2013 National Training Program

Workbook

Module: 11

Medicare Advantage Plans and Other Medicare Plans

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Inside front cover

Module 11: Medicare Advantage Plans and Other Medicare Plans

Contents

Contents

This module can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers, and the learning activities.

Module 11, *Medicare Advantage Plans & Other Medicare Plans*, explains Medicare health plan options other than Original Medicare.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. The information in this module was correct as of May 2013.

To check for updates on the new health care legislation, visit www.healthcare.gov.

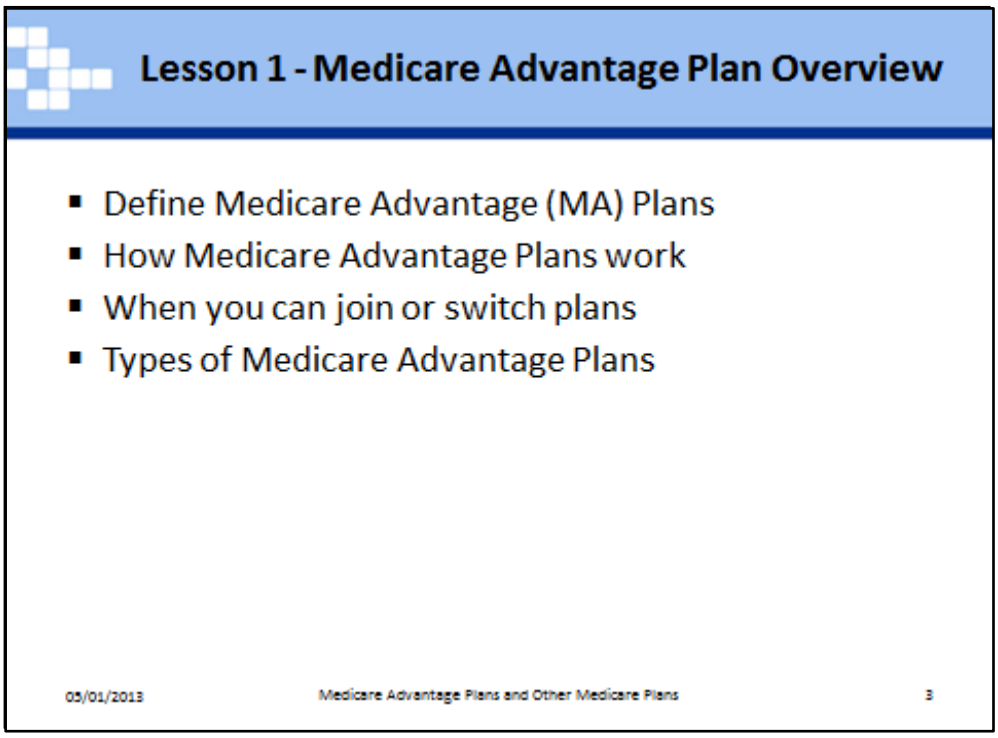
To view the Affordable Care Act, visit www.healthcare.gov/law/full/index.html.

To check for an updated version of this training module, visit http://cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html.

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

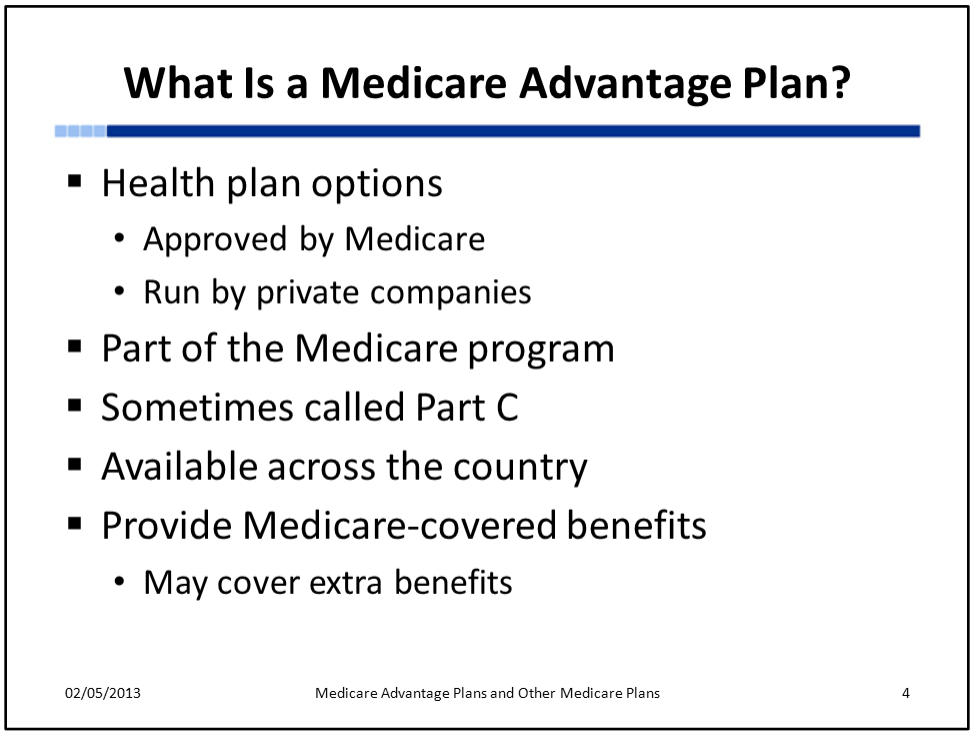
This session will help you to

- Define Medicare Advantage (MA) plans;
- Describe how MA plans work;
- Explain eligibility requirements and enrollment;
- Identify types of MA plans;
- Identify other Medicare plans;
- Recognize rights, protections, and appeals; and
- Understand Medicare Marketing Guidelines (MMG).



Lesson 1, *Medicare Advantage Plan Overview*, will provide you with information about

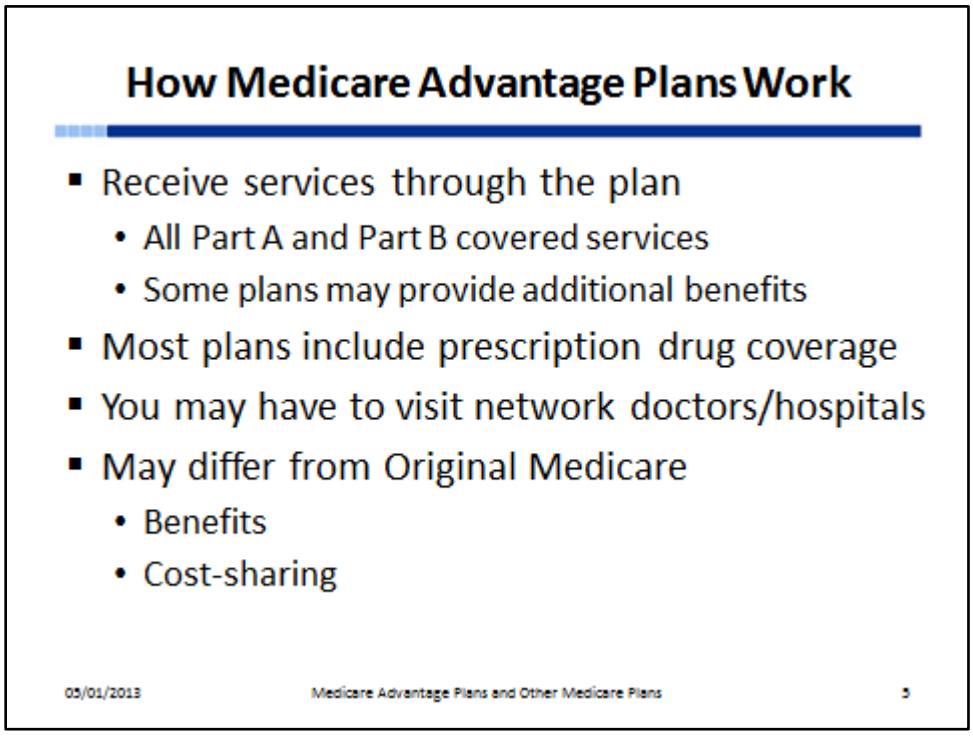
- How to define Medicare Advantage (MA) plans;
- How MA plans work;
- When you can join a plan or switch plans; and
- Types of MA plans.



Medicare Advantage (MA) plans 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 these private plans for their members' expected health care.

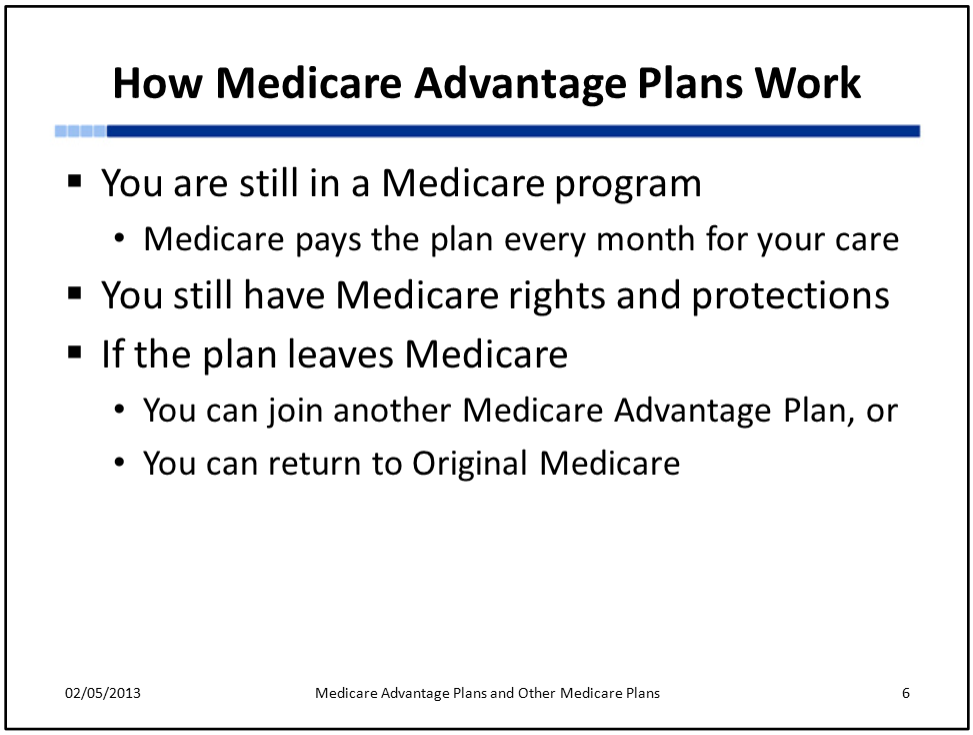
Medicare Advantage plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Original Medicare doesn't cover, such as extra vision or dental services. The plan may have special rules that its members need to follow.



In Medicare Advantage (MA) plans, you receive all Part A and B Medicare–covered services through that plan. Some MA plans provide additional benefits. Many plans also include Medicare prescription drug coverage. This is Medicare Part D coverage.

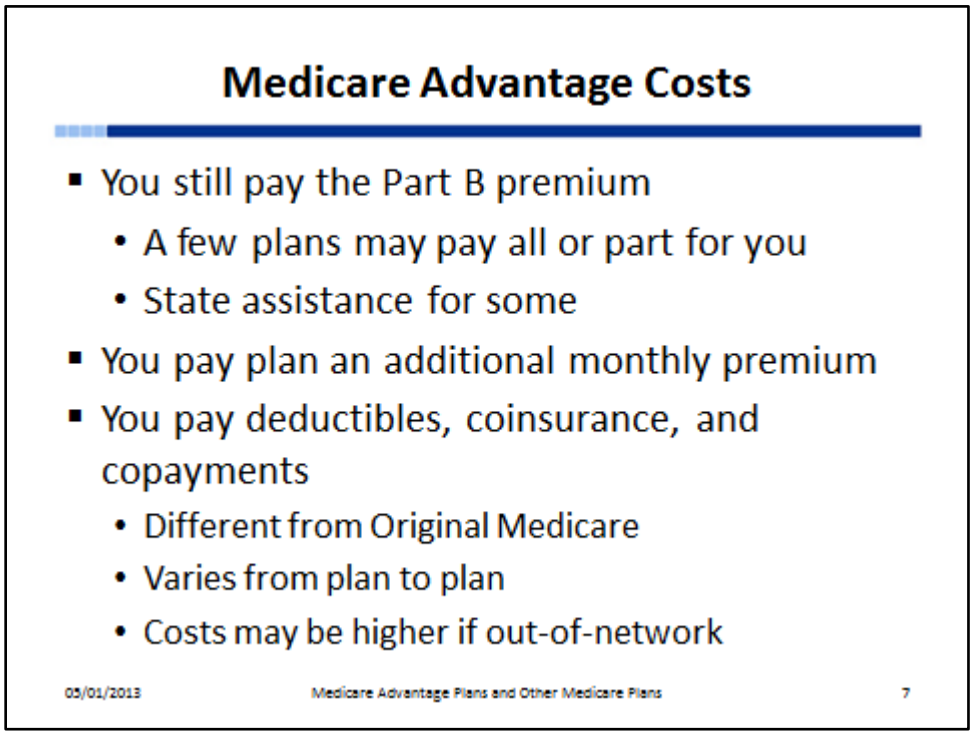
In some plans, like HMOs, you may only be able to see certain doctors or go to certain hospitals.

Benefits and cost-sharing in a Medicare Advantage plan may differ from Original Medicare.



It's important to note that when you join a Medicare Advantage plan or other Medicare plan, the following are true:

- You are still in the Medicare program. Medicare pays for your care every month to these private health plans whether you use services or not.
- You still have Medicare rights and protections.
- You will have the opportunity to join another MA plan or return to Original Medicare if the plan decides to stop participating in Medicare.

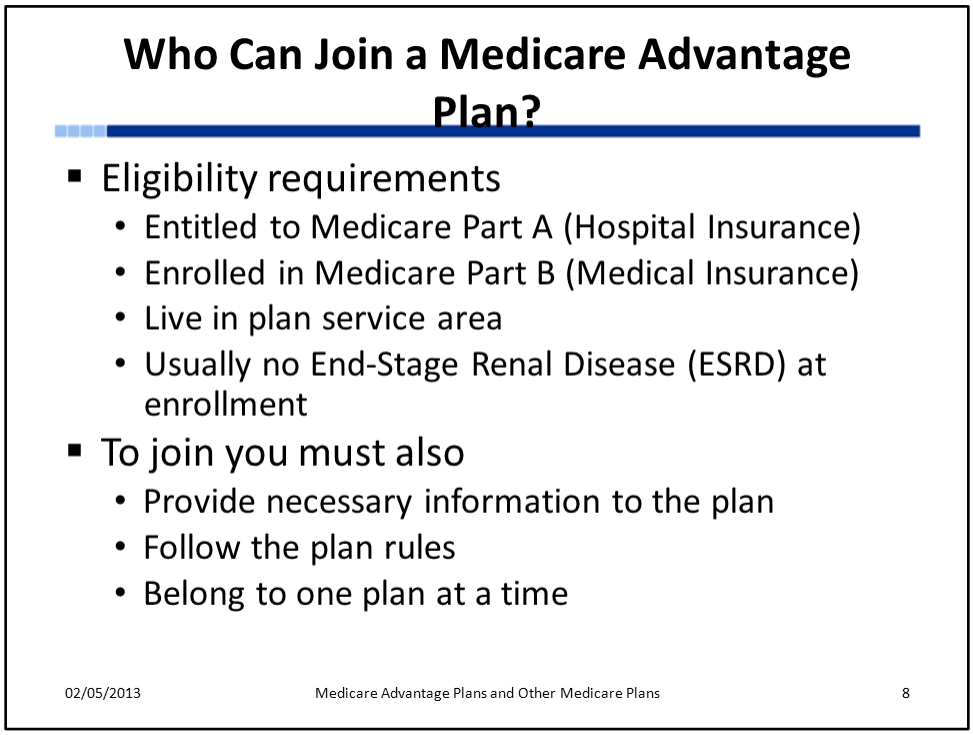


If you join a Medicare Advantage (MA) plan, you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2013 is $104.90 for most people.

- A few plans may pay all or part of the Part B premium for you.
- Some people may be eligible for state assistance.

When you join an MA plan, there are other costs you may have to pay, including the following:

- An additional monthly premium to the plan;
- Deductibles, coinsurance, and copayments. These costs may
  - Be different from Original Medicare;
  - Vary from plan to plan; and
  - Be higher if you go out of network.



Medicare Advantage (MA) plans are available to most people with Medicare. To be eligible to join an MA plan, you must be entitled to Medicare Part A (Hospital) and enrolled in Medicare Part B (Medical Insurance). You must also live in the plan's geographic service area.

People with End-Stage Renal Disease (ESRD) usually can't join an MA plan or other Medicare plan. However, there are some exceptions. For example, an individual who develops ESRD while enrolled in an employer group health plan may be allowed to enroll in an MA plan when transitioning from group coverage without a break between coverage. A person who receives a kidney transplant and no longer requires a regular course of dialysis treatment is not considered to have ESRD for purposes of MA eligibility.

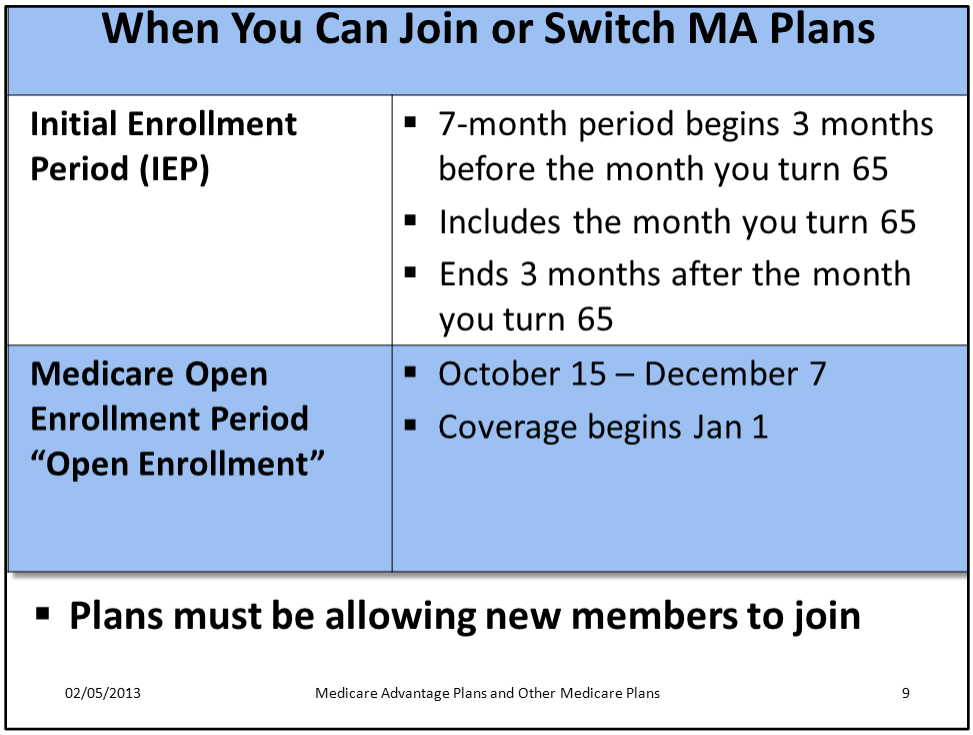
To join an MA plan, you must also

- Agree to provide the necessary information to the plan;
- Agree to follow the plan's rules; and
- Belong to only one MA plan at a time.

Need More Information?

To find out what MA plans are available in your area, visit www.medicare.gov and click on *Find Health and Drug Plans*, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

More information on the enrollment exceptions for people with ESRD can be found in Section 20.2 of the MA enrollment and disenrollment guidance available at http://www.cms.gov/MedicareMangCareEligEnrol/.



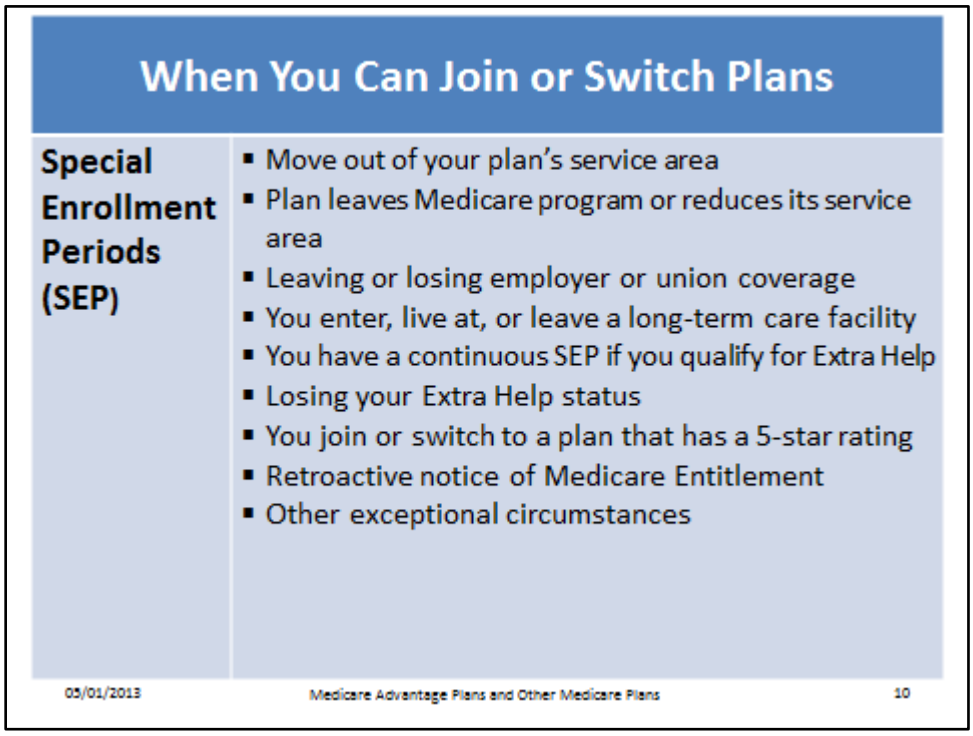
You can join a Medicare Advantage (MA) plan

- When you first become eligible for Medicare, i.e., during your Initial Enrollment Period (IEP), which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B; and/or
- During the Medicare Open Enrollment Period (OEP).

You can switch to another Medicare Advantage plan or to Original Medicare during the OEP, also known as "Open Enrollment." This period runs from October 15 through December 7 each year, with coverage starting January 1.

You can only join one MA plan at a time, and enrollment in a plan is generally for a calendar year.

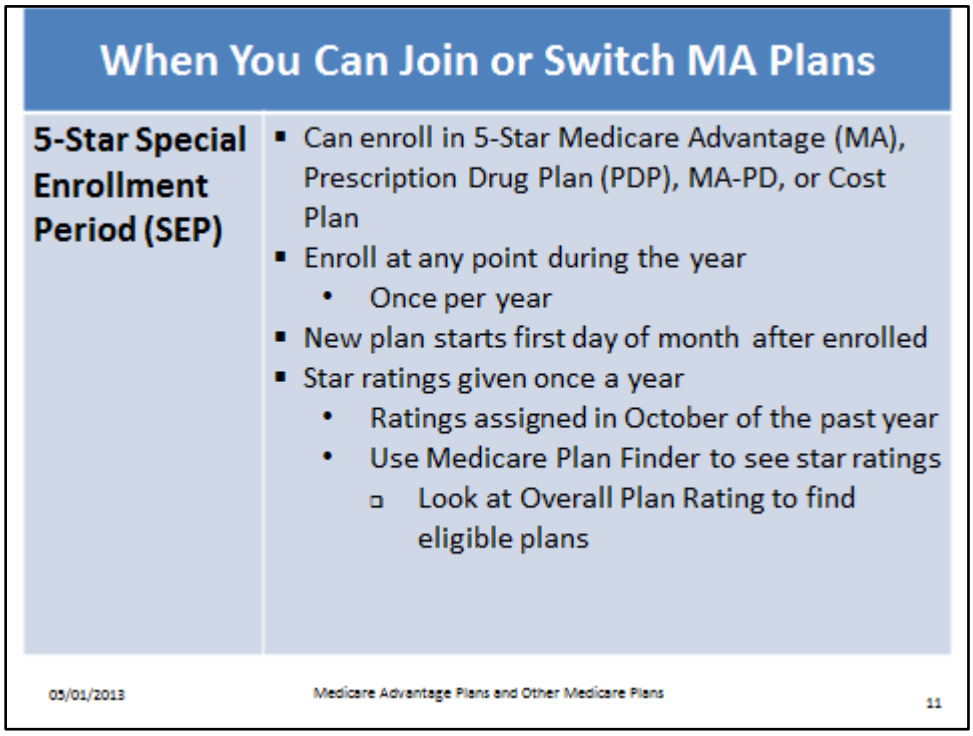
- Plans must be allowing new members to join. Plans may be prohibited from accepting new members if there is a CMS-approved capacity limit or a CMS-issued enrollment sanction is in effect.



You may be able to join or switch plans under special circumstances that grant a Special Enrollment Period (SEP). For example, if you

- Move out of your plan's service area;
- Are enrolled in a plan that decides to leave the Medicare program or reduce its service area at the end of the year;
- Leave or are losing employer or union coverage;
- Enter, live at, or are leaving a long-term care facility;
- Qualify for Extra Help (you have a continuous SEP);
- Lose your Extra Help status;
- Join or switch to a plan that has a 5-star rating; or
- Receive retroactive notice of Medicare entitlement.

NOTE: In the case of retroactive entitlement, there are special rules that allow for enrollment in a different Medicare Advantage plan, or Original Medicare and a Medigap policy. There are other exceptional circumstances. More information about conditions that allow an exception can be found in Chapter 2 of the Medicare Managed Care Manual, Section 30.4.



Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall star ratings to plans. Plans get rated from one to five stars. A 5-star rating is considered excellent.

At any time during the year, you can use the 5-Star Special Enrollment Period (SEP) to enroll in a 5-star Medicare Advantage-only plan, a 5-star Medicare Advantage plan with prescription drug coverage (MA-PD), a 5-star Medicare Prescription Drug Plan (PDP), or a 5-star Cost Plan, as long as you meet the plan's enrollment requirements (for example, living within the service area). If you're currently enrolled in a plan with a 5-star overall rating, you may use this SEP to switch to a different plan with a 5-star overall rating.

CMS also created a coordinating SEP for PDPs. This SEP lets people who enroll in certain types of 5-star plans without drug coverage choose a PDP, if that combination is allowed under CMS rules.

You may use the 5-star SEP to change plans one time between December 8 and November 30 of the following year. Once you enroll in a 5-star plan, your SEP ends for that year and you're allowed to make changes only during other appropriate enrollment periods. Your enrollment will start the first day of the month following the month in which the plan gets your enrollment request.

Plans get their star ratings once a year, in October of the past year. The plan won't actually have the rating until January 1, but will be assigned the rating in the October before that January 1. To find star rating information, visit the Medicare Plan Finder at www.medicare.gov. Look for the Overall Plan Rating to identify 5-star plans that you can change to during this SEP. The *Medicare & You* handbook doesn't have the full, updated ratings for this SEP.

For more information, please see the 5-Star Enrollment Period Job Aid on your resource card.

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 applicable enrollment period to get coverage and may have to pay a penalty.

If you belong to a Medicare Advantage (MA) plan, you can 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 on which the election or change was made.

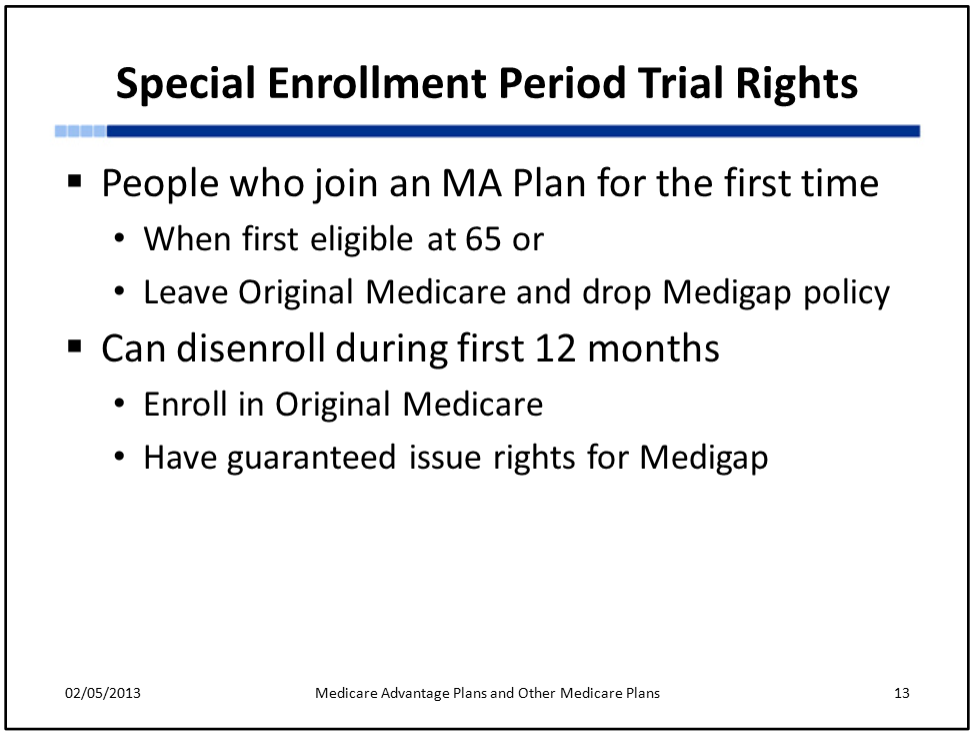
To disenroll from an MA plan and return to Original Medicare during this period, you can

- Make a request directly to the MA organization; or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you make this change, you may also join a Medicare PDP to add drug coverage. Coverage begins the first of the month after the plan receives the enrollment form.

You may not join another MA plan during this period.

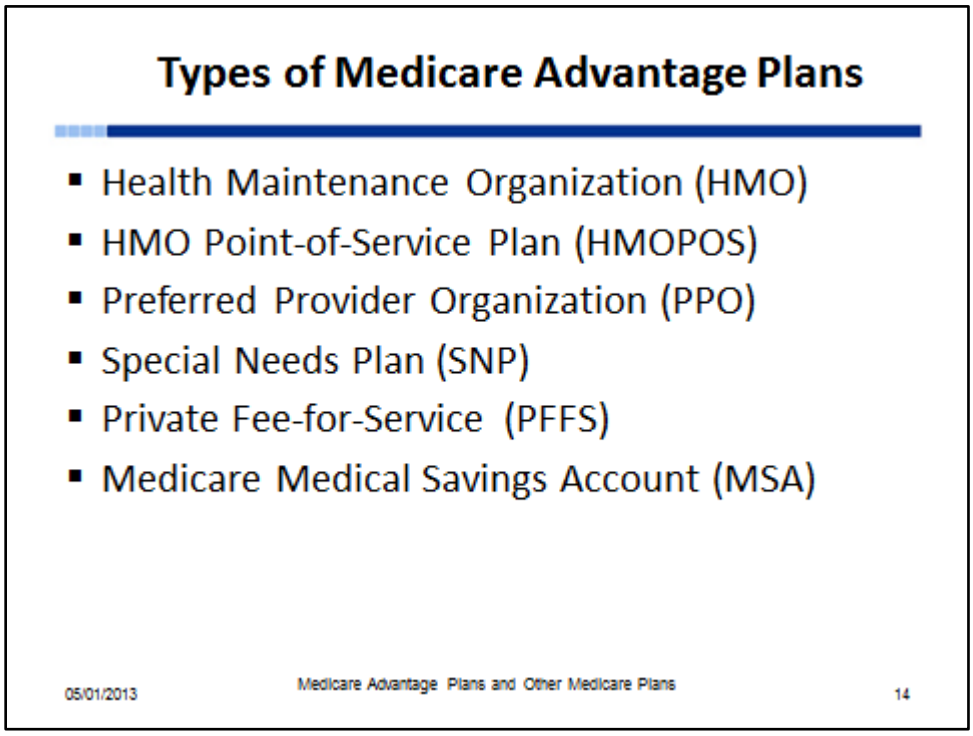
It is important to remember that any time you enroll in a new MA or PDP, it will automatically disenroll you from your previous plan. This includes MA-only HMO) and Preferred Provider Organization (PPO) plans. However, there are limited exceptions for members of MA-only Private Fee-for-Service (PFFS), Cost, and Medical Savings Account (MSA) plans. Once enrolled, coverage begins the first of the month after the plan gets the enrollment form.



There are special trial rights for a Special Enrollment Period (SEP) available when you join a Medicare Advantage (MA) plan for the first time. You are eligible for this trial right if you either

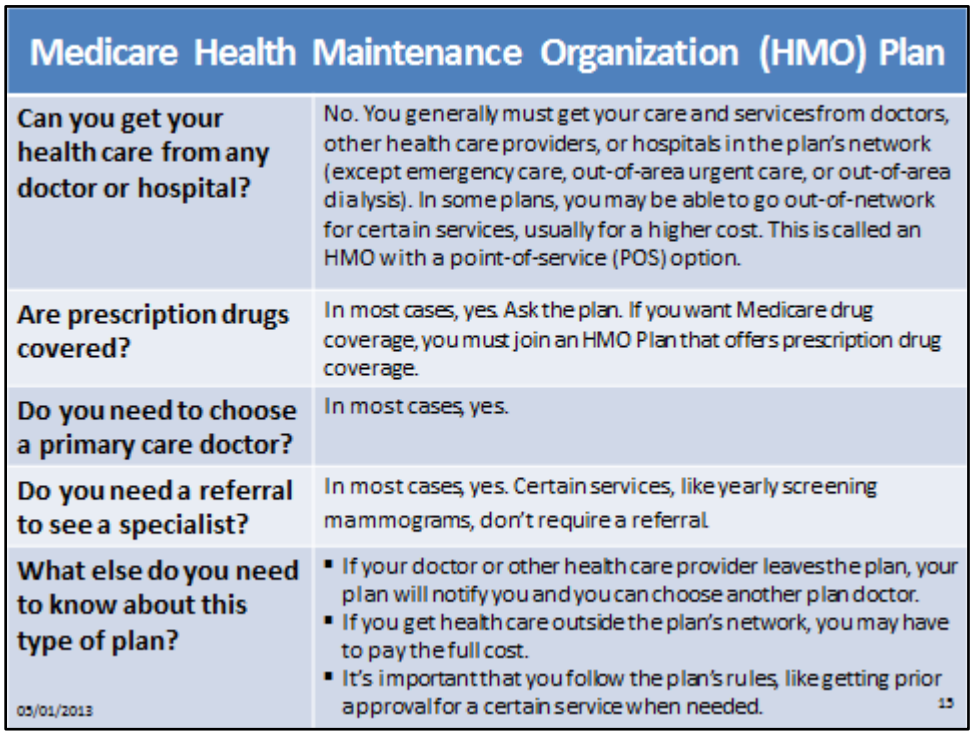
- Joined an MA plan when first eligible for Medicare at age 65; or
- Were in Original Medicare, enrolled in an MA plan for the first time, and dropped a Medigap policy.

The trial right allows you to disenroll from the MA plan during the first 12 months and return to Original Medicare. You also have a guaranteed issue right to purchase a Medigap (Medicare supplement insurance) policy.



There are six types of MA plans, including the following:

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



In a Medicare Health Maintenance Organization (HMO) plan, you generally must get your care and services from doctors or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out of network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (POS) option.

In most cases, prescription drugs are covered. Ask the plan. If you want drug coverage, you must join an HMO plan that offers prescription drug coverage.

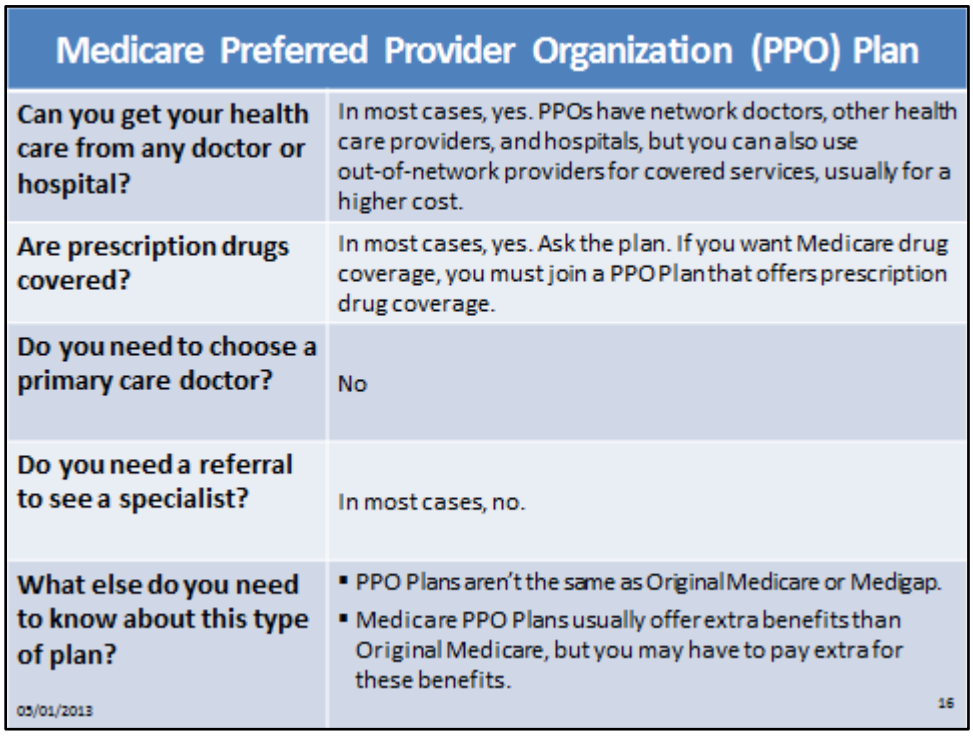
In most cases, you need to choose a primary care doctor and will have to get a referral to see a specialist. Certain services like yearly screening mammograms don't require a referral.

If your doctor leaves the plan, your plan will notify you and you can choose another doctor in the plan.

If you get care outside the plan network, you may have to pay the full cost.

It's important that you follow the plan rules, like getting prior approval for a certain service when needed.

Medicare Advantage plans can vary. Read individual plan materials carefully to ensure you understand the plan rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.



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. Ask the plan. If you want Medicare drug coverage, you must join a PPO Plan that offers 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 than Original Medicare, but you may have to pay extra for these benefits.

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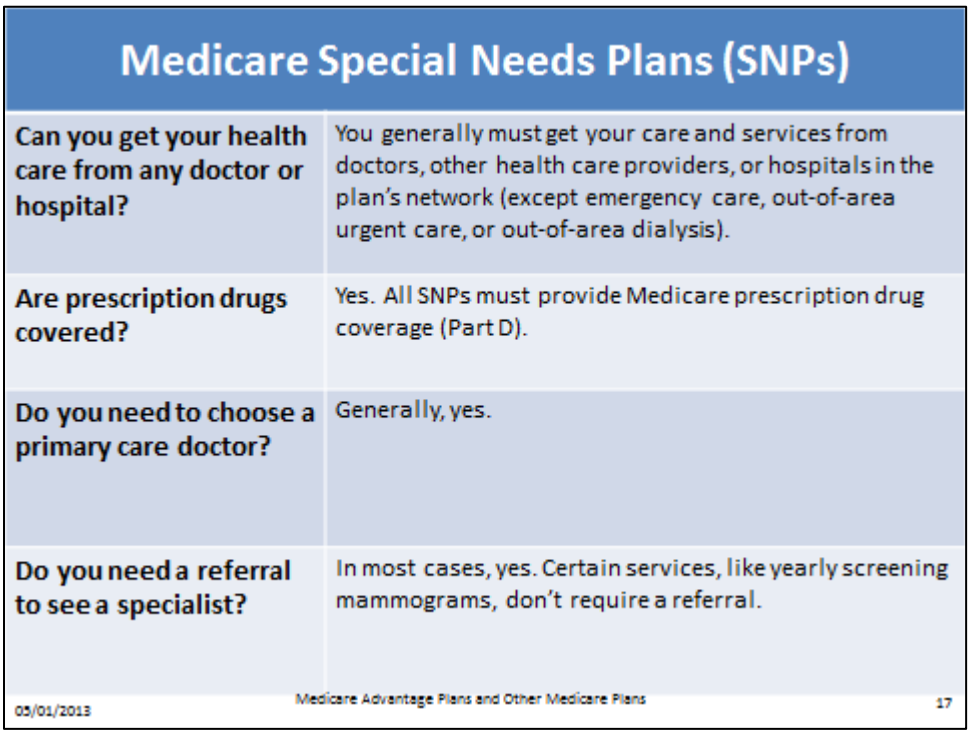
In a Medicare Preferred Provider Organization (PPO) plan, you have PPO network doctors and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.

In most cases, prescription drugs are covered. Ask the plan. If you want drug coverage, you must join a PPO plan that offers prescription drug coverage.

You do not need to choose a primary care doctor and do not have to get a referral to see a specialist.

PPO plans are not the same as Original Medicare or Medigap supplemental plans and the plans in your area can vary. Read individual plan materials carefully to make sure you understand the plan rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.

Medicare PPO plans may also offer extra benefits that are not available under Original Medicare, but you may have to pay extra for these benefits.



Medicare Special Needs Plans (SNPs) are Medicare Advantage plans designed to provide focused care management, special expertise of the plan's providers, and benefits tailored to enrollee conditions.

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).

All SNPs must provide Medicare prescription drug coverage (Part D).

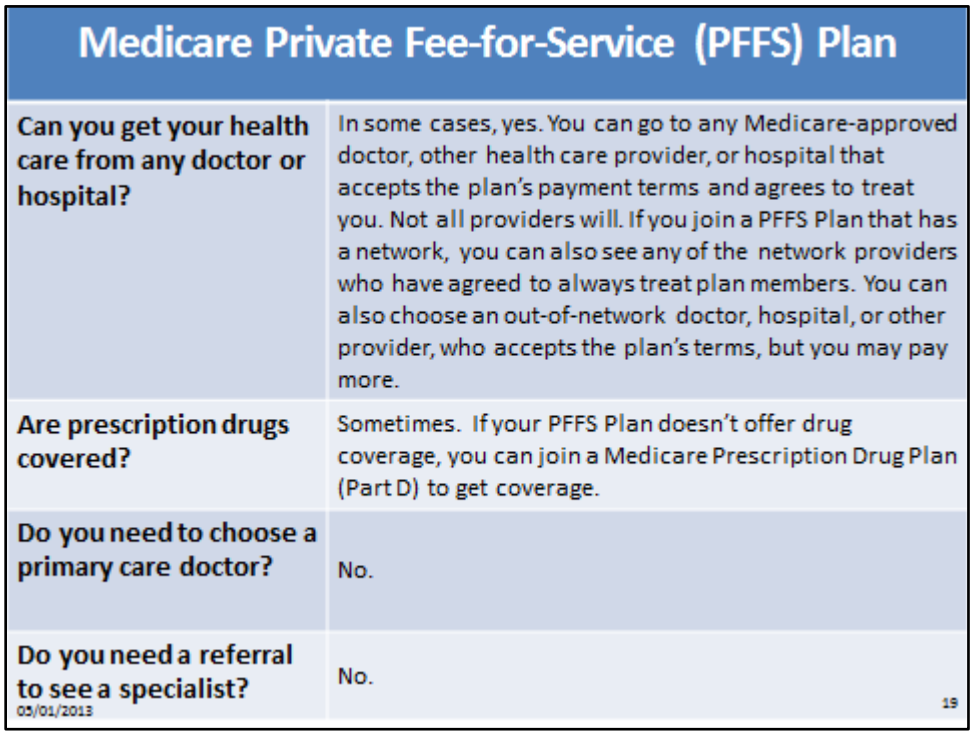
You generally do need to choose a primary care doctor.

In most cases, you do need a referral to see a specialist. Certain services, like yearly screening mammograms, don't require a referral.

Other things you need to know about Special Needs Plans (SNPs) include

- A plan must limit plan membership to people in one of the following groups:
  - People who live in certain institutions (like a nursing home), or who require nursing care at home;
  - People who are eligible for both Medicare and Medicaid; or
  - People who have specific chronic or disabling conditions (like diabetes, ESRD, HIV/AIDS, chronic heart failure, or dementia).
- Plans may further limit membership within these groups.
- Plans should coordinate the services and providers you need to help you stay healthy and follow your doctor's orders.
- If you have Medicare and Medicaid, your plan should make sure that all of the plan doctors or other health care providers you use accept Medicaid.
- If you live in an institution, make sure that plan doctors or other health care providers serve people where you live.

Medicare Advantage (MA) plans can vary. Read individual plan materials carefully to make sure you understand the plan's rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.



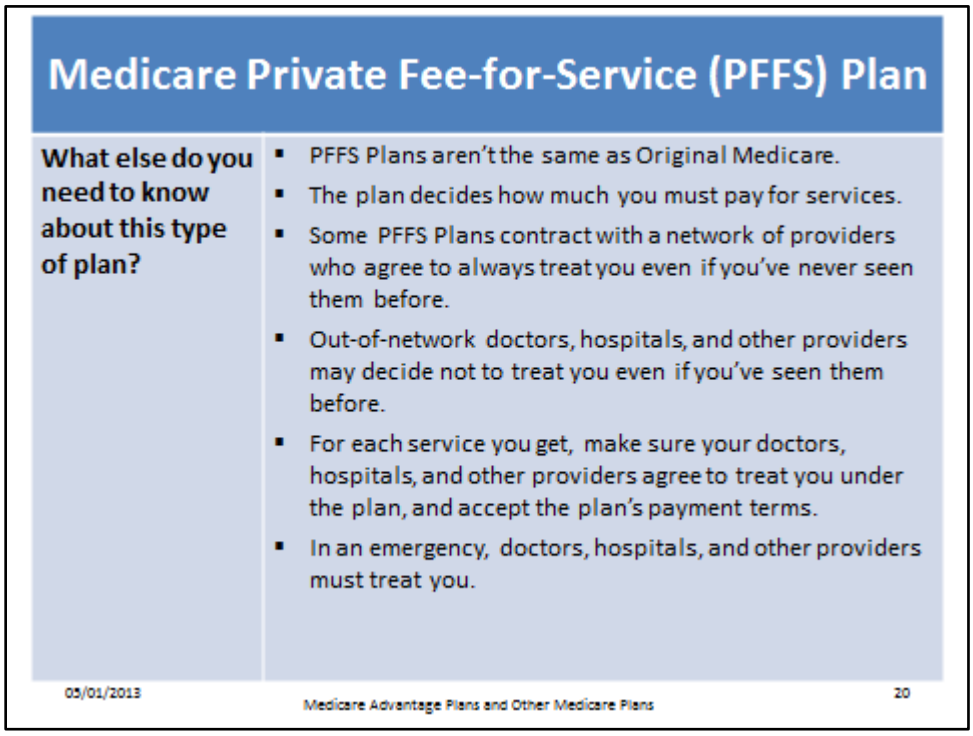
In a Medicare Private Fee-for-Service (PFFS) plan, you can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. Not all providers will.

If you join a PFFS plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can also choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, but you may pay more.

Prescription drugs are sometimes covered. If your PFFS plan doesn't offer drug coverage, you can join a Medicare PDP to get coverage.

You don't need to choose a primary care doctor and you don't have to get a referral to see a specialist.

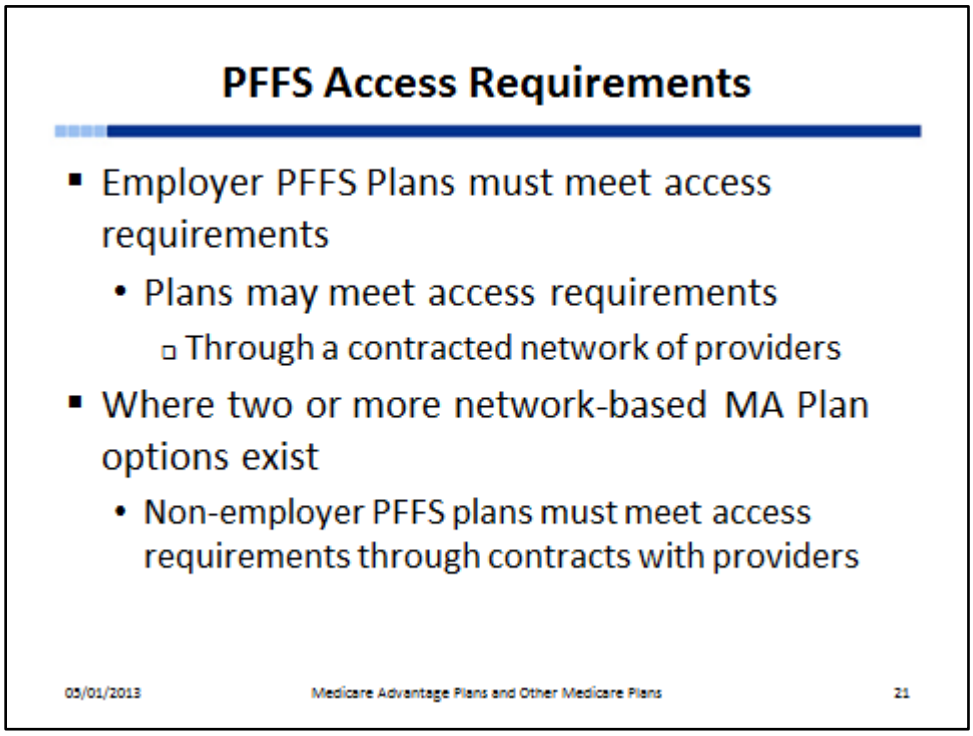
Additionally, all non-employer PFFS plans must meet Medicare access requirements through contracts with providers if two or more network-based Medicare Advantage plan options exist.



Other things you need to know about Medicare Private Fee-for-Service (PFFS) plans include the following:

- PFFS plans aren't the same as Original Medicare.
- The plan decides how much you must pay for services.
- Some PFFS plans contract with a network of providers who agree to always treat you even if you've never seen them before.
- Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before.
- For each service you get, make sure your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan's payment terms.
- In an emergency, doctors, hospitals, and other providers must treat you.

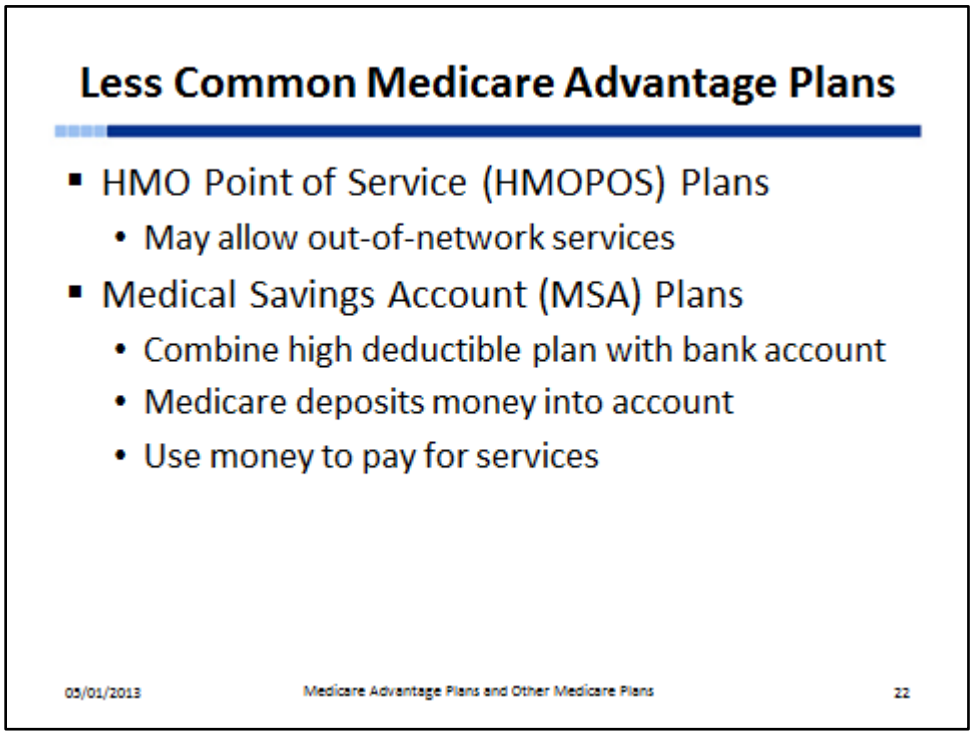
Medicare Advantage plans can vary. Read individual plan materials carefully to make sure you understand the plan's rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.



Medicare access requirements are in place to make sure that beneficiaries have access to a sufficient number of providers in their area who are willing to treat them.

Access requirements:

- Employer/union-sponsored PFFS plans are required to establish contracts with a sufficient number of providers across service categories in their services areas.
- Non-employer PFFS plans operating in network areas must establish contracts with a sufficient number of providers across service categories in order to operate. Network areas are those in which at least two network-based plans are operating with enrollment for a given plan year.

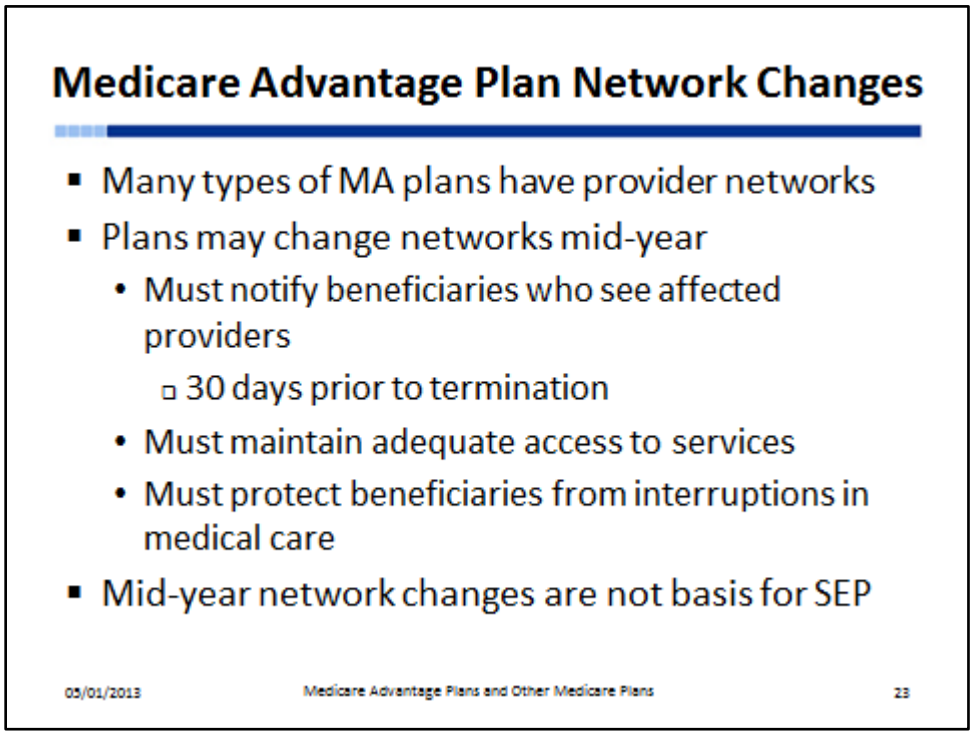


Other, less common types of Medicare Advantage plans include the following:

- **HMO Point of Service (HMOPOS) plans** — A plan that may allow you to get some services out of network for a higher cost.
- **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.

Need More Information?

For more information about MSAs, visit www.medicare.gov/Publications/Pubs/pdf/11206.pdf to view the booklet, *Your Guide to Medicare Medical Savings Account Plans*. You can also call 1-800-MEDICARE (1-800-633-4227) to have a copy mailed to you. TTY users should call 1-877-486-2048.



Network-based Medicare Advantage (MA) plans (e.g., HMOs, PPOs, and PFFS plans with networks) can make changes to their network of contracted providers at any time during the year. It is important to note that CMS has safeguards in place to ensure that Medicare beneficiaries are protected from medical care interruptions.)

- As an example, CMS requires plans to maintain continuity of care for impacted enrollees by ensuring continuous access to medically necessary services, without interruption, should a Medicare beneficiary's medical condition require it.

When MA plans make changes to their networks, CMS also requires that they maintain adequate access to all medically necessary Medicare Parts A and B services through their remaining provider network. If the remaining network does not 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 beneficiaries who are seen on a regular basis by the provider whose contract is terminating. This notice must be given at least 30 days in advance of the termination date. In this notice, the plan must also provide a list of alternative providers and allow beneficiaries to choose another provider.

Loss of a provider network during the year is not usually a basis for an Enrollment Exception/Special Election Period.

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 provide a requirement for notification of termination without cause for a longer period of time.

CMS does not get involved in contracting disputes.

Check Your Knowledge
Lesson 1 – Medicare Advantage Plan Overview

Answer the following questions:

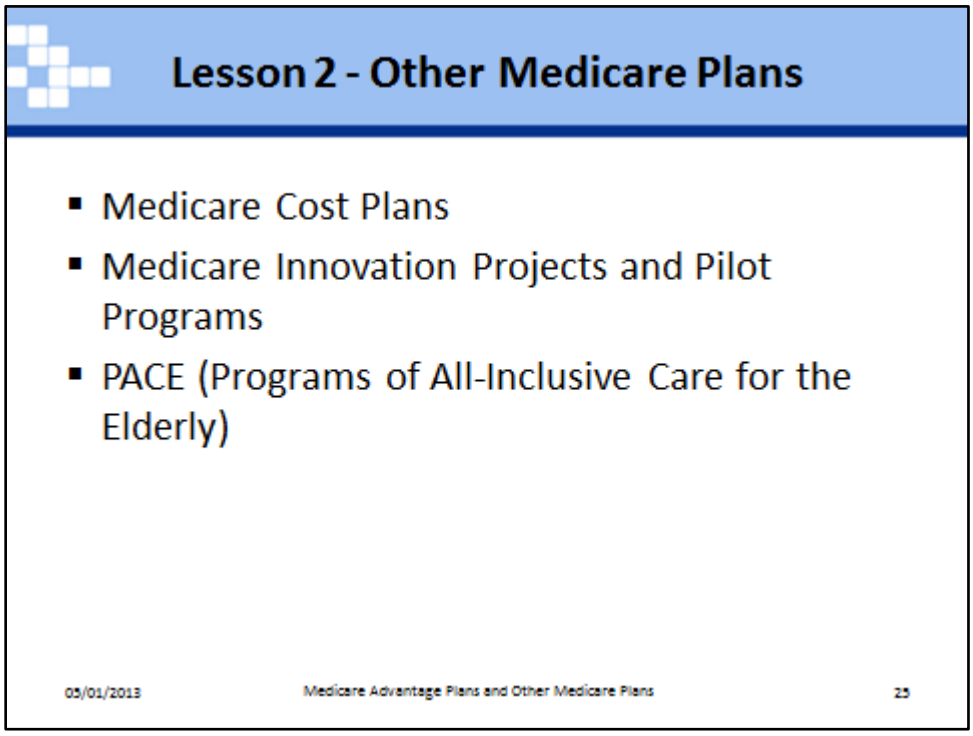
1. Medicare Advantage (MA) plans are sometimes called:

    a. Part A
    b. Part B
    c. Part C
    d. Part D

2. George is currently enrolled in Original Medicare. In June, he decides he would like to enroll in an MA plan with a 5-Star overall rating. Is he able to do so?

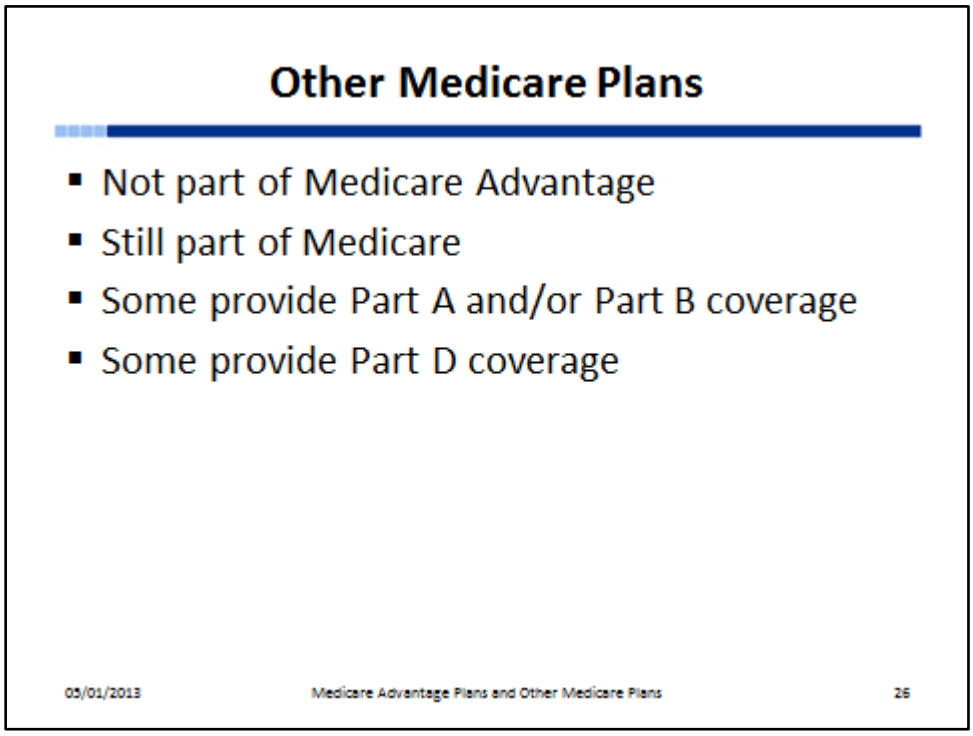
    a. No, he is not eligible for an MA plan
    b. No, he must wait for the Open Enrollment Period (Oct. 7-Dec. 7)
    c. Yes, only if he moved outside of his current plan's service area
    d. Yes, he can enroll in a 5-Star MA plan at any time during the year

Refer to page 60 to check your answers.



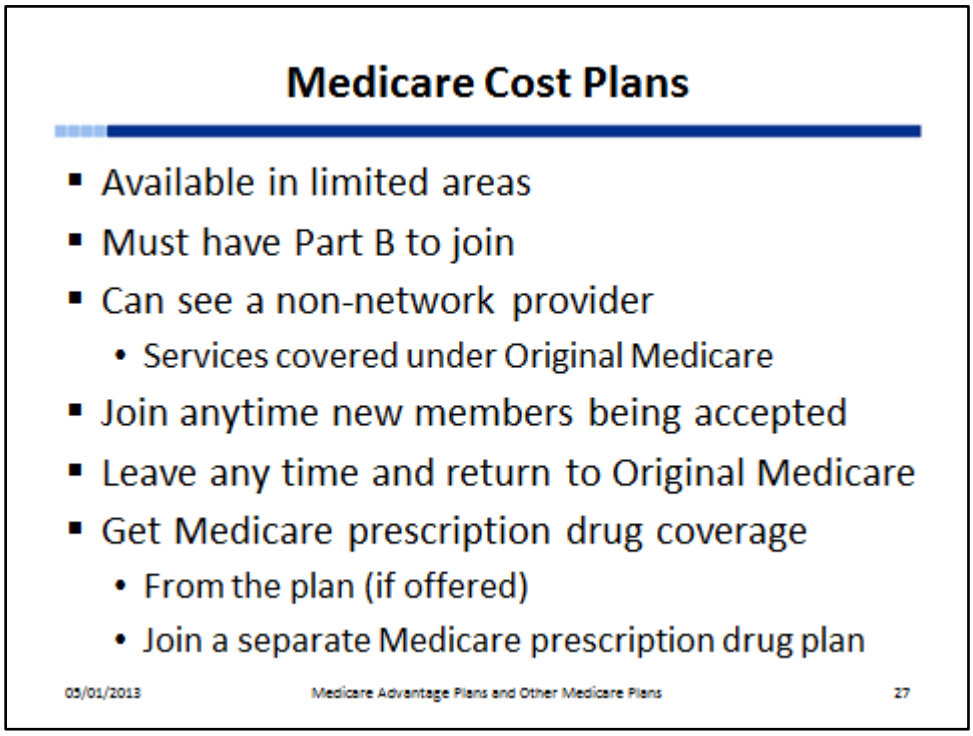
Lesson 2, *Other Medicare Plans*, provides information on the following:

- Medicare Cost Plans;
- Medicare Innovation Projects (demonstrations and pilot programs); and
- PACE (Programs of All-Inclusive Care for the Elderly).



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, and 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.

NOTE: The next several slides provide a brief overview of each of the types of other Medicare plans. The instructor is encouraged to insert slides and information specific to the plans available in the area.

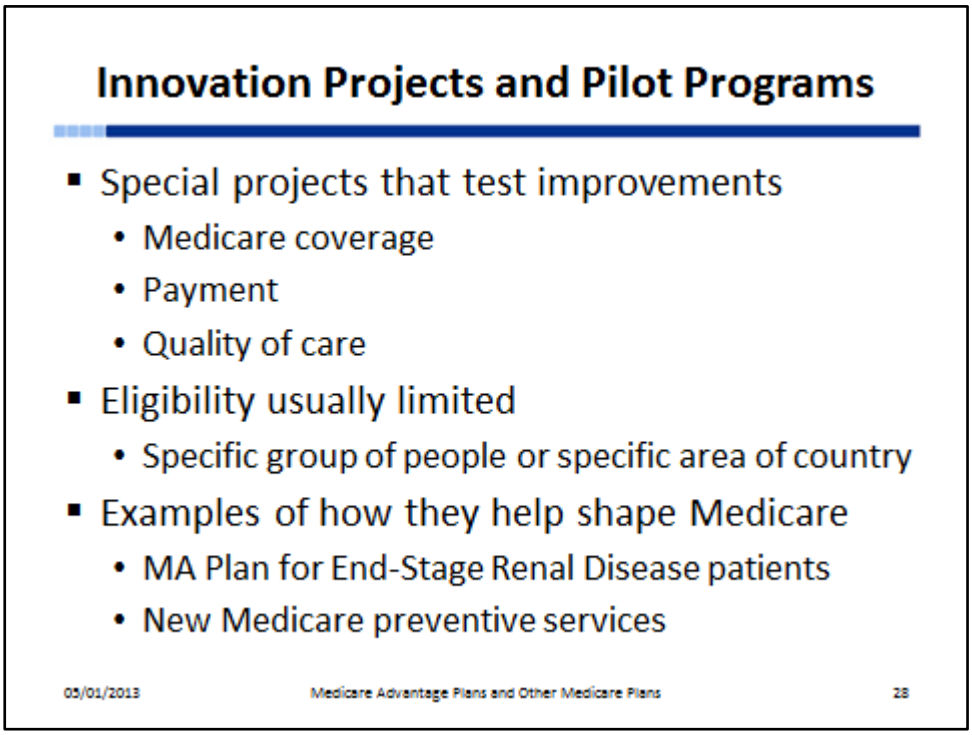


Medicare Cost Plans are a type of Medicare health plan available only in certain areas of the country.

- You can join even if you only have 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 PDP to add prescription drug coverage. You can only add or drop Medicare prescription drug coverage at certain times.

Need More Information?

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



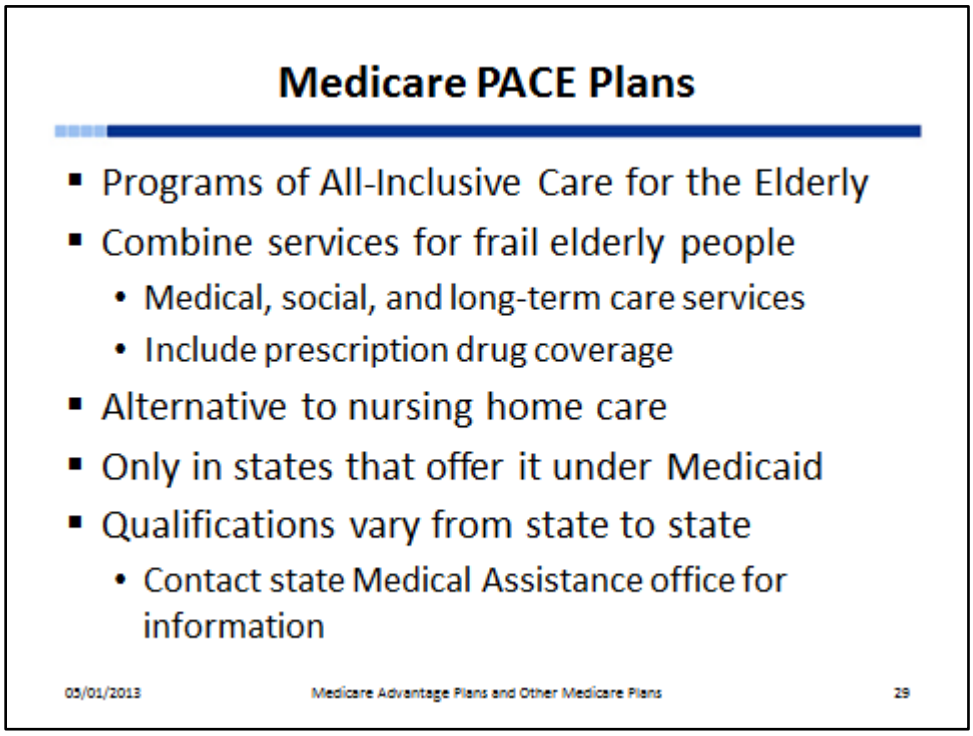
Medicare Innovation Projects and Pilot Programs are special projects that test improvements in Medicare coverage, payment, and quality of care. They are usually for a specific group of people and/or are offered only in specific areas. Some follow Medicare Advantage plan rules, but others don't. The results of innovation projects have helped shape many of the changes in Medicare over the years.

Check with the innovation project or pilot program for more information about how it works.

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

Need More Information?

Visit www.cms.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.



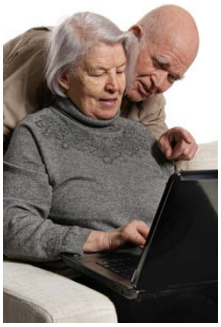
Programs of All-Inclusive Care for the Elderly (PACE) combine medical, social, and long-term care services for frail elderly people who live in and get health care in the community. PACE programs provide all medically necessary services, including prescription drugs. PACE might be a better choice for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

NOTE: Instructor may highlight local plans.

Check Your Knowledge
Lesson 2 – Other Medicare Plans

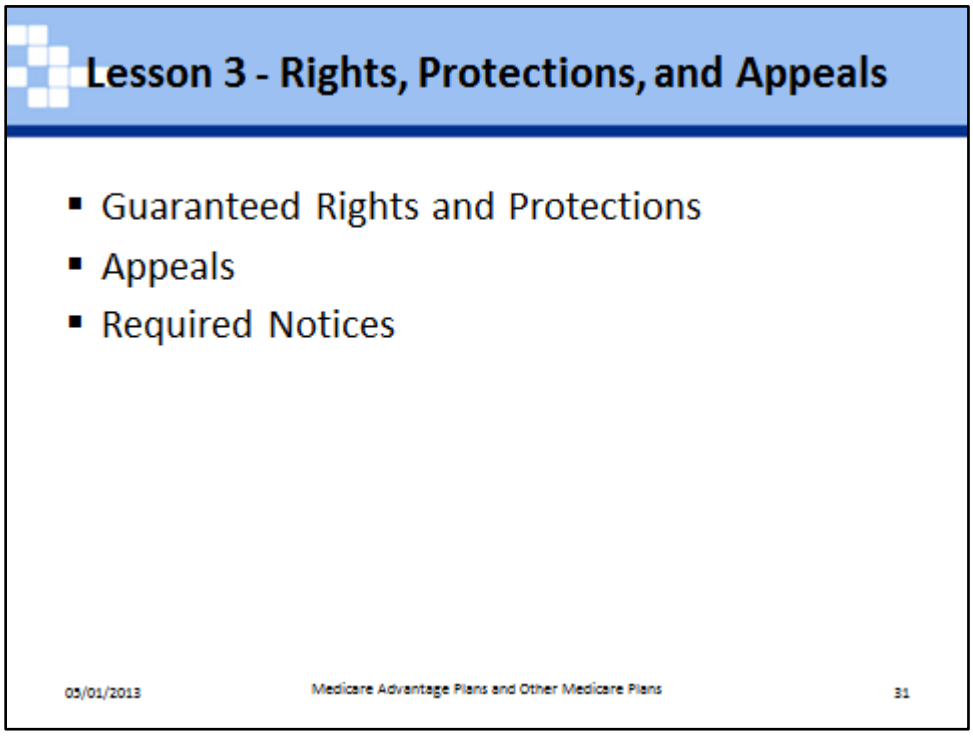
Answer the following questions:



1. Linda participates in Programs of All-Inclusive Care for the Elderly (PACE). What kind of services are coordinated for her under PACE?

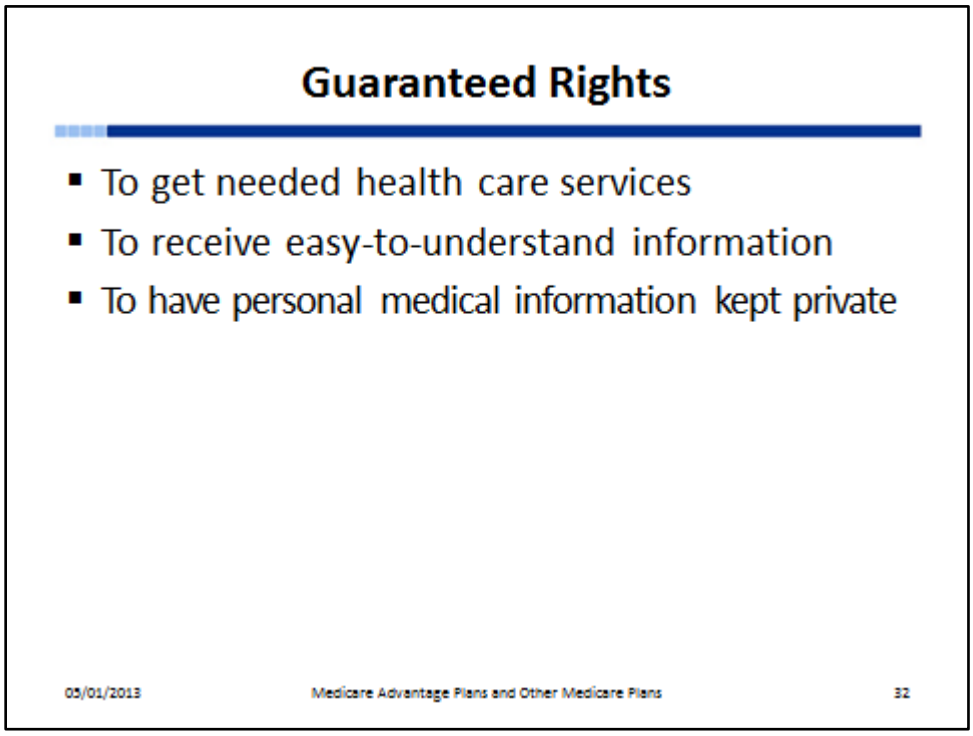
    a. Prescription drug coverage
    b. Medical services
    c. Social services
    d. Transportation services
    e. All of the above

Refer to page 61 to check your answers.



Lesson 3, *Rights, Protections, and Appeals,* provides information on the following:

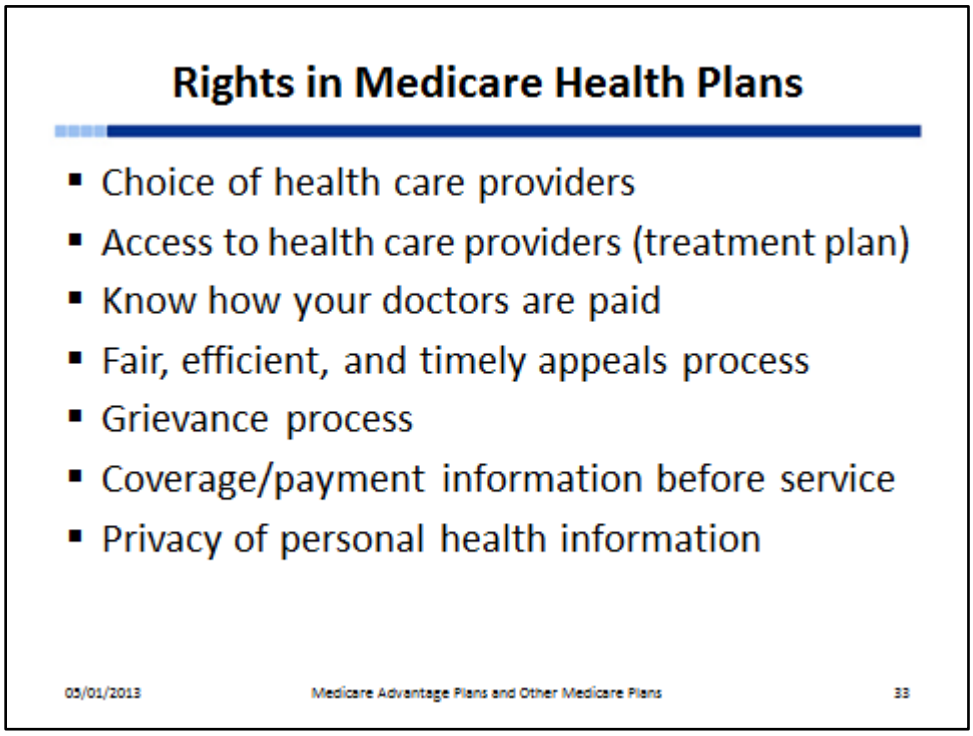
- Guaranteed Rights and Protections;
- Appeals; and
- Required Notices.



All people with Medicare have certain guaranteed rights and protections. You have these rights and protections whether you are in Original Medicare; in a Medicare Advantage plan, or other Medicare plan; have a Medicare drug plan; or have a Medigap policy.

The following rights are guaranteed:

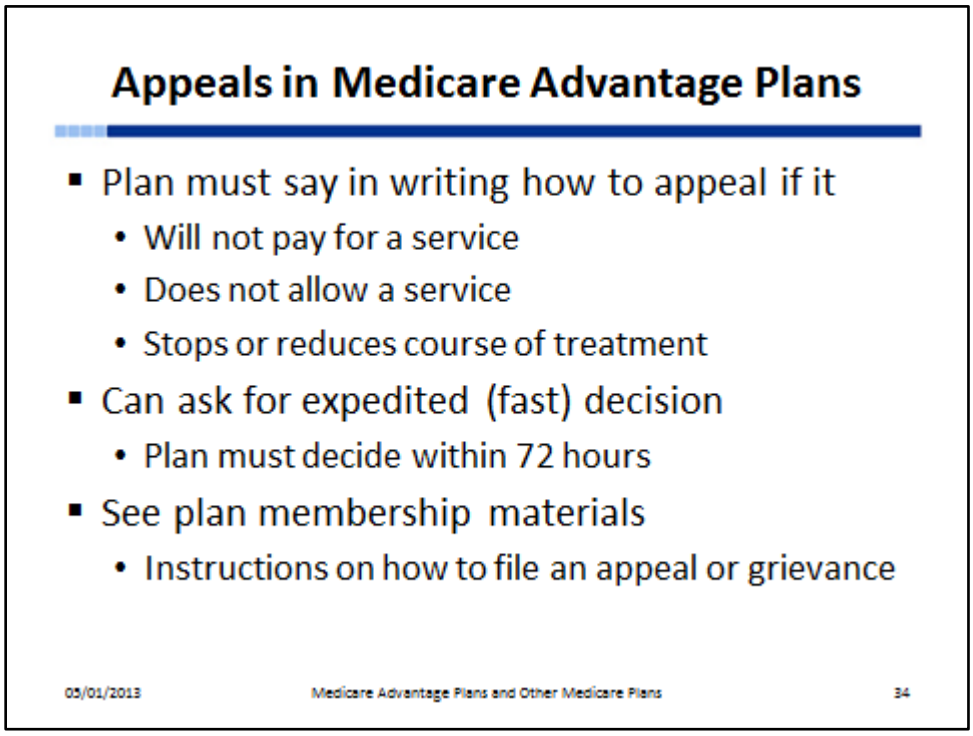
- To get the health care services you need;
- To receive easy-to-understand information; and
- To have your personal medical information kept private.



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

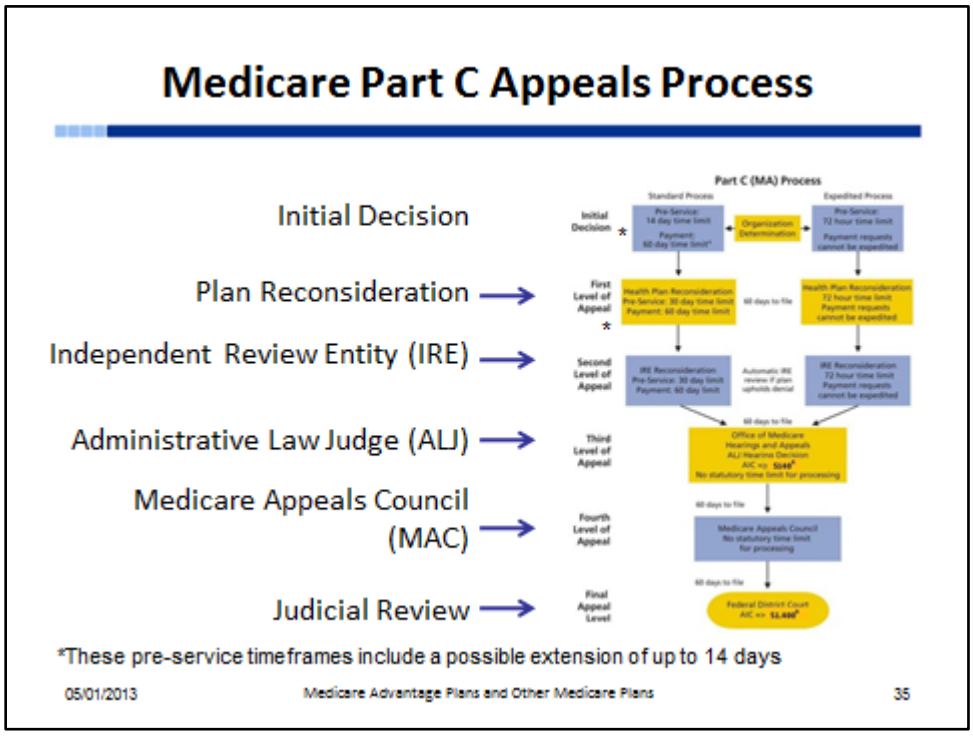
- Choose health care providers in the plan so you can get covered health care.
- Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need to. Women 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 you getting needed care.
- 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 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 or coverage information from your plan before getting a service to find out if it 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.
- Privacy of personal health information. For more information about your privacy rights, look in your plan materials, or call your plan.

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



The plan must tell you in writing how to appeal. You can appeal if your plan will not pay for, does not allow, or stops or reduces a course of treatment that you think should be covered or provided. 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 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. 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 does not decide in your favor, an independent organization that works for Medicare, not for the plan, reviews the decision. See the plan membership materials or contact the plan for details about your Medicare appeal rights.



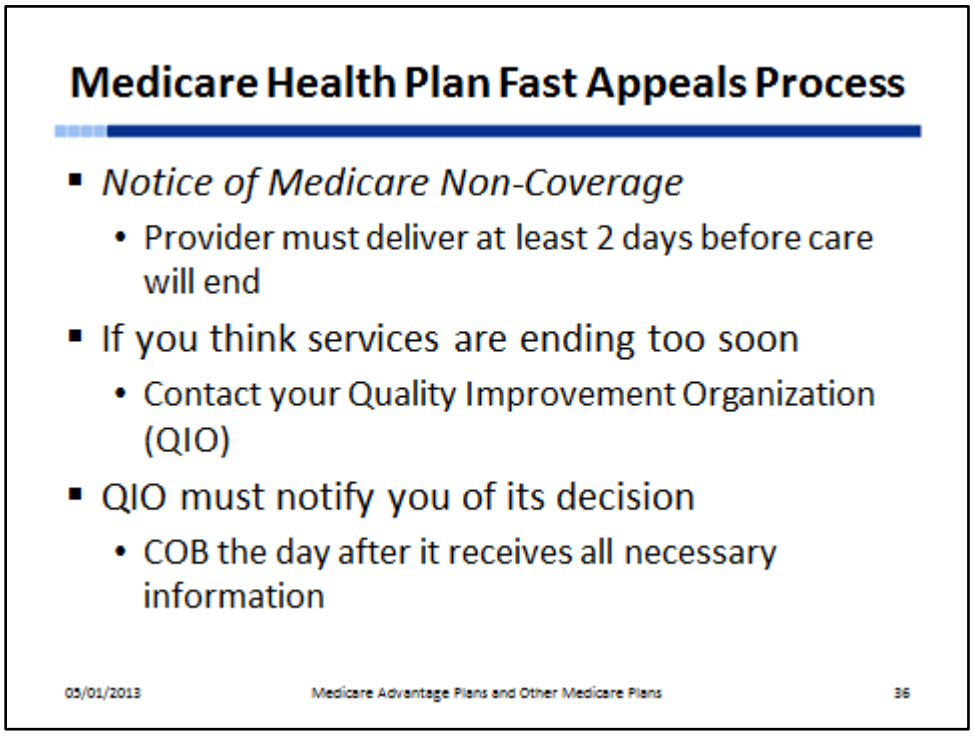
This chart shows the appeal process for Medicare Advantage plan or other Medicare health plan enrollees. The time frames differ depending on whether you are requesting a standard appeal, or if you qualify for an expedited (fast) appeal.

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 will get a notice explaining why your plan denied your request and instructions on how to appeal your plan's decision.

There are five levels of appeal. 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.

After each level, you will get instructions on how to proceed to the next level of appeal. The five levels are of appeal are as follows:

- Reconsideration by the plan;
- Reconsideration by the Independent Review Entity (IRE);
- Hearing with the Administrative Law Judge (ALJ);
- Review by the Medicare Appeals Council (MAC); and
- Review by a federal district court.



With the Medicare Health Plan Fast Appeals Process

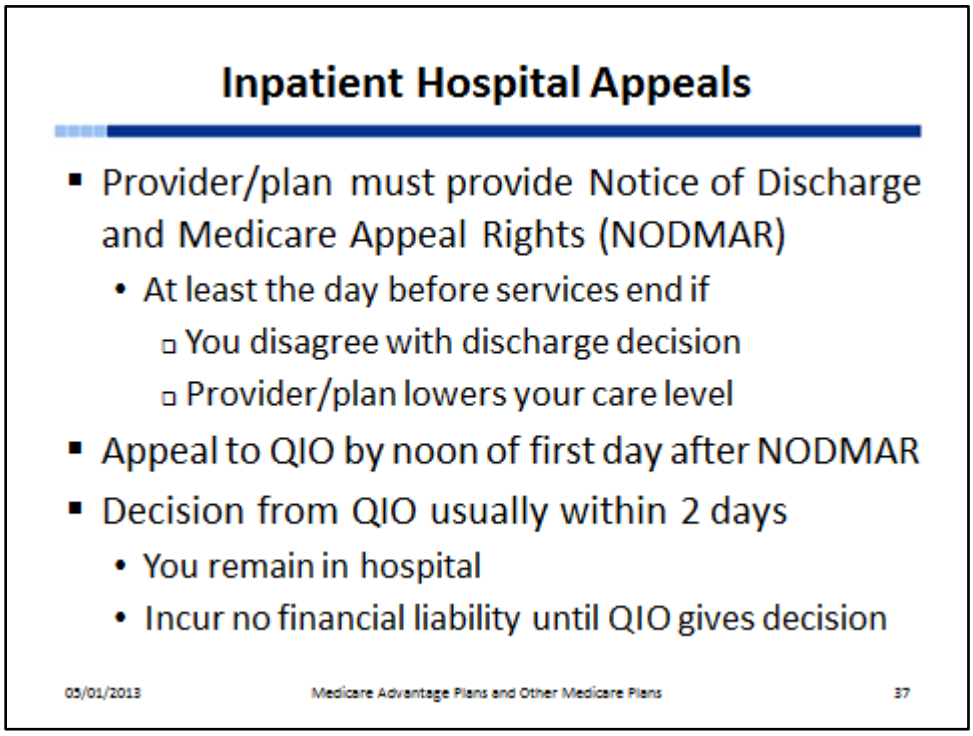
- You have the right to ask your plan to provide or pay for a Medicare-covered service you think should be continued in a skilled nursing facility (SNF), from a home health agency (HHA), or in a comprehensive outpatient rehabilitation facility (CORF).
- Your provider must deliver a Notice of Medicare Non-Coverage at least 2 days before Medicare-covered SNF, CORF, or HHA care will end.

If you think services are ending too soon, contact your Quality Improvement Organization (QIO) no later than noon the day before Medicare-covered services end to request a fast appeal. See your notice for how to contact your QIO and for other important information.

The QIO must notify you of its decision by close of business of the day after it receives all necessary information.

The plan must give you a Detailed Explanation of Non-Coverage. This notice will explain why the coverage is being discontinued.

You have the right to ask for reconsideration by the QIO if you are dissatisfied with the results of the fast appeal.

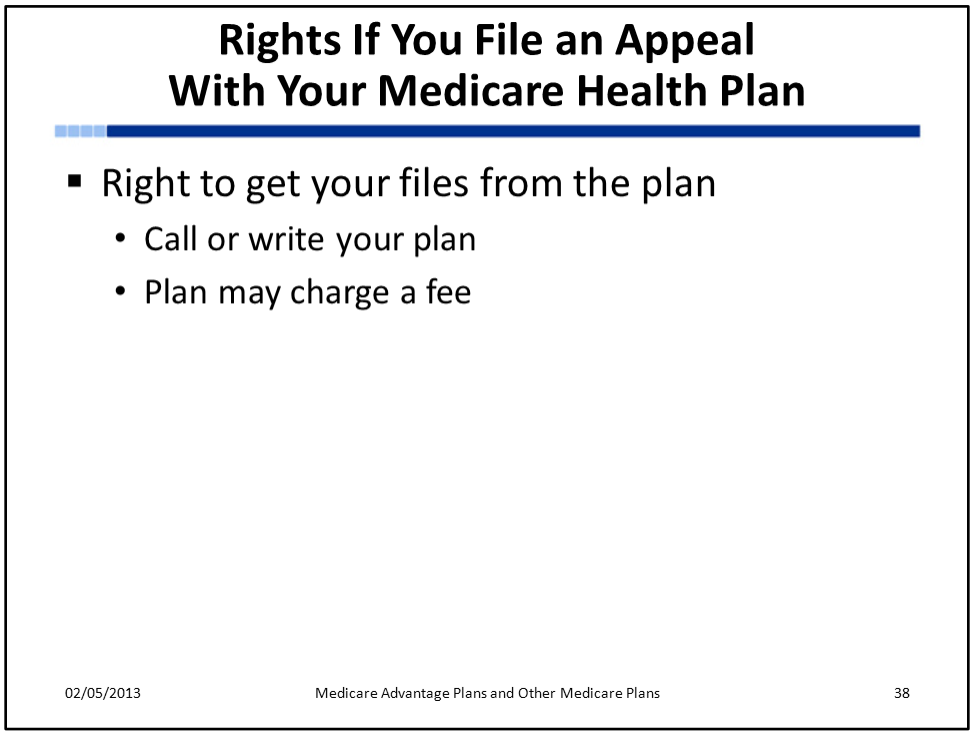


For inpatient hospital appeals, the provider or plan must provide a Notice of Discharge and Medicare Appeal Rights (NODMAR) at least the day before services end if you disagree with the discharge decision, or if the provider or plan is lowering the level of your care within the same facility.

You can then appeal by sending a request to the Quality Improvement Organization (QIO) by noon of the first day after receiving the NODMAR. The decision from the QIO is usually received within 2 days. You remain in the hospital pending the QIO's decision, and generally incur no financial liability.

However, you should be aware that you could be financially liable for inpatient hospital services provided after noon of the day after the QIO gives its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

More information on the notice and links to download the forms is available at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/Hospital Discharge AppealNotices.html.



If you are in a Medicare health plan and you are filing an appeal, you have certain rights. You may want to call or write your plan and ask for a copy of your file. Look at your Evidence of Coverage (EOC), or the notice you received that explained why you could not get the services you requested, to get the phone number or address of your plan.

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.

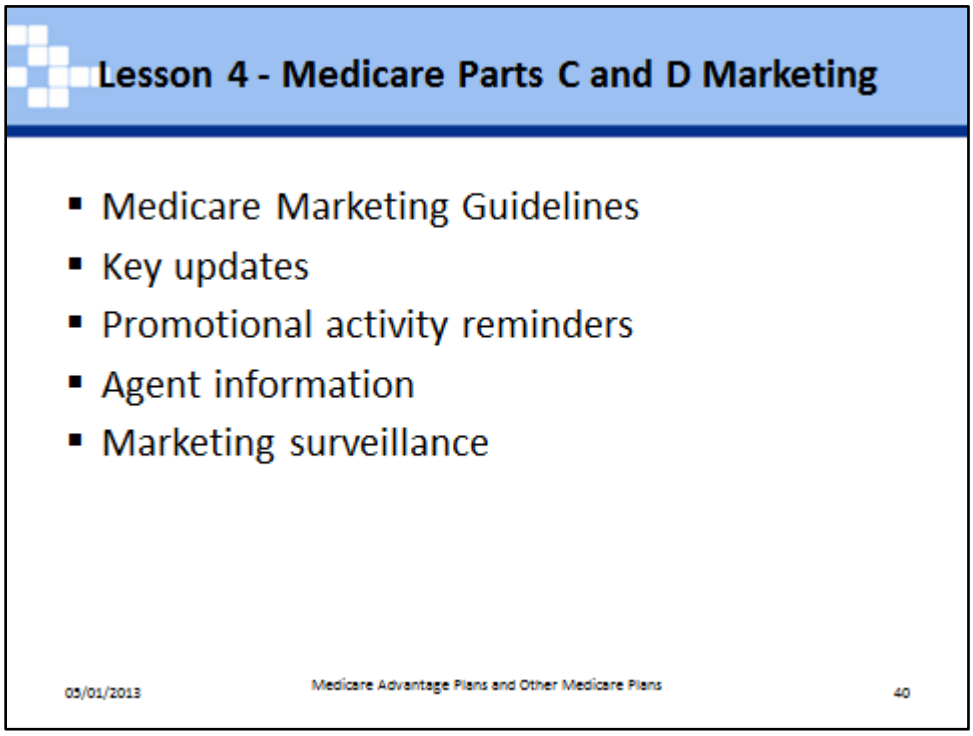
Check Your Knowledge
Lesson 3 – Rights, Protections and Appeals

Answer the following questions:

1. Whom do you need to contact if you think services for home health care are ending too soon?

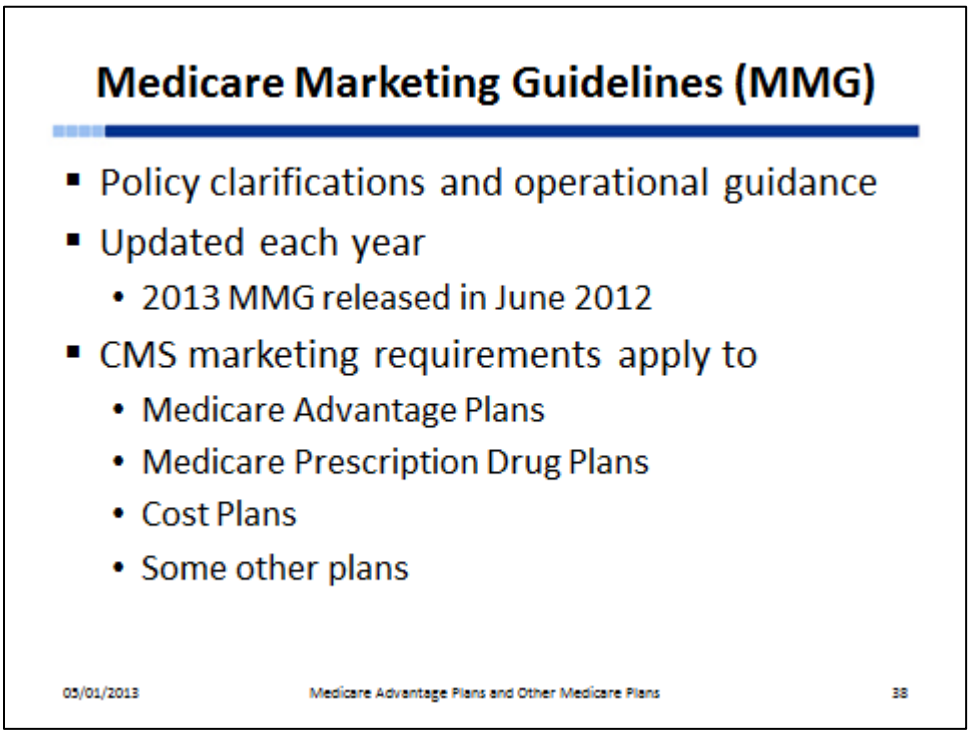
    a. State Health Insurance Assistance Program (SHIP)
    b. Quality Improvement Organization (QIO)
    c. Social Security
    d. Home Health Agency (HHA)

Refer to page 62 to check your answers.



Lesson 4, *Medicare Parts C and D Marketing*, provides information on the following:

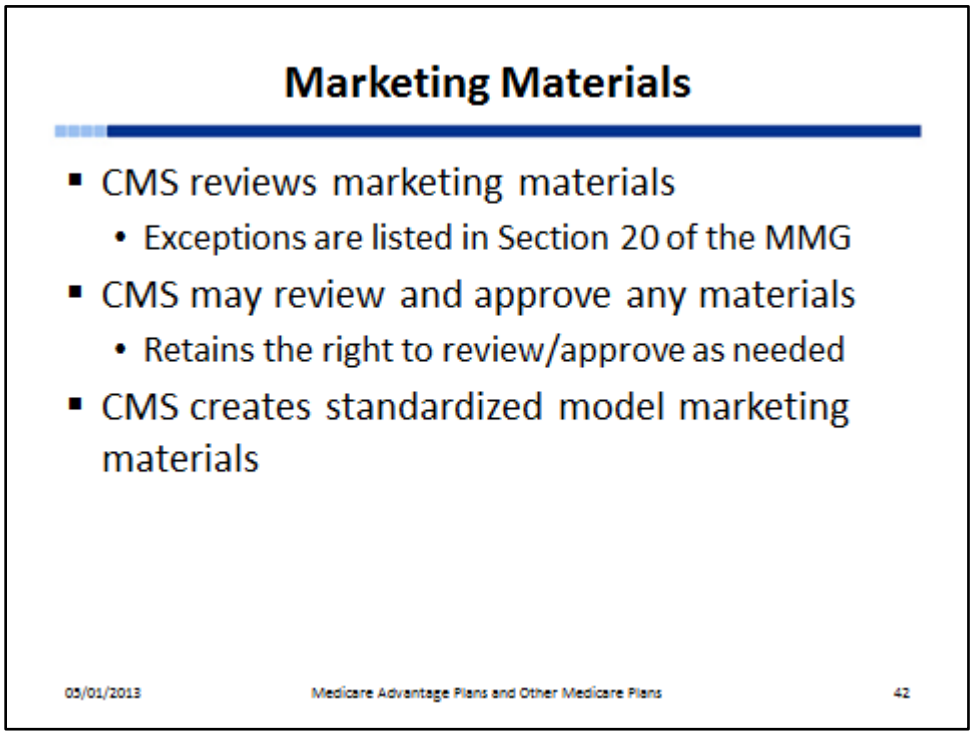
- Medicare Marketing Guidelines;
- Key updates;
- Promotional activity reminders;
- Agent information; and
- Marketing surveillance.



The CMS Medicare Marketing Guidelines (MMG) provides policy clarifications and operational guidance to contracted plan sponsors. In June 2012, CMS released the 2013 MMG. Requirements apply to Medicare Advantage Organizations (MAOs), Prescription Drug Plan (PDP) sponsors, Section 1876 cost-based contractors, demonstration plans and employer and union-sponsored group plans, including employer/union-only group waiver plans.

Need More Information?

The 2013 MMG is posted at: http://www.cms.gov/Regulations-and-Guidance/Guidance/ Manuals/Downloads/mc86c03.pdf and are also issued as Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual.

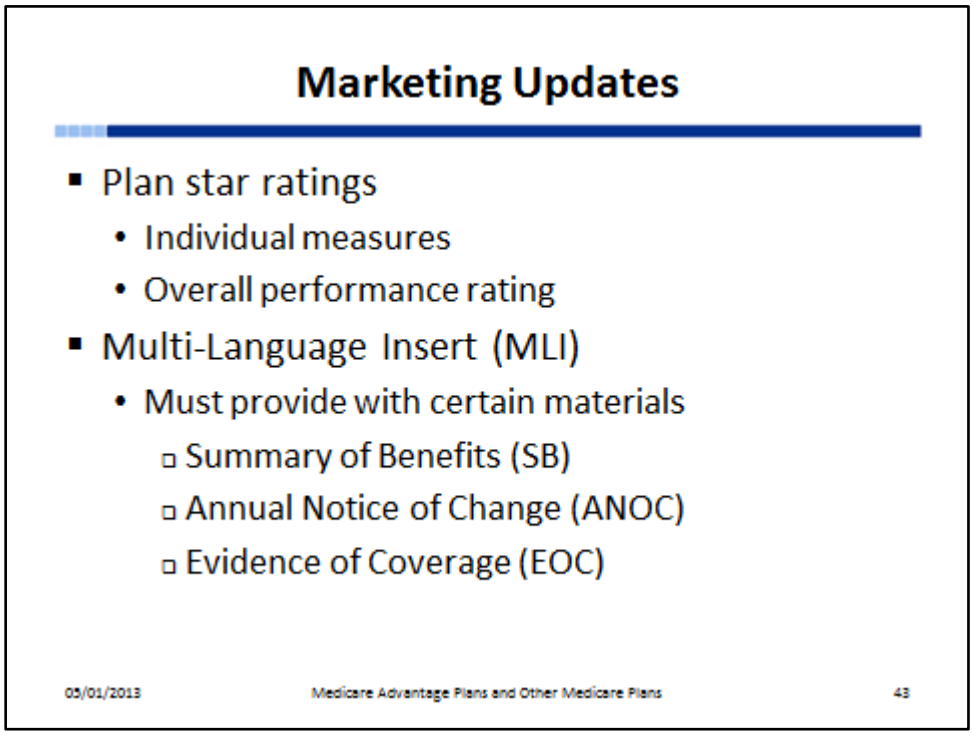


CMS reviews marketing materials, with the exception of those in Section 20 of the Medicare Marketing Guidelines (MMG). While not an exhaustive list, some examples of excluded materials include the following:

- Certain member newsletters;
- Press releases;
- Blank letterhead; and
- Privacy notices.

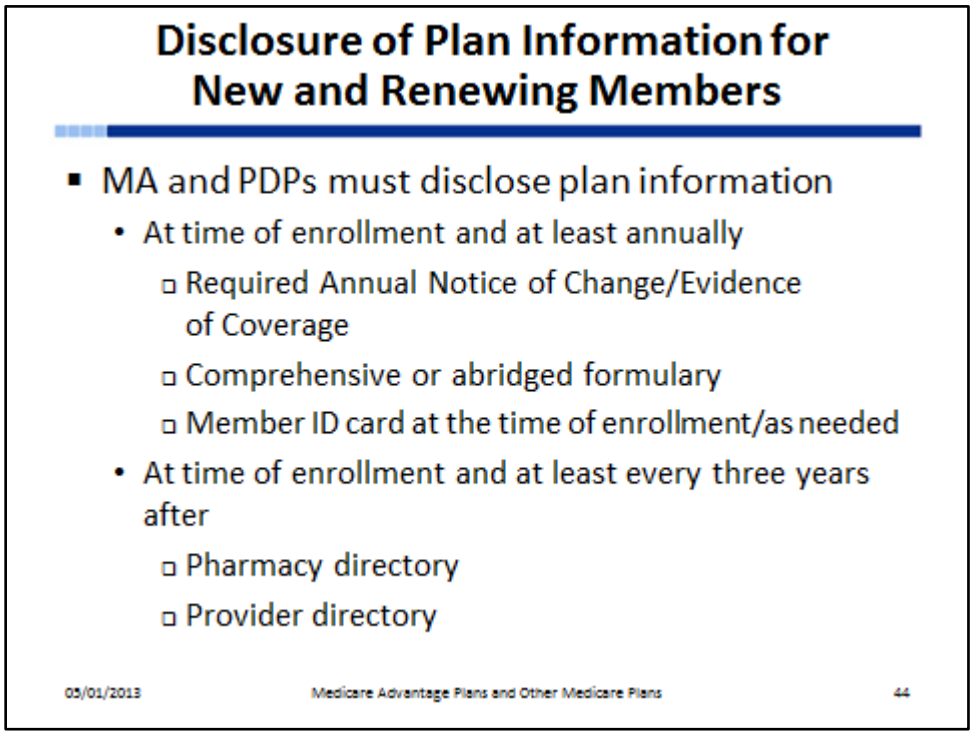
Although current enrollee communication materials are not subject to the review and approval process that applies to marketing materials, CMS retains the right to review and approve current enrollee communication materials at any time.

MA Organizations and PDP sponsors are required to use standardized marketing material language and format, without modification, in every instance in which CMS provides standardized language and formatting. Examples of standardized documents include, but are not limited to the Annual Notice of Change (ANOC), Evidence of Coverage (EOC), and Multi-Language Insert (MLI).



Medicare Advantage and Prescription Drug Plans receive 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, provided they are communicated in conjunction with a contract's overall performance rating.

Plan sponsors must provide the new Multi-Language Insert (MLI) any time they distribute a Summary of Benefits (SB) and Annual Notice of Change (ANOC)/Evidence of Coverage (EOC). The Multi-Language Insert (MLI) is a standardized document that provides information about the availability of interpreter services to help answer questions about a health or drug plan. The MLI makes this information available in numerous languages for non-English-speaking beneficiaries.



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

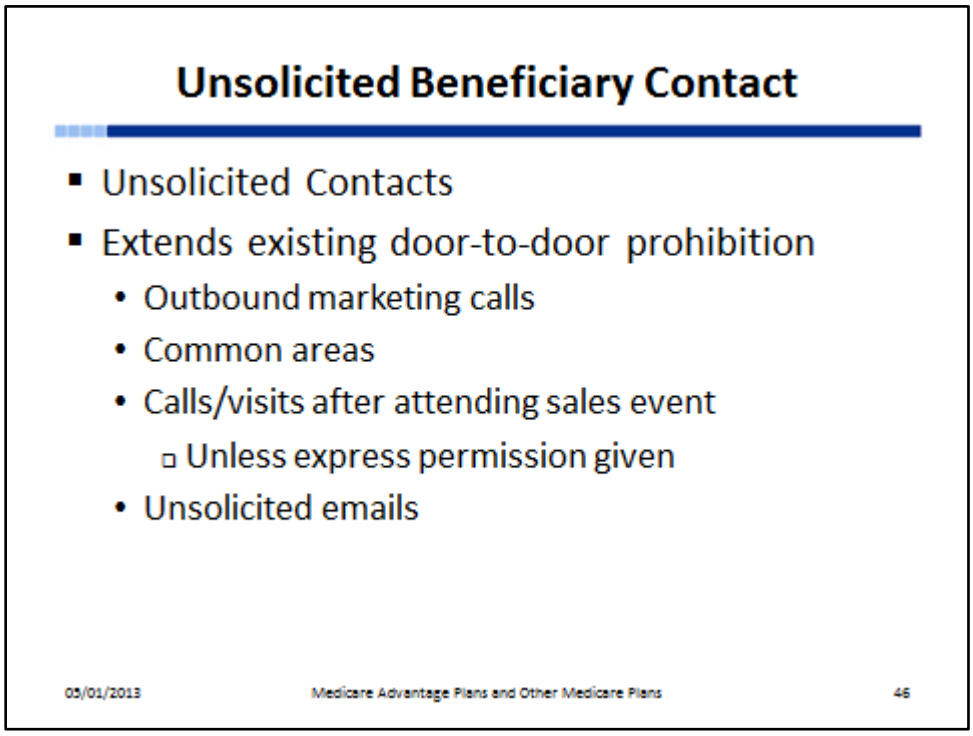
This requirement includes the annual dissemination of

- Standardized Annual Notice of Change (ANOC) and Evidence of Coverage or EOC as applicable, that must be received by members no later than September 30 each year;
- Comprehensive formulary or abridged formulary including information on how the beneficiary can obtain a complete formulary (Part D sponsors only); and
- Membership identification card (required only at time of enrollment and as needed or required by plan sponsor post-enrollment).

Other key plan information must be disclosed both at the time of enrollment and at least every 3 years after that for

- Pharmacy directory (for all plan sponsors offering a Part D benefit); and
- Provider directory (for all plan types except PDPs).

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. CMS currently defines nominal value in the MMG, Section 70.1, as an item worth $15 or less, based on the retail value of the item. CMS will update the nominal value in guidance as necessary to account for inflation and other relevant factors.

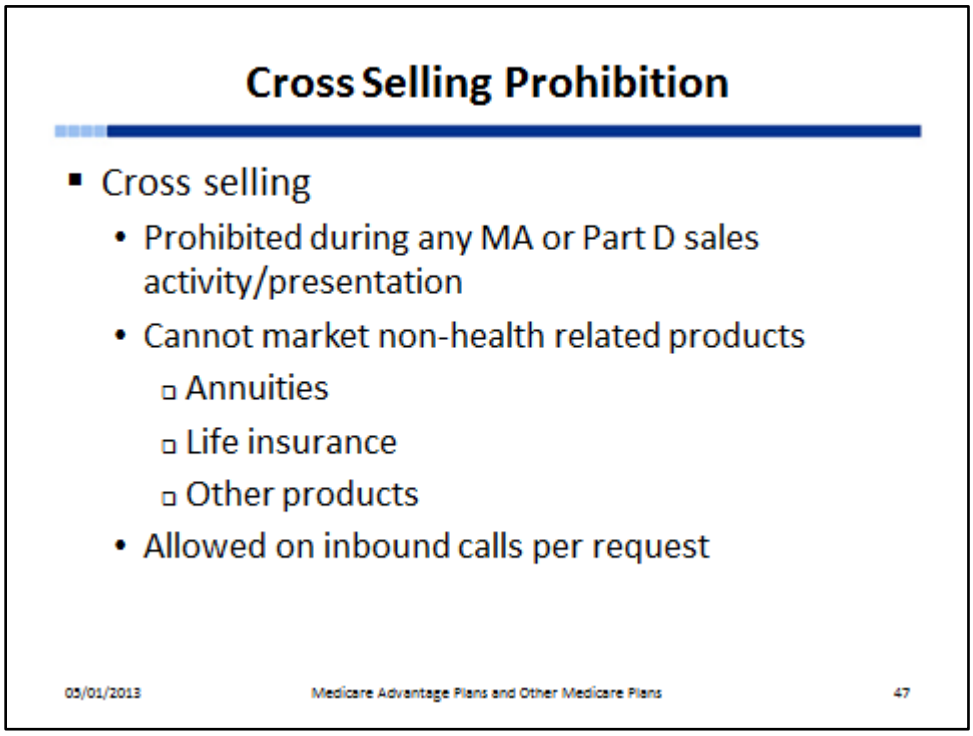


The current prohibition on door-to-door solicitation extends to other instances of unsolicited contact that may occur outside of sales or educational events. Prohibited activities include, but are not limited to, the following:

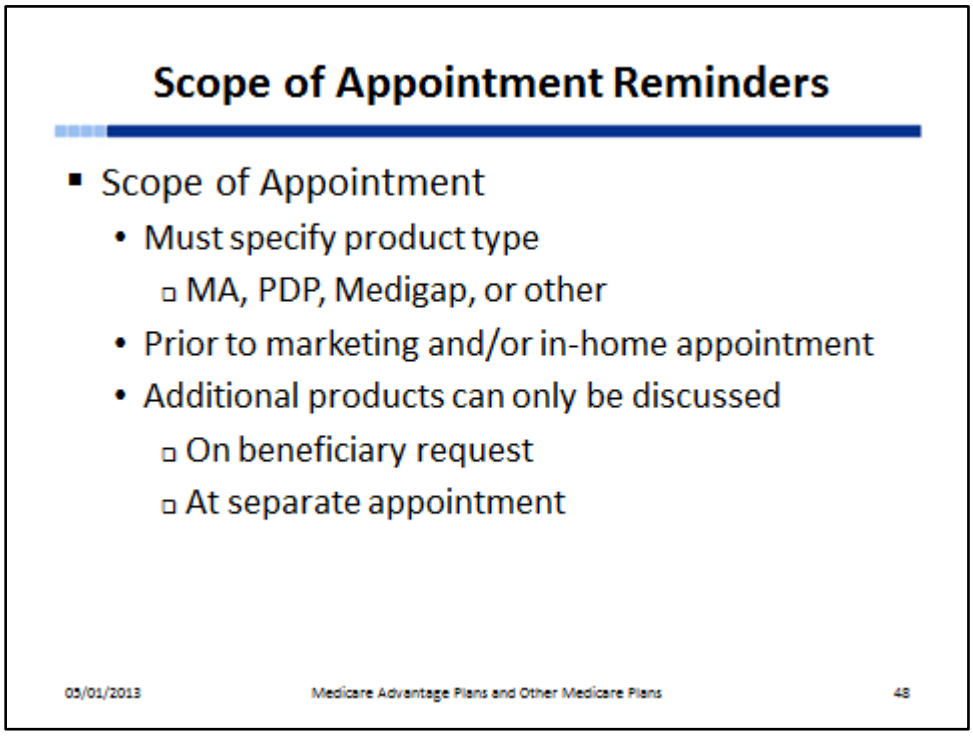
- Outbound marketing calls, unless the beneficiary requested the call;
- Calls to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling, to market plans or products (except as permitted below);
- Calls to beneficiaries to confirm receipt of mailed information;
- Calls to beneficiaries to confirm acceptance of appointments made by third parties or independent agents;
- Approaching beneficiaries in common areas (e.g., parking lots, hallways, lobbies, sidewalks);
- 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; and
- Unsolicited e-mails.

Organizations may do the following:

- 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; and/or
- Contact their members who are eligible for Extra Help, call beneficiaries (with CMS Regional Office approval), and contact beneficiaries who have expressly given permission for a plan or sales agent to contact them (e.g., complete business reply card).



Marketing health care–related products (such as annuities, life insurance, etc.) to prospective enrollees during any Medicare Advantage (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.



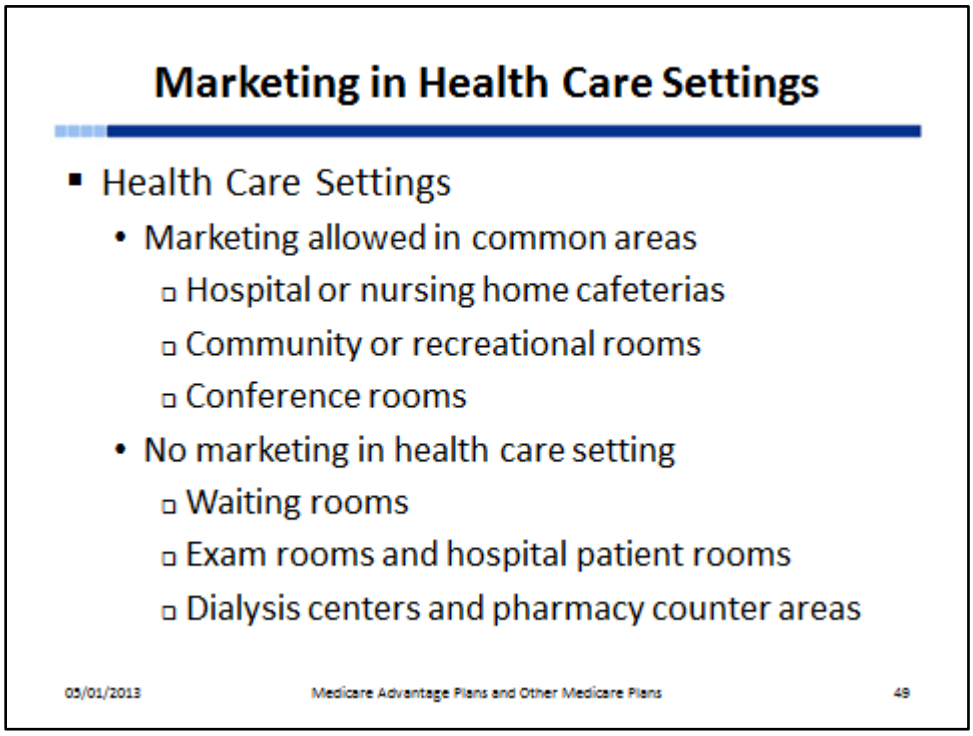
Medicare Marketing Guidelines requires marketing representatives to clearly identify the types of products to be discussed before marketing to a potential enrollee. Marketing representatives who initially meet with a beneficiary to discuss specific lines of plan business (separate lines of business include Medigap, MA, and PDP) must inform the beneficiary of all products to be discussed prior to the in-home appointment so they have accurate information to make an informed choice about their Medicare benefits without pressure.

Before a marketing appointment, the beneficiary must agree to the scope of the appointment. The agreement must be documented by the plan in writing or recorded by phone.

- Example: A beneficiary attends a sales presentation and schedules an appointment. The agent must get written documentation signed by the beneficiary, agreeing to the products that will be discussed during the appointment.

Appointments made over the phone must be documented by a recording. Organizations should use 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. Moreover, any additional lines of plan business that are not identified prior to the in-home appointment will require a separate appointment.

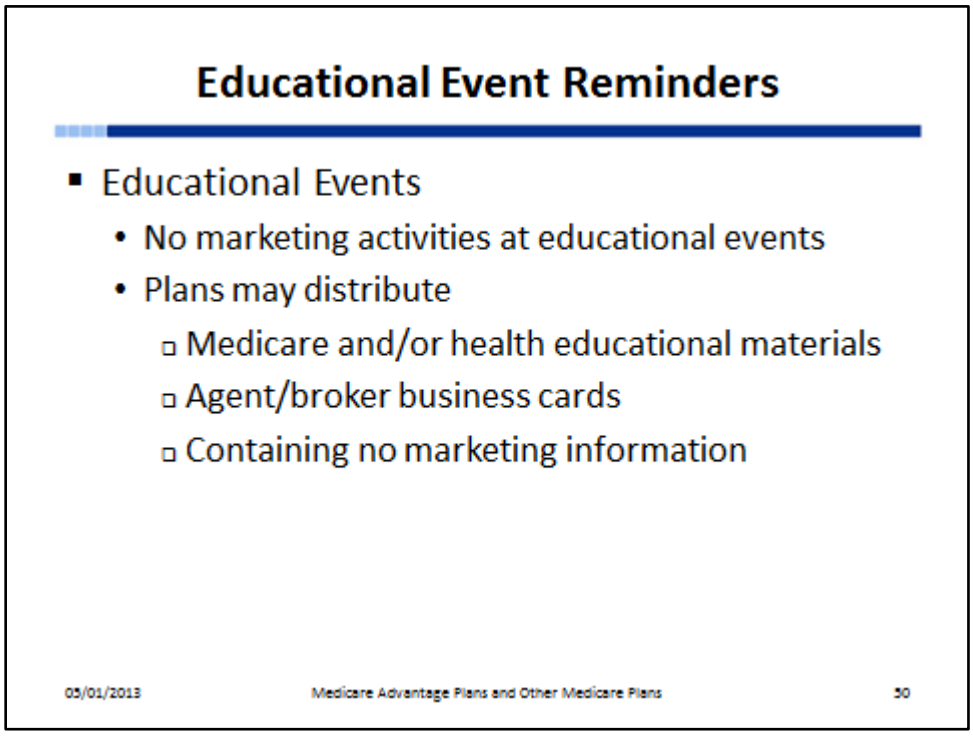


Organizations may not conduct marketing activities in health care settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter is located within 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 beneficiaries residing in long-term care facilities.

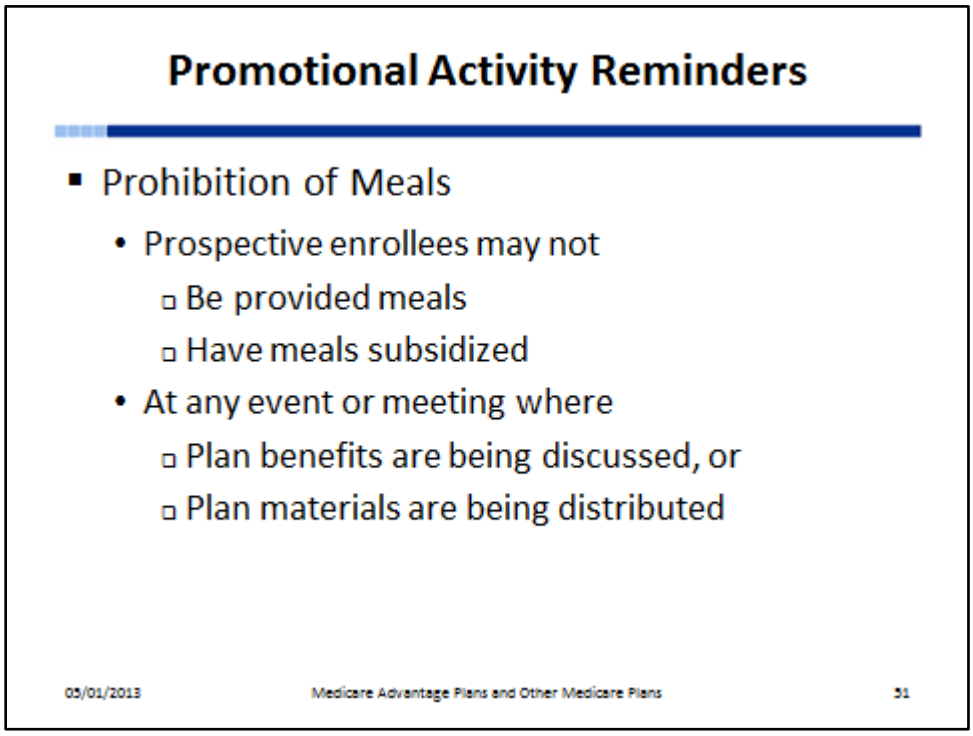
Additionally, providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships.



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. As such, educational events should not be used to steer or attempt to steer a beneficiary toward a specific plan or plans.

Educational events may be sponsored by the plan(s) or by outside entities, and are 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 beneficiary requests one. Anything distributed may not have plan marketing information on or attached to the item(s).

The prohibited items mentioned are allowed to be distributed at a sales event. 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 toward a plan or plans.

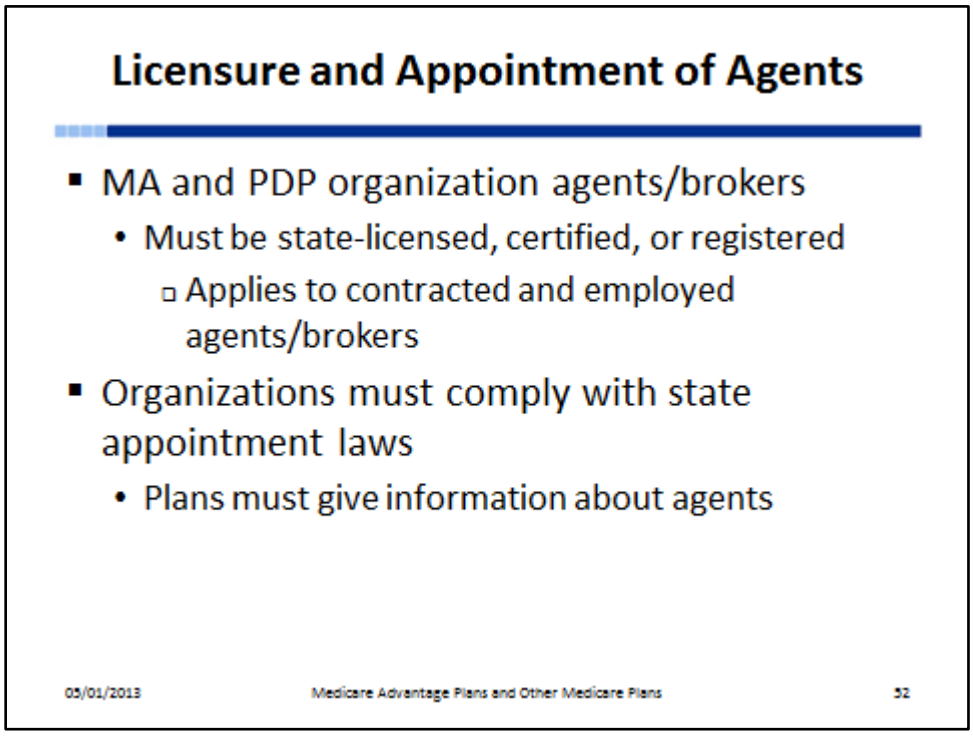


Medicare Advantage (MA) and Medicare Prescription Drug Plans (PDP) may not allow prospective enrollees to be provided meals, or have meals subsidized, at sales events or any meeting at which plan benefits are being discussed and/or plan materials are being distributed.

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.

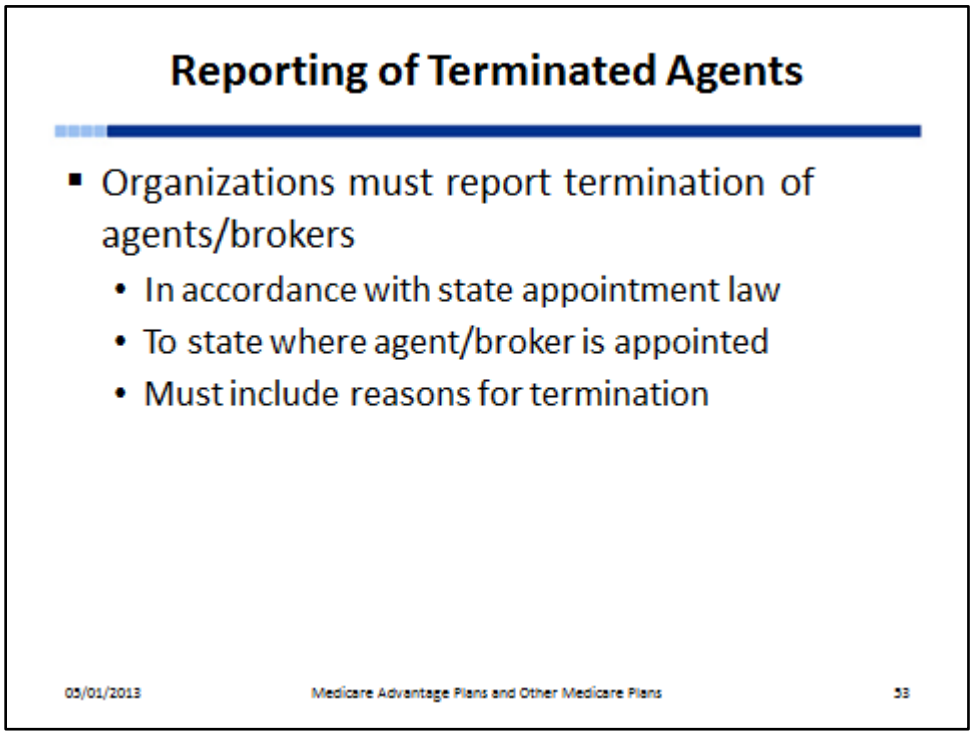
While CMS does not intend to define the term "meal" or create a comprehensive list of food products that qualify as light snacks, items similar to the following could generally be considered acceptable: fruit, raw vegetables, pastries, cookies or other small dessert items, crackers, muffins, cheese, chips, yogurt, and 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.

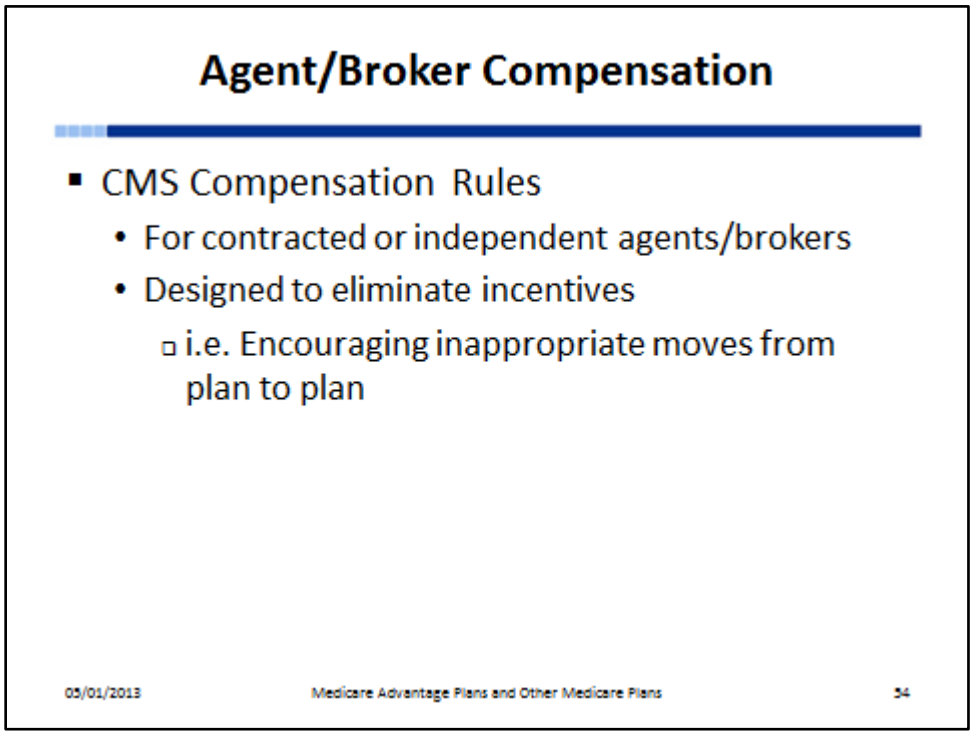


Medicare Advantage (MA) organizations and Part D plan sponsors that conduct marketing through independent agents must use state-licensed, certified, or registered individuals. Both independent agents and internal sales staff that perform marketing must comply with applicable state licensure laws. Some plan activities, typically carried out by the plan sponsor's customer service department, do not require the use of state-licensed marketing representatives, such as providing factual information or fulfilling a request for materials.

MA and Prescription Drug Plan 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.

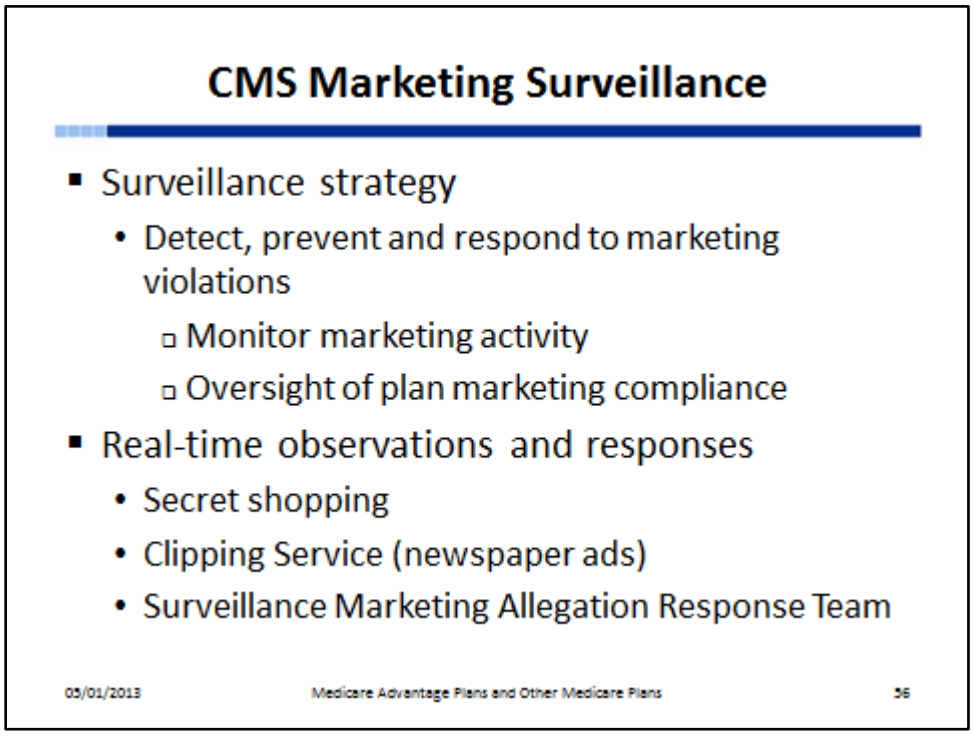


Medicare Advantage Organizations (MAOs) and Part D sponsors must report the termination of any brokers or agents, and the reasons for the termination, to the state in which the broker or agent has been appointed in accordance with the state appointment law.



CMS compensation rules are for Medicare Advantage plans and Medicare Prescription Drug Plans that market through contracted or independent agents/brokers. The rules are designed to eliminate incentives that encouraged inappropriate moves from plan to plan (also called churning). The compensation rules also contain guidelines for plan recoupment of paid compensation under certain circumstances.

Medicare Advantage Organizations (MAOs) and Part D sponsors must ensure that, annually, brokers and agents selling Medicare products are trained and tested on Medicare rules and regulations, and on plan details specific to the plan products being sold by the brokers and agents. Training and testing must be completed prior to the start of the new marketing season in order for the broker/agent to market after that date.



CMS initiated a surveillance strategy due to complaints and evidence of agent and broker misconduct. This strategy is designed to detect, prevent, and respond to marketing violations. CMS continues to add to its surveillance strategy of monitoring and oversight of plan sponsors' internal and external marketing activity, including

- Ensuring that health and drug plans monitor, detect, report, and respond to agent/broker marketing misrepresentation and other issues.

The CMS surveillance philosophy of real-time observations and responses includes

- Secret shopping to determine compliance with marketing requirements at public sales events;
- Clipping service (newspaper ads) to assess whether marketing events are reported to CMS;
- Surveillance Marketing Allegation Response Team (SMART), which reviews complaints and ad hoc marketing issues;
- Providing the industry the opportunity to research and respond to violations; and
- Compliance action is taken only when deficiencies are confirmed and validated.
  - The severity of compliance action is based on the severity and recurrence of violations.
  - Organizations continue to improve their performance over previous years.

Check Your Knowledge
Lesson 4 – Medicare Parts C and D Marketing

Answer the following questions:

1. How often are the Medicare Marketing Guidelines (MMG) updated?

    a. Every 6 months
    b. Every year
    c. Every 2 years
    d. Every 5 years

2. Which of the following listed is NOT considered an acceptable promotional activity?

    a. Calling a beneficiary who filled out a business reply card
    b. Distributing broker business cards requested at an educational event
    c. Offering $20 gift cards to beneficiaries who enroll in a Medicare plan
    d. Providing a light snack during a sales event

Refer to pages 63 to check your answers.

Resources for More Information

Resources	Medicare Products
Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) www.medicare.gov www.CMS.gov	**State Health Insurance Assistance Programs (SHIPs)*** *For telephone numbers call CMS 1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 for TTY users www.HealthCare.gov www.pcip.gov **Affordable Care Act** www.healthcare.gov/law/full/index.htm **2013 Medicare Marketing Guidelines** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c03.pdf	***Medicare & You Handbook*** CMS Product No. 10050) ***Your Guide to Medicare Private Fee-for-Service Plans*** CMS Product No. 10144 ***Understanding Medicare Enrollment Periods*** CMS Product No. 11219 ***Your Guide to Medicare Savings Account Plans*** CMS Product No. 11206 ***Your Guide to Special Needs Plans*** CMS Product No. 11302 **To access these products** View and order single copies at www.medicare.gov Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.
Social Security 1-800-772-1213 TTY 1-800-325-0778 **www.socialsecurity.gov/** **Railroad Retirement Board** 1-877-772-5772 www.rrb.gov/		

This training module is provided by the CMS National Training Program. For questions about training products, e-mail training@cms.hhs.gov. To view all available CMS National Training Program materials or to subscribe to our e-mail list, visit www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram.

Check Your Knowledge
Lesson 1 – Medicare Advantage Plan Overview
(from p. 24)

Answer the following questions:

1. Medicare Advantage (MA) plans are sometimes called:

    a. Part A
    b. Part B
    c. Part C
    d. Part D

    ANSWER: c. MA plans are part of the Medicare program and are sometimes called Part C. (p.4)

2. George is currently enrolled in Original Medicare. In June, he decides he would like to enroll in an MA plan with a 5-Star overall rating. Is he able to do so?

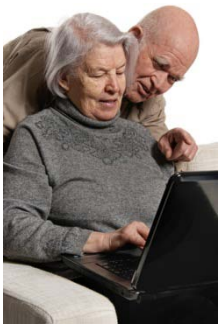
    a. No, he is not eligible for an MA plan
    b. No, he must wait for the Open Enrollment Period (Oct. 7-Dec. 7)
    c. Yes, only if he moved outside of his current plan's service area
    d. Yes, he can enroll in a 5-Star MA plan at any time during the year

    ANSWER: d. You can enroll in a 5-Star MA plan at any time during the year, provided you meet the plan's enrollment requirements. (p.11)

Lesson 2 – Other Medicare Plans
(from p. 30)

Answer the following questions:

1. Linda participates in Programs of All-Inclusive Care for the Elderly (PACE). What kind of services are coordinated for her under PACE?



   a. Prescription drug coverage
   b. Medical services
   c. Social services
   d. Transportation services
   e. All of the above

   ANSWER: e. All of the above. PACE combines medical, social, and long-term care services for frail elderly people who live in and get health care in the community. PACE provides all medically necessary services, including prescription drugs. (p.29)

Check Your Knowledge
Lesson 3 – Rights, Protections, and Appeals
(from p. 39)

Answer the following questions:

1. Whom do you need to contact if you think services for home health care are ending too soon?

   a. State Health Insurance Assistance Program (SHIP)
   b. Quality Improvement Organization (QIO)
   c. Social Security
   d. Home Health Agency (HHA)

   ANSWER: b. QIO. If you think services are ending too soon, contact your QIO no later than noon the day before Medicare-covered services end to request a fast appeal. See your notice for how to contact your QIO and for other important information. (p.36)

Check Your Knowledge
Lesson 4 – Medicare Parts C and D Marketing
(from p. 57)

Answer the following questions:

1. How often are the Medicare Marketing Guidelines (MMG) updated?

    a. Every 6 months
    b. Every year
    c. Every 2 years
    d. Every 5 years

    ANSWER: b. The MMG is updated each year. (p.41)

2. Which of the following listed is NOT considered an acceptable promotional activity?

    a. Calling a beneficiary who filled out a business reply card
    b. Distributing broker business cards requested at an educational event
    c. Offering $20 gift cards to beneficiaries who enroll in a Medicare plan
    d. Providing a light snack during a sales event

    ANSWER: c. 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. CMS currently defines nominal value in the MMG, Section 70.1, as an item worth $15 or less, based on the retail value of the item. CMS will update the nominal value in guidance as necessary to account for inflation and other relevant factors. (p. 45-51)

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANOC	Annual Notice of Change
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COB	Close of Business
CORF	Comprehensive Outpatient Rehabilitation Facility
CSR	Customer Service Representative
EOC	Evidence of Coverage
ESRD	End-Stage Renal Disease
HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
IEP	Initial Enrollment Period
MA	Medicare Advantage
MAO	Medicare Advantage Organizations
MLI	Multi-Language Insert
MMG	Medicare Marketing Guidelines
MSA	Medical Savings Account
NODMAR	Notice of Discharge and Medicare Appeal Rights
OEP	Open Enrollment Period
PACE	Programs of All-Inclusive Care for the Elderly
PDP	Prescription Drug Plan
PFFS	Private Fee-for-Service
POS	Point-of-Service
PPO	Preferred Provider Organization
QIO	Quality Improvement Organization
SB	Summary of Benefits
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
TTY	Teletypewriters

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Inside back cover

Website: cms.gov/www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram

E-mail training@cms.hhs.gov

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244