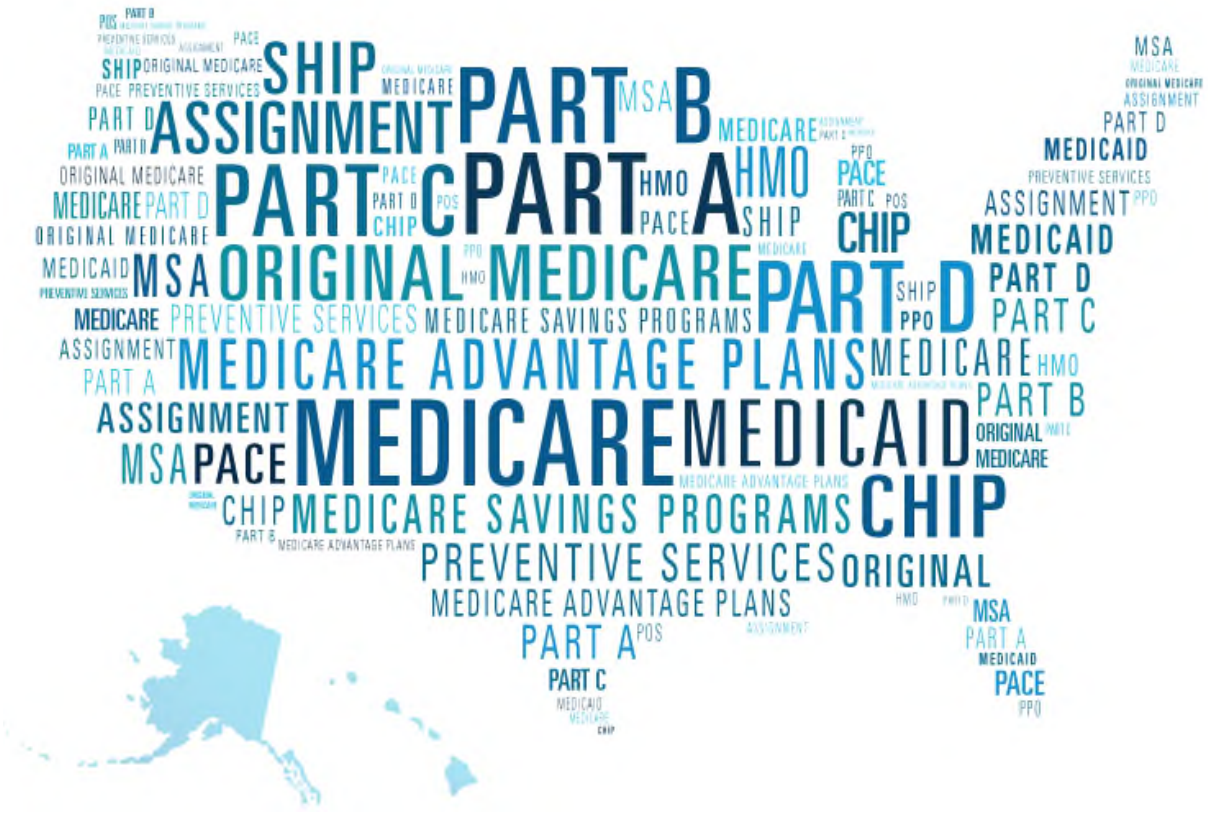
CENTERS FOR MEDICARE & MEDICAID SERVICES

2017 National Training Program



Module 11

Medicare Advantage and Other Medicare Health Plans

Contents

Session Objectives

- This session should help you
  - 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
  - Explain rights, protections, and appeals
  - Summarize the Medicare Marketing Guidelines—know the rules for gifts, rewards and incentives, educational and promotional activities, and agents and brokers

Lesson 1—Medicare Advantage (MA) Plan Overview

- What's an MA Plan?
- How do MA Plans work?
- When you can join or switch plans
- What are the types of MA Plans?

What are Medicare Advantage Plans?

- Health plans run by private companies that provide Part A and Part B benefits
  - Part of the Medicare Program
  - Approved by Medicare
  - Most plans include prescription drug coverage—Part D
  - May provide vision and dental services
- Sometimes called Part C
- Available across the country

How do Medicare Advantage Plans work?

- Medicare pays the plan every month for your care
  - Provides Medicare-covered benefits
  - You still have Medicare rights and protections
- You may have to use in-network doctors/ hospitals
- May differ from Original Medicare—cost sharing
- If the plan leaves Medicare, you can
  - Join another MA Plan, or
  - Return to Original Medicare

Medicare Advantage Plan Costs

- You still pay the monthly Part B premium
  - A few plans may pay all or part for you
  - State assistance is available for some
- You may pay an additional monthly premium to the plan
- Plan 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?

- To be eligible, you must
  - Be enrolled in Medicare Part A (Hospital Insurance)
  - Be enrolled in Medicare Part B (Medical Insurance)
  - Live in the plan's service area
  - Be a United States (U.S.) citizen or lawfully present in the U.S.
  - Not be incarcerated
- To join you must also
  - Provide necessary information to the plan
  - Follow the plan's rules
  - Only belong to one plan at a time

Medicare Advantage (MA) Plans and End-Stage Renal Disease (ESRD)

- 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
  - If you joined the plan without ESRD, but developed ESRD while in the plan, you may stay in the plan
- If you've had a successful kidney transplant or no longer require a regular course of dialysis
  - You aren't considered to have ESRD for MA eligibility purposes

When You Can Join Medicare Advantage (MA) Plans

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 **Important:** If you delay Part B enrollment (for example, due to active employer group coverage), your time to enroll in an MA Plan may be more restricted. For more information, visit CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2017_MA_Enrollment_and_Disenrollment_Guidance_8-25-2016.pdf
Medicare due to a disability	▪ 7-month period begins 3 months before the 25th month of disability benefits ▪ Ends 3 months after the 25th month of disability benefits

When You Can Join or Switch Medicare Advantage (MA) Plans

Medicare Open Enrollment Period "open enrollment"	▪ October 15—December 7 ▪ Coverage begins January 1

*You can only join one MA Plan at a time, and enrollment is generally for a calendar year.
*Plans must be allowing new members to join

When You Can Join or Switch Medicare Advantage (MA) Plans (continued)

Special Enrollment Period (SEP)	▪ You move out of your plan's service area ▪ You have Medicaid and Medicare ▪ Your plan leaves the Medicare Program or reduces its service area ▪ You leave or lose employer or union coverage ▪ You enter, live at, or leave a long-term care facility (like a nursing home) ▪ You have a continuous (SEP) if you qualify for Extra Help ▪ You lose your Extra Help status ▪ You're sent a retroactive notice of Medicare entitlement ▪ Other exceptional circumstances

When You Can Join or Switch MA Plans

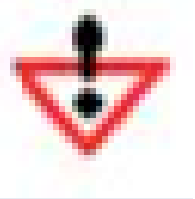
5-Star Special Enrollment Period (SEP)

- Can switch to 5-Star Medicare Advantage (MA), Prescription Drug Plan (PDP), MA Plan with prescription drug coverage (MA-PD), or Cost Plan
- Enroll once per year from December 8, 2016–November 30, 2017
- New plan starts first day of month after enrolled
- Star ratings given once per year
  - Ratings assigned in October and effective January 1
  - Use Medicare Plan Finder to see star ratings
    - Look at Overall Star Rating to find eligible plans

Caution: You may lose prescription drug coverage if you use this SEP to move from a plan that has drug coverage to a plan that doesn't. You'll have to wait until the next applicable enrollment period to get coverage and may have to pay a penalty.

Low Performing Drug 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 can't attempt to discredit their LPI status by showcasing a separate higher rating

When You Can Leave Medicare Advantage (MA) Plans

January 1–February 14

- May leave an MA Plan
- May 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 (MA) Trial Rights and Medigap

- Special Medigap rights for people who join an MA Plan for the first time
  - When first eligible at 65, or
  - 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 in certain geographic areas.
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

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. 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.
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?	▪ PPO plans aren't the same as Original Medicare or Medigap. ▪ Medicare PPO plans usually offer extra benefits (like dental or vision services) than Original Medicare, but you may have to pay extra for these benefits.

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.

Medicare Special Needs Plans (SNPs) (continued)

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

- SNPs must limit plan membership to people in one of the following groups:
  1. Institutional SNP (I-SNP): Those living in certain institutions (like a nursing home), or who require nursing facility-level of care at home
  2. Dual Eligible SNP (D-SNP): Those eligible for both Medicare and Medicaid
  3. Chronic Condition SNP (C-SNP): Those with specific chronic or disabling conditions
- Plans may further limit enrollment based on rules for the specific type of SNP
- Plans should coordinate your needed services and providers
- Plans should make sure that providers you use accept Medicaid if you have Medicare and Medicaid
- Plans should make sure that the plan's providers serve people where you live, if you live in an institution

Medicare Private Fee-for-Service (PFFS) Plan

Can you get your health care from any doctor or hospital?	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've 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. Check with the plan for more information.
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)

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. ▪ Show your plan membership ID card each time you visit a health care provider. 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 and Medical Savings Account Plans

- Combine a high-deductible plan with a bank account
- Medicare deposits money into account
  - Use money to pay for health care services
  - No cost sharing once the deductible has been paid

Medicare Advantage (MA) Plan Network Changes

- Many types of MA Plans have provider networks
- Plans may change networks at any time
  - Must protect you from interruptions in medical care
  - Must maintain adequate access to services
  - Must notify enrollees who see affected providers
    - At least 30 days prior to the provider's contract termination
- In most cases, network changes aren't a basis for a Special Enrollment Period
  - CMS determines eligibility on a case-by-case basis

Check Your Knowledge—Question 1

Medicare Advantage (MA) 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 (MA) Plan will continue to pay a monthly Medicare Part B premium.

a. True

b. False

Lesson 2—Other Medicare Health Plans

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

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
    - With Part A and Part B cost sharing
- 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 (Part D)

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
  - Medicare Advantage (MA) Plan for End-Stage Renal Disease (ESRD) patients
  - New Medicare preventive services

Program of All-inclusive Care for the Elderly (PACE) Plans

- Is a Medicare and Medicaid Program
- Combines services for frail, elderly people
  - Medical, social, and long-term care services
  - Includes 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) isn't 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
- Plan rewards and incentive programs

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 within the plan
- 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
- You and your doctor can file an appeal
- 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 →

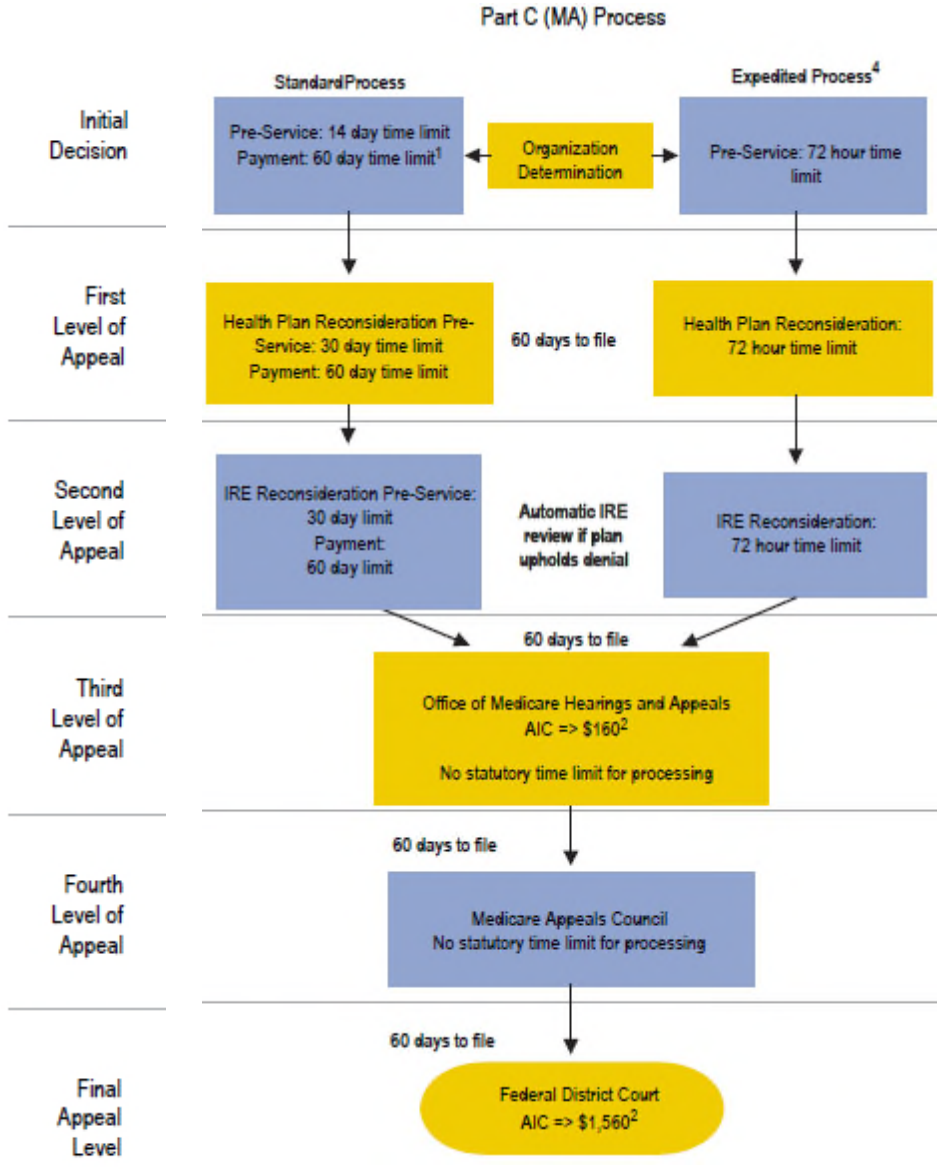
Plan Reconsideration →

Independent Review Entity (IRE) →

Administrative Law Judge (ALJ) →

Medicare Appeals Council (MAC) →

Judicial Review →



Rights If You File an Appeal With Your Medicare Health Plan

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

Lesson 4—Medicare Marketing Guidelines

- Marketing and Disclosure
- Gifts
- Promotional Educational Activities
- Agents/Brokers
- Rewards and Incentives

Marketing Materials

- The Centers for Medicare and Medicaid Services (CMS) requires review and approval of certain materials
  - Exceptions are listed in Section 20 of the Medicare Marketing Guidelines.
    - For more information visit CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2017MedicareMarketingGuidelines2.pdf
  - Plans must maintain materials and make them available at 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 must get equal or greater prominence
  - Individual measures may be marketed/ communicated with overall performance rating
  - Low-performing star rating status
    - Low Performance Icon (LPI) 
    - Plans may not try 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
- Must provide the hard copy pharmacy and provider directories or a notice describing where they can be found online together with how to request a hardcopy
- Documents for new enrollees must be provided no later than 10 calendar days or the last day of the month before to effective date, whichever is later

Nominal Gift Reminders

- Organizations can offer gifts to potential enrollees
  - Must be of nominal value
    - Defined in Medicare Marketing Guidelines
    - Currently $15 or less per individual gift based on retail value
    - There's a maximum aggregate of all gifts of $75 per person, per year
- Given regardless of beneficiary enrollment and without discrimination
- May not be in the form of cash or other monetary rebates
  - Gift cards are acceptable, if they can't be converted into cash

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 permission is given
  - Common areas (e.g., parking lots, hallways, sidewalks, etc.)

NOTE: Prohibited activities don't include conventional mail or other print media

Cross-Selling Prohibition

- 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 the request of the person with Medicare

Scope of Appointment Reminders

- Must specify product type
  - Medicare Advantage, Medicare Prescription Drug, and Cost Plans
- 48 hours before personal/individual marketing and/or in-home appointment
- Additional products can only be discussed
  - With person with Medicare's 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 get care
  - Waiting rooms
  - Exam rooms and hospital patient rooms
  - Dialysis centers and pharmacy counter areas

Promotional Activity Reminders

- 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

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

Licensure and Appointment of Agents

- Medicare Advantage and Prescription Drug Plan organization agents/brokers or other marketing representatives
  - Must comply with state-licensure laws
    - Applies to all agents/brokers
  - Must be appointed by the plan, if required by the state

Reporting of Terminated Agents

- Organizations must report termination of agents/brokers to
  - State(s), per state law
  - CMS Account Manager—for-cause terminations

Agent/Broker Compensation Rules

- The Centers for Medicare & Medicaid Services' (CMS's) compensation rules
  - CMS sets limits on how much independent agents/brokers can be paid for enrollments
  - Designed to eliminate inappropriate enrollment moves from plan to plan
    - Also called "churning"

Agent/Broker Compensation

- Two types of compensation
  - Initial—for people new to Medicare or who make an "unlike plan" change (e.g., Medicare Advantage with Prescription Drug [MA-PD] to Original Medicare with a Prescription Drug Plan)
  - Renewal—begins second year in a plan and for like plan changes (MA-PD to a different MA-PD)
- Agents can only be paid for the number of months an enrollee is in the plan

Agent/Broker Training and Testing

- All agents/brokers must be trained and tested annually
  - Medicare rules and regulations
  - Plan details specific to plan products sold
  - Applies to all agents/brokers
- Completed prior to marketing the product
  - Must pass test with 85%

Rewards and Incentives

- CFR 422.134 expands rewards and incentive programs
- Applies to Medicare Advantage Organizations only
- Focus on encouraging participation in activities that promote
  - Improved health
  - Prevention of injuries and illness
  - Efficient use of health care resources

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. Insurance associations
b. The Centers for Medicare & Medicaid Services
c. State Department of Insurance
d. Medicare health and drug plans

Check Your Knowledge—Question 5

Agents or brokers aren't permitted to set up individual marketing appointments at educational events.

a. True

b. False

Medicare Advantage and Other Medicare Health Plans Resource Guide

Resources

Centers for Medicare & Medicaid Services (CMS)

- Call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.
- Medicare.gov
- CMS.gov

Social Security

- Call 1-800-772-1213. TTY: 1-800-325-0778.
- socialsecurity.gov

Railroad Retirement Board

- Call 1-877-772-5772. TTY: 1-312-751-4701.
- RRB.gov

Medicare Marketing Guidelines

- CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2017MedicareMarketingGuidelines2.pdf

Medicare Managed Care Manual

- CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html

State Health Insurance Assistance Programs and State Insurance Departments

- shiptacenter.org/
- Call 1-877-839-2675.
- info@shiptacenter.org

Medicare Advantage and Other Medicare Health Plans Resource Guide (continued)

Medicare Products

1. **"Medicare & You Handbook"** (CMS Product No. 10050)
2. **"Have You Done Your Yearly Medicare Plan Review?"** (CMS Product No. 11220)
3. **"Understanding Medicare Part C & D Enrollment Periods"** (CMS Product No. 11219)
4. **"Understanding your Medicare Advantage Plan's provider network"** (CMS Product No. 11941)
5. **"How Medicare Prescription Drug Plans and Medicare Advantage Plans with Prescription Drug Coverage (MA-PDs) Use Pharmacies, Formularies, & Common Coverage Rules"** (CMS Product No. 11136)
6. **"Your Guide to Medicare Medical Savings Account Plans"** (CMS Product No. 11206)
7. **"What's a Medicare Advantage Plan?"** (CMS Product No. 11474)

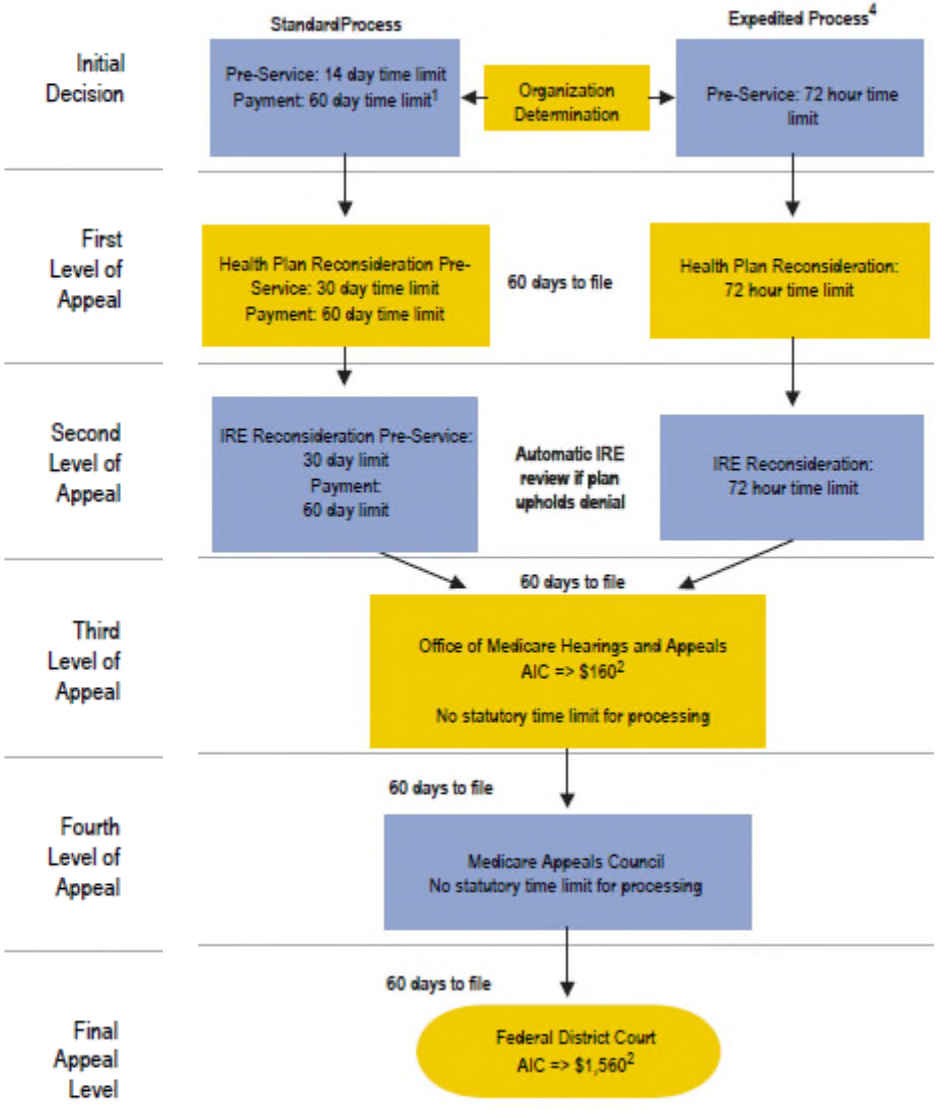
To access these products:

- View and order single copies at Medicare.gov/publications.
- Order multiple copies (partners only) at Productordering.cms.hhs.gov.

You must register your organization.

Appendix: Part C (MA) Appeals Process and Footnotes

Part C (MA) Process



Appendix: Part C (MA) Appeals Process and Footnotes (continued)

1: 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.

2: The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2017 AIC amounts.

3: A request for a coverage determination includes a request for a tiering exception or a formulary exception. The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.

4: Payment requests cannot be expedited.

- **AIC** = Amount in Controversy
- **ALJ** = Administrative Law Judge
- **IRE** = Independent Review Entity
- **MA-PD** = Medicare Advantage Prescription Drug PDP = Prescription Drug Plan

This chart reflects the CY 2017 AIC amounts.

Acronyms

- **AIC** Amount in Controversy
- **ALJ** Administrative Law Judge
- **ANOC** Plan Annual Notice of Change
- **CHIP** Children's Health Insurance Program
- **CMS** Centers for Medicare & Medicaid Services
- **EOC** Evidence of Coverage
- **ESRD** End-Stage Renal Disease
- **HIPAA** Health Insurance Portability and Accountability Act
- **HMO** Health Maintenance Organization
- **IRE** Independent Review Entity
- **LIS** Low Income Subsidy
- **LPI** Low Performance Icon
- **MA** Medicare Advantage
- **MAC** Medicare Appeals Council
- **MA-PD** Medicare Advantage with Prescription Drug Coverage
- **MAO** Medicare Advantage Organizations
- **MMG** Medicare Marketing Guidelines
- **MSA** Medical Savings Account
- **NTP** National Training Program
- **OEP** Open Enrollment Period
- **PACE** Programs of All-Inclusive Care for the Elderly
- **PDP** Prescription Drug Plan
- **PFFS** Private Fee-for-Service
- **PPO** Preferred Provider Organization
- **SEP** Special Enrollment Period
- **SHIP** State Health Insurance Assistance Program
- **SNP** Special Needs Plan
- **TTY** Teletypewriter

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