Updated: 2025 Agent and Broker Training & Testing Guidelines

Introduction

Each year, the Centers for Medicare & Medicaid Services (CMS) provides Medicare Advantage (MA) plans, Medicare Advantage-Prescription Drug (MA-PD) plans, Medicare Prescription Drug plans (PDPs), section 1876 cost plans, and Medicare-Medicaid plans (MMPs) (when applicable per state policy), hereinafter "organizations," training and testing guidelines to use in development of the training and testing of their agents and brokers. Organizations and the third-party marketing organizations (TPMOs) that operate on their behalf must ensure that all the agents and brokers (including employed, subcontracted, downstream, and/or delegated entities) that sell Medicare products on behalf of the organization are trained and tested annually on Medicare rules and regulations and on the specific benefits of the plan(s) their agents and brokers sell.[1] To ensure that they are satisfying these testing and training requirements, organizations should, at a minimum, use the criteria outlined below in developing their individual training and testing.

These agent and broker training and testing guidelines are based on the regulations at Title 42 of the Code of Federal Regulations, Parts 417, 422, and 423, and on CMS's guidance interpreting those regulations in the Medicare Managed Care Manual (MMCM) and the Medicare Prescription Drug Benefit Manual (MPDBM).

Organizations must ensure the integrity of their training and testing program, including ensuring that all agents and brokers are tested independently. Finally, organizations must maintain information on their training and testing program and make this information available to CMS upon request. This includes tools, exams, policies and procedures, and evidence of completion.

As a reminder, in addition to the agent and broker testing and training requirements outlined in these guidelines, organizations must also provide appropriate oversight any TPMO with which they do business, consistent with the requirements outlined in 42 CFR §§ 422.2274 (c) and (g) and 423.2274 (c) and (g). These requirements include, as provided by 42 CFR §§ 422.2274 (g)(2)(ii) and 423.2274 (g)(2)(ii) and as outlined below, that organizations ensure that TPMOs that operate on their behalf "record all marketing, sales, and enrollment calls, including the audio portion of calls via web-based technology, in their entirety." Calls other than those involving marketing, sales, and enrollments do not have to be recorded.

The training topics that CMS expects organizations to cover, address, and test on are outlined below. Organizations also should ensure that their agents and brokers can speak to these general topics and their relation to the types of plan products they sell (e.g., MA, MA-PD, PDP, cost plans, MMP).

1. **Medicare Basics**
    a. Overview of Medicare
        i. Medicare Parts and covered services

[1] 42 CFR §§ 422.2274(b)(2) and (c)(4), 423.2274(b)(2) and (c)(4). See also 42 CFR § 417.428, requiring Section 1876 cost plans to comply with 42 CFR §§ 422.2260 through 422.2276.

1. Medicare Part A: Original Medicare - Hospital Insurance
2. Medicare Part B: Original Medicare - Medical Insurance
3. Medicare Part C: Medicare Advantage
4. Medicare Part D: Prescription Drug Coverage – stand-alone PDP and MA-PD

b. Eligibility Requirements and Premiums
   i. Original Medicare (Part A and Part B)
   ii. Part C
   iii. Part D
      1. Including applicable premiums and cost sharing subsidies for low-income individuals
   iv. Section 1876 Cost Plans
   v. Program of All-inclusive Care for the Elderly (PACE)
c. Overview of Medigap
d. Options for Receiving Medicare
   i. Original Medicare only
   ii. Original Medicare with a stand-alone PDP
   iii. MA-PD Plans
   iv. MA or Cost Plan without a stand-alone PDP
   v. Cost Plan with a stand-alone PDP
   vi. Private Fee-for-Service (PFFS) Plans
   vii. Medical Savings Account (MSA) Plans
e. High-level Description for Each of the Plan Types
   i. Original Medicare (Parts A and B)
      1. Benefits and beneficiary protections (1-800-Medicare, FFS appeal rights, etc.)
      2. Medicare Supplement Health Insurance (Medigap)
   ii. Part C
      1. Description of coordinated care plans (e.g., HMO, PPO, RPPO, SNP)
      2. Description of PFFS Plans
      3. Description of Special Needs Plans
         a. Dual-eligible special needs plans (D-SNPs), which include coordination-only D-SNPs, fully integrated dual eligible SNPs (FIDE SNPs), highly integrated dual eligible SNPs (HIDE SNPs), and applicable integrated plans (AIPs)
         b. Institutional Special Needs Plans (I-SNPs)
         c. Chronic Condition Special Needs Plans (C-SNPs)
      4. Description of MSA Plans
      5. Benefits and beneficiary protections (grievance and appeal rights, prior authorization, step therapy, benefit limitations)
      6. Out-of-Pocket costs (e.g., premiums, cost sharing, copayments/coinsurance, maximum out-of-pocket (MOOP) limits)
      7. Network requirements (in- and out-of-network providers)

iii. Part D
    1. Description of plan types (MA-PD, PDP)
    2. Benefits and beneficiary protections (grievance and appeal rights)
    3. Standard benefit
        a. Deductible phase, initial coverage phase, catastrophic phase
        b. TrOOP
    4. Inflation Reduction Act changes
        a. Vaccines and insulin,
        b. Low-Income Subsidies (LIS),
        c. $0 catastrophic coverage cost-sharing,
        d. Manufacturer Discount Program,
        e. Elimination of the coverage gap phase and the Coverage Gap Discount Program
    5. Plan Features
        a. Formularies (Plan Drug Lists), Protected Class Drugs,
        b. Formulary/Drug Tiers,
        c. Plan-Specific Coverage Rules (prior authorization, quality limits, step therapy)
    6. Pharmacy Networks

iv. Other Plan Types
    1. Employer Group Waiver Plans (EGWPs)
    2. Section 1876 Cost Plans
    3. Medicare-Medicaid Plans (MMP)
    4. Optional: PACE Plans

2. **Enrollment and Disenrollment (Part C, Part D, and Section 1876 Cost Plans – where applicable)**
    a. Enrollment Procedures
        i. Format of enrollment requests (use of approved enrollment mechanisms)
        ii. Appropriate use of short enrollment forms or model plan selection forms (Part C and D) or Simplified (Opt-In) Enrollment Mechanism (Part C)
        iii. Requirement that enrollment mechanism capture beneficiary's acknowledgment and consent to required key elements
        iv. Requirement to record all marketing, sales, and enrollment calls (including those calls made by TPMOs that work on organization's behalf)
        v. Requirement to review items on the Pre-Enrollment Checklist (PECL) with beneficiary before completing the enrollment request
    b. Enrollment Processing
        i. Enrollment effective dates
        ii. Notifications
    c. Non-discrimination Requirements for Enrollment
    d. Part C and D Enrollment Periods
        i. Description of the limited circumstances for making a mid-year change in enrollment

ii. Initial Coverage Election Period (ICEP)
iii. Annual Election Period (AEP)
iv. Initial Enrollment Period for Part D (IEP for Part D)
v. Medicare Advantage Open Enrollment Period (MA OEP)
    1. Review of what MA organizations may do
    2. Review of what MA organizations may not do
        a. Knowingly target or send unsolicited marketing materials during MA OEP
vi. Open Enrollment Period for Institutionalized Individuals (OEPI)
vii. Special Enrollment Periods (SEPs)
    1. 5-Star SEP
    2. Provide other examples of SEPs (e.g., moving to a different service area, change in dual/LIS status, CMS/State Assignment)
    3. Monthly dual/LIS SEP for Part D
    4. Integrated Care SEP for full benefit dual eligibles
    5. Further restriction of the duals/LIS SEP for "potential at-risk" or "at-risk" individuals
viii. Section 1876 Cost Plan open enrollment

e. Disenrollment
    i. Voluntary disenrollment
    ii. Involuntary disenrollment (i.e., when a member must be disenrolled for moving out of service area, loss of dual eligible status)

3. **Marketing and Communications Requirements and Other Regulations (Part C, Part D, and Section 1876 Cost Plans – where applicable)**
    a. Agent and Broker Responsibilities
        i. HIPAA privacy
        ii. Other responsibilities required by plan
        iii. *TPMO Oversight – including new rules on sharing personal beneficiary data*
    b. Marketing and Communications Overview
        i. Overview of defined terms in the marketing and communications regulations and the required materials to be issued to potential enrollees
        ii. Description of general rules and requirements for marketing and communications
        iii. Provision of Star Ratings information, including instructions on how to access and use the information
        iv. Information on how to access and use the Summary of Benefits, Provider/Pharmacy Directory, Evidence of Coverage, Annual Notice of Change, and Formulary, as applicable
    c. Standards for Marketing and Communications - Inappropriate/Prohibited Marketing and Communications Activities
        i. Conducting health screenings at marketing events
        ii. Providing cash or monetary rebates

iii. Unsolicited contact with beneficiaries
iv. Comparing plan to other plans (requirement and restriction)
v. Displaying names or logos or both of provider co-branding partners (requirement and restrictions)
vi. Failure to record all sales and enrollment-related telephonic contact

d. Potential Consequences of Engaging in Inappropriate or Prohibited Marketing and Communications Activities
    i. Reporting requirements
    ii. Disciplinary actions
    iii. Termination
    iv. Other consequences as per contractual agreement with the plan
e. Marketing/Sales Events
    i. Definition of marketing/sales events
    ii. Appropriate promotion of sales events
    iii. Examples of "dos and don'ts," including, but not limited to:
        1. Provision of refreshments, snacks, and meals
        2. Soliciting enrollment applications prior to the start of the AEP
        3. Requiring information as a prerequisite for events (e.g., contact information)
f. Personal/Individual Marketing Appointments
    i. Scope of appointment and advance agreement on the scope of appointment
    ii. Requirement to record all individual marketing/sales calls
    iii. Discussion of required disclaimers, including TPMO disclaimer mentioning the number of organizations the agent represents and the number of products the agent sells
    iv. Examples of dos and don'ts, including, but not limited to:
        1. Discussion/marketing of non-health care products
        2. Discussing products not agreed upon by the beneficiary
g. Educational Events
    i. Appropriate promotion of educational events
    ii. Sponsorship, promotion
    iii. Examples of "dos and don'ts," including, but not limited to:
        1. Topics (Medicare, plan-specific premiums and/or benefits, etc.)
        2. Display and/or distribution of marketing materials
        3. Marketing activities
        4. Provision of refreshments, snacks, and meals
h. Nominal Gifts – Social Security Act, section 1128A(a)(5)
i. Cross-selling – definition
    i. Health care related products – definition and "dos and don'ts"
    ii. Non-health care related products – definition and "dos and don'ts"
j. Unsolicited contact, outside of advertised sales or educational events or mailings
k. Referrals – solicitation of leads from current enrollees for new enrollees

i. Any solicitation for leads – all communication types (requirements and restrictions)
ii. Gifts for referrals (requirements and restrictions)

l. Marketing in Health Care Setting
    i. Examples of "dos and don'ts," including, but not limited to:
        1. Conducting sales activities in common areas
        2. Conducting activities where patients get care
    ii. Conducting activities in long-term care facilities

m. Agent and Broker Compensation
    i. Compensation Eligibility
        1. Independent agent (eligible)
        2. Employed agent (agent/broker who only sells for one plan/Part D sponsor are exempt from compensation requirements)
        3. Referral fee
    ii. Definition of compensation
    iii. Compensation types and definitions
        1. Initial Compensation
        2. Renewal Compensation
        3. Referral Fees
    iv. Definition of "like plan type" and "unlike plan type" changes
    v. Guidance on compensation payments
        1. Compensation year is Jan. 1 through Dec. 31, regardless of beneficiary enrollment date
        2. Initial enrollment year payment is either a pro-rated amount or the full compensation
        3. Payment must be pro-rated for mid-year renewals
        4. Recoupment must occur for months an enrollee is not in the plan
        5. Recoupment for rapid disenrollment

4. Consistent with §§ 422.2274(c)(12) and 423.2274(c)(12), plans must ensure that all agents and brokers (employed, captive, and independent) discuss the following CMS-developed list of items during the marketing and sale of an MA or Part D plan, prior to the beginning of the enrollment process:

a. Review the beneficiary-specific information:
    i. What kind of health plan does the beneficiary wish to enroll in (such as low premium and higher copay, or vice versa)?
    ii. Are the beneficiary's current providers (primary care and specialists) in-network?.
    iii. Is the beneficiary's current pharmacy in-network? If not, explain that they will need to choose a new pharmacy.
    iv. Are the beneficiary's prescriptions on the formulary? If not, explain that they may have to pay the full price of the prescription.
    v. Does the beneficiary require hearing, dental, and/or vision coverage?
    vi. Does the beneficiary have any other healthcare needs, such as durable medical equipment or physical therapy?

vii. **Is the beneficiary's preferred hospital is in-network? If not, explain that they will need to pick a new one.**
viii. **Are there other preferred facilities that need to be in-network?**
ix. **Does the beneficiary have any other specific healthcare needs?**

b. **Review premiums, including Part B premium, {insert dollar amount} per month/quarter/year. [This one only applies if there is a premium >$0.] If applicable, review current premium vs. another plan premium.**
c. **Review beneficiary cost sharing such as deductibles, copays, and coinsurances. Go over deductible cost, PCP copay, Specialist copay, inpatient hospital copay, and any other copays for services/items the beneficiary needs.**
d. **Discuss the costs/limitations on dental, vision, and hearing.**
e. **Review coverage for out-of-network providers and services (e.g., except in emergency or urgent situations, plan does not cover services by out-of-network providers (i.e., doctors who are not listed in the provider directory)).**
f. **Review coverage outside the United States.**
g. **Explain the potential effect that enrolling in this plan will have on other, current coverage, which may in some cases mean that the beneficiary is disenrolled from their current health coverage (e.g., another MA plan, Medigap). Explain that this is not a hearing/dental/vision "rider" but a full plan.**
h. **Explain that the plan operates on a calendar year basis, so benefits may change on January 1 of the following year.**
i. **Explain that the Evidence of Coverage provides all of the costs, benefits, and rules for the plan.**
j. **Review how to file a complaint.**
k. **Items only applicable to certain plan types:**
    i. **Review PPO or PFFS out-of-network coverage.**
    ii. **Review need to have a specific chronic condition to qualify for a C-SNP.**
    iii. **Review needs to have Medicaid to qualify for a D-SNP.**
    iv. **Review needs to require an institutional level of care to qualify for an I-SNP.**
    v. **Review needs to maintain trust/custodial account in order to remain enrolled in an MSA plan.**
l. **Inform beneficiary of their right to cancel this enrollment as well as the specific date on which cancellation may occur.**

Appendix: Associated References

Content	Reference(s)
Original Medicare Basics	42 CFR- Subpart A General Provisions
Medicare Advantage Basics	42 CFR Part 422 • Subpart A—General Provisions • Subpart B—Eligibility, Election, and Enrollment • Subpart C—Benefits and Beneficiary Protections Medicare Managed Care Manual (MMCM) Ch. 1 MA Enrollment and Disenrollment Guidance
Part D Basics	42 CFR Part 423 • Subpart A—General Provisions • Subpart B—Eligibility and Enrollment Medicare Prescription Drug Benefit Manual (PDBM) Ch. 1 & 3
1876 Cost Plans	42 CFR Part 417MMCM Ch. 17 D Cost Plan Enrollment and
Extra Help	42 CFR Part 423 • Subpart P—Premiums and Cost-sharing Subsidies for Low Income Individuals • Subpart S—Special Rules for States-Eligibility Determinations for Subsidies and General Payment Provisions PDBM Ch. 13
Election Periods	42 CFR §422.62- Election of coverage under an MA plan 42 CFR §423.38- Enrollment periods MA Enrollment and Disenrollment Guidance Section 30
Enrollment and Disenrollment Process	42 CFR Part 422; Subpart B—Eligibility, Election, and Enrollment 42 CFR Part 423; Subpart B—Eligibility and Enrollment MA Enrollment and Disenrollment Guidance
Beneficiary Protections	42 CFR Part 422; Subpart C—Benefits and Beneficiary Protections 42 CFR Part 423; Subpart C – Benefits and Beneficiary Protections MMCM Ch. 17f; PDBM Ch. 5
Part C Organizational Determinations and Appeals, Part D Coverage Determinations and Redeterminations, and Grievances	42 CFR Part 422; Subpart M—Grievances, Organization Determinations, and Appeals 42 CFR Part 423; Subpart M—Grievances, Coverage Determinations, Redeterminations, and Reconsiderations Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
Overview of Marketing	42 CFR Part 422; Subpart V—Medicare Advantage Marketing Requirements 42 CFR Part 423; Subpart V—Marketing Requirements
Overview of Marketing Materials Requirements	42 CFR §422.2260 - 422.2276 42 CFR §423.2260 - 423.2276
Agent/Broker Compensation	42 CFR §422.2274- Agent, broker, and third-party requirements 42 CFR §423.2274- Agent, broker, and third-party requirements

Content	Reference(s)
Marketing Event Requirements	42 CFR Part 422; Subpart V—Medicare Advantage Marketing Requirements §422.2264 Beneficiary Contact 42 CFR Part 423; Subpart V—Marketing Requirements §423.2264 Beneficiary Contact
Marketing Event Type	42 CFR Part 422; Subpart V—Medicare Advantage Marketing Requirements §422.2264 (c) Events with beneficiaries 42 CFR Part 423; Subpart V—Marketing Requirements §423.2264(c) Events with beneficiaries

Agent and Broker Training & Testing
Sample Test

Below are sample test questions that may be used by Plans/Part D sponsors.

Part I: Medicare Basics

1) A prospective beneficiary asks an agent if plan XYZ has an urgent care benefit and if so, what the benefit includes. Where would the agent find this information for plan XYZ?
   A. Summary of Benefits
   B. Provider Directory
   C. Evidence of Coverage
   D. None of the above

2) If a beneficiary enrolled in an MA HMO tells you that she wants to see a specialist, you should tell her:
   A. You will likely need a referral from your primary care physician (PCP) to see a specialist. If you see your specialist without this referral, the plan may not pay for your visit.
   B. Call and make the appointment
   C. You do not need to see a specialist
   D. All of the above

3) True or False? Once a beneficiary is enrolled in an MA plan and has paid his plan-specific monthly premium, he no longer needs to pay his Part B premium.
   A. True
   B. False

4) Match the Medicare Part in the first column with the correct description in the second.

Medicare Part	Description
A. Part A B. Part B C. Part C D. Part D	1. Physician services, outpatient hospital care, lab tests, mental health services, some preventative services, and medical equipment considered medically necessary to treat a disease or condition 2. Prescription Drug Benefit 3. Hospital inpatient care, some SNF care, and home health and hospice care 4. An option for beneficiaries to receive Parts A and B benefits from an MA Plan offered by a private company that has a contract with Medicare.

Part II: Enrollment and Disenrollment

5) Mrs. Doe will turn 65 at the end of March and signed up for an MA plan in January during her Initial Coverage Election Period (ICEP). When will her coverage begin?
   A. On February 1
   B. On March 1
   C. On April 1
   D. On May 1

6) Which of the following periods provide an opportunity for a beneficiary to move from Original Medicare to an MA plan?
   A. October 15 through December 7
   B. January 1 through April 15
   C. January 1 through March 31
   D. Between six and twelve months after losing employer group coverage.
   E. All of the above

7) Which of the following conditions would qualify an MA plan member to switch plans during a Special Enrollment Period (SEP) (more than one may be correct)?
   A. The member recently moved into a nursing home.
   B. The member's plan was terminated.
   C. The member does not like his/her doctor.
   D. The member is not satisfied with the plan.
   E. The member has a change in permanent residence.
   F. The member was recently admitted into the hospital.

8) During a formal sales event held on October 5, an agent tells attendees, "You can enroll in Acme's Traditional Medicare Advantage HMO plan between October 15 and December 7, but the plan will not take effect until January 1. However, if you do not like the plan after you enroll, you have until February 14 to switch back to Original Medicare." Following the presentation, the agent assists a couple in filling out an enrollment form for Acme's Traditional HMO plan and tells the couple that she will "hold on to it" until the October 15 enrollment date. Which of the following statements are true (more than one may be true)?
   A. The agent is not allowed to assist beneficiaries in completing their enrollment form.
   B. The presenter provided incorrect Annual Election Period (AEP) information.
   C. The agent is not allowed to accept an enrollment prior to October 15.
   D. The presenter provided incorrect Medicare Advantage Open Enrollment Period (MA-OEP) information.

9) True or False: Plans are expected to submit beneficiary responses to the race and ethnicity fields on all MA and Part D enrollments.
   A. True
   B. False

Part III: Beneficiary Protections

10) Mrs. Doe has decided to file a grievance because she feels that she was treated with disrespect while communicating with a plan's customer services representative (CSR). What is the first step Mrs. Doe should take to file a grievance?
   A. File an appeal with the plan
   B. File an appeal with an Administrative Law Judge
   C. Contact the plan in writing or by telephone to file a grievance
   D. None of the above

11) For all MA plans, a dually eligible beneficiary will not have to pay cost-sharing for Medicare Part A and B services if they are in which of the categories below?
   A. QMB
   B. Full Benefit Dual Eligible (full Medicaid benefits)
   C. SLMB only
   D. QI
   E. A and B only
   F. All of the above

12) For ***all*** MA plans, an enrollee that chooses to join a PDP will be automatically disenrolled from his/her current plan.
   A. True
   B. False

13) A Medicare beneficiary is eligible for a dual-eligible special needs plan (D-SNP) if:
   A. The individual is enrolled in any Medicaid category
   B. The individual has full Medicaid benefits
   C. The individual receives the Part D low-income subsidy (Extra Help)
   D. The individual meets the D-SNP specific eligibility criteria, including limits on categories of dual eligibility, Medicaid eligibility, and/or age restriction

14) A plan may end an enrollee's membership if:
   A. The enrollee is away from the service area for more than 6 months and the plan doesn't have a visitor/travel benefit
   B. The enrollee is no longer entitled to Medicare Part A or enrolled in Part B benefits

C. For individuals enrolled in SNPs, the enrollee no longer meets the special needs status of the SNP (or deemed continued eligibility, if applicable)
D. All of the above

15) When can a full-benefit dually eligible individual elect a HIDE SNP?

A. Only during AEP
B. During AEP or OEP
C. In any month
D. In any month, if they are currently enrolled or in the process of enrolling in the HIDE SNP's affiliated Medicaid MCO.

Part IV: Communication and Marketing Regulations and Materials for Sales Agents/Brokers

16) True or False: A state insurance department would like to investigate a sales agent that they suspect is violating Medicare communication and marketing regulations. The plan does not need to provide information because the agent is licensed and has followed the guidelines to date.
A. True
B. False

17) Which of the following is NOT considered a Third-Party Marketing Organization (TPMO)?
A. A state licensed independent agent/broker
B. A lead generated organization
C. A member of the plan who speaks highly of the plan
D. A marketing agency that develops content for multiple MA plans

18) True or False: CMS requires plans to record the names of all attendees attending their plan-sponsored marketing/sales events.
A. True
B. False

Part V: Agent and Broker Compensation

19) A beneficiary enrolls into Acme Health Plan in November 2014 as an initial enrollment. Assuming the beneficiary remains enrolled in the plan in 2015, in what month does their first renewal cycle begin?
A. December 2014
B. January 2015
C. November 2015
D. December 2015

20) If a beneficiary who is a member of an MA plan enrolls in a different MA plan offered by another organization during the middle of an enrollment year, and the new organization does not use agent and brokers, which of the following statements are true?
    A. The new organization would continue to make payments to the enrolling agent from the previous organization.
    B. The initial organization would continue to pay the enrolling agent for one full renewal cycle.
    C. The new organization will not pay compensation to any agent or broker for the new enrollment and the organization offering the prior plan would have to recoup for the number of months the member was not in the plan.
    D. None of the above

Part VI: Medicare Marketing Activities

21) Mr. Smith, an agent with ACME Health Plan, is giving a sales presentation and wants to provide some food for his guests. What can Mr. Smith provide?
    A. A sit-down meal offered in a separate room, before or after the promotional portion of the event
    B. A buffet dinner
    C. Snacks such as cheese and crackers
    D. None of the above

22) In which of these situations must a Scope of Appointment form be collected at least 48 hours prior to the interaction between the agent and the individual with Medicare?
    A. A formal marketing event that a beneficiary did not pre-register to attend
    B. A one-on-one appointment occurring in the beneficiary's home on November 3rd
    C. An unscheduled meeting with a beneficiary who arrives at an agent's office without an appointment and requests information
    D. A person with Medicare calling in to a sales agent for the first time
    E. A and D
    F. All of the above scenarios require a Scope of Appointment form be collected.

23) All individual sales/marketing and enrollment calls between TPMOs and beneficiaries are required to be recorded.
    a. True
    b. False

Agent and Broker Training & Testing
Sample Test: Answer Key

Question	Topic	Answer	Explanation
1	Medicare Basics - Selling Multiple Plans: Information Location	**C**	Because the beneficiary asked if plan XYZ has an urgent care benefit and what the benefit includes, the only correct answer is C. If the beneficiary only wanted to know if plan XYZ has an urgent care benefit, the answer would be A and C.
2	Medicare Basics	**A**	Because the beneficiary is enrolled in an HMO, she should work with her PCP prior to seeing a specialist (except in an emergency).
3	Medicare Basics	**B**	The answer is false. Beneficiaries are required to continue paying their Part B premium (unless they receive Extra Help) in addition to any plan-specific premium.
4	Medicare Basics		**Option A = 3.** Part A of Medicare covers hospital inpatient care, some SNF care, and home health and hospice care. **Option B = 1.** Part B of Medicare covers physician services, outpatient hospital care, lab tests, mental health services, some preventative services, and medical equipment considered medically necessary to treat a disease or condition. **Option C = 4.** Part C of Medicare provides an option for beneficiaries to receive Parts A and B benefits from an MA Plan offered by a private company that has a contract with Medicare. **Option D = 2.** Part D of Medicare provides prescription drug benefit.
5	Enrollment and Disenrollment	**B**	The ICEP coverage begins the first day of the month of entitlement to Medicare Part A and Part B, OR the first of the month following the month the enrollment request was made (if after entitlement has occurred).

Question	Topic	Answer	Explanation
6	Enrollment and Disenrollment	**A**	The Annual Election Period (AEP) for enrolling in an MA Plan is October 15 through December 7. Answer B is incorrect because there is no enrollment period during these dates. Answer C is the Medicare Advantage Open Enrollment Period (MA-OEP), but this period does not provide an opportunity for an individual enrolled in Original Medicare to join an MA plan). Answer D is incorrect because the EGHP SEP ends three months after the individual's employer group coverage ends.
7	Enrollment and Disenrollment	**A, B and E**	If an individual moves into, resides in, or moves out of a long-term care facility (such as a nursing home) / she is eligible for a SEP. S/he would also be eligible for an SEP as a result of moving out of the plan's service area or if his/her current plan is terminated.
8	Enrollment and Disenrollment	**C and D**	Although agents may assist beneficiaries in completing their forms, an agent may not accept, collect, or take possession of completed enrollment forms before October 15 and may not encourage beneficiaries to mail the enrollment form to the plan prior to October 15. Further, although the agent provided the correct dates for the AEP (October 15 – December 7), she misstated the window for which a beneficiary may disenroll and revert back to Original Medicare. The MA-OEP is January 1 – March 31.
9	Enrollment and Disenrollment	**A**	MA and Part D plans are required to include the race and ethnicity fields on the enrollment form. While applicant response is optional, plans are expected to submit to CMS the beneficiary response to the race and ethnicity field, including confirming if the beneficiary did not provide the optional data.
10	Beneficiary Protections	**C**	The first step in the process for filing a grievance is to contact the health plan by telephone or in writing. An appeal is intended to handle different circumstances involving coverage decisions or organizational determinations.

Question	Topic	Answer	Explanation
11	Beneficiary Protections	**E**	The Qualified Medicare Beneficiary (QMB) program helps beneficiaries who are eligible for Medicare pay for their Medicare costs. This means that Medicaid will pay for the Medicare premiums, co-insurance and deductibles for Medicare covered services. Full Dual beneficiaries are individuals who are eligible for full Medicaid benefits and qualify for Medicaid to cover Medicare premiums, co-insurance and deductibles for Medicare covered services. Specified Low-Income Medicare Beneficiary (SLMB) – A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources. Qualifying Individual (QI) – This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, Medicaid pays full or a percentage of Medicare Part B premiums only.
12	Beneficiary Protections	**B**	The statement is false. A person who is enrolled in an MSA or an MA-PFFS plan without drug coverage and is joining a PDP will not be automatically disenrolled from the MSA or MA-PFFS plan. To disenroll, the beneficiary must call 1-800-MEDICARE or submit a written disenrollment request to the plan. A person enrolled in **any** MA coordinated care plan (HMO, PPO), or an MA-PFFS plan that includes drug coverage, who is joining a PDP will be automatically disenrolled from their current plan upon enrolling in a PDP.
13	Beneficiary Protections	**D**	The individual meets the D-SNP specific eligibility criteria, including limits on categories of dual eligibility, enrollment in an affiliated Medicaid plan and/or age restriction. Beneficiaries meet eligibility requirements for both Medicare (age requirement or qualifying disability) and Medicaid (individual's income and asset level falls below state determined thresholds determined by the state) and are enrolled in both.
14	Beneficiary Protections	**D**	A plan may end an enrollee's membership for any of the reasons listed (involuntary disenrollment), so long as the enrollee is part of a plan for which the rule applies.

Question	Topic	Answer	Explanation
15	Enrollment and Disenrollment	**D**	A dually eligible/LIS enrollee may use the monthly dual/LIS SEP to elect Original Medicare with a standalone Part D plan in any month. These members can also switch between PDPs in any month. A full benefit dually eligible individual may elect a FIDE, HIDE or AIP D-SNP in any month using the Integrated Care SEP, but only to align enrollment to the enrollee's Medicaid MCO. These enrollees can also use the SEP to switch between plans in any month. Eligible enrollees can only elect a coordination-only D-SNP and a regular MAPD plan during AEP or OEP.
16	Marketing and Communication Regulations and Materials for Sales Agents and Brokers	**B**	The statement is false. Plans must comply with requests from state insurance departments or other state agencies investigating sales agents licensed by that agency.
17	Marketing and Communication Regulations and Materials for Sales Agents and Brokers	**C**	A member of the plan who speaks highly of the plan is not marketing organization.
18	Marketing and Communication Regulations and Materials for Sales Agents and Brokers	**B**	The statement is false. There is no such requirement. On the contrary, any sign-in or attendance sheet distributed during an event must clearly indicate that providing personal information is optional. Similarly, agents are prohibited from insisting that attendees provide additional information (or implying that they are required to provide information) as a requirement for attending an event. Agents are also prohibited from requiring attendees to pre-register.
19	Agent and Broker Compensation	**B**	For purposes of determining compensation for initial enrollments and renewals, an enrollment year means the year beginning January 1 and ending December 31. In this example, the beneficiary's initial enrollment year ends December 31, 2014, and their first renewal year would be January 1, 2015 through December 31, 2015.
20	Agent and Broker Compensation	**C**	When a switch happens across organizations, and the new organization doesn't use agents and brokers, the new MA organization would not make payments. The initial plan must recoup the compensation paid for the number of months the member was not in the plan.

Question	Topic	Answer	Explanation
21	Medicare Marketing Activities	**C**	Meals (either provided or subsidized) are prohibited at marketing events where plan-specific benefits are discussed and plan materials are distributed. Refreshments and light snacks are permitted, however agents and brokers should consider the appropriateness of food products provided and should 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.
22	Medicare Marketing Activities	**B**	B is correct because collection of a Scope of Appointment form is required 48 hours before a scheduled personal marketing appointment where MA, MA-PD, PDP and Cost Plan products are to be discussed as indicated in 42 CFR §§ 422.2264(c)(3)(i) and 423.2264(c)(3)(i). This excludes in-bound calls and unexpected beneficiaries who wish to attend a pre-scheduled marketing event.
23	Medicare Marketing Activities	**A**	This statement is true. Enrollment and sales calls are required to be recorded in accordance with 42 CFR §§ 422.2274(g) and 423.2274(g). This includes TPMO sales and enrollment calls.