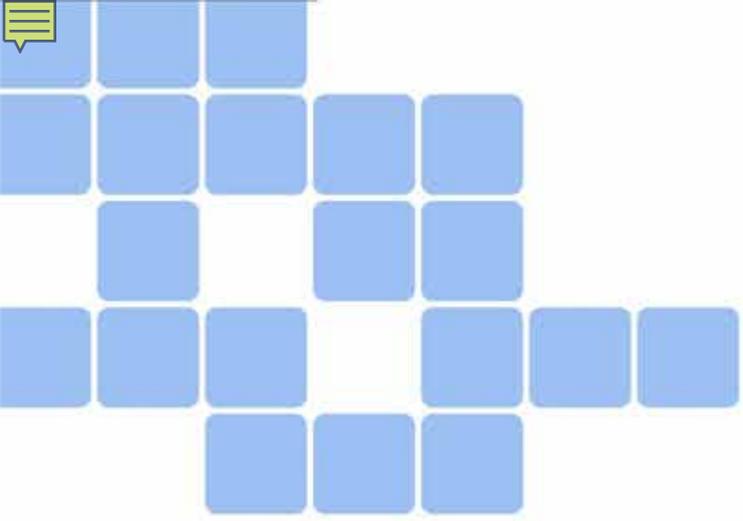




# Module 11: Medicare Advantage (MA) Plans and Other Medicare Plans



 **National Medicare  
TRAINING PROGRAM**  
...helping people with Medicare  
make informed health care decisions





# 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)



# 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



# 1. Overview

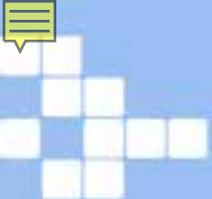
## § Medicare Advantage (MA) Plan Overview



# 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



## 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



# Who Can Join?

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## § 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



# When You Can Join or Switch MA Plans\*

<b>Initial Enrollment Period (IEP)</b>	§ 7 month period begins 3 months before the month you turn 65 <ul style="list-style-type: none"><li>• Includes the month you turn 65</li><li>• Ends 3 months after the month you turn 65</li></ul>
<b>Medicare Open Enrollment Period “Open Enrollment”</b>	§ 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



# Special Enrollment Period Trial Rights

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§ 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



## 3. How Medicare Advantage Plans Work

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



# 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 visit network doctors/hospitals
- § May differ from Original Medicare
  - Benefits
  - Cost-sharing



# How Medicare Advantage Plans Work

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- § 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



# Medicare Advantage Costs

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§ 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



## 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)

# 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 (POS) 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's rules, like getting prior approval for a certain service when needed.</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. Ask the plan. If you want Medicare drug coverage, you must join a PPO Plan that offers 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>	<ul style="list-style-type: none"><li>§ There are two types of PPOs: Regional PPOs and Local PPOs.</li><li>§ If your doctor or other health care provider leaves the plan, your plan will notify you. You can choose another doctor in the plan.</li><li>§ If you get health care outside the plan's network, you may have to pay the full cost.</li></ul>

# 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. 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.
<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

**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.



# PFFS Access Requirements

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- § 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



# Medicare Special Needs Plans (SNPs)

<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 SNPs

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

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

- 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



# Less Common Medicare Advantage Plans

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## § 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



# Medicare Advantage Plan Networks

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- § 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



# 5. Other Medicare Plans

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



# Other Medicare Plans

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- § 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)



# Medicare Cost Plans

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- § 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



# Innovation Projects and Pilot Programs

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§ 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



# Medicare PACE Plans

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- § 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



# 6. Rights, Protections, and Appeals

- § Guaranteed Rights and Protections
- § Appeals
- § Required Notices



# Guaranteed Rights

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- § To get needed health care services
- § To receive easy-to-understand information
- § To 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 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

# Medicare Part C Appeals Process



Initial Decision

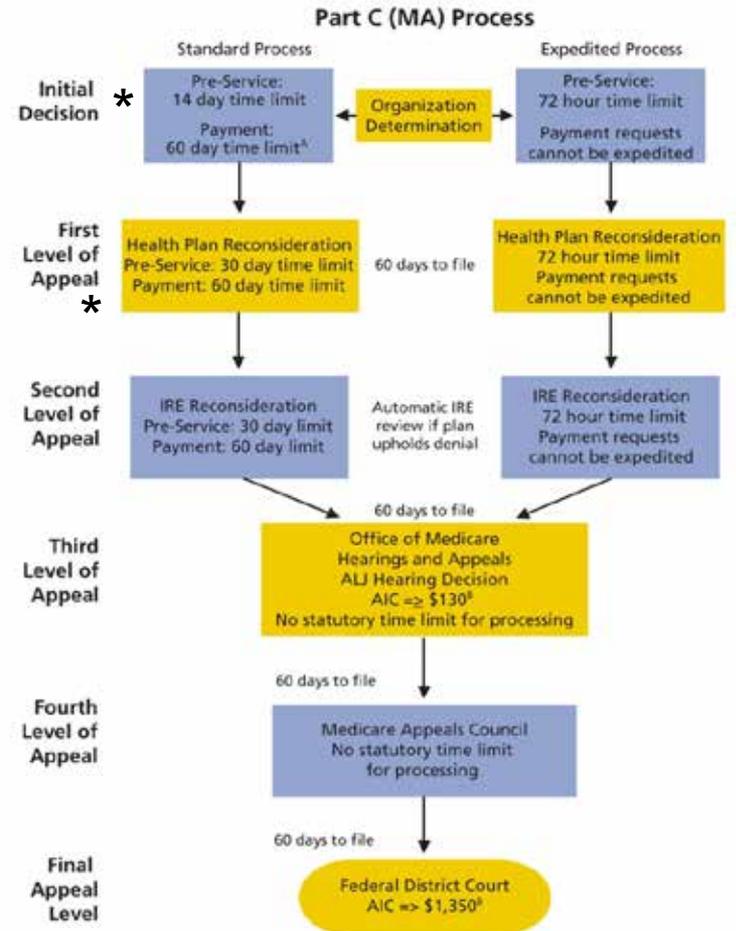
Plan Reconsideration →

Independent Review Entity (IRE) →

Administrative Law Judge (ALJ) →

Medicare Appeals Council (MAC) →

Judicial Review →



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



# Medicare Health Plan Fast Appeals Process

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## § *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



# Inpatient Hospital Appeals

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§ 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



# 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



# Required Notices

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§ Plans must provide notices after every

- Adverse determination
- Adverse appeal

§ Notice must include

- Detailed explanation of services denied
- Next appeal level
- Specific instructions



# 7. Medicare Marketing Guidelines

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



# Marketing Provisions

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## § 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



# Marketing Provisions

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- § 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



# Marketing Updates

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



# Disclosure of Plan Information for New and Renewing Members

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§ 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



# Promotional Activity Reminders

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## 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



# Promotional Activity Reminders

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## 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



# Promotional Activity Reminders

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## 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



# Promotional Activity Reminders

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## Scope of Appointments

### § Must specify product type

- Prior to marketing and/or in-home appointment
  - q Medigap
  - q MA
  - q PDP
  - q Other

### § Additional products can only be discussed

- On beneficiary request
- At separate appointment



# Promotional Activity Reminders

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## 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



# Promotional Activity Reminders

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## 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



# Promotional Activity Reminders

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## 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



# State Licensure of Agents

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## § MA and PDP organization agents/brokers

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



# State Appointment of Agents

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



# Reporting of Terminated Agents

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§ 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



# Agent/Broker Compensation

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## § Rules

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



# Agent/Broker Training and Testing

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§ 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



# Agent/Broker Training and Testing

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§ Passing score of 85% required

- Written or computerized
- Must maintain integrity
- Must have process for those who don't pass the test



# CMS Marketing Surveillance

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## § 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



# CMS Marketing Surveillance

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## § Surveillance strategy

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

# 8. Resources for More Information

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



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