

National Medicare Training Program Workbook



**Module 11:
Medicare Advantage Plans
and Other Medicare Plans**



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

Module 11: Medicare Advantage Plans and Other Medicare Plans



This module, Medicare Advantage and Other Medicare Plans, is designed for Medicare partners, trainers, and other information intermediaries.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The information in this module was correct as of April 2009.

Slides with this symbol in your workbook are not included in the presentation, but are provided as a resource for more detail.

To check for an updated version of this training module, visit www.cms.hhs.gov/NationalMedicareTrainingProgram/TL/list.asp on the web.

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

Notes:

SLIDE 2 *Speaker's Notes*

People with Medicare may be able to get health care coverage in several ways. Original Medicare, available nationwide, is a fee-for-service plan managed by the Federal government. In Original Medicare, people with Medicare Part A (hospital coverage) and Part B (medical coverage) can get all medically-necessary Medicare-covered services and preventive services.

In addition, there are other ways besides Original Medicare that people can get their Medicare health coverage.

Congress created Medicare Advantage (MA) to let more private insurance companies offer coverage to people with Medicare, giving them more choices in how to get their Medicare benefits. Medicare Advantage Plans (sometimes called Part C) and other Medicare plans are health plan options that are part of the Medicare program. If people join one of these plans, they generally get all their Medicare-covered health care through that plan. Not all types of Medicare Advantage and other Medicare health plans (like demonstrations) are available in all areas.

People can also choose to get Medicare prescription drug coverage (sometimes called Part D) in one of two ways:

- Join a stand-alone Medicare Prescription Drug Plan (PDP). People can enroll in a stand-alone PDP to add drug coverage to Original Medicare, Medicare Cost Plans, Medicare Medical Savings Account Plans, and Private Fee-for-Service Plans that do not offer Part D drug coverage.
- Join a Medicare Advantage Plan (like an HMO or PPO) or other Medicare plan that includes prescription drug coverage as part of the plan.

Medicare Choices

- Original Medicare
- Medicare Advantage (MA) Plans
- Other Medicare health plans
- Medicare drug plans
 - Medicare Prescription Drug Plans
 - Medicare Advantage Plans and other Medicare plans with prescription drug coverage

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Notes:

SLIDE 3 *Speaker's Notes*

In this training session, we'll be talking about Medicare Advantage Plans and other Medicare health plans. When we use the term "Medicare Advantage Plans," we mean those with and without prescription drug coverage. Unless we state otherwise, we also intend the term to include other Medicare plans. (We will not be covering Original Medicare or stand-alone Medicare Prescription Drug Plans.)

We will explain what Medicare Advantage Plans are. We'll cover who is eligible to join a plan, and the times they can join or switch plans. Next we'll describe how Medicare Advantage Plans work and the differences between types of plans. We'll end with a discussion of rights and protections in an MA Plan and a review of the marketing guidelines plans must follow.

Medicare Advantage Plans

- What are Medicare Advantage (MA) Plans
- Who can join and when
- How MA Plans work
- Types of MA Plans
- Rights and protections
 - Including appeals and marketing guidelines

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Notes:

SLIDE 4 *Speaker's Notes*

Medicare offers different ways to get your Medicare benefits. Original Medicare is a fee-for-service option. You may purchase a Medigap (Medicare Supplemental Insurance) policy to pay for the gaps in Original Medicare coverage. You may also join a Medicare Prescription Drug Plan to add drug coverage.

Medicare Health Plan Options

- Original Medicare
 - With Medigap
 - With Medicare Prescription Drug Plan, OR
- Medicare Advantage Plans
 - Health plan options approved by Medicare
 - Run by private companies
 - Part of the Medicare program
 - Sometimes called “Part C”

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The other way to get Medicare benefits is through Medicare Advantage (MA) Plans. These are health plan options that are approved by Medicare and are run by private companies. They are part of the Medicare program and are sometimes called “Part C.”

Medicare Advantage Plans are offered in many areas of the country by private companies that sign a contract with Medicare. Medicare pays a set amount of money to these private health plans for their members’ health care. **People must have both Medicare Part A and Part B to join a Medicare Advantage Plan.**

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

Notes:

SLIDE 5 *Speaker's Notes*

Medicare Advantage Plans are available to most people with Medicare. To be eligible to join a Medicare Advantage Plan, a person must:

- Live in the plan's geographic service area or continuation area
- Be entitled to Medicare Part A and enrolled in Medicare Part B

People with End-Stage Renal Disease (ESRD) usually can't join a Medicare Advantage (MA) Plan or other Medicare health plan. However, there are some exceptions, including: (1) an individual who develops ESRD while enrolled in an MA Plan may continue to be enrolled in the MA Plan; (2) a person who develops ESRD while enrolled in a commercial, group health or Medicaid plan offered by the same MA are eligible to elect an MA Plan offered by that same organization; (3) some Medicare Advantage Special Needs Plans accept people with ESRD; (4) a person with ESRD whose enrollment in an MA Plan was terminated on or after December 31, 1998, as a result of a contract termination, nonrenewal, or service area reduction can make one enrollment request into a new MA Plan.

A person who receives a kidney transplant and who no longer needs a regular course of dialysis treatment is not considered to have ESRD for purposes of MA eligibility.

To find the Medicare Advantage Plans in your area, go to www.medicare.gov and click on the "Learn More About Plans in Your Area".

Reference: *Medicare Managed Care Manual, Ch. 2, 20.2.2*

Who Can Join?

- Eligibility requirements
 - Live in plan's service area
 - Entitled to Medicare Part A
 - Enrolled in Medicare Part B
 - Not have End-Stage Renal Disease (ESRD) at time of enrollment
 - Some exceptions

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Notes:

SLIDE 6 *Speaker's Notes*

People can join a Medicare Advantage Plan:

- When they first become eligible for Medicare (i.e., during their Initial Enrollment Period, which begins 3 months immediately before the individual's first entitlement to **both** Medicare Part A and Part B) and three months after turning 65
- During the Medicare fall Open Enrollment Period (also known as the "Annual Election Period")
- During the Medicare Advantage Open Enrollment Period
- In certain special situations that provide a Special Enrollment Period

When Can People Join?

- A person can join MA Plan or other plan
 - When first eligible for Medicare
 - Initial Enrollment Period
 - During specific enrollment periods
 - Annual Election Period
 - MA Open Enrollment Period
 - Special Enrollment Period

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Notes:

SLIDE 7 *Speaker's Notes*

Generally, enrollment in a plan is for a year. People can only join one plan at a time.

A person can make changes:

- During the Medicare fall Open Enrollment Period, also referred to as the "Annual Enrollment Period" (AEP)
- During the Medicare Advantage Open Enrollment Period (OEP)
- Under special circumstances, during a Special Enrollment Period (SEP). For example, if a person moves out of the service area, or moves to where new MA or Part D options are now available to them, if a person qualifies for extra help to pay for Medicare prescription drug coverage, or if the plan decides to leave the Medicare program or reduce its service area at the end of the year, there are special rules that allow for enrollment in a different Medicare Advantage Plan, or Original Medicare and a Medigap policy.

The changes the individual can make depend on the enrollment period. For example, during the AEP the individual can join or leave a Medicare Advantage Plan, switch to Original Medicare, or join or leave a Medicare Prescription Drug Plan. However, during the Medicare Advantage OEP, the individual can join or change Medicare Advantage Plans but cannot add or drop Medicare prescription drug coverage.

When Can People Switch?

- Annual Election Period (AEP)
- MA Open Enrollment Period (MA-OEP)
- Special Enrollment Period (SEP)
 - Move out of the plan's service area OR move and have new MA or Part D options available
 - Plan leaves Medicare program
 - Other special situations

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Notes:

SLIDE 8 *Speaker's Notes*

The Annual Election Period is often referred to in Medicare publications as the Medicare fall Open Enrollment Period occurs every year from November 15 — December 31. People can make changes in their plan enrollment, including choosing which Medicare Advantage Plan or Medicare Prescription Drug Plan they want to join for the upcoming year. They can also choose to return to Original Medicare. Their new plan is effective January 1 of the following year.

This is the key time for individuals to review their health care and drug coverage and make changes for the following year, if they choose.

Unless they have a capacity limit waiver, Medicare Advantage Plans must accept eligible new members from November 15 — December 31 of each year. A capacity limit waiver means that the plan has been authorized to close enrollment because it has already reached a certain number of enrollees.

Annual Election Period

- November 15 – December 31
 - Can choose new plan
 - MA Plan
 - Medicare Prescription Drug Plan
 - Original Medicare
 - New plan effective January 1

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Notes:

SLIDE 9 *Speaker's Notes*

In addition to the Annual Election Period, people have the opportunity to change how they get their Medicare benefits during the Medicare Advantage Open Enrollment Period (OEP) each year. During the OEP they can join a new plan, switch plans, or return to Original Medicare. This occurs from January 1 through March 31 every year.

MA Open Enrollment Period

- January 1 – March 31
- Same period each year
- Change effective first day of following month
- Cannot be used to start or stop Medicare drug coverage
- May only make one change during this time period

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Changes made during this period are effective the first day of the month after the plan gets the person's enrollment form.

The Medicare Advantage OEP can be used to switch to a different type of Medicare plan, but it cannot be used to change whether or not a person is enrolled in Medicare prescription drug coverage.

The OEP cannot be used to enroll or disenroll in a Medicare Medical Savings Account. Other Medicare plans, such as Cost Plans, may follow different rules.

People may only make one change during the OEP. Once they make a change, they cannot make anymore changes during that OEP.

Notes:

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SLIDE 10 Speaker's Notes

This chart shows the various options during the Medicare Advantage (MA) Open Enrollment Period, depending on the type of coverage the person is starting with. For example, a person who has a Medicare Advantage Plan with prescription drug coverage (MA-PD) can use the OEP to get a different MA-PD, to switch to Original Medicare and a PDP, or to enroll in a Medicare Advantage Private-Fee-for-Service Plan (PFFS) without drug coverage and in a separate PDP.

| MA Open Enrollment Period Limits | | |
|---|---|--|
| If coverage is | Can use OEP to get | Cannot use OEP to get |
| Medicare Advantage with prescription drug coverage (MA-PD) | A different MA-PD or Original Medicare + PDP or MA-Private Fee-for-Service (PFFS) + PDP | MA-only or Original Medicare only (cannot drop drug coverage) |
| Medicare Advantage with no prescription drug coverage (MA-only) | A different MA-only or Original Medicare only | MA-PD or Original Medicare + PDP (cannot add drug coverage) |
| MA-only PFFS + PDP | MA-PD or different MA-only PFFS and same PDP or Original Medicare and same PDP | MA-only or Original Medicare only (cannot drop drug coverage) |
| Original Medicare and a Prescription Drug Plan (PDP) | MA-PD or MA-PFFS and the same PDP | MA-only or a different PDP to use with Original Medicare (cannot drop drug coverage) |
| Original Medicare only | MA-only | MA-PD or Original Medicare + PDP (cannot add drug coverage) |
| MSA | N/A | The MA OEP does not apply to enroll into or disenrollment from an MSA Plan |

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This person could not use the OEP to enroll in an MA-only Plan or to switch to Original Medicare without enrolling as well in a stand-alone PDP.

Remember, the Medicare Advantage Open Enrollment Period can be used to switch to a different plan or type of plan, but it cannot be used to change whether or not a person is enrolled in Medicare prescription drug coverage.

Notes:

SLIDE 11 *Speaker's Notes*

There are special trial rights available for people who have joined a Medicare Advantage Plan for the first time. The trial right allows them to disenroll from the MA Plan during the first 12 months to join Original Medicare. They also have a guaranteed issue opportunity to purchase a Medigap (Medicare supplement insurance) policy.

People are eligible for this trial right if they either:

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

Trial Rights for People New to MA

- Join an MA Plan for the **first time**
 - When first eligible for Medicare at age 65 or
 - Leave Original Medicare and drop Medigap policy
 - Can disenroll during first 12 months
 - Join or return to Original Medicare
 - Have guaranteed issue for Medigap policy

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Notes:

SLIDE 12 *Speaker's Notes*

In most Medicare Advantage Plans, members generally get all their Medicare-covered health care through that plan. Some plans also include Medicare prescription drug coverage. Medicare pays a set amount of money for a person's care every month to these private health plans, whether or not the member uses services.

In some plans, like Medicare Health Maintenance Organizations (HMOs), people may only be able to see certain doctors or go to certain hospitals. However, members have the right to get emergency care anywhere in the United States when they need it, without any prior approval from the plan.

Benefits and cost-sharing in a Medicare Advantage Plan may be different from those in Original Medicare. Since each plan can vary, it's important that people review plan materials carefully for details about copayment and coverage information.

How Do MA Plans Work?

- Generally get all Medicare-covered services through the plan
- Can include prescription drug coverage
- May have to see certain doctors or go to certain hospitals to get care
 - Emergency care covered anywhere in the U.S.
- Benefits and cost-sharing may be different from Original Medicare

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Notes:

SLIDE 13 *Speaker's Notes*

People who join a Medicare Advantage Plan or other Medicare plan need to know:

- They must continue to pay the monthly Medicare Part B premium (\$96.40 for most people in 2009). However, some Medicare Advantage Plans may offer an additional benefit by reducing the amount members pay for their Medicare Part B premiums. The Federal government pays plans a set amount each month to cover services the plan members receive. The Part B premium a person with Medicare pays is included in that monthly payment amount.
- They may pay an additional monthly premium to the plan.
- They will have to pay other costs (such as copayments or coinsurance) for services they get.

Out-of-Pocket Costs

- Generally must still pay Part B premium
 - Some plans may pay all or part
- May pay additional monthly premium
- Will have to pay other out-of-pocket costs

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Notes:

SLIDE 14 *Speaker's Notes*

It's important to note that people who join a Medicare Advantage Plan or other Medicare plan:

- Are still in the Medicare program
- Still have Medicare rights and protections
- Through the plan, they still get all their regular Medicare-covered services that are offered under Part A and Part B
- May get additional benefits offered through the plan, including Medicare prescription drug coverage. Other extra benefits could include coverage for vision, hearing, or dental care and/or health and wellness programs. Extent or duration of coverage may vary.

People In MA Plan

- Still in Medicare program
- Still have Medicare rights and protections
- Still get all regular Medicare-covered services
- May get extra benefits
 - Such as vision, hearing, dental care

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Notes:

SLIDE 15 *Speaker's Notes*

There are five main types of Medicare Advantage Plans.

Types of MA Plans

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

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Notes:

SLIDE 16 *Speaker's Notes*

These are the general rules. Plans may differ slightly, so it's important to read the plan materials carefully.

In Medicare HMOs, the copayment or co-insurance amounts a member pays for services are set by the plan. There are doctors and hospitals that contract with the plan (called the plan's "network"). People generally

must get their care and services from the plan's network. Call or get a list from the plan to see which doctors and hospitals are in the plan's network.

People who get health care outside of the network may have to pay for those services themselves. In most cases, neither the Medicare HMO nor Original Medicare will pay for those services. The service area is where the plan accepts members and where plan services are provided. Members are covered for emergency or urgently needed out-of-network care. Some Medicare HMOs offer a Point-of-Service option. This allows people to go to other doctors and hospitals who aren't a part of the plan ("out-of-network"), but they may pay more.

People who join a Medicare HMO may be asked to choose a primary care doctor. Members must see their primary care doctor before they see any other health care provider. They usually need a referral to see a specialist (such as a cardiologist). A referral is a written OK from the primary care doctor for the member to see a specialist or get certain services.

Medicare HMO Plans

- Copayment amounts set by plan
- Usually must use network doctors and hospitals
- May pay in full for care outside plan's network
 - Covered if emergency or urgently needed care
 - POS option allows visits to "out-of-network" providers
- May need to choose primary care doctor
 - Usually need a referral to see a specialist
 - Doctors can join or leave
- May include prescription drug coverage

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Notes:

SLIDE 17 *Speaker's Notes*

Medicare PPOs use many of the same rules as Medicare HMOs discussed on the previous slides. However, people in a PPO generally can see any doctor or provider that accepts Medicare. They don't need a referral to see a specialist. If they go to doctors, hospitals, or other providers that aren't part of the plan ("out-of-network" or "non-preferred"), they don't need a referral, but they will usually pay more. Every Medicare PPO Plan must pay for all covered services received out-of-network, but every plan is different in what their members must pay.

PPO members may also be able to get their Medicare prescription drug coverage from the PPO Plan. If the PPO does not offer drug coverage, the beneficiary may NOT join a stand alone PDP.

Medicare PPO Plans

- Can see any doctor or provider that accepts Medicare
 - Don't need referral to see specialist
 - Don't need referral to see out-of-network provider
 - Copayment and coinsurance amounts set by plan
 - Will usually pay more for out-of-network care
- May get Medicare prescription drug coverage

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Notes:

SLIDE 18 *Speaker's Notes*

Regional PPOs are available in most areas of the country. Unlike local PPOs, which serve individual counties, regional PPOs serve an entire region, which may be a single state or multi-state area. This helps bring more plan options to people with Medicare.

In a regional PPO, members will have an added protection for Medicare Part A and Part B benefits because regional PPOs limit members' annual out-of-pocket costs. The annual out-of-pocket limit varies by plan. Regional PPOs may have a higher yearly deductible and/or premium than other PPOs.

Medicare PPO Plans (continued)

- Regional PPOs
 - Available in most areas of the country
 - Have annual limit on out-of-pocket costs
 - Varies by plan
 - May have higher deductible and/or premium than other PPOs

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Notes:

SLIDE 19 *Speaker's Notes*

A Medicare Private Fee-for-Service (PFFS) Plan is a Medicare Advantage Plan offered by a private insurance company under contract Medicare. Some companies offer more than one plan in an area, with different benefits and costs. PFFS Plans may not be available in all areas. The general rules for how Medicare Private Fee-for-Service Plans work include:

Medicare PFFS Plans

- Can see any Medicare-approved doctor or hospital that accepts the plan
 - Can get services outside service area
 - Don't need referral to see a specialist
 - Plan sets copayment amounts
- If offered, can get Medicare prescription drug coverage
 - If not offered, can join a Medicare Prescription Drug Plan

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- Members can choose which provider they will see, do not need a referral to see a specialist, and can get services outside their service area. However, while they can go to any Medicare-approved doctor or hospital, the provider must accept the terms and conditions of their plan's payment.
- Members may get extra benefits not covered under Original Medicare, such as extra days in the hospital.
- The private company, rather than the Medicare program, decides what amount members pay for the services they get.
- They can get Medicare prescription drug coverage from the Medicare Private Fee-for-Service Plan if it's offered, or join a stand-alone Medicare Prescription Drug Plan to add prescription drug coverage if drug coverage isn't offered by the plan.
- If a doctor sees a PFFS patient, they become a "deemed" provider and must accept the plans terms and conditions except during emergency care.
- Providers are "deemed" when they know before providing a service, that you a patient is in a Medicare PFFS Plan; they have reasonable access to the plan's terms and conditions of payment; and the service is covered by the plan.

Notes:

SLIDE 20 *Speaker's Notes*

Employer and non-employer PFFS Plans may meet access requirements:

- Through a contracted network of providers that meets CMS requirements, OR
- By paying not less than the Original Medicare payment rate, and having providers deemed to be contracted as

providers accepting the plans' terms and conditions of payment on a patient-by-patient and visit-by-visit basis. This process is also known as deeming.

Changes in Access Requirements for PFFS Plans

- Employer and non-employer PFFS Plans may meet access requirements:
 - Through a contracted network of providers that meets CMS requirements
 - By paying not less than the Original Medicare payment rate
 - Having providers deemed to be contracted as providers

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Notes:

SLIDE 21 *Speaker's Notes*

The Medicare Improvements for Patients and Providers Act (MIPPA) requires that beginning in 2011 all employer PFFS Plans must meet Medicare access requirements through contracts with providers. Additionally, all non-employer PFFS Plans must meet Medicare access requirements through contracts with providers if two or more network-based MA Plan options exist.

Changes in Access Requirements for PFFS Plans

- PFFS must meet access requirements by 2011
 - Must have contracts with a sufficient number and range of providers
- Non-employer PFFS
 - Must meet Medicare access requirements
 - If two or more network-based MA Plan options exist

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Notes:

SLIDE 22 *Speaker's Notes*

Medicare Special Needs Plans are Medicare Advantage Plans designed to provide:

- Focused care management
- Special expertise from the plan's providers
- Benefits tailored to enrollee conditions

For example, a Medicare Special Needs Plan for people with diabetes might have additional providers with experience caring for conditions related to diabetes, have focused special education or counseling, and/or nutrition and exercise programs designed to help control the condition.

A Medicare Special Needs Plan for people with both Medicare and Medicaid might help members access community resources and coordinate many of their Medicare and Medicaid services.

Medicare Special Needs Plans must include Medicare prescription drug coverage.

Special Needs Plans (SNPs)

- Designed to provide
 - Focused care management
 - Special expertise of plan's providers
 - Benefits tailored to enrollee conditions
- Must include prescription drug coverage

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Notes:

SLIDE 23 *Speaker's Notes*

There are three types of Medicare Special Needs Plans. Medicare SNPs must limit all or most of their membership to people with certain chronic or disabling conditions, those eligible for both Medicare and Medicaid, or people in certain institutions (like a nursing home). Medicare Special Needs Plans are only available in some areas.

Special Needs Plans (continued)

- Three types of SNPs
 - Must limit membership to people
 - With certain chronic or disabling conditions
 - Eligible for Medicare and Medicaid or
 - In certain institutions
- Available in some areas
 - Visit www.medicare.gov
 - Select “Search Tools” at top of the page
 - Call 1-800-Medicare

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To find out if any Medicare Special Needs Plans are available in your area:

- Visit www.medicare.gov on the web. Select “Search Tools” at the top of the page, or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Notes:

SLIDE 24 *Speaker's Notes*

Medicare Medical Savings Account (MSA) Plans are similar to Health Savings Account Plans available outside of Medicare. They have two parts. The first part is a Medicare Advantage Plan with a high deductible. This health plan won't begin to pay covered costs until the person has met the annual deductible, which varies by plan. The second part is a Medical Savings Account into which Medicare deposits money that the person with Medicare may use to pay health care costs.

There is a MSA demonstration program available in some areas that allows preventive services before the deductible is met, and has cost-sharing after the deductible is met, up to a separate out-of-pocket limit.

For more information on MSA Plans, visit www.medicare.gov/Publications/Pubs/pdf/11206.pdf or call 1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048) and ask for a copy of *Your Guide to Medicare Medical Savings Account Plans*, CMS Pub #11206. To learn which Medicare MSA Plans are available in a specific area of the country, use the Medicare Options Compare tool on the www.medicare.gov website.

MSA Plans

- Similar to Health Savings Account Plans
- Have two parts
 - Medicare Advantage Plan with high deductible
 - Pays covered costs after deductible is met
 - Medical Savings Account
 - Medicare deposits money the person may use
 - To pay health care costs
- Not available in all areas

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Notes:

SLIDE 25 *Speaker's Notes*

There are three other types of Medicare plans:

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

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

Other Medicare Plans

- Medicare Cost Plans
- Demonstrations/Pilot Programs
- Programs of All-inclusive Care for the Elderly (PACE)

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Notes:

SLIDE 26 *Speaker's Notes*

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

You can join a Medicare Cost Plan even if you only have Part B. If you go to a non-network provider, the services are covered under Original Medicare. You would pay the Part B premium, and the Part A and Part B coinsurance and deductibles. You can join a Medicare Cost Plan any time it is accepting new members.

You can leave a Medicare Cost Plan any time and return to Original Medicare. You can either get your Medicare prescription drug coverage from the plan (if offered), or you can buy a Medicare Prescription Drug Plan to add prescription drug coverage.

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

Cost Plans

- Available only in certain areas of the country
- Only have to have Part B
- Original Medicare covers services for a non-network provider
- Can join any time accepting new members
- Can leave any time
 - Return to Original Medicare
- Medicare prescription drug coverage
 - From the plan (if offered)
 - Join Medicare Prescription Drug Plan (if not offered)

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Notes:

SLIDE 27 *Speaker's Notes*

Medicare Demonstrations and Pilot Programs are special projects that test improvements in Medicare coverage, payment, and quality of care. They are usually for a specific group of people and/or are offered only in specific areas.

Some follow Medicare Advantage Plan rules, but others don't. The results of demonstrations have helped shape many of the changes in Medicare over the years.

Check with the demonstration or pilot program for more information about how it works. To find more information, visit www.cms.hhs.gov/DemoProjectsEvalRpts/ or www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Demonstrations/Pilot Programs

- Special projects test improvements
 - Medicare coverage
 - Payment
 - Quality of care
- Eligibility usually limited to a specific
 - Group of people
 - Area of country
- Examples
 - MA Plan for ESRD patients
 - New Medicare preventive services
 - MSA demonstration in some areas

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Notes:

SLIDE 28 *Speaker's Notes*

Programs of All-inclusive Care for the Elderly (PACE) combine medical, social, and long-term care services for frail elderly people who live in and get health care in the community. PACE programs provide all medically-necessary services, including prescription drugs.

PACE is a joint Medicare and Medicaid program that may be available in states that have chosen it as an optional Medicaid benefit. PACE might be a better choice for some people instead of getting care through a nursing home. PACE is available only in states that have chosen to offer it under Medicaid, and the qualifications for PACE vary from state to state.

Call your State Medical Assistance (Medicaid) office to find out about eligibility and if a PACE site is near you. You can also visit www.cms.hhs.gov/pace/pacesite.asp on the web for PACE locations and telephone numbers.

NOTE: Instructor may highlight local plans.

Medicare PACE Plans

- Programs of All-inclusive Care for the Elderly
- Combine services for frail elderly people
 - Medical
 - Social
 - Long-term care services
 - Include prescription drug coverage
- Might be better choice than nursing home
- Only in states that offer it under Medicaid
- Qualifications vary from state to state
 - Contact state Medical Assistance office for information

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 29 *Speaker's Notes*

Since each plan can vary, it's important that people with Medicare read the plan materials carefully. People may have different preferences and needs.

When comparing plans, people should consider things like:

- Other coverage they may have
- Costs (premiums and deductibles)
- Doctor and hospital choice
- Prescription drug needs
- The quality of care
- The convenience of the location of providers, and their hours
- Whether they spend part of the year in another state (whether they would be covered there)

Comparing Plans – What to Consider

- Other coverage they may have
- Costs (premiums and deductibles)
- Doctor and hospital choice
- Prescription drug needs
- Quality of care
- Convenience (like provider location, hours)
- Whether they spend part of the year in another state (whether they would be covered there)

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 30 *Speaker's Notes*

All people with Medicare have certain guaranteed rights and protections. They have them whether they are in Original Medicare, in a Medicare Advantage Plan or other Medicare health plan, have a Medicare drug plan, or have a Medigap (Medicare Supplement Insurance) policy.

Rights in All Medicare Plans

- People with Medicare have certain guaranteed rights to:
 - Get the health care services they need
 - Receive easy-to-understand information
 - Have personal medical information kept private

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 31 *Speaker's Notes*

People also have additional rights when they are enrolled in an MA Plan, including:

- If they have a complex or serious medical condition, they have the right to get a treatment plan that lets them see a specialist within the plan as many times as they and their doctor think they need to. Women have the right to go directly to a women's health care specialist within the plan for routine and preventive health care services.
- When people in a Medicare Advantage Plan ask their plan how it pays its doctors, the plan must tell them. Medicare doesn't allow a health plan to pay doctors in a way that wouldn't let its members get the care they need.
- People in a Medicare Advantage Plan have the right to file an appeal or complaint, and to a fair, efficient, and timely process to resolve differences with their health plan. This process includes the initial decision made by the plan, an internal review, and an independent external review. They have the right to ask their plan to provide or pay for a service they think should be covered, provided, or continued. We'll talk about the appeals process in more detail in a few minutes.
- Members also have the right to a fast appeals process whenever they are getting services from a skilled nursing facility, home health agency, or comprehensive out-patient rehabilitation facility.

NOTE: Visit www.cms.hhs.gov/pace/downloads/prtemp.pdf on the web, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. People who have a Medicare Cost Plan will need to follow Original Medicare appeal process for any services they receive outside the plan's network.

Rights in MA Plans

- Additional rights and protections
 - Access to health care providers
 - Know how doctors are paid
 - Fair, efficient, and timely appeals process
 - Fast appeals in certain health care settings

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 32 *Speaker's Notes*

The plan must tell its members in writing how to appeal. People in a Medicare Advantage Plan or other Medicare plan can appeal if their plan will not pay for, does not allow, or stops or reduces a course of treatment that they think should be covered or provided. If they think their health could be seriously harmed by waiting for a decision about a service, they should ask the plan for an expedited appeal decision.

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

Appeals in MA

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

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 33 *Speaker's Notes*

Plans sponsors are required to provide notices after every adverse coverage determination (plan's initial decision) or appeal.

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

Required Notices

- After every
 - Adverse determination
 - Adverse appeal
- Include
 - Detailed explanation of why services denied
 - Information on next appeal level
 - Specific instructions

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 34 *Speaker's Notes*

This slide outlines the appeal process in Medicare Advantage Plans.

- **Plan Reconsideration:** must be filed within 60 days of the date of the determination notice; no minimum amount in controversy needed; health plan has jurisdiction.
- **Independent Review Entity:** automatic if Plan Reconsideration does not change initial determination; no minimum amount in controversy needed; Independent Review Entity has jurisdiction.
- **Administrative Law Judge (ALJ) hearing:** must be filed within 60 days of the date of Independent Review Entity decision; minimum amount \$120 in 2009; this amount is adjusted annually based on inflation.
- **Review by the Medicare Appeals Council (MAC):** Must be made in writing within 60 days from the date of receiving the unfavorable ALJ decision.
- **Judicial Review:** must be filed within 60 days of receipt of MAC decision/declination; minimum amount in 2009 is \$1,180, to be adjusted annually; jurisdiction of U.S. District Court.

Appeal Levels

- Plan Reconsideration
- Independent Review Entity (IRE)
- Administrative Law Judge (ALJ)
- Medicare Appeals Council (MAC)
- Judicial Review

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 35 *Speaker's Notes*

As we mentioned earlier, people in Medicare Advantage Plans also have the right to a fast-track appeals* process. This process is available when a person believes his or her services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility are ending too soon.

The provider or plan must give the person a Notice of Medicare Non-coverage (NOMNC) at least 2 days before their services are expected to end. These fast-track appeals are not automatic, but if the person does appeal, the plan must provide a *Detailed Explanation of Non-coverage*. In general, the person will get a decision within approximately 2 days from the Quality Improvement Organization that will decide if services need to continue.

* The fast-track appeal process does not apply to Health Care Prepayment Plans (HCPP). An HCPP is an organization, union, or employer-sponsored plan that provides or arranges for some or all of Part B Medicare benefits on a prepayment basis. Payment for Part A services is made on a fee-for-service basis.

Fast-Track Appeals

- When services are ending too soon
 - Skilled nursing facility
 - Home health agency
 - Comprehensive outpatient rehabilitation facility
- Will get Notice of Medicare Non-coverage
 - At least 2 days before services end
 - If appealed, will get Detailed Explanation of Non-coverage
- Decision from Quality Improvement Organization (QIO) within 2 days

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 36 *Speaker's Notes*

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

Inpatient Hospital Appeals

- When services are ending too soon
- Provider/plan must give Notice of Discharge and Medicare Appeal Rights
 - At least the day before services end if
 - The enrollee disagrees with the discharge decision, or
 - The provider/plan is lowering the level of the enrollee's care within the same facility
- Decision from QIO usually within 2 days

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Medicare Advantage Plans and Other Medicare Plans

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The person can then appeal by sending a request to the QIO by noon of the first day after receiving the NODMAR. The decision from the QIO is usually received within 2 days. If an appeal is received by the QIO by noon of the day after receipt of a non-coverage notice, the patient is not responsible for paying for the days in the hospital during the QIO review (except for charges such as copays and deductibles), even if the QIO disagrees.

If a person decides to stay in the hospital past the planned discharge date without appealing, he or she may have to pay for any services received after that date.

The QIO will decide within one day after it receives the necessary information. However, people should be aware that they could be financially liable for inpatient hospital services provided after noon of the day after the QIO gives its decision. They may leave the hospital on or before that time and avoid any possible financial liability.

Notes:

SLIDE 37 *Speaker's Notes*

Note to instructor: A chart that lists allowed and prohibited marketing practices is printed in the back of the participants' workbooks. You may wish to refer to pages 67 and 68 during your review of the marketing regulations.

Lesson 2

New Marketing Regulations

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Notes:

SLIDE 38 *Speaker's Notes*

In September 2008, CMS released final regulations that further protected Medicare beneficiaries from deceptive or high-pressure marketing tactics by private insurance companies and their agents during the 2009 Medicare Advantage and prescription drug open enrollment period. Most of the marketing rules were already required by our Marketing Guidelines, but now they are codified in regulation and statute.

The regulations include prohibitions on telemarketing and other unsolicited sales contacts. The new rules also prohibit financial incentives that could encourage agents and brokers to maximize commissions by inappropriately moving beneficiaries from one plan to another each year. Plans had to be in compliance with these provisions when they began their marketing activities October 1, 2008.

Marketing Provisions

- Final regulations released September 2008
 - Further protect beneficiaries from deceptive or high-pressure marketing tactics
 - Codified existing Marketing Guidelines
 - Prohibit
 - Telemarketing
 - Other unsolicited sales contacts
 - Certain financial incentives for agents and brokers
- Plans in compliance by October 1, 2008

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Notes:

SLIDE 39 *Speaker's Notes*

To ensure that beneficiaries receive comprehensive plan information regarding their healthcare options, CMS regulations now provide that MA and PDP organizations must disclose certain plan information both at the time of enrollment and at least annually, 15 days prior to the Annual Election Period. This requirement includes the annual dissemination of the standardized Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) that must be received by members no later than October 31 each year.

Disclosure of Plan Information

- Codifies existing guidance
- MA and PDPs must disclose plan information
 - At time of enrollment
 - At least annually, 15 days prior to AEP
 - ANOC/EOC must be received by members no later than October 31 each year

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 40 *Speaker's Notes*

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

Nominal Gifts

- Codifies existing guidance
- Can offer gifts to potential enrollees
 - Must be of nominal value
 - Defined in marketing guidelines
 - Currently set at \$15, based on retail price
 - Must be given whether beneficiary enrolls or not

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Notes:

SLIDE 41 *Speaker's Notes*

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

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

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

- Fruit, Raw vegetables, Pastries, Cookies or other small dessert items, Crackers, Muffins, Cheese, Chips, Yogurt, and/or Nuts

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

Prohibition of Meals

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

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Notes:

SLIDE 42 *Speaker's Notes*

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

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

Only upon request by the beneficiary are plans permitted to schedule appointments with residents of long-term care facilities. Additionally, providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships.

Marketing in Health Care Settings

- Codifies existing guidance
- No marketing activities in healthcare setting
 - Examples: waiting rooms, exam rooms, hospital patient rooms, dialysis centers, pharmacy counter areas
- Marketing allowed in common areas
 - Examples: hospital or nursing home cafeterias, community or recreational rooms, conference rooms

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Notes:

SLIDE 43 *Speaker's Notes*

Effective September 18, 2008, the prohibition on door-to-door solicitation extends to other instances of unsolicited contact that may occur outside of advertised sales or educational events. Prohibited activities include, but are not limited to, the following:

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

Prohibited Contacts

- Door-to-door solicitation
- Outbound marketing calls
- Approaching in common areas
 - Parking lots, hallways, lobbies, etc
- Calls/visits after attendance at sales event
 - Unless express permission given
- Unsolicited emails

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Notes:

SLIDE 44 *Speaker's Notes*

Organizations may do the following:

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

Allowed Contacts

- Conduct outbound calls to existing members
 - To conduct normal enrollment business
- Conduct disenrollment survey
- Call reassigning LIS-eligible members
 - Under limited circumstances to encourage them to remain enrolled in current plan
 - Subject to advance CMS Regional Office approval
- Call beneficiaries who have given permission
 - For plan or sales agent contact

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 45 *Speaker's Notes*

Effective September 18, 2008, marketing non-health care related products (such as annuities and life insurance) to prospective enrollees during any MA or Part D sales activity or presentation is considered cross-selling and is a prohibited activity. Beneficiaries already face difficult decisions regarding Medicare coverage options and should be able to focus on Medicare options

without confusion or implication that the health and the non-health products are a package.

Plans may sell non-health related products on inbound calls when a beneficiary requests information on other non-health related products. Marketing to current plan members of non-MA Plan covered health care products, and/or non-health care products, is subject to Health Insurance Portability and Accountability Act (HIPAA) rules.

CMS is concerned about the marketing of non-health related products during hold-time messages and on interactive voice response (IVR) systems that plans may use to automate their inbound calling interface.

Cross-selling

- New guidance
- Cross-selling prohibited during any MA or Part D sales activity or presentation
 - Cannot market non-health care related products
 - Examples: annuities, life insurance
 - Allowed on inbound calls when requested by beneficiary

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Notes:

SLIDE 46 *Speaker's Notes*

Effective September 15, 2008, prior to a marketing appointment, the beneficiary must agree to the scope of the appointment and that agreement must be documented by the plan. For example, if a beneficiary attends a sales presentation and schedules an appointment, the agent must obtain written documentation that is signed by the beneficiary agreeing to the products that will be discussed during the appointment.

Appointments that are made over the phone must be recorded in order to provide documentation using their existing systems to monitor and track calls where there is beneficiary interaction. Organizations that contact a beneficiary in response to a reply card may only discuss the products that were included in the advertisement.

Additional products may not be discussed unless the beneficiary requests the information. Any additional lines of plan business that are not identified prior to the in-home appointment will require a separate appointment. Appointments may not be re-scheduled until 48 hours after the initial appointment. Marketing representatives may leave plan materials, not including enrollment applications, related to the other product lines during the initial appointment.

Scope of Appointments

- Codifies existing guidance
- Must identify lines of business to be discussed with potential enrollee
 - Prior to marketing and/or in-home appointment
 - Examples: Medigap, MA, or PDP
- Additional products can only be discussed
 - On beneficiary request and
 - At a separate appointment
 - At least 48 hours later

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 47 *Speaker's Notes*

Beginning September 18, 2008, educational events may not include sales activities such as the distribution of marketing materials or the distribution or collection of plan applications. CMS has clarified that the purpose of educational events is to provide objective information about the Medicare program and/or health improvement and wellness.

Educational events should not be used to steer or attempt to steer a beneficiary towards a specific plan. Organizations that sponsor or participate in educational events must include a disclaimer on event advertising materials that the event is “educational only and information regarding the plan will not be available.”

Educational events may be sponsored by the plan(s) or by outside entities, and are events that are promoted to be educational in nature and have multiple vendors, such as health information fairs, conference expositions, state- or community-sponsored events, etc. A sales event is an event that is sponsored by a plan or another entity with the purpose of marketing to potential members and steering, or attempting to steer, potential members towards a plan.

Marketing at Educational Events

- New guidance
- No marketing activities at educational events
 - Examples: health information fairs, conference expositions, state- or community-sponsored events
- Plans may distribute
 - Medicare and/or health educational materials
 - Agent/broker business cards, upon request
 - Containing no marketing information

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Notes:

SLIDE 48 *Speaker's Notes*

CMS has prohibited the use of names and/or logos of co-branded network providers on membership plan identification cards. This prohibition extends to entities and/or co-branding partners with substantially similar names and/or logos of a network provider or providers. In addition, organizations are required to include the following disclaimer on all marketing materials that include the name and/or logo of a co-branded network partner: "Other (pharmacies/physician/providers) are available in our network."

CMS must ensure that beneficiaries understand the availability of multiple network providers and are not misled to believe that the co-branded network provider is the only provider available to them. (Plans that have a network exclusive to that co-branded provider do not have to include the disclaimer.)

MA organizations may include provider names, and/or logos on the member ID card related to member selection of specific providers or provider organizations (e.g., physicians, hospitals). For example, in some plan types MA enrollees may select a primary care provider or particular group of service delivery providers, such as a hospital network. Given that the beneficiary has made the selection to identify the provider, that provider's name or logo may appear on the card.

Co-branding

- Codifies existing guidance
- Prohibits names and/or logos of co-branded network partners on plan ID cards
- Other marketing materials must include disclaimer
- Exceptions
 - Plans that have a network exclusive to that co-branded provider
 - Plans may include names/logos of member-selected provider(s) on ID card

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 49 *Speaker's Notes*

The final rule codifies existing guidance that MA organizations and Part D sponsors that conduct marketing through independent agents must use state-licensed, certified, or registered individuals. Independent agents and internal sales staff that perform marketing must be licensed.

State Licensure of Agents

- Codifies existing guidance
- If MA and PDP organizations use agents/brokers
 - Must be state-licensed, certified, or registered
 - Applies to both contracted and employed agents/brokers

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 50 *Speaker's Notes*

Effective September 18, 2008, organizations must comply with State appointment laws that require plans to give the state information about which agents are marketing the Part C and D plans. As provided under section 103(d)(1) of MIPPA, and the new section 1851(h)(7) of the Act, effective January 1, 2009, organizations must also pay any fees that would be charged in connection with State appointment laws.

State Appointment of Agents

- New guidance
- MA and PDP organizations must comply with State appointment laws
 - Require plans to give state information about which agents are marketing their plans
- Any required appointment fees must be paid
 - Effective January 1, 2009

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 51 *Speaker's Notes*

Effective January 1, 2009, MA organizations or Part D sponsors must report the termination of any brokers or agents, and the reasons for the termination, to the State in which the broker or agent has been appointed in accordance with the State appointment law.

Terminated Agents

- MAs and PDPs must report agent/broker terminations
 - In accordance with state appointment law
 - To state in which agent/broker is appointed
 - Must include reasons for termination

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 52 *Speaker's Notes*

MIPPA required that CMS establish limits on agent and broker compensation that ensure that agents and brokers enroll individuals in the Medicare Advantage Plan or Medicare Prescription Drug Plan that is intended to best meet their health care needs. The limits in 42 CFR 422.2274(a) and 423.2274(a) implement this requirement. These limits apply to Medicare Advantage organizations and Part D sponsors that market through brokers or agents, including agents and brokers employed by the MA organization or sponsor.

These compensation rules are designed to eliminate inappropriate moves of beneficiaries from plan to plan. CMS expects that plans will set compensation at levels that are reasonable, and reflect fair market value for services performed. CMS encourages plans to keep compensation as level as possible across plan types, and among agents providing similar services.

The Office of the Inspector General (OIG) advisory opinion process is available to parties seeking OIG's opinion as to the legality of a particular arrangement. Information about this process is available on the OIG's web site at <http://oig.hhs.gov/fraud/advisoryopinions.html>.

Agent/Broker Compensation

- New guidance
- MAs and PDPs must limit agent/broker compensation
 - Designed to eliminate inappropriate beneficiary moves
 - Applies to contracted and employed agents/brokers

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 53 *Speaker's Notes*

MA organizations and Part D sponsors must ensure that brokers and agents selling Medicare products are trained annually on Medicare rules and regulations, and on plan details specific to the plan products being sold by the brokers and agents.

MA organizations and Part D sponsors must also ensure that brokers and agents selling Medicare products are tested annually on their knowledge of Medicare rules and regulations as well as, on the plan specific details of the plan products being sold. In order to sell Medicare products, a broker or agent should receive a passing score of at least 85% on the test. Tests may be in the form of a written test or computerized.

Organizations and sponsors must ensure that their training and testing programs are designed and implemented in a way that the integrity of the training and testing is maintained. In doing so, they must have a process for handling instances in which agents do not pass the test on the first try.

Agent/Broker Training and Testing

- Codifies existing guidance
- All agents/brokers must be trained and tested annually
 - Medicare rules and regulations
 - Plan details specific to plan products being sold
 - Both contracted and employed agents
 - Completed by October 1, 2009, to market after that date
 - Testing requires passing score of 85%

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 54 *Speaker's Notes*

CMS efforts will build upon the success of past marketplace surveillance program activities to ensure that drug plans' and health plans' marketing practices reflect the new requirements.

Surveillance will include:

- Tripling the number of "secret shopper" activities in which a Medicare official poses as a prospective enrollee and monitors sales agents' presentations for inaccurate information and prohibited sales tactics
- Reviewing plans' local print and broadcast advertisements
- Reviewing recordings of enrollment calls to ensure compliance with the new regulations
- Ensuring that health and drug plans detect, report, and respond to agent/broker marketing misrepresentation and other issues

During last year's open enrollment period, CMS' marketplace surveillance activities included secret-shopping 300 sales and marketing events. As a result, three organizations were required to develop corrective action plans and one organization's marketing activities were suspended. Other plans with lesser deficiencies received warning letters from CMS.

CMS Marketing Surveillance

- Surveillance will include
 - Tripling the number of "secret shopper" activities
 - Reviewing plans' local print and broadcast advertisements
 - Reviewing recordings of enrollment calls to ensure compliance with the new regulations
 - Ensuring plans detect, report, and respond to marketing misrepresentation and other issues

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 55 *Speaker's Notes*

There are a number of resources you can use to get more information or assistance regarding Medicare Advantage and other Medicare plans:

- *Medicare & You* handbook, CMS Pub. No. 11050
- *Understanding the Choices You Have in How You Get Your Medicare Health Care Coverage* brochure, CMS Pub. No. 11225
- Your local State Health Insurance Assistance Program (SHIP) (Their telephone number is on the back cover of the *Medicare & You* handbook.)
- www.medicare.gov, where you can find the Medicare Options Compare tool, the Medicare publications listed above, and other publications on health plan choices
- www.cms.hhs.gov
- 1-800-MEDICARE (1-800-633-4227)

Resources

- Medicare publications
 - *Medicare & You* handbook
 - *Understanding the Choices You Have in How You Get Your Medicare Health Care Coverage*
- State Health Insurance Assistance Programs
- www.medicare.gov
 - Medicare Options Compare tool
 - Medicare publications
- www.cms.hhs.gov
- 1-800-MEDICARE (1-800-633-4227)
 - TTY/TDD 1-877-486-2048

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 56

Exercise

1. Medicare Advantage Plans are sometimes referred to as
 - A. Medigap
 - B. Part D
 - C. Part C
 - D. Medicaid

Exercise

1. Medicare Advantage Plans are sometimes referred to as
 - A. Medigap
 - B. Part D
 - C. Part C
 - D. Medicaid

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 57

Exercise

2. Which is NOT a requirement to join a Medicare Advantage Plan?
- A. Entitled to Part A
 - B. Limited income and resources
 - C. Enrolled in Part B
 - D. Live in plan's service area

Exercise

2. Which is NOT a requirement to join a Medicare Advantage Plan?
- A. Entitled to Part A
 - B. Limited income and resources
 - C. Enrolled in Part B
 - D. Live in plan's service area

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 58

Exercise

3. If you are in a Medicare Advantage Plan
 - A. You can change to another plan at any time
 - B. You may have prescription drug coverage
 - C. You should buy a Medigap policy
 - D. Benefits and cost-sharing will always be the same as Original Medicare

Exercise

3. If you are in a Medicare Advantage Plan
 - A. You can change to another plan at any time
 - B. You may have prescription drug coverage
 - C. You should buy a Medigap policy
 - D. Benefits and cost-sharing will always be the same as Original Medicare

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

SLIDE 59
Exercise

4. Which one is NOT a type of Medicare Advantage Plan?
- A. HMO
 - B. PPO
 - C. SNP
 - D. SNF

Exercise

4. Which one is NOT a type of Medicare Advantage Plan?
- A. HMO
 - B. PPO
 - C. SNP
 - D. SNF

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Notes:

SLIDE 60 *Exercise*

5. Which statement is true about Medicare Savings Accounts?
- A. They were offered beginning in 2006
 - B. They have no annual deductible
 - C. Medicare deposits money in the account that the person may use to pay health care costs
 - D. These plans are available everywhere

Exercise

5. Which statement is true about Medicare Savings Accounts?
- A. They were offered beginning in 2006
 - B. They have no annual deductible
 - C. Medicare deposits money in the account that the person may use to pay health care costs
 - D. These plans are available everywhere

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Medicare Advantage Plans and Other Medicare Plans

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Notes:

Module 11: Medicare Advantage Plans and Other Medicare Plans

This training module provided by the



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Notes:

Medicare Advantage Plans

CAN:

- Use direct mail (i.e., postcards, reply cards), *but* plans cannot include enrollment forms
- Use television advertisements
- Use radio advertisements
- Use outdoor advertising (i.e., billboards)
- Use banners
- Use print advertisements (i.e., newspaper, magazine, flyers, posters, brochures)
- Use internet advertisements
- Conduct sales presentations
- Distribute and accept enrollment applications
- Educate potential enrollees at health fairs
- Schedule appointments with beneficiaries upon request (including those in long-term care settings)
- Offer gifts to potential enrollees if they attend a marketing presentation as long as the gifts are of nominal value and are provided whether or not the individual enrolls in the plan
- Offer a drawing, prize or giveaway of any value to the general public as long as it is not routinely or frequently awarded (as long as there is no obligation to enroll in the plan in order to win the gift)
- Offer gifts of nominal value for patient referrals as long as the gift is available to all members and is not conditioned on actual enrollment of the person being referred
- Distribute marketing materials
- Offer health-related or non health-related “value added items and services” to plan members

CANNOT:

- Offer cash gifts - including charitable contributions, gift certificates or gift cards that can be readily converted to cash
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Offer anything of value to induce potential plan enrollees to select them as their Medicare Advantage Plan
- Conduct sales presentations and distribute and accept enrollment applications in areas of health care settings where patients primarily intend to receive health care services
- Solicit door-to-door for Medicare beneficiaries or through other unsolicited means of direct contact, including calling a beneficiary without beneficiary initiating the contact
- Provide or subsidize meals at any sales/marketing event or meeting where plan benefits are being discussed or plan materials are being distributed
- Market non-health care related products to prospective enrollees during any MA or Part D sales activity or presentation
- Market any health care related products during a marketing appointment beyond the scope agreed upon by the beneficiary

More information about Managed Care Marketing may be viewed at www.cms.hhs.gov/ManagedCareMarketing

Health Plan Employee/Independent Contractor Sales and Marketing Agents

MUST:

- Use marketing materials that have been reviewed and approved by CMS
- Comply with the “Do not call registry;” honor “do not call” requests and abide by calling hours set forth in Federal and State law
- Provide information in a professional manner
- Ensure that sales and marketing agents have received training and testing regarding compliance with CMS rules and regulations
- Use state-licensed, certified, or registered individuals to market plans (if the state requires it)
- Ensure that a marketing agent clearly identifies the types of products the marketing agent will discuss prior to marketing

MUST NOT:

- Solicit door-to-door for Medicare beneficiaries or through other unsolicited means of direct contact, including calling a beneficiary without beneficiary initiating the contact
- Imply that a face-to-face meeting is required for a beneficiary to receive information about a Medicare Advantage Plan
- Send unsolicited email
- Enroll beneficiaries through outbound telemarketing
- Offer cash payment as an inducement to enroll
- Misrepresent or use high pressure sales tactics
- Engage in any activity which a Medicare Advantage Plan is prohibited from engaging in
- Market non-health care related products to prospective enrollees during any MA or Part D sales activity or presentation
- Market any health care related products during a marketing appointment beyond the scope agreed upon by the beneficiary

Provider

CAN:

- Provide the names of plans which they contract and/or participate in
- Provide information and assistance in applying for the low income subsidy
- Provide objective information on specific plan formularies, based on a particular patient’s medications and health care needs
- Provide objective information regarding specific plans, such as covered benefits, cost sharing, and utilization management tools
- Distribute marketing materials, except for Medicare Advantage Plan enrollment application forms
- Refer patients to other sources of information and share information from the CMS website
- Use comparative marketing materials comparing plan information created by a third-party who doesn’t provide benefits or health care services
- Display posters or other materials that advertise their relationship with the plans
- Help beneficiaries enroll in a plan that “best meets the beneficiaries’ needs”

CANNOT:

- Direct, urge, or attempt to persuade any prospective enrollee to enroll in a particular plan or to insure with a particular company based on financial or any other interest of the provider (or subcontractor)
- Collect enrollment applications
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Health screen when distributing information to patients, as health screening is a prohibited marketing activity
- Offer anything of value to induce plan enrollees to select them as their provider
- Expect compensation in consideration for the enrollment of a beneficiary
- Expect compensation directly or indirectly from the plan for beneficiary enrollment activities