirements.

Also, when an MA plan make a change in its provider network, it must provide written notification to beneficiaries who are seen on a regular basis by the provider whose contract is terminating. This notice must be given at least 30 days in advance of the termination date. In this notice, the plan must also provide a list of alternative providers and allow beneficiaries to choose another provider.

Loss of a provider network during the year is not usually a basis for an Enrollment Exception/Special Election Period.

An MA organization and a contracting provider must provide at least 60 days written notice to each other before terminating a contract without cause. A contract between an MA organization and a contracting provider may provide a requirement for notification of termination without cause for a longer period of time.

CMS does not get involved in contracting disputes.



5. Other Medicare Plans

- Medicare Cost Plans
- Medicare Innovation Projects
- PACE (Programs of All-inclusive Care for the Elderly)

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Medicare Advantage Plans and Other Medicare Plans

28

Lesson 5, *Other Medicare Plans*, provides information on

- Medicare Cost Plans
- Medicare Innovation Projects (demonstrations and pilot programs)
- PACE (Programs of All-inclusive Care for the Elderly)

Other Medicare Plans

- Not part of Medicare Advantage
- Still part of Medicare
- Some provide Part A and/or Part B coverage
- Some provide Part D coverage
- They include
 - Medicare Cost Plans
 - Medicare Innovation Projects
 - Programs of All-inclusive Care for the Elderly (PACE)

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Medicare Advantage Plans and Other Medicare Plans

29

Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage (MA) Plans but are still part of Medicare. Some of these plans provide Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage, and some also provide Part D (Medicare prescription drug) coverage. These plans have some of the same rules as MA Plans. Some of these rules are explained briefly on the next few slides. However, each type of plan has special rules and exceptions, so you should contact any plans you're interested in to get more details.

These plans include

- Medicare Cost Plans—similar to a HMO, but services received outside the plan are covered under Original Medicare
- Medicare Innovation Projects—special projects such as demonstrations and pilot programs that test possible future improvements in Medicare coverage, costs, and quality of care
- PACE (Programs of All-inclusive Care for the Elderly)—combine medical, social, and long-term care services for frail elderly people

NOTE: The next several slides provide a brief overview of each of the types of other Medicare plans. You are encouraged to insert slides and information specific to the plans available in your area.

Medicare Cost Plans

- Available in limited areas
- Must have Part B to join
- Can see a non-network provider
 - Services covered under Original Medicare
- Join anytime new members being accepted
- Leave any time and return to Original Medicare
- Get Medicare prescription drug coverage
 - From the plan (if offered)
 - Join a separate Medicare prescription drug plan

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Medicare Advantage Plans and Other Medicare Plans

30

Medicare Cost Plans are a type of Medicare health plan available only in certain areas of the country.

Medicare Cost Plans work like this:

- You can join even if you only have Part B.
- If you go to a non-network provider, the services are covered under Original Medicare. You would pay the Part B premium, and the Part A and Part B coinsurance and deductibles.
- You can join a Medicare Cost Plan any time it is accepting new members.
- You can leave a Medicare Cost Plan any time and return to Original Medicare.
- You can either get your Medicare prescription drug coverage from the plan (if offered), or you can buy a Medicare prescription drug plan to add prescription drug coverage. You can only add or drop Medicare Prescription Drug coverage at certain times.

For more information about Medicare Cost Plans, contact the plan you're interested in. Your State Health Insurance Assistance Program (SHIP) can also give you more information. You can also visit www.medicare.gov on the web.

Innovation Projects and Pilot Programs

- Special projects that test improvements
 - Medicare coverage
 - Payment
 - Quality of care
- Eligibility usually limited
 - Specific group of people or specific area of country
- Examples of how they help shape Medicare
 - MA Plan for End-Stage Renal Disease patients
 - New Medicare preventive services

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Medicare Advantage Plans and Other Medicare Plans

31

Medicare Innovation Projects and Pilot Programs are special projects that test improvements in Medicare coverage, payment, and quality of care. They are usually for a specific group of people and/or are offered only in specific areas. Some follow Medicare Advantage Plan rules, but others don't. The results of innovation projects have helped shape many of the changes in Medicare over the years.

Check with the innovation project or pilot program for more information about how it works.

To find more information, visit www.cms.gov/DemoProjectsEvalRpts/ or www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

NOTE: Instructor may add state specific content or provide an example.

Medicare PACE Plans

- Programs of All-inclusive Care for the Elderly
- Combine services for frail elderly people
 - Medical, social, and long-term care services
 - Include prescription drug coverage
- Alternative to nursing home care
- Only in states that offer it under Medicaid
- Qualifications vary from state to state
 - Contact state Medical Assistance office for information

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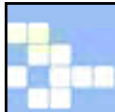
Medicare Advantage Plans and Other Medicare Plans

32

Programs of All-inclusive Care for the Elderly (PACE) combine medical, social, and long-term care services for frail elderly people who live in and get health care in the community. PACE programs provide all medically-necessary services, including prescription drugs. PACE might be a better choice for some people instead of getting care through a nursing home. PACE is a joint Medicare and Medicaid program that may be available in states that have chosen it as an optional Medicaid benefit, and the qualifications for PACE vary from state to state.

Call your state Medical Assistance (Medicaid) office to find out about eligibility and if a PACE site is near you.

NOTE: Instructor may highlight local plans.



6. Rights, Protections, and Appeals

- Guaranteed Rights and Protections
- Appeals
- Required Notices

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Medicare Advantage Plans and Other Medicare Plans

33

Lesson 6, *Other Medicare Plans*, provides information on

- Guaranteed Rights and Protections
- Appeals
- Required Notices

Guaranteed Rights

- To get needed health care services
- To receive easy-to-understand information
- To have personal medical information kept private

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Medicare Advantage Plans and Other Medicare Plans

34

All people with Medicare have certain guaranteed rights and protections. You have these rights and protections whether you are in Original Medicare, in an Medicare Advantage Plan or other Medicare plan, have a Medicare drug plan, or have a Medigap policy.

The following rights are guaranteed:

- To get the health care services you need
- To receive easy-to-understand information
- To have your personal medical information kept private

Rights in Medicare Health Plans

- Choice of health care providers
- Access to health care providers (treatment plan)
- Know how your doctors are paid
- Fair, efficient, and timely appeals process
- Grievance process
- Coverage/payment information before service
- Privacy of personal health information

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Medicare Advantage Plans and Other Medicare Plans

35

If you're in a Medicare health plan, in addition to the rights and protections previously described, you have the right to:

- Choose health care providers in the plan so you can get covered health care.
- Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need to. Women have the right to go directly to a women's health care specialist within the plan without a referral for routine and preventive health care services.
- Know how your doctors are paid if you ask your plan. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
- A fair, efficient, and timely appeals process to resolve payment and coverage disputes with your plan. You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued.
- File a grievance about other concerns or problems with your plan, e.g., if you believe your plan hours of operation should be different, or there aren't enough specialists in the plan to meet your needs. Check your plan membership materials or call your plan to find out how to file a grievance.
- Get a coverage decision or coverage information from your plan before getting a service to find out if it will be covered or to get information about your coverage rules. You can also call your plan if you have questions about home health care rights and protections. Your plan must tell you if you ask.
- Privacy of personal health information. For more information about your rights to privacy, look in your plan materials, or call your plan.

For more information, read your plan's membership materials or call your plan.

Appeals in Medicare Advantage Plans

- Plan must say in writing how to appeal if it
 - Will not pay for a service
 - Does not allow a service
 - Stops or reduces course of treatment
- Can ask for fast (expedited) decision
 - Plan must decide within 72 hours
- See plan membership materials
 - Instructions on how to file an appeal or grievance

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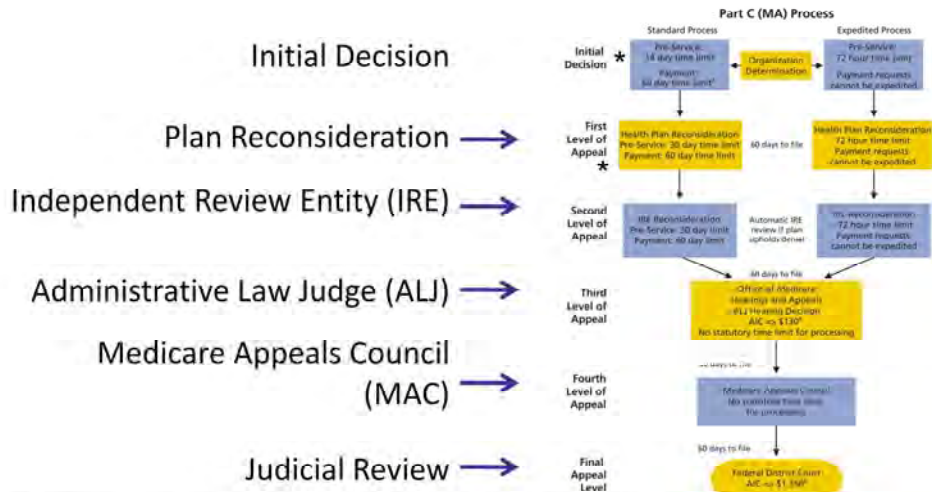
Medicare Advantage Plans and Other Medicare Plans

36

The plan must tell you in writing how to appeal. You can appeal if your plan will not pay for, does not allow, stops or reduces a course of treatment that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, you should ask the plan for an expedited appeal decision.

If a request for an expedited decision is requested or supported by a doctor, the plan must make a decision within 72 hours. You or the plan may extend the time-frame up to 14 days to get more medical information. After an appeal is filed, the plan will review its decision. Then, if the plan does not decide in your favor, an independent organization that works for Medicare—not for the plan—reviews the decision. See the plan membership materials or contact the plan for details about your Medicare appeal rights.

Medicare Part C Appeals Process



*These pre-service timeframes include a possible extension of up to 14 days

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Medicare Advantage Plans and Other Medicare Plans

37

This chart shows the appeal process for Medicare Advantage Plan or other Medicare health plan enrollees. The time frames differ depending on whether you are requesting a standard appeal, or if you qualify for an expedited (fast) appeal.

If you ask your plan to provide or pay for an item or service and your request is denied, you can appeal the plan’s initial decision (the “organization determination”). You will get a notice explaining why your plan denied your request and instructions on how to appeal your plan’s decision.

There are five levels of appeal. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so.

After each level, you will get instructions on how to proceed to the next level of appeal.

The five levels of appeal are

- Reconsideration by the plan
- Reconsideration by the Independent Review Entity (IRE)
- Hearing with the Administrative Law Judge (ALJ)
- Review by the Medicare Appeals Council (MAC)
- Review by a Federal district court

NOTE: This chart is available as a handout in the corresponding workbook (see Appendix B).

Medicare Health Plan Fast Appeals Process

- *Notice of Medicare Non-Coverage*
 - Provider must deliver at least 2 days before care will end
- If you think services are ending too soon
 - Contact your Quality Improvement Organization (QIO)
- QIO must notify you of its decision
 - COB the day after it receives all necessary information

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Medicare Advantage Plans and Other Medicare Plans

38

With the Medicare Health Plan Fast Appeals Process

- You have the right to ask your plan to provide or pay for a Medicare-covered service you think should be continued in a skilled nursing facility, from a home health agency, or in a comprehensive outpatient rehabilitation facility.
- Your provider must deliver a *Notice of Medicare Non-Coverage* at least 2 days before Medicare-covered skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), or home health aide (HHA) care will end.

If you think services are ending too soon, contact your Quality Improvement Organization (QIO) no later than noon the day before Medicare-covered services end to request a fast appeal. See your notice for how to contact your QIO and for other important information.

The QIO must notify you of its decision by close of business of the day after it receives all necessary information.

The plan must give you a *Detailed Explanation of Non-Coverage*. This notice will explain why the coverage is being discontinued.

You have the right to ask for a reconsideration by the QIO if you are dissatisfied with the results of the fast appeal.

Inpatient Hospital Appeals

- Provider/plan must provide Notice of Discharge and Medicare Appeal Rights (NODMAR)
 - At least the day before services end if
 - You disagree with discharge decision
 - Provider/plan lowers your care level
- Appeal to QIO by noon of first day after NODMAR
- Decision from QIO usually within 2 days
 - You remain in hospital
 - Incur no financial liability until QIO gives decision

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Medicare Advantage Plans and Other Medicare Plans

39

For inpatient hospital appeals, the provider or plan must provide a *Notice of Discharge and Medicare Appeal Rights (NODMAR)* at least the day before services end if you disagree with the discharge decision, or if the provider or plan is lowering the level of your care within the same facility.

You can then appeal by sending a request to the Quality Improvement Organization (QIO) by noon of the first day after receiving the NODMAR. The decision from the QIO is usually received within 2 days. You remain in the hospital pending the QIO's decision, and generally incur no financial liability.

However, you should be aware that you could be financially liable for inpatient hospital services provided after noon of the day after the QIO gives its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

More information on the notice is available at www.cms.gov/Transmittals/Downloads/R4QIO.pdf

Rights if You File an Appeal with Your Medicare Health Plan

- Right to get your files from the plan
 - Call or write your plan
 - Plan may charge a fee

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Medicare Advantage Plans and Other Medicare Plans

40

If you are in a Medicare health plan and you are filing an appeal, you have certain rights. You may want to call or write your plan and ask for a copy of your file. Look at your *Evidence of Coverage*, or the notice you received that explained why you could not get the services you requested, to get the phone number or address of your plan.

The plan may charge you a fee for copying this information and sending it to you. Your plan should be able to give you an estimate of how much it will cost based on the number of pages contained in the file, plus normal mail delivery.

Required Notices

- Plans must provide notices after every
 - Adverse determination
 - Adverse appeal
- Notice must include
 - Detailed explanation of services denied
 - Next appeal level
 - Specific instructions


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Medicare Advantage Plans and Other Medicare Plans

41

Plans are required to provide notices after every adverse coverage determination, also referred to as initial decision or appeal.

In addition, all appeal entities are required to send written notice when they make adverse decisions. These notices will explain the decision, including a detailed explanation of why the services were denied, information on the next appeal level, and specific instructions about how to file the appeal.



7. Medicare Marketing Guidelines

- Marketing Provisions
- Key Updates
- Promotional Activity Reminders
- Agent Information
- Marketing Surveillance

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Medicare Advantage Plans and Other Medicare Plans

42

Lesson 7, *Medicare Marketing Guidelines*, provides information on

- Marketing Provisions
- Key Updates
- Promotional Activity Reminders
- Agent Information
- Marketing Surveillance

Marketing Provisions

- Final 2012 Medicare Marketing Guidelines
 - Released May 18, 2011
- Policy clarifications and operational guidance
- CMS marketing requirements apply to
 - Medicare Advantage Plans
 - Medicare Prescription Drug Plans
 - Cost Plans

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Medicare Advantage Plans and Other Medicare Plans

43

On May 18, 2011, CMS released the final 2012 Medicare Marketing Guidelines for Medicare Advantage organizations (MAOs), prescription drug plan (PDP) sponsors, section 1876 cost-based contractors, demonstration plans and employer and union-sponsored group plans, including employer/union-only group waiver plans. The final 2012 Medicare Marketing Guidelines are posted at: <http://www.cms.hhs.gov/ManagedCareMarketing/> and are also being issued as Chapters 3 of the Medicare Managed Care Manual and 2 of the Prescription Drug Benefit Manual.

Marketing Provisions

- Certain beneficiary communication materials
 - Do not require review
 - Part C and Part D Plan sponsors are required
 - To use standardized model marketing materials
 - Under Parts C & D
 - When CMS provides standardized model materials

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Medicare Advantage Plans and Other Medicare Plans

44

Ad Hoc beneficiary communications materials under Medicare Parts C and D are materials that go out to a small subset of individuals in regard to a specific situation. Ad hoc communications materials about claims processing activities are excluded from the definition of marketing materials.

While current enrollee communication materials are not subject to the review and approval process that applies to marketing materials, CMS retains the right to review and approve current enrollee communication materials.

Medicare Advantage Organizations and Prescription Drug Plan sponsors are required to use standardized marketing material language and format, without modification, in every instance in which CMS provides standardized language and formatting.

Marketing Updates

- Non-health, non-plan related beneficiary mailings
 - Must include plan name or logo
- Social networking website marketing allowed
- Broker/agent compensation limits

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Medicare Advantage Plans and Other Medicare Plans

45

Plan sponsors must include the plan name or logo on non-health related, non-plan related beneficiary mailings.

Plan sponsors may use social networking sites, such as Facebook and Twitter, to market their products. CMS will monitor these sites carefully and as a result, may make future policy changes.

CMS has established limits on compensation to make sure that brokers and agents are not incentivized to encourage beneficiaries to select plans that may not meet their needs and/or preferences.

Disclosure of Plan Information for New and Renewing Members

- MA and PDPs must disclose plan information
 - At time of enrollment and at least annually
 - Required Annual Notice of Change/Evidence of Coverage
 - Comprehensive or Abridged Formulary
 - Pharmacy Directory
 - Provider Directory
 - Member ID card at the time of enrollment/as needed

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Medicare Advantage Plans and Other Medicare Plans

46

To ensure that beneficiaries receive comprehensive plan information regarding their healthcare options, CMS requires MA and PDP organizations to disclose certain plan information both at the time of enrollment and at least annually, 15 days prior to the Annual Election Period.

This requirement includes the annual dissemination of

- Standardized Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) that must be received by members no later than September 30 each year
- Comprehensive formulary or abridged formulary including information on how the beneficiary can obtain a complete formulary (Part D sponsors only)
- Pharmacy directory (for all plan sponsors offering a Part D benefit)
- Provider directory (for all plan types except PDPs)
- Membership identification card (required only at time of enrollment and as needed or required by plan sponsor post-enrollment)

Promotional Activity Reminders

Nominal Gifts

- Organizations can offer gifts to potential enrollees
 - Must be of nominal value
 - Defined in marketing guidelines
 - Currently set at \$15 or less based on retail price
- Must be given whether beneficiary enrolls or not

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Medicare Advantage Plans and Other Medicare Plans

47

Organizations can offer gifts to potential enrollees as long as such gifts are of nominal value and are provided whether or not the individual enrolls in the plan. Nominal value currently is defined as an item worth \$15 or less, based on the retail purchase price of the item regardless of the actual cost. CMS will update the nominal value in guidance as necessary to account for inflation and other relevant factors.

Promotional Activity Reminders

Unsolicited Contacts

- Extends existing door-to-door solicitation prohibition
 - Outbound marketing calls
 - Common areas
 - Calls/visits after attending sales event
 - Unless express permission given
 - Unsolicited emails

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Medicare Advantage Plans and Other Medicare Plans

48

The prohibition on door-to-door solicitation extends to other instances of unsolicited contact that may occur outside of advertised sales or educational events. Prohibited activities include, but are not limited to, the following

- Outbound marketing calls, unless the beneficiary requested the call. This includes contacting existing members to market other Medicare products, except as permitted below.
- Calls to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling, to market plans or products, except as permitted below.
- Calls to beneficiaries to confirm receipt of mailed information, except as permitted below.
- Calls to beneficiaries to confirm acceptance of appointments made by third parties or independent agents.
- Approaching beneficiaries in common areas, (i.e. parking lots, hallways, lobbies, etc.)
- Calls or visits to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call or visit.

Organizations may do the following

- Outbound calls to existing members to conduct normal business related to enrollment in the plan, including calls to members who have been involuntarily disenrolled to resolve eligibility issues.
- Call former members after the disenrollment effective date to conduct disenrollment survey for quality improvement purposes. Disenrollment surveys may be done by phone or sent by mail, but neither calls nor mailings may include sales or marketing information.
- Under limited circumstances and subject to advance approval from the appropriate CMS Regional Office, call LIS-eligible members when their plan is prospectively losing due to reassignment to encourage them to remain enrolled in their current plan.
- Call beneficiaries who have expressly given permission for a plan or sales agent to contact them, for example by filling out a business reply card or asking a Customer Service Representative (CSR) to have an agent contact them.

Promotional Activity Reminders

Cross Selling

- Prohibited during any MA or Part D sales activity/presentation
- Cannot market non-health related products
 - Annuities
 - Life insurance
 - Other products
- Allowed on inbound calls per request

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Medicare Advantage Plans and Other Medicare Plans

49

Marketing health care related products, (such as annuities and life insurance), to prospective enrollees during any MA or Part D sales activity or presentation is considered cross-selling and is a prohibited activity. Beneficiaries already face difficult decisions regarding Medicare coverage options and should be able to focus on Medicare options without confusion or implication that the health and the non-health products are a package. Plans may sell non-health related products on inbound calls when a beneficiary requests information on other non-health related products. Marketing to current plan members of non-MA plan covered health care products, and/or non-health care products, is subject to Health Insurance Portability and Accountability Act (HIPAA) rules.

The Centers for Medicare & Medicaid Services (CMS) is concerned about the marketing of non-health related products during hold-time messages and on interactive voice response (IVR) systems that plans may use to automate their inbound calling interface. We are considering providing guidance on prohibiting or limiting cross-selling during these types of messages, and are interested in receiving industry feedback during User Group calls.

Promotional Activity Reminders

Scope of Appointments

- Must specify product type
 - Prior to marketing and/or in-home appointment
 - Medigap
 - MA
 - PDP
 - Other
- Additional products can only be discussed
 - On beneficiary request
 - At separate appointment

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Medicare Advantage Plans and Other Medicare Plans

50

Medicare Marketing Guidelines require marketing representatives to clearly identify the types of products to be discussed before marketing to a potential enrollee. Marketing representatives who initially meet with a beneficiary to discuss specific lines of plan business, (separate lines of business include Medigap, MA, and PDP), must inform the beneficiary of all products to be discussed prior to the in-home appointment so they have accurate information to make an informed choice about their Medicare benefits without pressure.

Before a marketing appointment, the beneficiary must agree to the scope of the appointment. The agreement must be documented by the plan in writing or recorded by phone.

- Example: A beneficiary attends a sales presentation and schedules an appointment. The agent must get written documentation signed by the beneficiary agreeing to the products that will be discussed during the appointment.

Appointments made over the phone must be documented by a recording. Organizations should use their existing systems to monitor and track calls where there is beneficiary interaction.

Organizations that contact a beneficiary in response to a reply card may only discuss the products that were included in the advertisement. Additional products may not be discussed unless the beneficiary requests the information. In addition, any additional lines of plan business that are not identified prior to the in-home appointment will require a separate appointment.

Promotional Activity Reminders

Health Care Settings

- Marketing allowed in common areas
 - Hospital or nursing home cafeterias
 - Community or recreational rooms
 - Conference rooms
- No marketing in health care setting
 - Waiting rooms
 - Exam rooms and hospital patient rooms
 - Dialysis centers and pharmacy counter areas

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Medicare Advantage Plans and Other Medicare Plans

51

Organizations may not conduct marketing activities in health care settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

Plans are prohibited from conducting sales presentations and distributing and accepting enrollment applications in areas where patients primarily intend to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis centers, and pharmacy counter areas (where patients wait for services or interact with pharmacy providers and obtain medications).

Only upon request by the beneficiary are plans permitted to schedule appointments with beneficiaries residing in long-term care facilities.

Additionally, providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships.

Promotional Activity Reminders

Educational Events

- No marketing activities at educational events
 - Health information fairs
 - Conference expositions
 - State- or community-sponsored events
- Plans may distribute
 - Medicare and/or health educational materials
 - Agent/broker business cards
 - Containing no marketing information

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Medicare Advantage Plans and Other Medicare Plans

52

Educational events may not include sales activities such as the distribution of marketing materials or the distribution or collection of plan applications. CMS has clarified that the purpose of educational events is to provide objective information about the Medicare program and/or health improvement and wellness. As such, educational events should not be used to steer or attempt to steer a beneficiary toward a specific plan.

Educational events may be sponsored by the plan(s) or by outside entities, and are events that are promoted to be educational in nature and have multiple vendors, such as health information fairs, conference expositions, state or community sponsored events, etc.

A sales event is an event that is sponsored by a plan or another entity with the purpose of marketing to potential members and steering, or attempting to steer, potential members towards a plan.

Promotional Activity Reminders

Prohibition of Meals

- Prospective enrollees may not
 - Be provided meals
 - Have meals subsidized
- At any event or meeting where
 - Plan benefits are being discussed, or
 - Plan materials are being distributed

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Medicare Advantage Plans and Other Medicare Plans

53

Medicare Advantage and Medicare Prescription Drug Plans may not allow prospective enrollees to be provided meals, or have meals subsidized, at sales events or any meeting at which plan benefits are being discussed and/or plan materials are being distributed.

Agents and/or Brokers are allowed to provide refreshments and light snacks to prospective enrollees. Plans must use their best judgment on the appropriateness of food products provided, and must ensure that items provided could not be reasonably considered a meal, and/or that multiple items are not being “bundled” and provided as if a meal.

While CMS does not intend to define the term “meal” or create a comprehensive list of food products that qualify as light snacks, items similar to the following could generally be considered acceptable:

- Fruit, raw vegetables, pastries, cookies or other small dessert items, crackers, muffins, cheese, chips, yogurt, and nuts.

As with all marketing regulation and guidance, it is the responsibility of MA and PDP organizations to monitor the actions of all agents selling their plan(s) and take proactive steps to enforce this prohibition. Oversight activities conducted by CMS will verify that plans and agents are complying with this provision, and enforcement actions will be taken as necessary.

State Licensure of Agents

- MA and PDP organization agents/brokers
 - Must be state-licensed, certified, or registered
 - Applies to contracted and employed agents/brokers

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Medicare Advantage Plans and Other Medicare Plans

54

MA organizations and Part D sponsors that conduct marketing through independent agents must use state-licensed, certified, or registered individuals.

Both independent agents and internal sales staff that perform marketing must comply with applicable state licensure laws.

State Appointment of Agents

- Organizations must comply with state appointment laws
 - Plans must give information about agents
- Required appointment fees must be paid

MA and PDP organizations must comply with state appointment laws that require plans to give the state information about which agents are marketing the Part C and Part D plans.

Organizations must also pay any fees that would be charged in connection with state appointment laws.

Reporting of Terminated Agents

- Organizations must report termination of agents/brokers
 - In accordance with state appointment law
 - To state where agent/broker is appointed
 - Must include reasons for termination

Medicare Advantage Organizations (MAOs) or Part D sponsors must report the termination of any brokers or agents, and the reasons for the termination, to the state in which the broker or agent has been appointed in accordance with the state appointment law.

Agent/Broker Compensation

- Rules
 - For contracted or independent agents/brokers
 - Designed to eliminate incentives
 - i.e. Encouraging inappropriate moves from plan to plan

Compensation rules for Medicare Advantage Plans and Medicare Prescription Drug Plans that market through contracted or independent agents/brokers are designed to eliminate incentives that encouraged inappropriate moves from plan to plan.

Agent/Broker Training and Testing

- Agents/brokers must be trained/tested annually
 - Medicare rules and regulations
 - Plan details specific to plan products sold
 - Both contracted and employed agents
 - Completed prior to start of marketing season
 - To market after that date

04/02/2012

Medicare Advantage Plans and Other Medicare Plans

58

Medicare Advantage Organizations (MAOs) and Part D sponsors must ensure that annually brokers and agents selling Medicare products are trained and tested on Medicare rules and regulations, and on plan details specific to the plan products being sold by the brokers and agents. Training and testing must be completed prior to the start of the new marketing season in order for the broker/agent to market after that date.

Agent/Broker Training and Testing

- Passing score of 85% required
 - Written or computerized
 - Must maintain integrity
 - Must have process for those who don't pass the test

04/02/2012

Medicare Advantage Plans and Other Medicare Plans

59

In order to sell Medicare products, a broker or agent should receive a passing score of at least 85% on the test. Tests may be in the form of a written or computerized test. Organizations and sponsors must ensure that their training and testing programs are designed and implemented in a way that the integrity of the training and testing is maintained. In doing so, they must have a process for handling instances in which agents do not pass the test on the first try.

CMS Marketing Surveillance

- Oversight of marketing activity
 - Detect, prevent and respond to marketing violations
 - Secret shopping public sales events
 - Secret shopping one-on-one appointments
 - Special focus on non-renewals (NR)
 - In 55 markets with highest NR rates
 - Plan call centers

04/02/2012

Medicare Advantage Plans and Other Medicare Plans

60

Oversight of marketing activity vulnerability in marketing was identified due to persistent complaints and evidence of agent and broker misconduct. CMS developed a comprehensive surveillance strategy designed to detect, prevent, and respond to marketing violations. CMS continues and adds to its surveillance strategy to monitor for marketing compliance, including:

- Secret shopping to assess compliance with marketing requirements at public sales events.
- One-on-one (staged) appointment secret shopping to assess compliance with marketing requirements at one-on-one settings with marketing agents and plan representatives.
- Non-renewal (NR) focused secret shopping in markets with highest non-renewing rates to ensure remaining plans were not using scare tactics to gain enrollees.
- Secret shopping of NR plan's call centers to assess the accuracy of customer services representative information to potential enrollees related to NR activity.

CMS Marketing Surveillance

- Surveillance strategy
 - Clipping Service (newspaper ads)
 - Website review
 - “Real-time” observations and responses
 - Ensure plans detect, report, and respond to agent/broker marketing misrepresentation

04/02/2012

Medicare Advantage Plans and Other Medicare Plans

61

CMS surveillance strategy to monitor for marketing compliance, continued:

- Clipping Service (newspaper ads) to assess whether marketing events are reported to CMS and to examine marketing ads for inappropriate/misleading language around NR activity.
- Marketing website review to verify that required marketing identification numbers and approval dates are present on each website and that required links are active.
- Ensuring that health and drug plans detect, report, and respond to agent/broker marketing misrepresentation and other issues.

The CMS surveillance philosophies include

- “Real-time” observations and responses
- Resources allocated initially based on risk (then adjusted based on performance)
- Providing the industry the opportunity to research and respond to violations
- Compliance action is taken only when deficiencies are confirmed and validated
 - The severity of compliance action is based on severity and recurrence of violations.

There is still room for improvement. Approximately 40% of public sales events had one or more violations. There has been a lower incidence of egregious behavior/aggressive marketing tactics than prior years, but there are still problems in providing clear, complete, and accurate information around health plan and drug benefits.

8. Resources for More Information

Resources		Medicare Products
<p>Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) www.medicare.gov</p> <p>www.CMS.gov</p> <p>Social Security 1-800-772-1213 TTY 1-800-325-0778 www.socialsecurity.gov/</p> <p>Railroad Retirement Board 1-877-772-5772 www.rrb.gov/</p>	<p>State Health Insurance Assistance Programs (SHIPs)*</p> <p>*For telephone numbers call CMS 1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 for TTY users</p> <p>www.HealthCare.gov</p> <p>www.pcip.gov</p> <p>Affordable Care Act www.healthcare.gov/law/full/index.htm</p>	<p>Medicare & You Handbook CMS Product No. 10050)</p> <p>Your Guide to Medicare Private Fee-for-Service Plans CMS Product No. 10144</p> <p>Understanding Medicare Enrollment Periods CMS Product No. 11219</p> <p>Your Guide to Medicare Savings Account Plans CMS Product No. 11206</p> <p>Your Guide to Special Needs Plans CMS Product No. 11302</p> <p>To access these products View and order single copies at www.medicare.gov</p> <p>Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.</p>



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 **National Medicare**
TRAINING PROGRAM

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NMTP@cms.hhs.gov

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or to subscribe to our listserv, visit
www.cms.gov/NationalMedicareTrainingProgram

When You Can Join or Switch MA Plans*

Initial Enrollment Period (IEP)

- 7 month period begins 3 months before the month you turn 65
 - Includes the month you turn 65
 - Ends 3 months after the month you turn 65

Medicare Open Enrollment Period “Open Enrollment”

- Oct 15 – Dec 7
- Coverage begins Jan 1

*Plan must be allowing new members to join

When You Can Join or Switch MA Plans*

Special Enrollment

Period (SEP)

- Move from plan service area
- Plan leaves Medicare program
- Other special situations

*Plan must be allowing new members to join

When You Can Join or Switch MA Plans*

5-Star Special Enrollment Period (SEP)

- Can enroll in a MA, MAPD or PDP Plan with a 5-Star Overall Rating
- Enroll at any point during the year
 - Once per year
- New plan starts first of month after enrolled
- Star ratings on Plan Finder in October
- Updated yearly

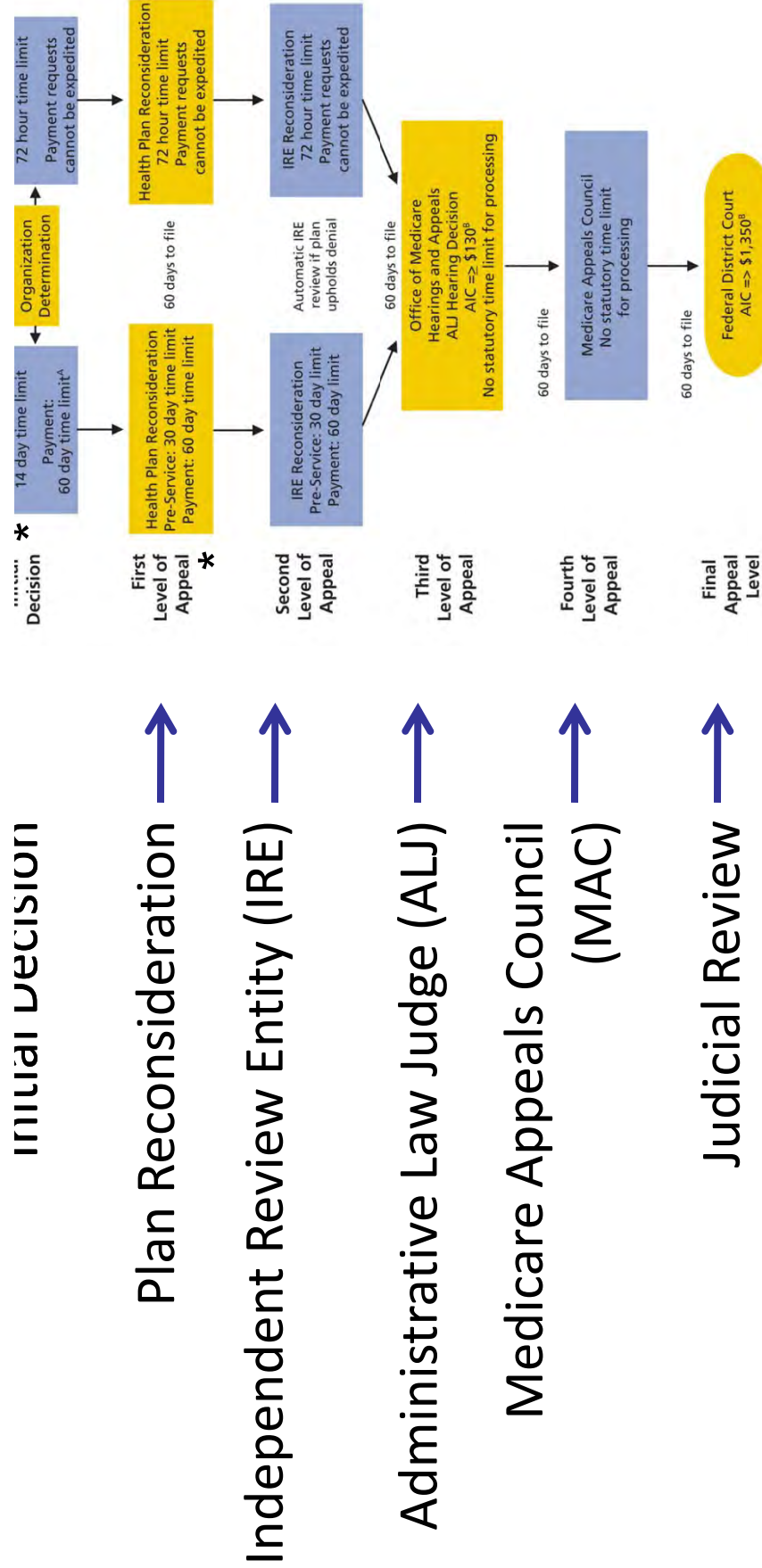
*Plan must be allowing new members to join

When You Can Leave MA Plans

Jan 1 – Feb 14

- Can leave MA Plan
- Switch to Original Medicare
- Coverage begins first day of month after switch
- May join Part D Plan
 - Drug coverage begins first day of month after plan gets enrollment
 - May not join another MA Plan during this period

Medicare Part C Appeals Process



*These pre-service timeframes include a possible extension of up to 14 days



E-mail: NMTP@cms.hhs.gov

Website: cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/

Centers for Medicare & Medicaid Services
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