Module 11 – Medicare Advantage and Other Medicare Health Plans

Section Objectives

- 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 are Medicare Advantage Plans?

- Medicare Advantage (MA) Plans are health plan options approved by Medicare and run by Medicare-approved private companies. In MA Plans, you get all Medicare-covered Part A (Hospital Insurance) and Part B (Medical Insurance) services through that plan.
- Many MA plans also include Medicare prescription drug coverage. This is called Medicare Part D coverage.
- MA Plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Original Medicare doesn't cover, like vision or dental services. The plan may have special rules that its members need to follow.
- MA Plans are part of the Medicare Program and are sometimes called Part C.
- MA Plans are offered in many areas of the country by Medicare-approved private companies that sign a contract with Medicare. Medicare pays these private plans for their members' expected health care.

How Medicare Advantage Plans Work

- It's important to note that when you join a Medicare Advantage (MA) Plan or other Medicare health plan
    - You're still in the Medicare Program. Medicare pays these private health plans for your care every month, whether you use services or not.
    - You still have Medicare rights and protections.
- In some plans, like Medicare Health Maintenance Organizations (HMOs), you may only be able to see certain doctors or go to certain hospitals. You save the most money out-of-pocket when you get services through the plan's network.
- Cost sharing in an MA Plan may differ from Original Medicare.
- If the plan decides to stop participating in Medicare, you will have the opportunity to join another MA Plan or return to Original Medicare.

Medicare Advantage Costs

- If you join a Medicare Advantage (MA) Plan, you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2017 is $109.
  - A few plans may pay all or part of the Part B premium for you.
  - Some people may be eligible for state assistance (programs for people with Medicare who lave limited income and resources).

- When you join an MA Plan there are other costs you may have to pay, like
  - An additional monthly premium to the plan
  - Deductibles, coinsurance, and copayments (required by most plans). These costs may
    - Be different from Original Medicare
    - Vary from plan to plan
    - Be higher if you go out of the plan's network

Who Can Join a Medicare Advantage Plan?

- Medicare Advantage (MA) Plans are available to most people with Medicare. To be eligible to join an MA Plan, you must be enrolled in Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). You must also live in the plan's geographic service area. You must be a United States (U.S.) citizen or lawfully present in the U.S., and you can't be incarcerated.
- To join an MA Plan, you must also agree to
  - Provide the necessary information to the plan, like your Medicare number, address, date of birth, and other important information
  - Follow the plan's rules
  - Belong to one MA Plan at a time

To find out which MA Plans are available in your area, visit Medicare.gov/finda-a-plan/questions/home.aspx or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Medicare Advantage and End-Stage Renal Disease (ESRD)

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. An individual with ESRD enrolled in employer-sponsored coverage, whether MA or commercial (i.e., non-Medicare), can enroll in another plan, if the plan is part of the same parent organization and meets the criteria for doing so. For example, an individual who develops ESRD while enrolled in an employer group health plan may be allowed to enroll in an MA Plan offered by the same plan parent organization, provided there's no break between coverage. People with Medicare with ESRD who are already enrolled in an MA Plan may also enroll in another MA Plan within the same parent organization as long as:

- The new MA Plan operates in the same state
- The person with Medicare meets all the other requirements for enrollment in that MA plan (and as in the previous MA Plan)

CMS will permit a change from a Health Maintenance Organization (HMO) to a Preferred Provider Organization (PPO) or a Private-Fee-for-Service (PFFS) Plan within the same parent organization, as long as the change meets all of the criteria. The term “parent organization” is defined as an entity that owns one or more contracts (H numbers) with CMS to provide MA Plans.

A person who has had a successful kidney transplant or no longer requires a regular course of dialysis treatment isn’t considered to have ESRD for purposes of MA eligibility.

NOTE: For more information on the enrollment exceptions for people with ESRD, see the MA enrollment and disenrollment guidance in Chapter 2 of the “Medicare Managed Care Manual”, section 20.2.2, available at CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2017_MA_Enrollment_and_Disenrollment_Guidance_8-25-2016.pdf and Medicare.gov/sign-up-change-plans/medicare-health-plans/medicareadvantage-plans/esrd-and-medicare-advantage-plans.html.

When You Can Join or Switch Medicare Advantage 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

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

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

NOTE: In the case of retroactive entitlement, there are special rules that allow for enrollment in a Medicare Advantage Plan or Original Medicare and a Medigap policy. More information about conditions that allow an exception can be found in Chapter 2 of the "Medicare Managed Care Manual," Section 30.4, at CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2017_MA_Enrollment_and_Disenrollment_Guidance_8-25-2016.pdf.

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.	

NOTE: 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 open enrollment period to get coverage and may have to pay a penalty.

Low Performing Plan

A contract that gets less than 3 stars for its Part C or Part D summary rating for at least the last 3 years gives these members a one-time option to switch to another Medicare drug plan with 3 stars or better. Visit CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/October-11627-combined.pdf for more information.

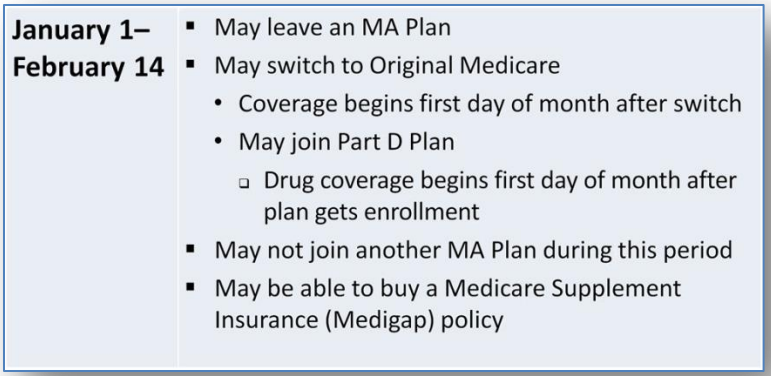
The summary scores the drug plan's quality and performance in many different topics that fall into 4 categories:

1. **Drug plan customer service**: Includes how well the plan handles member appeals.
2. **Member complaints and changes in the drug plan's performance**: Includes how often Medicare found problems with the plan, and how often members had problems with the plan, and how much the plan's performance has improved (if at all) over time.
3. **Member experience with the plan's drug services**: Includes ratings of member satisfaction with the plan.
4. **Drug safety and accuracy of drug pricing**: Includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that's considered safer and clinically recommended for their condition.

This information is gathered from several different sources like member surveys done by Medicare, reviews of billing and other information that plans submit to Medicare, and results from Medicare's regular monitoring activities.

Reference: Medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx

When You Can Leave Medicare Advantage Plans



If you belong to a Medicare Advantage (MA) Plan or Medicare Advantage with Prescription Drug (MA-PD) Plan, you may switch to Original Medicare from January 1 through February 14. If you go back to Original Medicare during this time, plan coverage will take effect on the first day of the calendar month following the date the election or change was made.

To disenroll from an MA Plan and return to Original Medicare during this period, you may

- Make a request directly to the MA organization.
- Call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.
- If you make this change, you may also join a Medicare Prescription Drug Plan to add drug coverage. Coverage begins the first day of the month after the plan gets the enrollment form.

If you leave an MA Plan, you may or may not, be able to buy a Medicare Supplement Insurance (Medigap) policy. It will depends on your individual circumstances. Certain federal rights may apply. States may provide additional protections. You can buy a Medigap policy any time a plan will sell you one.

You may not join another MA Plan during this period. It's important to remember that anytime you enroll in a new MA, MA-PD, or Medicare Prescription Drug Plan, it will automatically disenroll you from your previous plan. This includes MA-only Health Maintenance Organization and Preferred Provider Organization Plans. However, there are limited exceptions for members of MA-only Private Fee-for-Service, Cost and Medicare Medical Savings Account Plans. Once enrolled, coverage begins the first day of the month after the plan gets the enrollment form.

Medicare Advantage (MA) Trial Rights and Medigap

If you join a Medicare Advantage (MA) Plan for the first time, and you aren't happy with the plan, and return to Original Medicare within the first 12 months of joining, you'll have special rights to buy a Medicare supplement insurance (Medigap) policy if

- You joined an MA Plan when first eligible for Medicare at 65.
    - If you joined an MA Plan when you were first eligible for Medicare, you can choose from any Medigap policy within the first year of joining.

- You were in Original Medicare, enrolled in an MA Plan for the first time, and dropped a Medigap policy.
    - If you had a Medigap policy before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another Medigap policy.

NOTE: The Medigap policy can't have prescription drug coverage even if you had it before, but you may be able to join a Medicare Prescription Drug Plan. You can buy a Medigap policy anytime a plan will sell you one. Visit Medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf for more information about Medigap policies.

Types of Medicare Advantage Plans

Medicare Advantage Plans include

- 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.

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.

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 Accounts

There are other, less common types of Medicare Advantage Plans, like Medical Savings Account (MSA) Plans—a plan that combines a high-deductible health plan with a bank account. Medicare deposits money into the account, and you use the money to pay for your health care services. Cost sharing isn't allowed once the deductible has been paid.

For more information about MSA Plans, visit Medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-savings-accounts/medical-savings-account-plans.html. You can also call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Medicare Advantage (MA) Plan Network Changes

Network-based Medicare Advantage (MA) Plans (e.g., Health Maintenance Organizations, Preferred Provider Organizations, and Private Fee-for-Service Plans with networks) can make changes to their network of contracted providers at any time during the year. It's important to note that the Centers for Medicare & Medicaid Services (CMS) has safeguards in place to ensure that you are protected from medical care interruptions.

For example, CMS requires plans to maintain continuity of care for impacted enrollees by making sure you have access to medically necessary services if you need it.

- When MA Plans make changes to their networks, CMS also requires that they maintain adequate access to all medically necessary Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) services through their remaining provider network. If the remaining network doesn't meet Medicare access and availability standards, plans must add new providers necessary to meet CMS's access requirements.
    - Also, when an MA Plan makes a change in its provider network, it must provide written notification to enrollees who are seen on a regular basis by the provider whose contract is ending. This notice must be given at least 30 days in advance of the termination date. In this notice, the plan must provide a list of alternative providers and allow you to choose another provider.
- In most cases, mid-year provider network changes aren't a basis for an Enrollment Exception/Special Enrollment Period (SEP). CMS determines SEPs in these instances, on a case-by-case basis

An MA organization and a contracting provider must provide at least 60 days written notice to each other before terminating a contract without cause. A contract between an MA organization and a contracting provider may require notification of termination without cause for a longer period of time. CMS doesn't get involved in contracting disputes.

Lesson 2: Other Medicare Health Plans

Other Medicare Health Plans

Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage (MA) Plans, but are still part of Medicare. Some of these plans provide

- Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage
- Some also provide Medicare prescription drug coverage (Part D)

These plans have some of the same rules as MA Plans. Some of these rules are explained briefly on the next few slides. However, each type of plan has special rules and exceptions, so you should contact any plans you're interested in to get more details.

Medicare Cost Plans

- Medicare Cost Plans are a type of Medicare health plan available only in certain areas of the country.
- You can join even if you only have Medicare Part B (you don't have to have Part A).
    - If you go to a non-network provider, the services are covered under Original Medicare. You would pay the same out-of-pocket costs as you would for coverage under Original Medicare (Part B premium, and the Part A and Part B coinsurance and deductibles).
- You can join a Medicare Cost Plan anytime it's accepting new members.
- You can leave a Medicare Cost Plan anytime 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. You can only add or drop Medicare prescription drug coverage at certain times.

For more information about Medicare Cost Plans, contact the plan you're interested in. Your State Health Insurance Assistance Program (SHIP) can give you more information. To find a local SHIP, visit shipttacenter.org.

Innovation Projects and Pilot Programs

Medicare innovation projects and pilot programs are special projects that test improvements in Medicare coverage, payment, and quality of care. They're usually for a specific group of people and/or are offered only in specific areas. Some follow Medicare Advantage (MA) Plan rules, but others don't. The results of innovation projects have helped shape many of the changes in Medicare over the years including

- Development of an MA Plan design for End-Stage Renal Disease patients
- New Medicare preventive services

Check with the innovation project or pilot program for more information about how it works. To find more information, visit CMS.gov/medicare/demonstration-projects/demoprojectsevalrpts/index.html, Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227), TTY: 1-877-486-2048.

NOTE: Instructor may add state-specific content or provide a local example.

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

Programs of All-inclusive Care for the Elderly (PACE) is a joint Medicare and Medicaid Program that helps frail elderly people meet their health care needs in the community instead of going to a nursing home or other care facility. PACE provides all medically necessary services, including prescription drugs. Based on the circumstances, PACE might be a better choice for some people instead of getting care through a nursing home. PACE is a joint Medicare and Medicaid program that may be available in states that have chosen it as an optional Medicaid benefit. The qualifications for PACE vary from state to state.

Call your state Medical Assistance (Medicaid) office to find out about eligibility and if you live in the service area a PACE plan. Contact the Medicaid office phone number in your state. You can look up that contact information at medicaid.gov/aboutus/contact-us/contact-state-page.html

Lesson 3: Rights, Protections, and Appeals

Guaranteed Rights

All people with Medicare have certain guaranteed rights and protections. You have these rights and protections whether you're in Original Medicare, a Medicare Advantage Plan, another Medicare health plan, a Medicare drug plan, or have a Medigap policy.

- All people with Medicare have guaranteed rights to
  - Get the health care services they need
  - Get easy-to-understand information
  - Have personal medical information kept private

To view the full list of rights and protections for people with Medicare, visit Medicare.gov/claims-and-appeals/medicare-rights/everyone/rights-for-everyone.html.

Rights in Medicare Health Plans

If you're in a Medicare health plan, in addition to the rights and protections previously described, you also have the right to

- Choose health care providers in the plan so you can get covered health care.
- Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need to. Women have the right to go directly to a women's health care specialist within the plan without a referral for routine and preventive health care services.
- Know how your doctors are paid if you ask your plan. Medicare doesn't allow a plan to pay doctors in a way that interferes with your getting needed care.

- Have a fair, efficient, and timely appeals process to resolve payment and coverage disputes with your plan. You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued.
- File a grievance about other concerns or problems with your plan (e.g., if you believe your plan's hours of operation should be different, or there aren't enough specialists in the plan to meet your needs). Check your plan membership materials, or call your plan to find out how to file a grievance.
- Get a coverage decision (sometimes called an organization determination) or coverage information from your plan before getting a service to find out if the item or service will be covered, or to get information about your coverage rules. You can also call your plan if you have questions about home health care rights and protections. Your plan must tell you if you ask.
- Maintain privacy of personal health information.

For more information, read your plan's membership materials or call your plan.

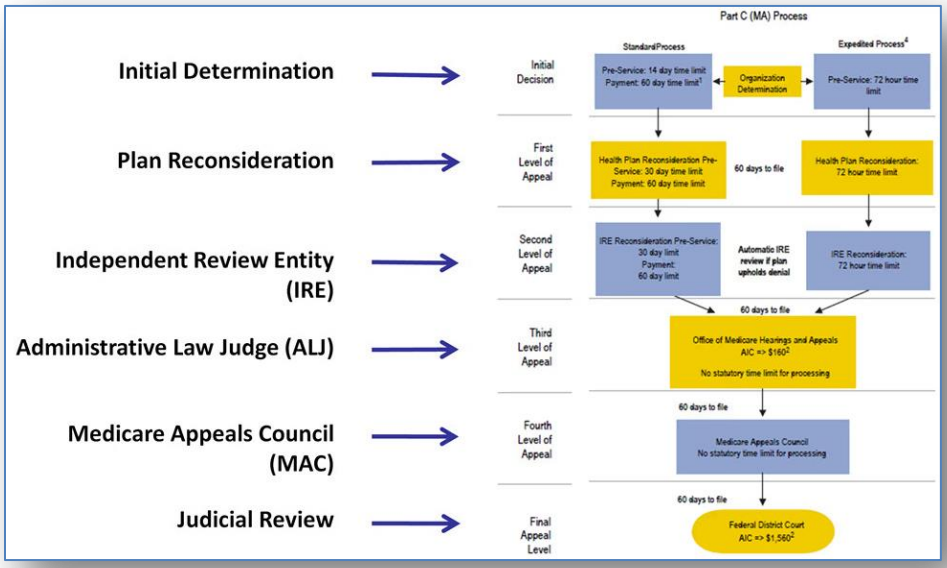
Appeals in Medicare Advantage Plans

The plan must tell you in writing how you can appeal if your plan won't pay for, doesn't allow, or stops or reduces a previously authorized course of treatment that you think should be covered or provided. You and your doctor can file an appeal. If you think your health could be seriously harmed by waiting for a decision about a service, you should ask the plan for an expedited (fast) decision.

If a doctor requests or supports an expedited decision, the plan must make a decision within 72 hours. You 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 doesn't decide in your favor, an independent organization that works for Medicare—not for the plan—automatically reviews the decision.

See the plan membership materials, or contact the plan for details about your Medicare appeal rights.

Medicare Part C Appeals Process



This chart shows the appeals process for Medicare Advantage or other Medicare health plan enrollees. The time frames differ depending on whether you're requesting a standard appeal, or if you qualify for an expedited (fast) appeal.

If you ask your plan to provide or pay for an item or service, and your request is denied, you can appeal the plan's initial decision (the "organization determination"). You'll get a notice explaining why your plan denied your request and instructions on how to appeal your plan's decision.
There are 5 levels of appeals. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so.

First, your plan will make an Initial Determination. These pre-service time frames include a possible extension of up to 14 days. After each level, you'll get instructions on how to proceed to the next level of appeal. The 5 levels of appeal are

1. Reconsideration by the plan
2. Reconsideration by the Independent Review Entity
3. Hearing with the Administrative Law Judge—the amount of your claim must meet a minimum dollar amount, a figure that's updated yearly ($160 in 2017)
4. Review by the Medicare Appeals Council
5. Review by a federal district court—to get a review by a federal court, the remaining amount in controversy of your case must meet a minimum dollar amount that's updated yearly ($1,560 in 2017)

For more information, visit CMS.gov/Medicare/Appeals-and-Grievances/MMCAG/..

NOTE: See the Appendix for a full-size copy of the Part C (Medicare Advantage) appeals process and footnote charts.

Rights If You File an Appeal With Your Medicare Health Plan

You have certain appeal rights if you're in a Medicare health plan.

You may want to call or write your plan and ask for a copy of your file. To get the phone number or address of your plan, look at your "Evidence of Coverage," or the notice you received that explained why you couldn't get coverage you requested.

The plan may charge you a fee for copying this information and sending it to you. Your plan should be able to give you an estimate of how much it will cost based on the number of pages contained in the file, plus normal mail delivery.

Lesson 4 – Medicare Marketing Guidelines

Marketing Materials

- CMS reviews marketing materials, with the exception of those in Section 20 of the Medicare Marketing Guidelines (MMG). While not an exhaustive list, some examples of excluded materials include the following:
    - Certain member newsletters
    - Press releases—if benefit information is included, it must be submitted for review
    - Blank letterhead
    - Privacy notices
    - Ad hoc materials as defined in Appendix 1 of the MMG
- Although certain materials aren't subject to the review and approval process that applies to marketing materials, plans must maintain materials and make them available at CMS's request.
- Medicare Advantage organizations and Prescription Drug Plan Sponsors must use standardized marketing material language and format, without modification (except where specified by CMS). Examples of standardized documents include, but aren't limited to:
    - Plan Annual Notice of Change (ANOC)
    - Evidence of Coverage (EOC)
- CMS also creates model materials, such as provider and pharmacy directories.

For more information visit CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2017MedicareMarketingGuidelines2.pdf and, also see the resources slide at the end of this presentation for the link to the MMG.

Marketing Reminders

Marketing for the upcoming plan year may not occur before October 1. Plan sponsors must stop current year marketing activities to existing people with Medicare once they begin marketing the plan benefits for the new contract year.

Medicare Advantage (MA), Medicare Advantage with Prescription Drug (MA-PD), , and Prescription Drug Plans (PDPs) get plan star ratings from CMS. Many individual performance measurements are used to determine the CMS overall star rating. When referencing a plan's ratings in marketing materials

- Individual measures may be marketed only with the overall star rating. The overall star rating must get equal prominence as individual measure(s) being marketed.
- Medicare Health Plans and Part D sponsors that have a Low Performance Icon (LPI) due to a low Part C (MA Plan) or Part D (PDPs) rating may not try to refute or discredit their LPI status by only showcasing a higher overall star rating. Any communications in reference to the LPI status must state what the status means.

NOTE: A contract that gets less than 3 stars for its Part C or Part D summary rating for at least the last 3 years (i.e., rated 2.5 or fewer stars for the 2014, 2015, and 2016 plan ratings for Part C or Part D) will be marked with the above icon on Medicare Plan Finder.

Disclosure of Plan Information for New and Renewing Members

To ensure that enrollees receive comprehensive plan information regarding their health care options, the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage and Prescription Drug Plan (PDP) organizations to disclose certain plan information both at the time of enrollment and at least annually, 15 days before to the Open Enrollment Period.

- This requirement includes the annual dissemination of the following that members must be get by members no later than September 30 each year:
    - Standardized Annual Notice of Change and Evidence of Coverage as applicable.
    - Low Income Subsidy (LIS) rider. This comes from the plan if someone qualifies for Extra Help and tells them how much help they'll get next year with their drug plan premium, deductible, and copayments.
    - Comprehensive formulary or abridged formulary including information on how the beneficiary can obtain a complete formulary (Part D sponsors only).
    - Membership identification card (required only at the time of enrollment and as needed or required by plan sponsor post-enrollment).
- Must provide the hard copy directories for the following, or a notice describing where they can be found online together with how to request a hard copy.
    - Pharmacy directory (for all plan sponsors offering a Part D benefit).
    - Provider directory (for all plan types except PDPs).
- Organizations are expected to provide required documents for new enrollees are expected to be provided no later than 10 calendar days after getting CMS's confirmation of enrollment, or by the last day of the month before to the effective date, whichever is later.

Nominal Gift Reminders

Organizations can offer gifts without discrimination to potential enrollees as long as such gifts are of nominal value and are provided whether or not the individual enrolls in the plan. The Centers for Medicare & Medicaid Services currently defines nominal value in the Medicare Marketing Guidelines (MMG), Section 70.1, as an item worth $15 or less, based on the fair market value of the item. There's a maximum aggregate of $75 per person, per year. Nominal gifts may not be in the form of cash or other monetary rebates. Gift cards are acceptable, if they can't be converted into cash.

NOTE: For more information, see the link to the MMG on the resources page near the end of this presentation.

Unsolicited Beneficiary Contact

Medicare health plans and Part D (Medicare prescription drug coverage) sponsors may not initiate separate electronic or direct contact with a person with Medicare unless they have agreed to get this communication. For example, on social media websites, such as Facebook and Twitter, if a person with Medicare comments or likes a plan/Part D sponsor on the site, that doesn't give permission to directly contact.

The current prohibition on door-to-door solicitation extends to other instances of unsolicited contact that may occur outside of sales or educational events. Prohibited activities include, but aren't limited to

- Outbound marketing calls, unless the beneficiary requested the call
- Calls to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling, in market plans or products
- Calls to people with Medicare to confirm receipt of mailed information
- Calls to people with Medicare to confirm acceptance of appointments made by third parties or independent agents
- Soliciting to people with Medicare when held in common areas (e.g., parking lots, hallways, sidewalks, etc.)

NOTE: These marketing prohibitions don't include conventional mail or other print media

Organizations may do the following:

- Make outbound calls to existing members to conduct normal business related to enrollment in the plan
- Call former members after the disenrollment effective date to conduct a disenrollment survey for quality improvement purposes
- Contact their members who are eligible for Extra Help, call people with Medicare (with CMS Regional Office approval), and contact people with Medicare who have expressly given permission for a plan or sales agent to contact them (e.g., completing a business reply card)

Cross-Selling Prohibition

Marketing health care–related products (such as annuities, life insurance, etc.) to prospective enrollees during any Medicare Advantage (MA) or Part D (Medicare prescription drug coverage) sales activity or presentation is considered cross-selling and is a prohibited activity.

People with Medicare already face difficult decisions regarding Medicare coverage options and should be able to focus on Medicare options without confusion. Plans should not imply that the health and the non-health products are a package. Plans may sell non-health related products on inbound calls when a person with Medicare 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 (known as HIPAA) rules.

Scope of Appointment Reminders

The Medicare Marketing Guidelines require marketing representatives to clearly identify the types they will discuss before marketing to a potential enrollee. Marketing representatives who initially meet with a person with Medicare to discuss specific lines of plan business (separate lines of business include Medicare Advantage, Medicare Prescription Drug, and Cost Plans) must tell the person with Medicare about all products they will discuss before the in-home appointment so they have accurate information to make an informed decision about their Medicare coverage choices without pressure.

- Before a marketing appointment, the person with Medicare must agree to the scope of the appointment. The plan can document the scope of the appointment in writing or telephone recording. The person with Medicare may sign the scope of appointment at least 48 hours before to the scheduled appointment, when practicable. If the agent is unable to get the signature 48 hours in advance, the agent should document the reason.

  > **Example**: A person with Medicare attends a sales presentation and schedules an appointment. The agent must get the person with Medicare to sign written documentation agreeing to the products that will be discussed during the appointment.
- Organizations should use their existing systems to monitor and track calls where there's interaction with people with Medicare. Organizations that contact a person with Medicare in response to a reply card may only discuss the products that were included in the advertisement.
- Organizations may not discuss additional products unless the person with Medicare requests the information. Moreover, any additional lines of plan business that aren't identified before the in-home appointment will require a separate appointment.

Marketing in Health Care Settings

Organizations may not conduct marketing 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 recreation 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 may not conduct sales presentations and distribute and accept enrollment applications in areas where patients primarily get health care services. These restricted areas generally include, but aren't 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).

Plans may schedule an appointment with someone living in long-term care facility only when the person with Medicare requests an appointment.

Additionally, providers may 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.

Promotional Activity Reminders

Medicare Advantage (MA) and Medicare Prescription Drug (PDP) Plan organizations may not give prospective enrollees meals, or subsidized meals at sales events or any meeting at which they discuss plan benefits and/or plan distribute plan materials.

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 they provide, and must ensure that items they provide couldn't be reasonably considered a meal, and/or that they aren't "bundling" and providing multiple items as if they are a meal.

As with all marketing regulations and guidance, it's 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 the Centers for Medicare & Medicaid Services (CMS) conducts will verify that plans and agents are complying with this provision, and CMS will take enforcement actions.

Educational Event Reminders

The plan or outside entities may sponsor educational events that are promoted to be educational in nature. Plans may distribute items related to education about the Medicare Program and general health and wellness. Agents and brokers may distribute their business cards if a person with Medicare requests one. Anything agents and brokers distribute may not have plan marketing information on or attached to the item(s).

Educational events for prospective members may not include sales activities such as the distribution of marketing materials or the distribution or collection of plan applications. The Centers for Medicare & Medicaid Services has clarified that the purpose of educational events is to provide objective information about the Medicare Program and/or health improvement and wellness. As such, educational events shouldn't be used to steer or attempt to steer a beneficiary toward a specific plan or plans. Plan sponsors or their representatives may not

- Discuss plan-specific premiums and/or benefits
- Distribute scope of appointment forms, enrollment forms, or sign-up sheets
- Set up individual sales appointments or get permission for an outbound call to the beneficiary
- Advertise an educational event and have a marketing/sales event immediately following in the same general location (e.g., at the same hotel)

The prohibited items mentioned may be distributed at a sales event. A sales event is an event sponsored by a plan or another entity with the purpose of marketing to potential members and steering, or attempting to steer, potential members toward a plan or plans.

NOTE: For more information, see the link to the Medicare Marketing Guidelines on the resources near the end of this presentation.

Licensure and Appointment of Agents

Medicare Advantage (MA) organizations and Medicare Prescription Drug Plan (PDP) sponsors that conduct marketing through agents, brokers, and other marketing representatives must comply with state licensure and appointment laws.

MA and PDP sponsors must comply with state appointment laws that require plans to give the state information about which agents are marketing the Part C and Part D plans.

Some plan activities, typically carried out by the plan sponsor's customer service department, don't require the use of state-licensed marketing representatives, such as providing factual information or fulfilling a request for materials.

Reporting of Terminated Agents

Medicare Advantage Organizations and Part D sponsors must report the termination of any brokers or agents, and the reasons for the termination, to the state(s) if required. In addition, any for-cause terminations (specific legal or organizational policy violations that made it necessary to terminate employment) must be reported to the CMS Account Manager, by email or letter.

Agent/Broker Compensation Rules

The Centers for Medicare & Medicaid Services' compensation rules are for Medicare Advantage Plans and Medicare Prescription Drug Plans that use independent agents/brokers. The rules are designed to eliminate incentives that encouraged inappropriate enrollment moves from plan to plan (also called churning).

Agent/Broker Compensation

CMS permits 2 types of compensation – an initial and a renewal

- Initial compensation is for people who age into Medicare and select a health plan; those whose pervious enrollment was Original Medicare; and those who make an "unlike plan" change.
    - "Unlike plan" changes include the following:
        - A Medicare Advantage (MA) or Medicare Advantage with Prescription Drug (MA-PD) Plan to Original Medicare with a PDP or Section 1876 Cost Plan
        - A PDP to a Section 1876 Cost plan, an MA Plan, or MA-PD Plan
        - A section 1876 Cost Plan to an MA Plan, MA-PD Plan, or PDP

- Renewal compensation is paid for each enrollment in year 2 and beyond in the same plan, or when "like plan" changes are made.
    - "Like plan" changes include the following:
        - A PDP to another PDP
        - An MA or MA-PD to another MA or MA-PD
        - A Section 1876 Cost Plan to another Section 1876 Cost Plan

Agents can only be paid for the number of months a member is enrolled in the plan. So if a member enrolls in January and disenrolls in May, the agent may only be paid 5 months of the yearly compensation amount.

Agent/Broker Training and Testing

Medicare Advantage Organizations and Part D plan sponsors must ensure that brokers and agents selling Medicare products are trained and tested annually on Medicare rules and regulations, and on plan details specific to the plan products they are selling. This requirement applies to a agents. Agents and brokers must pass a test with a score of 85% before to marketing products.

Rewards and Incentives

The Centers for Medicare & Medicaid Services has expanded reward and incentive program options for Medicare Advantage Organizations (MAOs) through CFR 422.134. MAOs are now permitted to offer health-driven reward and incentive programs that may be applied to health-related services and activities. Before 4159-F, rewards and incentives were only allowed to be offered with preventive services. Now, an MAO may create one or more program(s) that provide rewards and incentives to enrollees who participate in any activities that focus on promoting improved health, preventing injuries and illness, and efficiently using health care resources.

- Each unique rewards and incentives program offered by an MAO must
  - Not discriminate against enrollees based on race, gender, chronic disease, institutionalization, frailty, health status, or other impairments
  - Be designed so that all enrollees are able to earn rewards
  - Be subject to sanctions at 42 CFR§422.752(a)(4)
  - Be offered in connection with the entire service or activity
  - Be offered to all eligible members without discrimination
  - Have a value that may be expected to affect enrollee behavior but not exceed the value of the health-related service or activity itself
  - Otherwise comply with all relevant fraud and abuse laws, including, when applicable, the anti-kickback statute and civil money penalty prohibiting inducements to people with Medicare
  - MAOs are required to abide by certain restrictions. This means the rewards and incentives program may not be
    - Offered in the form of cash or other monetary rebates, or
    - Used to target potential enrollees

At this time, rewards and incentives only apply to Part C.

NOTE: For more information, see Chapter 4 of the "Medicare Managed Care Manual", CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.

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

SHIP

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

May 2017 Medicare Advantage and Other Health Plans 59

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

Medicare Products

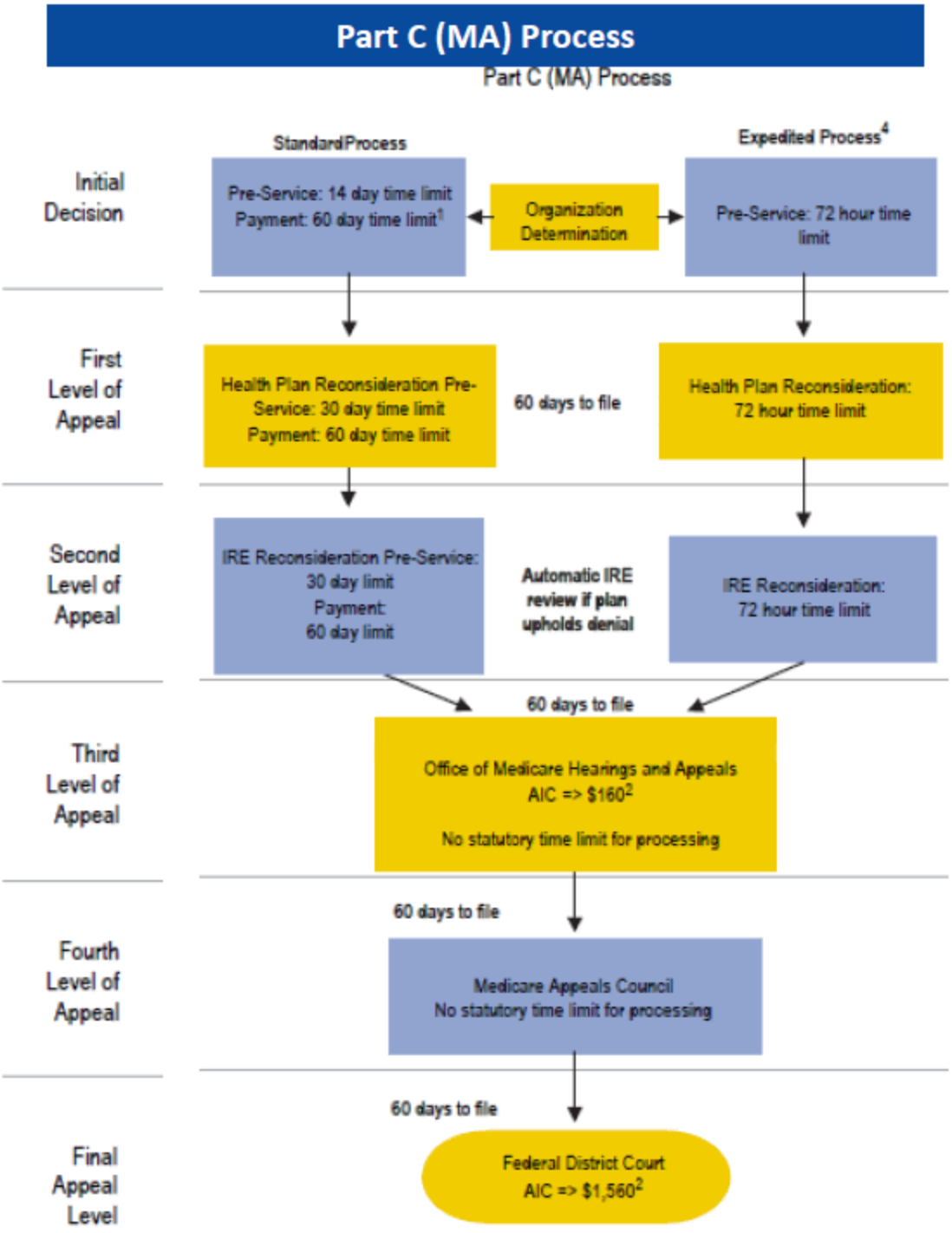
1. **"Medicare & You Handbook"** (CMS Product No. 10050)
2. **"Have You Done Your Yearly Medicare Plan Review?"** (CMS Product No. 11220)
3. **"Understanding Medicare Part C & D Enrollment Periods"** (CMS Product No. 11219)
4. **"Understanding your Medicare Advantage Plan's provider network"** (CMS Product 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)

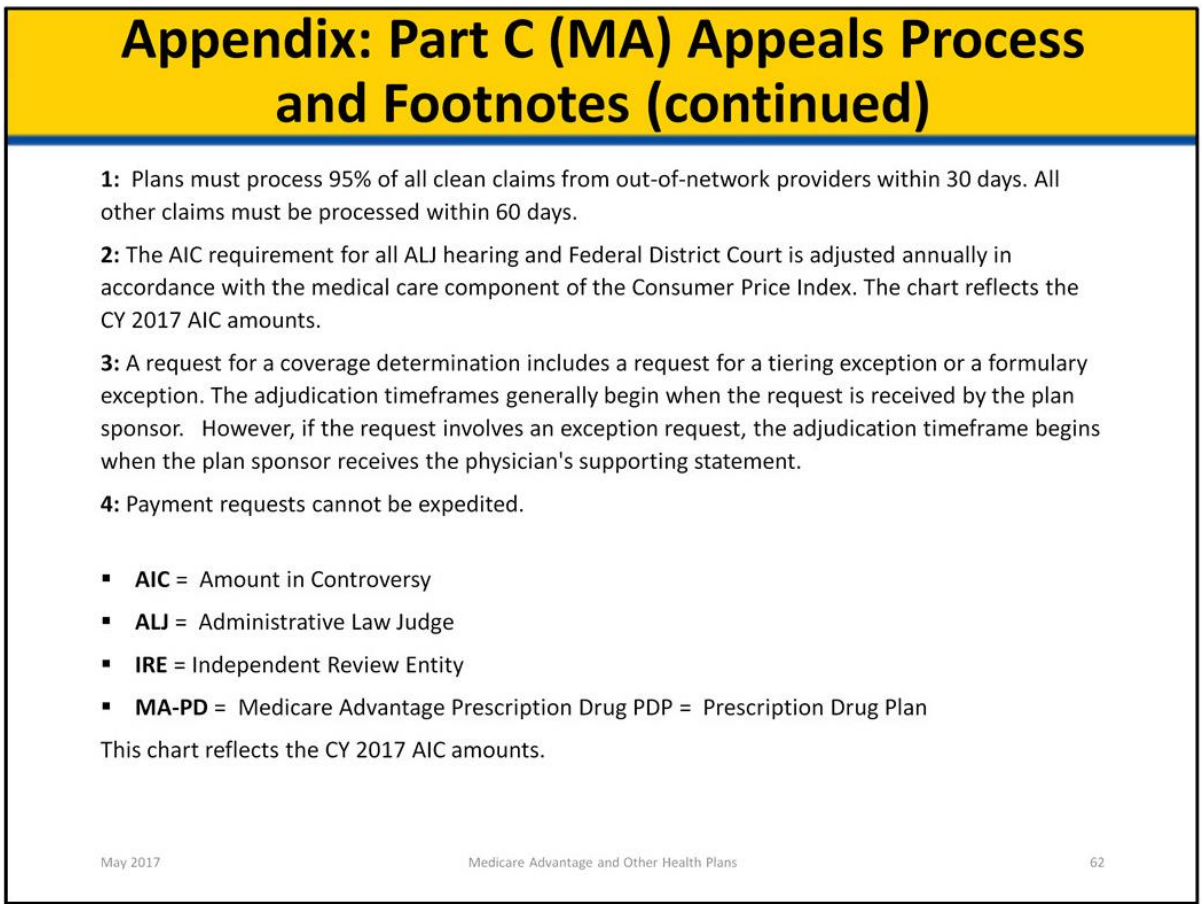
To access these products:

- 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 2017 (see next page for footnotes)





Appendix: Footnote from Part C (MA) Appeals Process

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