

# 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?

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## § 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

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- § 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)

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- § You're still in the Medicare program
  - Medicare pays the plan every month for your care
- § You still have Medicare rights and protections
- § If the plan leaves Medicare you can
  - Join another MA Plan, or
  - Return to Original Medicare



# Medicare Advantage Costs

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- § 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?

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## § 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)

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- § Usually you can't enroll if you have ESRD
- § 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
- § 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



# When You Can Join or Switch Medicare Advantage Plans

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## Initial Enrollment Period

- § 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”

- § October 15–December 7
- § Coverage begins January 1

## Medicare due to a Disability

- § 7-month period begins 3 months before the 25<sup>th</sup> month of disability.
- § Ends 3 months after the 25<sup>th</sup> month of disability.

§ Plans must be allowing new members to join



# When You Can Join or Switch Plans

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## Special Enrollment Periods (SEP)

- § Move out of your plan's service area
- § Plan leaves Medicare program or reduces its service area
- § Leaving or losing employer or union coverage
- § You enter, live at, or leave a long-term care facility
- § You have a continuous SEP if you qualify for Extra Help
- § Losing your Extra Help status
- § You join or switch to a plan that has a 5-star rating
- § Retroactive notice of Medicare entitlement
- § Other exceptional circumstances



# When You Can Join or Switch MA Plans

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## 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

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January 1 –  
February 14

- § You can leave a Medicare Advantage (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
- § May be able to buy a Medicare Supplement Insurance (Medigap) policy



# Medicare Advantage Trial Rights and Medigap

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- § 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

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- § 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

<b>Can you get your health care from any doctor or hospital?</b>	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.
<b>Are prescription drugs covered?</b>	In most cases, yes. Ask the plan. If you want Medicare drug coverage, you must join an HMO Plan that offers prescription drug coverage.
<b>Do you need to choose a primary care doctor?</b>	In most cases, yes.
<b>Do you need a referral to see a specialist?</b>	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.
<b>What else do you need to know about this type of plan?</b>	<ul style="list-style-type: none"><li>§ If your doctor or other health care provider leaves the plan, your plan will notify you and you can choose another plan doctor.</li><li>§ If you get health care outside the plan's network, you may have to pay the full cost.</li><li>§ It's important that you follow the plan rules. For example, the plan may require prior approval for certain services.</li></ul>



# Medicare Preferred Provider Organization (PPO) Plan

<b>Can you get your health care from any doctor or hospital?</b>	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.
<b>Are prescription drugs covered?</b>	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.
<b>Do you need to choose a primary care doctor?</b>	No.
<b>Do you need a referral to see a specialist?</b>	In most cases, no.
<b>What else do you need to know about this type of plan?</b>	<p>§ PPO Plans aren't the same as Original Medicare or Medigap.</p> <p>§ Medicare PPO Plans usually offer extra benefits than Original Medicare, but you may have to pay extra for these benefits.</p>



# Medicare Special Needs Plans (SNPs)

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



# Medicare Special Needs Plans (SNPs) Continued

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

§ A plan must limit plan membership to people in one of the following groups:

1. Those living in certain institutions (like a nursing home), or who require nursing care at home
2. Those eligible for both Medicare and Medicaid
3. Those with specific chronic or disabling conditions

§ Plan may further limit membership

§ Plan should coordinate your needed services and providers

§ Plan should make sure providers that you use accept Medicaid if you have Medicare and Medicaid

§ Plan should make sure that plan's providers serve people where you live, if you live in an institution



# Medicare Private Fee-for-Service (PFFS) Plan

<b>Can you get your health care from any doctor or hospital?</b>	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.
<b>Are prescription drugs covered?</b>	Sometimes. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan (Part D) to get coverage.
<b>Do you need to choose a primary care doctor?</b>	No.
<b>Do you need a referral to see a specialist?</b>	No.



# Medicare Private Fee-for-Service (PFFS) Plan (Continued)

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**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 that 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 Private Fee-for-Service (PFFS) Plan Access Requirements

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- § 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



# Medicare and Medical Savings Accounts

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## § Medical Savings Account Plans

- Combine high-deductible plan with a bank account
- Medicare deposits money into account
- Use money to pay for services



# Medicare Advantage (MA) Plan Network Changes

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- § 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

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§ 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

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- § 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

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§ 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

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- § 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

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- § Get needed health care services
- § Get easy-to-understand information
- § Have personal medical information kept private



# Rights in Medicare Health Plans

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- § 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

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- § 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

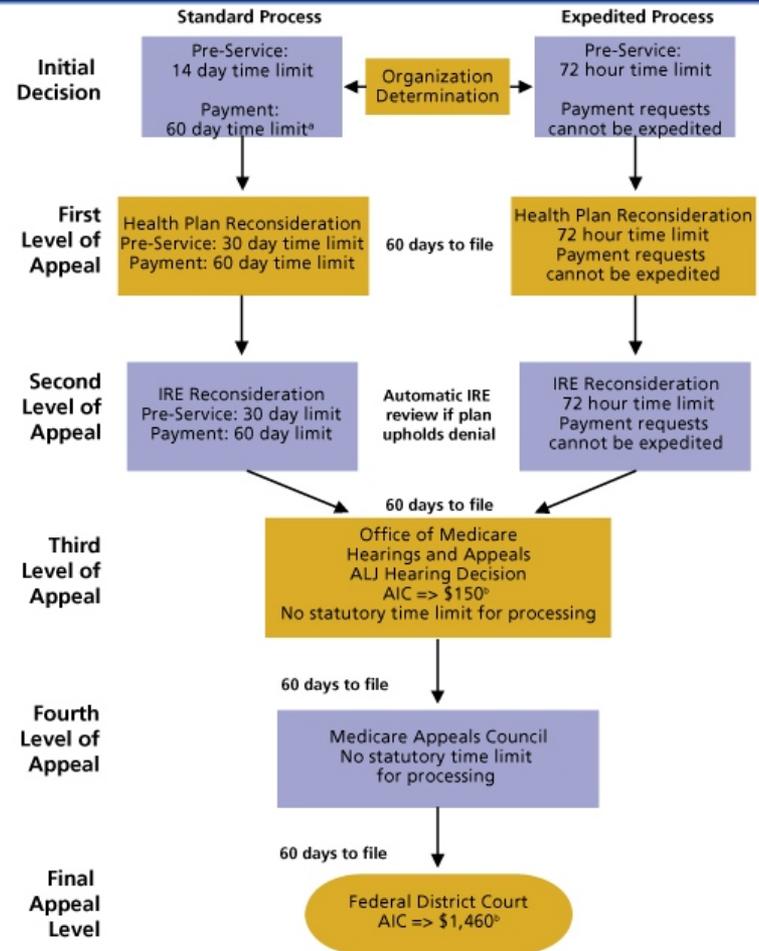
Plan Reconsideration

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

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



# Marketing Materials

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§ 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
  - q Communicated in conjunction with overall performance rating
- Low-performing star rating status
  - q Low Performance Icon (LPI) 
  - q Plans may not attempt to discredit their LPI status by showcasing a separate higher rating



# Disclosure of Plan Information for New and Renewing Members

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§ 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

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## § Nominal gifts

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



# Unsolicited Beneficiary Contact

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## § 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

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## § Cross-selling

- Prohibited during any Medicare Advantage or Part D sales activity or presentation
- Can't market non-health related products
  - q Annuities
  - q Life insurance
  - q Other products
- Allowed on inbound calls per beneficiaries' request



# Scope of Appointment Reminders

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## § 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

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- § 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

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## § 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

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- § 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

NEW!

- § 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

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

- Must comply with state-licensure laws
  - ◻ Applies to contracted and employed agents/brokers
- Organizations must comply with state appointment laws
  - ◻ Plans must give information about agents



# Reporting of Terminated Agents

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- § 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

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§ 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

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§ 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

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§ 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



# Check Your Knowledge—Question 5

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

a. True

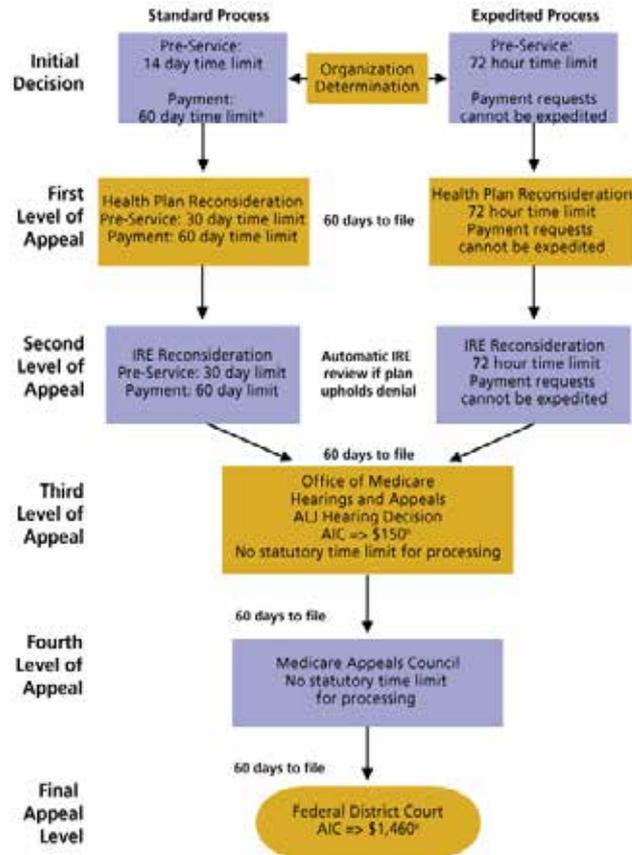
**b. False**

# Medicare Advantage and Other Medicare Plans Resource Guide

Resources		Medicare Products
<p><b>Centers for Medicare &amp; Medicaid Services (CMS)</b> 1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048 <a href="http://Medicare.gov">Medicare.gov</a></p> <p><a href="http://CMS.gov">CMS.gov</a></p> <p><b>Social Security</b> 1-800-772-1213. TTY users should call 1-800-325-0778 <a href="http://socialsecurity.gov">socialsecurity.gov</a></p> <p><b>Railroad Retirement Board</b> 1-877-772-5772. TTY users should call 1-312-751-4701 <a href="http://RRB.gov">RRB.gov</a></p>	<p><b>2015 Medicare Marketing Guidelines</b> <a href="http://CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c03.pdf">CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c03.pdf</a></p> <p><b>Medicare Managed Care Manual</b> <a href="http://CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html">CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html</a></p> <p><b>State Health Insurance Assistance Programs</b> For telephone numbers call CMS 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048</p> <p><b>Affordable Care Act</b> <a href="http://HealthCare.gov/law/full/index.htm">HealthCare.gov/law/full/index.htm</a></p>	<p><b>“Medicare &amp; You Handbook”</b> CMS Product No. 10050</p> <p><b>“Have You Done Your Yearly Medicare Plan Review?”</b> CMS Product No. 11220</p> <p><b>“Medicare Supplement Insurance, Getting Started”</b> CMS Product No. 11575</p> <p><b>“Your Guide to Medicare Private Fee-for-Service Plans”</b> CMS Product No. 10144</p> <p><b>“Understanding Medicare Enrollment Periods”</b> CMS Product No. 11219</p> <p><b>“Your Guide to Medicare Savings Account Plans”</b> CMS Product No. 11206</p> <p><b>“Your Guide to Special Needs Plans”</b> CMS Product No. 11302</p> <p><b>To access these products</b> View and order single copies at <a href="http://Medicare.gov/publications">Medicare.gov/publications</a> Order multiple copies (partners only) at <a href="http://productordering.cms.hhs.gov">productordering.cms.hhs.gov</a>. You must register your organization</p>

# Appendix A

## Part C (MA) Process





# Appendix B—Appeals Flowcharts Footnote

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**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.



# CMS National Training Program

To view all available NTP training materials, or to subscribe to our email list, visit

[CMS.gov/Outreach-and-Education/Training/  
CMSNationalTrainingProgram/index.html](https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html)

For questions about training products email  
[training@cms.hhs.gov](mailto:training@cms.hhs.gov)