2015 National Training Program

Module 11
Medicare Advantage and Other Medicare Health Plans
Session Objectives

This session should help you to

- Define Medicare Advantage (MA) Plans
- Describe how MA Plans work
- Explain eligibility requirements and enrollment
- Recognize types of MA Plans
- Identify other Medicare Health plans
- Recall rights, protections, and appeals
- Summarize Medicare Marketing Guidelines
Lesson 1—Medicare Advantage (MA) Plan Overview

- What is an MA Plan
- How MA Plans work
- When you can join or switch plans
- Types of 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
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 use network doctors/hospitals
- May differ from Original Medicare
  - Benefits
  - Cost sharing
How Medicare Advantage (MA) Plans Work (Continued)

β You’re still in the Medicare program
  • Medicare pays the plan every month for your care
β You still have Medicare rights and protections
β If the plan leaves Medicare you can
  • Join another MA Plan, or
  • Return to Original Medicare
Medicare Advantage Costs

- You still pay the Part B premium
  - A few plans may pay all or part for you
  - State assistance for some

- You may pay plan an additional monthly premium

- You pay deductibles, coinsurance, and copayments
  - Different from Original Medicare
  - Vary from plan to plan
  - May be higher if out of network
Who Can Join a Medicare Advantage Plan?

Eligibility requirements
- Enrolled in Medicare Part A (Hospital Insurance)
- Enrolled in Medicare Part B (Medical Insurance)
- Live in the plan’s service area

To join you must also
- Provide necessary information to the plan
- Follow the plan’s rules

Can only belong to one plan at a time
Medicare Advantage and End-Stage Renal Disease (ESRD)

β Usually you can’t enroll if you have ESRD
β There are limited exceptions
  • Transition from one plan to another within the same parent organization
  • No break between coverage
  • Must meet all other enrollment requirements
β Person who receives a kidney transplant or no longer requires a regular course of dialysis
  • Isn’t considered to have ESRD for Medicare Advantage (MA) eligibility purposes
<table>
<thead>
<tr>
<th><strong>When You Can Join or Switch Medicare Advantage Plans</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Enrollment Period</strong></td>
</tr>
<tr>
<td>- 7-month period begins 3 months before the month you turn 65</td>
</tr>
<tr>
<td>- Includes the month you turn 65</td>
</tr>
<tr>
<td>- Ends 3 months after the month you turn 65</td>
</tr>
<tr>
<td><strong>Medicare Open Enrollment Period “Open Enrollment”</strong></td>
</tr>
<tr>
<td>- October 15–December 7</td>
</tr>
<tr>
<td>- Coverage begins January 1</td>
</tr>
<tr>
<td><strong>Medicare due to a Disability</strong></td>
</tr>
<tr>
<td>- 7-month period begins 3 months before the 25th month of disability.</td>
</tr>
<tr>
<td>- Ends 3 months after the 25th month of disability.</td>
</tr>
</tbody>
</table>

Plans must be allowing new members to join
### When You Can Join or Switch Plans

<table>
<thead>
<tr>
<th>Special Enrollment Periods (SEP)</th>
<th>Move out of your plan’s service area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan leaves Medicare program or reduces its service area</td>
</tr>
<tr>
<td></td>
<td>Leaving or losing employer or union coverage</td>
</tr>
<tr>
<td></td>
<td>You enter, live at, or leave a long-term care facility</td>
</tr>
<tr>
<td></td>
<td>You have a continuous SEP if you qualify for Extra Help</td>
</tr>
<tr>
<td></td>
<td>Losing your Extra Help status</td>
</tr>
<tr>
<td></td>
<td>You join or switch to a plan that has a 5-star rating</td>
</tr>
<tr>
<td></td>
<td>Retroactive notice of Medicare entitlement</td>
</tr>
<tr>
<td></td>
<td>Other exceptional circumstances</td>
</tr>
</tbody>
</table>
When You Can Join or Switch MA Plans

5-Star Special Enrollment Period (SEP)

- Can enroll in 5-star Medicare Advantage (MA), Prescription Drug Plan (PDP), Medicare Advantage Plan with prescription drug coverage (MA-PD), or Cost Plan
- Enroll once per year from December 8, 2014–November 30, 2015
- New plan starts first day of month after enrolled
- Star ratings given once per year
  - Ratings assigned in October and effective January 1st
  - Use Medicare Plan Finder to see star ratings
  - Look at Overall Plan Rating to find eligible plans
Low Performing Plan

Low performing star rating status

• You may have a one-time option to switch to another Medicare drug plan with a rating of 3, 4, or 5 stars if your plan’s summary rating was less than 3 stars for 3 years

• Low Performance Icon (LPI) appears on Plan Finder

• Plans may not attempt to discredit their LPI status by showcasing a separate higher rating
### When You Can Leave Medicare Advantage Plans

<table>
<thead>
<tr>
<th>January 1 – February 14</th>
<th>You can leave a Medicare Advantage (MA) Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Switch to Original Medicare</td>
</tr>
<tr>
<td></td>
<td>• Coverage begins first day of month after switch</td>
</tr>
<tr>
<td></td>
<td>• May join Part D Plan</td>
</tr>
<tr>
<td></td>
<td>• Drug coverage begins first day of month after plan gets enrollment</td>
</tr>
<tr>
<td></td>
<td>May not join another MA Plan during this period</td>
</tr>
<tr>
<td></td>
<td>May be able to buy a Medicare Supplement Insurance (Medigap) policy</td>
</tr>
</tbody>
</table>
Medicare Advantage Trial Rights and Medigap

Special Medigap rights for people who join a Medicare Advantage Plan for the first time

- When first eligible at 65 or
- Leave Original Medicare and drop a Medigap policy

Can disenroll during the first 12 months

- Return to Original Medicare
- Have guaranteed issue rights for Medigap
Types of Medicare Advantage Plans

- Health Maintenance Organization (HMO)
- HMO Point-of-Service
- Preferred Provider Organization
- Special Needs Plan
- Private Fee-for-Service
- Medicare Medical Savings Account
**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 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? | • 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 rules. For example, the plan may require prior approval for certain services. |
# Medicare Preferred Provider Organization (PPO) Plan

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you get your health care from any doctor or hospital?</td>
<td>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.</td>
</tr>
<tr>
<td>Are prescription drugs covered?</td>
<td>In most cases, yes. If you want Medicare drug coverage, you must join a PPO Plan that offers prescription drug coverage. You may contact individual plans to find out if they offer prescription drug coverage.</td>
</tr>
<tr>
<td>Do you need to choose a primary care doctor?</td>
<td>No.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>In most cases, no.</td>
</tr>
<tr>
<td>What else do you need to know about this type of plan?</td>
<td>ß PPO Plans aren’t the same as Original Medicare or Medigap. ß Medicare PPO Plans usually offer extra benefits than Original Medicare, but you may have to pay extra for these benefits.</td>
</tr>
</tbody>
</table>
## Medicare Special Needs Plans (SNPs)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you get your health care from any doctor or hospital?</td>
<td>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).</td>
</tr>
<tr>
<td>Are prescription drugs covered?</td>
<td>Yes. All SNPs must provide Medicare prescription drug coverage (Part D).</td>
</tr>
<tr>
<td>Do you need to choose a primary care doctor?</td>
<td>Generally, yes.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.</td>
</tr>
</tbody>
</table>
Medicare Special Needs Plans (SNPs) Continued

<table>
<thead>
<tr>
<th>What else do you need to know about this type of plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ A plan must limit plan membership to people in one of the following groups:</td>
</tr>
<tr>
<td>1. Those living in certain institutions (like a nursing home), or who require nursing care at home</td>
</tr>
<tr>
<td>2. Those eligible for both Medicare and Medicaid</td>
</tr>
<tr>
<td>3. Those with specific chronic or disabling conditions</td>
</tr>
<tr>
<td>☐ Plan may further limit membership</td>
</tr>
<tr>
<td>☐ Plan should coordinate your needed services and providers</td>
</tr>
<tr>
<td>☐ Plan should make sure providers that you use accept Medicaid if you have Medicare and Medicaid</td>
</tr>
<tr>
<td>☐ Plan should make sure that plan’s providers serve people where you live, if you live in an institution</td>
</tr>
</tbody>
</table>
### 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. 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 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.
### Medicare Private Fee-for-Service (PFFS) Plan (Continued)

<table>
<thead>
<tr>
<th>What else do you need to know about this type of plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ PFFS Plans aren’t the same as Original Medicare or Medigap</td>
</tr>
<tr>
<td>✅ The plan decides how much you must pay for services</td>
</tr>
<tr>
<td>✅ Some PFFS Plans contract with a network of providers who agree to always treat you even if you’ve never seen them before</td>
</tr>
<tr>
<td>✅ Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you’ve seen them before</td>
</tr>
<tr>
<td>✅ For each service you get, make sure that your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan’s payment terms</td>
</tr>
<tr>
<td>✅ In an emergency, doctors, hospitals, and other providers must treat you</td>
</tr>
</tbody>
</table>
Medicare Private Fee-for-Service (PFFS) Plan Access Requirements

- Employer/union-sponsored PFFS Plans must meet access requirements
  - Plans may meet access requirements through a contracted network of providers
- Non-employer PFFS Plans must meet access requirements through contracts with providers
  - Where 2 or more network-based Medicare Advantage Plan options exist
Medical Savings Account Plans

- Combine high-deductible plan with a bank account
- Medicare deposits money into account
- Use money to pay for services
Many types of MA Plans have provider networks.

Plans may change networks at any time:
- Must protect beneficiaries from interruptions in medical care.
- Must maintain adequate access to services.
- Must notify beneficiaries who see affected providers at least 30 days prior to termination.

Mid-year network changes aren’t a basis for a Special Enrollment Period in most cases.
Check Your Knowledge—Question 1

Medicare Advantage Plans are sometimes called

a. Part A
b. Part B
**c. Part C**
d. Part D
Check Your Knowledge—Question 2

Most people enrolled in a Medicare Advantage Plan are no longer required to pay a monthly Medicare Part B premium.

a. True

b. False
Lesson 2—Other Medicare Health Plans

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

Other types of Medicare health plans that provide health care coverage aren’t part of Medicare Advantage

- But are still part of Medicare
- Some provide Part A and/or Part B coverage
- Some provide Medicare prescription drug coverage
Medicare Cost Plans

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

Special projects that test improvements in:
- 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
Medicare Program of All-inclusive Care for the Elderly (PACE) Plans

- Combines 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 (Medicaid) office for information
Check Your Knowledge—Question 3

Programs of All-inclusive Care for the Elderly (PACE) is a type of Medicare Advantage Plan.

a. True

b. False
Lesson 3—Rights, Protections, and Appeals

- Guaranteed Rights and Protections
- Appeals
- Required Notices
- Medicare Advantage Plan Marketing Reminders
Guaranteed Rights

- Get needed health care services
- Get easy-to-understand information
- Have 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
Appeals in Medicare Advantage Plans

Plan must say in writing how you can appeal if it
• Won’t pay for a service
• Doesn’t allow a service
• Stops or reduces course of treatment

Can ask for expedited (fast) decision
• Plan must decide within 72 hours

See plan membership materials
• Instructions on how to file an appeal or grievance
Medicare Part C Appeals Process

Initial Determination

Plan Reconsideration

Independent Review Entity (IRE)

Administrative Law Judge (ALJ)

Medicare Appeals Council (MAC)

Judicial Review

*These pre-service time frames include a possible extension of up to 14 days.
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
The Centers for Medicare & Medicaid Services (CMS) requires review and approval of certain materials. Exceptions are listed in Section 20 of the Medicare Marketing Guidelines. Plans must maintain materials and make them available upon CMS’s request. CMS creates standardized and model marketing materials.
Marketing Reminders

Marketing for upcoming plan year
  - May not occur before October 1

Marketing star ratings in materials
  - Individual measures may be marketed
    - Communicated in conjunction with overall performance rating
  - Low-performing star rating status
    - Low Performance Icon (LPI)
    - Plans may not attempt to discredit their LPI status by showcasing a separate higher rating
Disclosure of Plan Information for New and Renewing Members

- Medicare Advantage and Prescription Drug Plans must disclose plan information
  - At time of enrollment and at least annually
    - Required Annual Notice of Change/Evidence of Coverage
    - Low Income Subsidy (LIS) rider
    - Comprehensive or abridged formulary
    - Member ID card at the time of enrollment/as needed
  - At time of enrollment and at least every 3 years after
    - Pharmacy directory
    - Provider directory

- Documents for new enrollees must be provided to CMS
Nominal Gift Reminders

Nominal gifts

- Organizations can offer gifts to potential enrollees
  - Must be of nominal value
  - Defined in Medicare Marketing Guidelines
  - Currently $15 or less based on retail value
  - Given regardless of beneficiary enrollment
  - May not be in the form of cash or other monetary rebates
Unsolicited Beneficiary Contact

Prohibited Unsolicited Marketing Activities

- Electronic communications
  - Unless express permission is given
- Door-to-door solicitation
- Calls/visits after attending sales event
  - Unless express permission given
- Common areas
Cross-Selling Prohibition

Cross-selling

• Prohibited during any Medicare Advantage or Part D sales activity or presentation
• Can’t market non-health related products
  • Annuities
  • Life insurance
  • Other products
• Allowed on inbound calls per beneficiaries’ request
Scope of Appointment Reminders

Scope of Appointment

• Must specify product type
  • Medicare Advantage, Medicare Prescription Drug Plans, Medigap, or other
• 48 hours prior to marketing and/or in-home appointment
• Additional products can only be discussed
  • Upon beneficiary request
  • At separate appointment
Marketing in Health Care Settings

Marketing allowed in health care common areas

- Hospital or nursing home cafeterias
- Community or recreational rooms
- Conference rooms

No marketing in health care settings where patients intend to receive care

- Waiting rooms
- Exam rooms and hospital patient rooms
- Dialysis centers and pharmacy counter areas
Promotional Activity Reminders

Prohibition of meals

• Prospective enrollees may not
  q Be provided meals
  q Have meals subsidized

• At any event or meeting where
  q Plan benefits are being discussed, or
  q Plan materials are being distributed
Educational Event Reminders

- Educational events for prospective members
  - No marketing activities at educational events
  - Plans may distribute
    - Medicare and/or health educational materials
    - Agent/broker business cards
  - Distributed material must not contain marketing information
Rewards and Incentives

 Regulation 4159-F expands rewards and incentive programs

 Applies to Medicare Advantage Organizations

 Focus on encouraging participation in activities that promote
  • Improved health
  • Prevention of injuries and illness
  • Efficient use of health care resources
Licensure and Appointment of Agents

Medicare Advantage and Prescription Drug Plan organization agents/brokers or other marketing representatives

• Must comply with state-licensure laws
  q Applies to contracted and employed agents/brokers

• Organizations must comply with state appointment laws
  q Plans must give information about agents
Reporting of Terminated Agents

β Organizations must report termination of agents/brokers

- Must include reasons for termination
- To the state(s) where agent/broker is appointed
- In accordance with state appointment law
Agent/Broker Compensation Rules

The Centers for Medicare & Medicaid Services compensation rules

- For contracted or independent agents/brokers
- Designed to eliminate incentives
  - For example, encouraging inappropriate moves from plan to plan
- Guidelines for plan recoupment of compensation under certain circumstances
Agent/Broker Compensation Definition

The Centers for Medicare & Medicaid Services defines compensation as monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy

- Compensation year January 1–December 31
- Initial compensation
  - “Unlike plan type”
- Renewal compensation
  - “Like plan type”
Agent/Broker Training and Testing

Agents/brokers must be trained and tested annually

- Medicare rules and regulations
- Plan details specific to plan products sold
- Applies to contracted and employed agents
- Completed prior to start of marketing season
  - Must pass with 85% to market after that date
Check Your Knowledge—Question 4

Who’s responsible for training and testing agents/brokers about the Medicare program and proper marketing of Medicare products?

a. The Centers for Medicare & Medicaid Services

b. Medicare health and drug plans

c. State Department of Insurance

d. Insurance associations
Agents or brokers are permitted to set up individual marketing appointments at educational events.

a. True

b. False
# Medicare Advantage and Other Medicare Plans Resource Guide

<table>
<thead>
<tr>
<th>Resources</th>
<th>Medicare Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare &amp; Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048 Medicare.gov</td>
<td>“Medicare &amp; You Handbook” CMS Product No. 10050</td>
</tr>
<tr>
<td>Medicare.gov</td>
<td>“Have You Done Your Yearly Medicare Plan Review?” CMS Product No. 11220</td>
</tr>
<tr>
<td>Social Security 1-800-772-1213. TTY users should call 1-800-325-0778 socialsecurity.gov</td>
<td>“Medicare Supplement Insurance, Getting Started” CMS Product No. 11575</td>
</tr>
<tr>
<td>Railroad Retirement Board 1-877-772-5772. TTY users should call 1-312-751-4701 RRB.gov</td>
<td>“Your Guide to Medicare Private Fee-for-Service Plans” CMS Product No. 10144</td>
</tr>
<tr>
<td>Medicare Managed Care Manual CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c03.pdf</td>
<td>“Understanding Medicare Enrollment Periods” CMS Product No. 11219</td>
</tr>
<tr>
<td>State Health Insurance Assistance Programs For telephone numbers call CMS 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048</td>
<td>“Your Guide to Special Needs Plans” CMS Product No. 11302</td>
</tr>
<tr>
<td>Affordable Care Act HealthCare.gov/law/full/index.htm</td>
<td><strong>To access these products</strong> View and order single copies at Medicare.gov/publications</td>
</tr>
<tr>
<td></td>
<td>Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization</td>
</tr>
</tbody>
</table>
Appendix A

Part C (MA) Process

- **Standard Process**
  - Initial Decision: Pre-Service: 14 day time limit; Payment: 60 day time limit
  - First Level of Appeal: Health Plan Reconsideration; Pre-Service: 30 day time limit; Payment: 60 day time limit
  - Second Level of Appeal: IRE Reconsideration; Pre-Service: 30 day time limit; Payment: 60 day limit
  - Third Level of Appeal: Office of Medicare Hearings and Appeals; ALJ Hearing Decision; AIC >= $150
  - Fourth Level of Appeal: Medicare Appeals Council
  - Final Appeal Level: Federal District Court; AIC >= $1,460

- **Expedited Process**
  - Initial Decision: Organization Determination; Pre-Service: 72 hour time limit; Payment requests cannot be expedited
  - Health Plan Reconsideration; Pre-Service: 72 hour time limit; Payment requests cannot be expedited
  - Automatic IRE review if plan upholds denial
  - Third Level of Appeal: Office of Medicare Hearings and Appeals; ALJ Hearing Decision; AIC >= $150
  - Fourth Level of Appeal: Medicare Appeals Council
  - Final Appeal Level: Federal District Court; AIC >= $1,460
Appendix B—Appeals Flowcharts Footnote

a: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days;
b: The AIC requirement for all ALJ hearings and Federal District Court hearings is adjusted annually in accordance with the medical care component of the Consumer Price Index;

AIC = Amount in Controversy;
ALJ = Administrative Law Judge;
MAC = Medicare Administrative Contractor;
IRE = Independent Review Entity;
QIC = Qualified Independent Contractor;

This chart reflects the CY 2015 AIC amounts.
To view all available NTP training materials, or to subscribe to our email list, visit

CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html

For questions about training products email training@cms.hhs.gov