

Module 11 – Medicare Advantage and Other Medicare Health Plans

Section Objectives

- Define Medicare Advantage (MA) Plans
- Describe how MA Plans work
- Explain eligibility requirements and enrollment
- Recognize types of MA Plans
- Identify other Medicare Health plans
- Recall rights, protections, and appeals
- Summarize the Medicare Marketing Guidelines

Lesson 1: Medicare Advantage (MA) Plan Overview

What Is a Medicare Advantage Plan?

- Medicare Advantage (MA) Plans are health plan options that are approved by Medicare and run by private companies.
- They're part of the Medicare program and are sometimes called Part C.
- MA 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.
- MA Plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Original Medicare doesn't cover, such as vision or dental services or allowances. The plan may have special rules that its members need to follow.

How Medicare Advantage Plans Work

- In Medicare Advantage (MA) Plans, you receive all Medicare-covered Part A (Hospital Insurance) and Part B (Medical Insurance) 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 Medicare Health Maintenance Organizations (HMOs), you may only be able to see certain doctors or go to certain hospitals. You save the most money out of pocket when you obtain services through the plan's network.
- Benefits and cost sharing in an MA Plan may differ from Original Medicare.

It's important to note that when you join a Medicare Advantage (MA) Plan or other Medicare health plan you

- Are still in the Medicare program. Medicare pays these private health plans for your care every month whether you use services or not
- Still have Medicare rights and protections

- Will have the opportunity to join another MA Plan or return to Original Medicare, if the plan decides to stop participating in Medicare

Medicare Advantage Costs

If you join a Medicare Advantage (MA) Plan you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2015 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, such as

- An additional monthly premium to the plan
- Deductibles, coinsurance, and copayments

These costs may

- Be different from Original Medicare
- Vary from plan to plan
- Be higher if you go out of network

Who Can Join a Medicare Advantage Plan?

- Medicare Advantage (MA) Plans are available to most people with Medicare. To be eligible to join an MA Plan you must be enrolled in Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). You must also live in the plan's geographic service area.
- To join an MA Plan, you must also agree to
 - Provide the necessary information to the plan, such as your Medicare number, address, date of birth, and other important information
 - Follow the plan's rules
- You can only belong to one MA Plan at a time

To find out which MA Plans are available in your area, visit 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.

Medicare Advantage and End-Stage Renal Disease (ESRD)

- People with End-Stage Renal Disease (ESRD) usually can't join an Medicare Advantage (MA) Plan or other Medicare health plan. However, there are some exceptions. An individual with ESRD enrolled in employer-sponsored coverage, whether MA or commercial (i.e., non-Medicare), can enroll in another plan, provided the plan is part of the same parent organization and meets the criteria for doing so. For example, an individual who develops ESRD while enrolled in an employer group health plan may be allowed to enroll in an MA Plan offered by the same plan parent organization, provided there is no break between coverage. Medicare beneficiaries with ESRD who are already enrolled in an MA plan may also elect to enroll in another MA plan within the same parent organization provided that

- The new MA plan operates in the same state.
- The beneficiary meets all the other requirements for enrollment in that MA plan, (and as in the previous MA plan).
- CMS will permit a change from an Health Maintenance Organization (HMO) to a Preferred Provider Organization (PPO) or a Private-Fee-for-Service (PFFS) plan within the same parent organization, as long as the change meets all of the criteria.
- For the purpose of this policy, the term “parent organization” is defined as an entity that owns one or more contracts (H numbers) with CMS to provide MA plans.
- A person who receives a kidney transplant or no longer requires a regular course of dialysis treatment isn’t considered to have ESRD for purposes of MA eligibility.

NOTE: For more information on the enrollment exceptions for people with ESRD, see the Medicare Advantage enrollment and disenrollment guidance in Chapter 2 of the Medicare Managed Care Manual, §20.2.2, subsection #2, item (b.), available at [CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY-2015-MA-Enrollment-and-Disenrollment-Guidance.pdf](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY-2015-MA-Enrollment-and-Disenrollment-Guidance.pdf).

When You Can Join or Switch Medicare Advantage Plans

Initial Enrollment Period	<ul style="list-style-type: none"> ▪ 7-month period begins 3 months before the month you turn 65 ▪ Includes the month you turn 65 ▪ Ends 3 months after the month you turn 65
Medicare Open Enrollment Period “Open Enrollment”	<ul style="list-style-type: none"> ▪ October 15–December 7 ▪ Coverage begins January 1
Medicare due to a Disability	<ul style="list-style-type: none"> ▪ 7-month period begins 3 months before the 25th month of disability. ▪ Ends 3 months after the 25th month of disability.

Special Enrollment Periods (SEP)	<ul style="list-style-type: none"> ▪ Move out of your plan’s service area ▪ Plan leaves Medicare program or reduces its service area ▪ Leaving or losing employer or union coverage ▪ You enter, live at, or leave a long-term care facility ▪ You have a continuous SEP if you qualify for Extra Help ▪ Losing your Extra Help status ▪ You join or switch to a plan that has a 5-star rating ▪ Retroactive notice of Medicare entitlement ▪ Other exceptional circumstances
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NOTE: In the case of retroactive entitlement, there are special rules that allow for enrollment in a Medicare Advantage Plan, or Original Medicare and a Medigap policy. More information about conditions that allow an exception can be found in Chapter 2 of the “Medicare Managed Care Manual,” Section 30.4 at CMS.gov/medicare/health-plans/healthplansgeninfo/downloads/mc86c02.pdf.

5-Star Special Enrollment Period (SEP)	<ul style="list-style-type: none">▪ Can enroll in 5-star Medicare Advantage (MA), Prescription Drug Plan (PDP), Medicare Advantage Plan with prescription drug coverage (MA-PD), or Cost Plan▪ Enroll once per year from December 8, 2014–November 30, 2015▪ New plan starts first day of month after enrolled▪ Star ratings given once per year<ul style="list-style-type: none">• Ratings assigned in October and effective January 1st• Use Medicare Plan Finder to see star ratings<ul style="list-style-type: none">▫ Look at Overall Plan Rating to find eligible plans
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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.

Low Performing Plan

- A contract that gets less than 3 stars for their Part C or D summary rating for at least the last 3 years (i.e., rated 2.5 or fewer stars for the 2013, 2014, and 2015 Plan Ratings for Part C or Part D) will be marked with the above  icon on Medicare Plan Finder. Medicare sends the “Important Information About Your Medicare Plan Options,” CMS Product Number 11633 to members of these plans, giving them a one-time option to switch to another Medicare drug plan with 3 stars or better. Visit CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareManagedCareEligEnrol/Downloads/Feb2015_LPI_Notice_CMS-11633.pdf to view the notice in English and Spanish.
- The summary rating gives an overall score on the drug plan's quality and performance in many different topics that fall into 4 categories:
 - **Drug plan customer service:** Includes how well the plan handles member appeals.
 - **Member complaints and changes in the drug plan's performance:** Includes how often Medicare found problems with the plan, and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.

- **Member experience with the plan's drug services:** Includes ratings of member satisfaction with the plan.
- **Drug safety and accuracy of drug pricing:** Includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that is considered safer and clinically recommended for their condition.
- This information is gathered from several different sources. In some cases it is based on member surveys. In other cases, it is based on reviews of billing and other information that plans submit to Medicare results from Medicare's regular monitoring activities.

When You Can Leave Medicare Advantage Plans

<p>January 1 – February 14</p>	<ul style="list-style-type: none"> ▪ You can leave a Medicare Advantage (MA) Plan ▪ Switch to Original Medicare <ul style="list-style-type: none"> • Coverage begins first day of month after switch • May join Part D Plan <ul style="list-style-type: none"> ○ Drug coverage begins first day of month after plan gets enrollment ▪ May not join another MA Plan during this period ▪ May be able to buy a Medicare Supplement Insurance (Medigap) policy
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If you belong to a Medicare Advantage (MA) Plan or Medicare Advantage with Prescription Drug (MA-PD) 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.
- 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 Prescription Drug Plan to add drug coverage. Coverage begins the first of the month after the plan receives the enrollment form.

If you leave an MA Plan you may, or may not, be able to buy a Medicare Supplement Insurance (Medigap) policy. It will depend on your individual circumstances. Certain federal rights may apply. States may provide additional protections. You can buy a Medigap policy any time a plan will sell you one. See slide 15 for more information.

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

Medicare Advantage Trial Rights and Medigap

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

- You joined an MA Plan when first eligible for Medicare at 65 If you joined an MA Plan when you were first eligible for Medicare, you can choose from any Medigap policy within the first year of joining.
- You were in Original Medicare, enrolled in an MA Plan for the first time, and dropped a Medigap policy
 - If you had a Medigap policy before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another Medigap policy.

NOTE: The Medigap policy can't have prescription drug coverage even if you had it before, but you may be able to join a Medicare Prescription Drug Plan. You can buy a Medigap policy any time a plan will sell you one. Visit [Medicare.gov/Publications/Search/results.asp?PubID=02110&PubLanguage=1&Type=PubID](https://www.medicare.gov/Publications/Search/results.asp?PubID=02110&PubLanguage=1&Type=PubID) for more information about Medigap policies.

Types of Medicare Advantage Plans

Medicare Advantage Plans include

- Health Maintenance Organization (HMO)
- HMO Point-of-Service
- Preferred Provider Organization
- Special Needs Plan
- Private Fee-for-Service
- Medicare Medical Savings Account

Medicare Health Maintenance Organization (HMO) Plan

Can you get your health care from any doctor or hospital?	No. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out of network for certain services, usually for a higher cost. This is called an HMO with a point-of-service option.
Are prescription drugs covered?	In most cases, yes. Ask the plan. If you want Medicare drug coverage, you must join an HMO Plan that offers prescription drug coverage.
Do you need to choose a primary care doctor?	In most cases, yes.
Do you need a referral to see a specialist?	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.
What else do you need to know about this type of plan?	<ul style="list-style-type: none"> ▪ If your doctor or other health care provider leaves the plan, your plan will notify you and you can choose another plan doctor. ▪ If you get health care outside the plan's network, you may have to pay the full cost. ▪ It's important that you follow the plan rules. For example, the plan may require prior approval for certain services.

Medicare Preferred Provider Organization (PPO) Plan

Can you get your health care from any doctor or hospital?	In most cases, yes. PPOs have network doctors, other health care providers, and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.
Are prescription drugs covered?	In most cases, yes. If you want Medicare drug coverage, you must join a PPO Plan that offers prescription drug coverage. You may contact individual plans to find out if they offer prescription drug coverage.
Do you need to choose a primary care doctor?	No.
Do you need a referral to see a specialist?	In most cases, no.
What else do you need to know about this type of plan?	<ul style="list-style-type: none"> ▪ 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.

Medicare Special Needs Plans (SNPs)

Can you get your health care from any doctor or hospital?	You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).
Are prescription drugs covered?	Yes. All SNPs must provide Medicare prescription drug coverage (Part D).
Do you need to choose a primary care doctor?	Generally, yes.
Do you need a referral to see a specialist?	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

Medicare Special Needs Plans (SNPs) cont.

What else do you need to know about this type of plan?	<ul style="list-style-type: none"> ▪ A plan must limit plan membership to people in one of the following groups: <ol style="list-style-type: none"> 1. Those living in certain institutions (like a nursing home), or who require nursing care at home 2. Those eligible for both Medicare and Medicaid 3. Those with specific chronic or disabling conditions ▪ Plan may further limit membership ▪ Plan should coordinate your needed services and providers ▪ Plan should make sure providers that you use accept Medicaid if you have Medicare and Medicaid ▪ Plan should make sure that plan's providers serve people where you live, if you live in an institution
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Medicare Private Fee-for-Service (PFFS) Plan

Can you get your health care from any doctor or hospital?	In some cases, yes. You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. 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 choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, but you may pay more.
Are prescription drugs covered?	Sometimes. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan (Part D) to get coverage.
Do you need to choose a primary care doctor?	No.
Do you need a referral to see a specialist?	No.

What else do you need to know about this type of plan?	<ul style="list-style-type: none"> ▪ PFFS Plans aren't the same as Original Medicare or Medigap ▪ The plan decides how much you must pay for services ▪ Some PFFS Plans contract with a network of providers who agree to always treat you even if you've never seen them before ▪ Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before ▪ For each service you get, make sure that your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan's payment terms ▪ In an emergency, doctors, hospitals, and other providers must treat you
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Medicare Private Fee-for-Service (PFFS) Access Requirements

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

- Access requirements
 - Employer/union-sponsored Private Fee-for-Service (PFFS) Plans are required to establish contracts with a sufficient number of providers across service categories in their service areas.
 - Non-employer PFFS Plans operating in network areas must establish contracts with a sufficient number of providers across service categories to operate.
 - Network areas are those in which at least 2 network-based plans are operating with enrollment for a given plan year.

Medicare and Medical Savings Accounts

There are other, less common types of Medicare Advantage Plans, such as 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.

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

Medicare Advantage (MA) Plan Network Changes

Network-based Medicare Advantage (MA) Plans (e.g., Health Maintenance Organizations, Preferred Provider Organizations, and Private Fee-for-Service Plans with networks) can make changes to their network of contracted providers at any time during the year. It's important to note that the Centers for Medicare & Medicaid Services (CMS) has safeguards in place to ensure that people with Medicare 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 Part A (Hospital Insurance) and Part B (Medical Insurance) services through their remaining provider network. If the remaining network doesn't meet Medicare access and availability standards, plans must add new providers necessary to meet CMS's access requirements.

- Also, when an MA Plan makes a change in its provider network, it must provide written notification to 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 provide a list of alternative providers and allow beneficiaries to choose another provider.
- In most cases, mid-year provider network changes aren't a basis for an Enrollment Exception/Special Enrollment 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 doesn't get involved in contracting disputes.

Lesson 2: Other Medicare Plans

Other Medicare Health Plans

Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage (MA) Plans but are still part of Medicare. Some of these plans provide Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage, 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 health plans.

Medicare Cost Plans

- Medicare Cost Plans are a type of Medicare health plan available only in certain areas of the country.
- You can join even if you only have Medicare Part B (Medical Insurance).
 - 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 (Hospital Insurance) and Part B coinsurance and deductibles.
- You can join a Medicare Cost Plan anytime it's accepting new members.
- You can leave a Medicare Cost Plan anytime and return to Original Medicare.
- You can either get your Medicare prescription drug coverage from the plan (if offered), or you can buy a Medicare Prescription Drug Plan to add prescription drug coverage. You can only add or drop Medicare prescription drug coverage at certain times.

For more information about Medicare Cost Plans, contact the plan you're interested in. Your State Health Insurance Assistance Program (SHIP) can give you more information. To get the phone number for your SHIP, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Innovation Projects and Pilot Programs

Medicare innovation projects and pilot programs are special projects that test improvements in Medicare coverage, payment, and quality of care. They 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. To find more information, visit [CMS.gov/medicare/demonstration-projects/demoprojectsevalrpts/index.html](https://www.cms.gov/medicare/demonstration-projects/demoprojectsevalrpts/index.html), Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

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 provides all medically necessary services, including prescription drugs. Based on the circumstances, PACE might be a better choice for some people instead of getting care through a nursing home. PACE is a joint Medicare and Medicaid program that may be available in states that have chosen it as an optional Medicaid benefit. The qualifications for PACE vary from state to state.

Call your state Medical Assistance (Medicaid) office to find out about eligibility and if a PACE site is near you. Visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts) for the Medicaid office phone number in your state.

NOTE: Instructor may highlight local plans.

Lesson 3: Rights, Protections, and Appeals

Guaranteed Rights

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

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

Rights in Medicare Health Plans

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

- Choose health care providers in the plan so you can get covered health care.
- Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need to. Women have the right to go directly to a women's health care specialist within the plan without a referral for routine and preventive health care services.
- Know how your doctors are paid if you ask your plan. Medicare doesn't allow a plan to pay doctors in a way that interferes with 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's hours of operation should be different, or there aren't enough specialists in the plan to meet your needs). Check your plan membership materials or call your plan to find out how to file a grievance.
- Get a coverage decision or coverage information from your plan before getting a service to find out if the item or service will be covered or to get information about your coverage rules. You can also call your plan if you have questions about home health care rights and protections. Your plan must tell you if you ask.
- Privacy of personal health information.

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

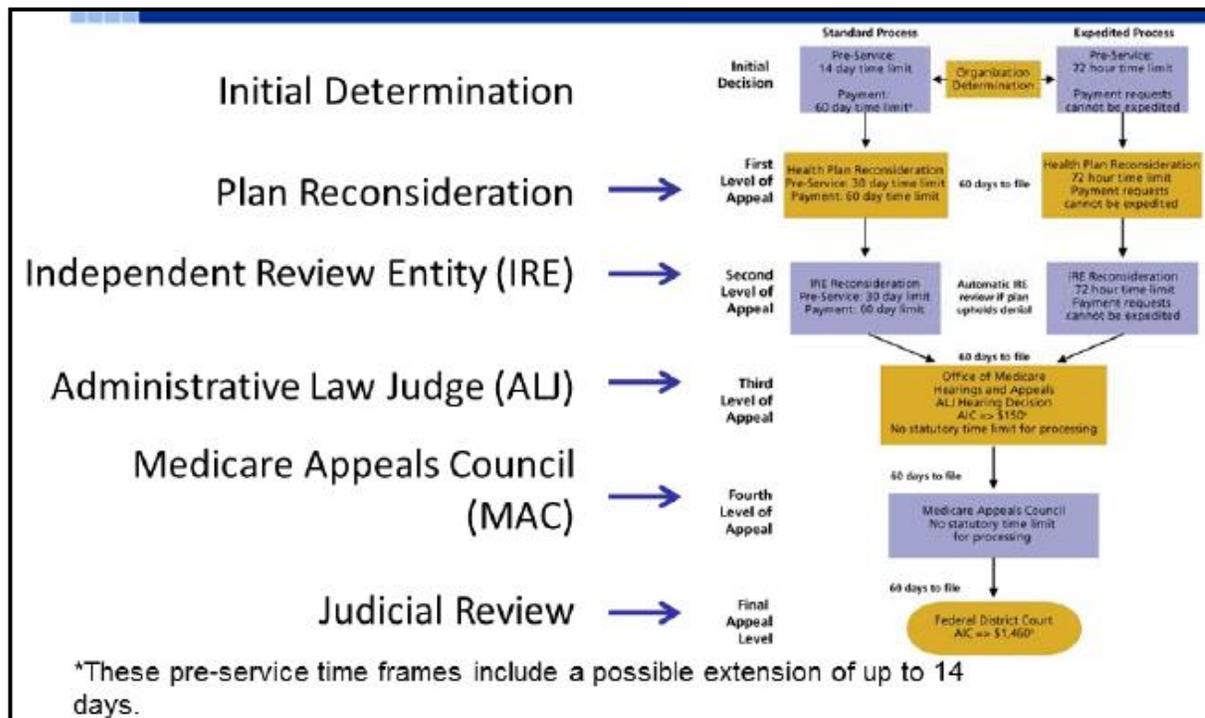
Appeals in Medicare Advantage Plans

The plan must tell you in writing how you can appeal if your plan won't pay for, doesn't allow, or stops or reduces a 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 (fast) 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 doesn't 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.

Medicare Part C Appeals Process



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

If you ask your plan to provide or pay for an item or service and your request is denied, you can appeal the plan's initial decision (the "organization determination"). You'll get a notice explaining why your plan denied your request and instructions on how to appeal your plan's decision.

There are 5 levels of appeals. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so.

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

- Reconsideration by the plan
- Reconsideration by the Independent Review Entity
- Hearing with the Administrative Law Judge—the amount of your claim must meet a minimum dollar amount, a figure that's updated yearly (\$150 in 2015)
- Review by the Medicare Appeals Council
- Review by a federal district court—to get a review by a federal court, the remaining amount in controversy of your case must meet a minimum dollar amount that's updated yearly (\$1,460 in 2015)

For more information, visit www.CMS.gov/Medicare/Appeals-and-rievances/OrgMedFFSAppeals/index.html.

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

Rights If You File an Appeal With Your Medicare Health Plan

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

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

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

Marketing Materials

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

CMS also creates model materials, such as the Provider and Pharmacy Directories.

NOTE: For more information, see the resources slide at the end of this presentation for a link to the MMG. 40

Marketing Reminders

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

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

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

NOTE: A contract that gets less than 3 stars for its Part C or D summary rating for at least the last 3 years (i.e., rated 2.5 or fewer stars for the 2013, 2014, and 2015 Plan Ratings for Part C or Part D), will be marked with the above icon on Medicare Plan Finder.

Disclosure of Plan Information for New and Renewing Members

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

This requirement includes the annual dissemination of the following that must be received by members no later than September 30 each year:

- Standardized Annual Notice of Change and Evidence of Coverage as applicable
- Low Income Subsidy (LIS) rider. This comes from the plan if someone qualifies for Extra Help and tells them how much help they'll get next year toward their drug plan premium, deductible, and copayments.
- Comprehensive formulary or abridged formulary including information on how the beneficiary can obtain a complete formulary (Part D sponsors only)
- Membership identification card (required only at the time of enrollment and as needed or required by plan sponsor post-enrollment)

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

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

Required documents for new enrollees are expected to be provided no later than 10 calendar days from receipt of CMS's confirmation of enrollment, or by the last day of the month prior to the effective date, whichever is later.

Nominal Gift Reminders

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. The Centers for Medicare & Medicaid Services currently defines nominal value in the Medicare Marketing Guidelines (MMG), Section 70.1, as an item worth \$15 or less, based on the fair market value of the item. Nominal gifts may not be in the form of cash or other monetary rebates.

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

Unsolicited Beneficiary Contact

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

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

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

Organizations may do the following:

- Make outbound calls to existing members to conduct normal business related to enrollment in the plan
- Call former members after the disenrollment effective date to conduct a disenrollment survey for quality improvement purposes
- Contact their members who are eligible for Extra Help, call 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., completing a business reply card)

Cross-Selling Prohibition

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

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 (known as HIPAA) rules.

Scope of Appointment Reminders

The Medicare Marketing Guidelines require 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 Medicare Advantage, Medicare Prescription Drug Plans, Medigap, or other Medicare health-related offerings) 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 coverage choices without pressure.

- Before a marketing appointment, the beneficiary must agree to the scope of the appointment. Documentation of the scope of the appointment by the plan can be in writing or recorded by telephone. The Scope of Appointment should be signed by the beneficiary at least 48 hours prior to the scheduled appointment, when practicable. If the agent is unable to get the signature 48 hours in advance, the agent should document the reason.
 - Example: A 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.
- 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 aren't identified prior to the in-home appointment will require a separate appointment.

Marketing in Health Care Settings

Organizations may not conduct marketing activities in health care settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or 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 aren't limited to: waiting rooms, exam rooms, hospital patient rooms, dialysis centers, and pharmacy counter areas (where patients wait for services or interact with pharmacy providers and obtain medications). 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.

Promotional Activity Reminders

Medicare Advantage (MA) and Medicare Prescription Drug (PDP) Plans 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 couldn't be reasonably considered a meal, and/or that multiple items aren't being "bundled" and provided as if a meal.

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

Educational Event Reminders

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).

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

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

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.

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

Rewards and Incentives

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

Each unique rewards and incentives program offered by an MAO must

- Not discriminate against enrollees based on race, gender, chronic disease, institutionalization, frailty, health status, or other impairments
- Be designed so that all enrollees are able to earn rewards
- Are subject to sanctions at 42 CFR§422.752(a)(4)
- Be offered in connection with the entire service or activity
- Be offered to all eligible members without discrimination
- Have a value that may be expected to affect enrollee behavior but not exceed the value of the health-related service or activity itself
- Otherwise comply with all relevant fraud and abuse laws, including, when applicable, the anti-kickback statute and civil money penalty prohibiting inducements to beneficiaries

- MAOs are still required to abide by certain restrictions. Meaning that the rewards and incentives program may not
 - Be offered in the form of cash or other monetary rebates or
 - Be used to target potential enrollees
- At this time, rewards and incentives only apply to Part C

NOTE: For more information, see Chapter 4 of the Medicare Managed Care Manual, [CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf).

Licensure and Appointment of Agents

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

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

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

Reporting of Terminated Agents

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

Agent/Broker Compensation Rules

The Centers for Medicare & Medicaid Services 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.

Agent/Broker Compensation Definition

The Centers for Medicare & Medicaid Services (CMS) defines compensation to include monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to commissions, bonuses, gifts, prizes, awards, referral fees, and finder's fees.

- The compensation year is January 1 through December 31 of each year.
- Initial compensation is paid at or below the fair market value cut-off amounts published by CMS annually. Additionally, an “unlike plan type” move would necessitate an initial compensation. These types of moves include the following:
 - A Medicare Advantage (MA) or Medicare Advantage with Prescription Drug (MA-PD) Plan to a Prescription Drug Plan (PDP) or Section 1876 Cost Plan
 - A PDP to a section 1876 Cost Plan or an MA (or MA-PD) Plan
 - A section 1876 Cost Plan to an MA (or MA-PD) Plan or PDP
- Renewal compensation is paid for each enrollment in Year 2 and beyond, up to 50% of the current fair market value. These types of moves include the following:
 - A PDP to another PDP
 - An MA or MA-PD to another MA or MA-PD
 - A Section 1876 Cost Plan to another Section 1876 Cost Plan

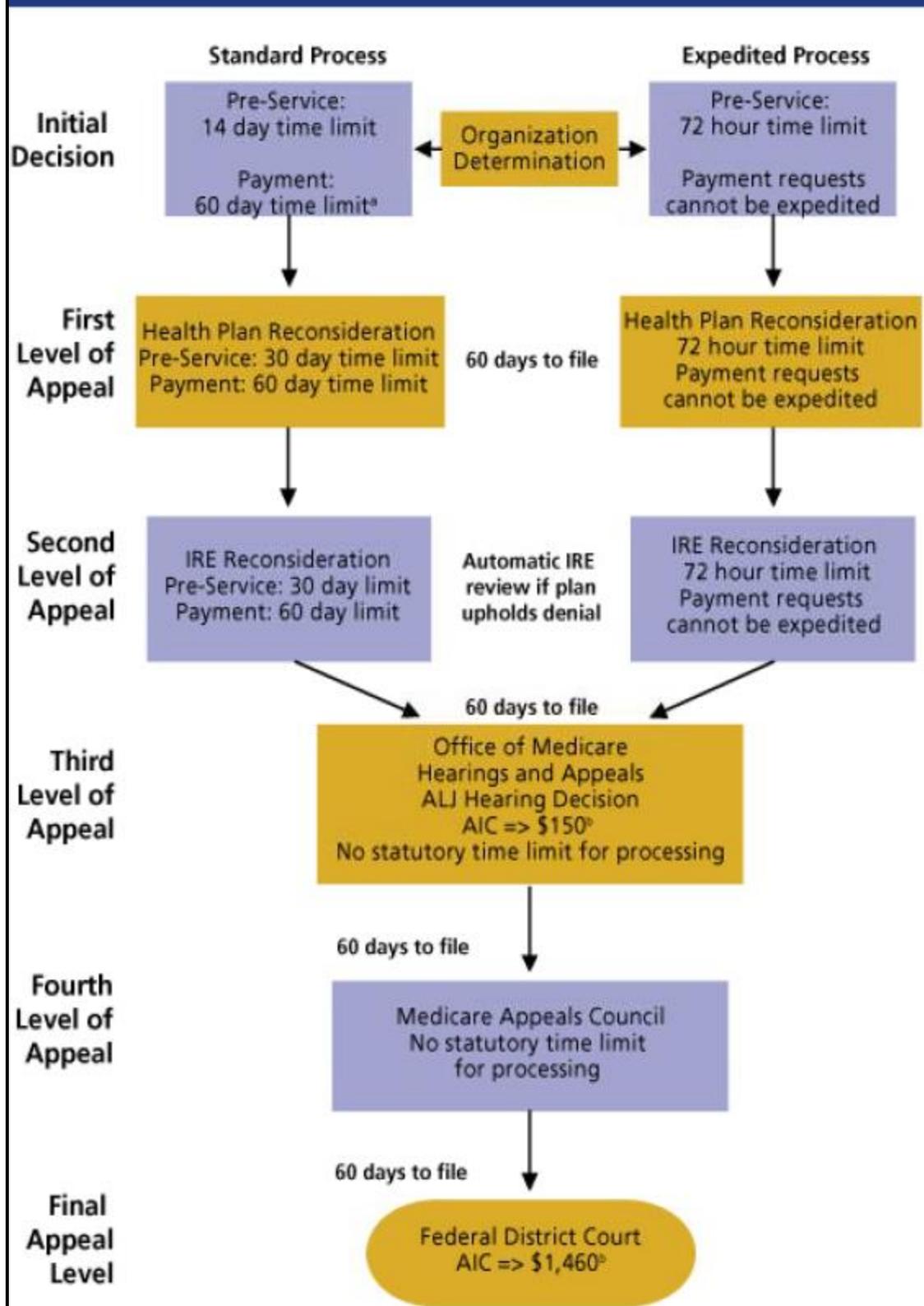
Agent/Broker Training and Testing

Medicare Advantage Organizations and Part D plan sponsors must ensure that brokers and agents selling Medicare products are trained and tested annually on Medicare rules and regulations, and on plan details specific to the plan products being sold by the brokers and agents. This requirement applies to contracted and employed agents. Training and testing must be completed by passing a test with 85% prior to the start of the new marketing season for the agent/broker to market after that date.

Medicare Advantage and Other Medicare Plans Resource Guide

Resources	Medicare Products
<p>Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Medicare.gov</p> <p>CMS.gov</p> <p>Social Security 1-800-772-1213. TTY users should call 1-800-325-0778. socialsecurity.gov</p> <p>Railroad Retirement Board 1-877-772-5772. TTY users should call 1-312-751-4701. RRB.gov</p>	<p>2015 Medicare Marketing Guidelines CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c03.pdf</p> <p>Medicare Managed Care Manual CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-iOMs-Items/CMS019326.html</p> <p>State Health Insurance Assistance Programs For telephone numbers call CMS 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.</p> <p>Affordable Care Act HealthCare.gov/law/full/index.htm</p>
<p>“Medicare & You Handbook” CMS Product No. 10050</p> <p>“Have You Done Your Yearly Medicare Plan Review?” CMS Product No. 11220</p> <p>“Medicare Supplement Insurance, Getting Started” CMS Product No. 11575</p> <p>“Your Guide to Medicare Private Fee-for-Service Plans” CMS Product No. 10144</p> <p>“Understanding Medicare Enrollment Periods” CMS Product No. 11219</p> <p>“Your Guide to Medicare Savings Account Plans” CMS Product No. 11206</p> <p>“Your Guide to Special Needs Plans” CMS Product No. 11302</p> <p>To access these products View and order single copies at Medicare.gov/publications. Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.</p>	

Part C (MA) Process



Appendix B—Appeals Flowcharts Footnote

a: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days;

b: The AIC requirement for all ALJ hearings and Federal District Court hearings is adjusted annually in accordance with the medical care component of the Consumer Price Index.;

AIC = Amount in Controversy;

ALJ = Administrative Law Judge;

MAC = Medicare Administrative Contractor;

IRE = Independent Review Entity;

QIC = Qualified Independent Contractor;

This chart reflects the **CY 2015 AIC** amounts.

Acronyms

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