



**Centers for Medicare & Medicaid Services  
National Training Program  
Instructor Information Sheet**

**Module 11 - Medicare Advantage and Other Medicare Health Plans**

**Module Description**

The lessons in this module explain the rights and protections afforded to Medicare beneficiaries whether they are enrolled in Original Medicare, a Medicare Advantage (MA) Plan (like a Health Maintenance Organization or Preferred Provider Organization), other Medicare health plan (like a Medicare Cost Plan or Program of All-Inclusive Care for the Elderly), or a Medicare Prescription Drug Plan.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers familiar with the Medicare program who would like to have prepared information for presentations.

**Objectives**

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

**Target Audience**

This comprehensive module is designed for presentation to trainers and other information givers.

**Time Considerations**

The module consists of 63 PowerPoint slides with corresponding speaker's notes and quiz questions. It has a resource guide and NTP contact slide to reference. It can be presented in 45 minutes. Allow approximately 20 more minutes for discussion, questions, and answers. Additional time may be added for add-on activities.

**Course Materials**

Materials are self-contained within the module. This module contains six "Check Your Knowledge" questions that give participants the opportunity to apply the module concepts in a real-world setting. Additional slides display as resources and Centers for Medicare & Medicaid Services National Training Program summary slide with email contact information.

# Module 11 – Medicare Advantage and Other Medicare Health Plans

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## Session Objectives

- This session will help you to
  - Define Medicare Advantage (MA) Plans
  - Recognize how MA Plans work
  - Explain eligibility requirements and enrollment
  - Identify types of MA Plans
  - Identify other Medicare plans
  - Recognize rights, protections, and appeals
  - Summarize Medicare Marketing Guidelines

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Medicare Advantage Plans and Other Medicare Plans

This session will help you to

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

## Lesson 1 — Medicare Advantage (MA) Plan Overview

- Define MA Plans
- How MA Plans work
- When you can join or switch plans
- Types of MA Plans

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Medicare Advantage Plans and Other Medicare Plans

Lesson 1, “Medicare Advantage (MA) Plan Overview,” will provide you with the following information:

- How to define MA Plans
- How MA Plans work
- When you can join a plan or switch plans
- Types of MA Plans

## What Is a Medicare Advantage Plan?

- Health plan options
  - Approved by Medicare
  - Run by private companies
- Part of the Medicare program
- Sometimes called Part C
- Available across the country
- Provide Medicare-covered benefits
  - May cover extra benefits

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Medicare Advantage Plans and Other Medicare 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.
- 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 extra vision or dental services. The plan may have special rules that its members need to follow.

## How Medicare Advantage Plans Work

- Receive services through the plan
  - All Part A and Part B covered services
  - Some plans may provide additional benefits
- Most plans include prescription drug coverage
- You may have to visit network doctors/hospitals
- May differ from Original Medicare
  - Benefits
  - Cost-sharing

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Medicare Advantage Plans and Other Medicare Plans

- In Medicare Advantage (MA) Plans, you receive all Part A (Hospital Insurance) and Part B (Medical Insurance) 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 Health Maintenance Organizations (HMOs), you may only be able to see certain doctors or go to certain hospitals.
- Benefits and cost-sharing in an MA Plan may differ from Original Medicare.

## How Medicare Advantage (MA) Plans Work Continued

- You are still in the Medicare program
  - Medicare pays the plan every month for your care
- You still have Medicare rights and protections
- If the plan leaves Medicare you can
  - Join another MA Plan, or
  - Return to Original Medicare

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Medicare Advantage Plans and Other Medicare Plans

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

- You still pay the Part B premium
  - A few plans may pay all or part for you
  - State assistance for some
- You pay plan an additional monthly premium
- You pay deductibles, coinsurance, and copayments
  - Different from Original Medicare
  - Vary from plan to plan
  - May be higher if out-of-network

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Medicare Advantage Plans and Other Medicare Plans

If you join a Medicare Advantage (MA) Plan you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2014 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

- 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?

- Eligibility requirements
  - Entitled to Medicare Part A (Hospital Insurance)
  - Enrolled in Medicare Part B (Medical Insurance)
  - Live in plan service area
  - Usually no End-Stage Renal Disease (ESRD) at enrollment
- To join you must also
  - Provide necessary information to the plan
  - Follow the plan rules
  - Belong to one plan at a time

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Medicare Advantage Plans and Other Medicare Plans

- Medicare Advantage (MA) Plans are available to most people with Medicare. To be eligible to join a Medicare Advantage Plan you must be entitled to Medicare Part A (Hospital Insurance) 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 off of group coverage without a break between coverage. A person who receives a kidney transplant and no longer requires a regular course of dialysis treatment isn't 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
  - Belong to only one Medicare Advantage Plan at a time

To find out what Medicare Advantage Plans are available in your area, visit [medicare.gov](http://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.

### Need more information?

More information on the enrollment exceptions for people with ESRD can be found in Section 20.2 of the Medicare Advantage enrollment and disenrollment guidance available at [cms.hhs.gov/medicare/eligibility-and-enrollment/medicaremangcareeligenrol/downloads/cy-2014-cost-plan-enrollment-and-disenrollment-guidance-r.pdf](http://cms.hhs.gov/medicare/eligibility-and-enrollment/medicaremangcareeligenrol/downloads/cy-2014-cost-plan-enrollment-and-disenrollment-guidance-r.pdf).



## When You Can Join or Switch Medicare Advantage Plans

### Initial Enrollment Period

- 7-month period begins 3 months before the month you turn 65
- Includes the month you turn 65
- Ends 3 months after the month you turn 65

### Medicare Open Enrollment Period “Open Enrollment”

- October 15 – December 7
- Coverage begins January 1

- Plans must be allowing new members to join

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Medicare Advantage Plans and Other Medicare Plans

- You can join a Medicare Advantage (MA) Plan during the following times:
  - When you first become eligible for Medicare, i.e., during your Initial Enrollment Period, which begins 3 months immediately before your first entitlement to both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
  - During the Medicare Open Enrollment Period (OEP).
- You can switch to another MA Plan or to Original Medicare during the OEP, also known as the Annual Enrollment Period. 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 Centers for Medicare & Medicaid Services (CMS)–approved capacity limit or a CMS-issued enrollment sanction is in effect.

## When You Can Join or Switch Plans

### Special Enrollment Periods (SEP)

- 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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Medicare Advantage Plans and Other Medicare Plans

You may be able to join or switch plans if any of these special circumstances that grant a Special Enrollment Period (SEP) apply to 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, meaning you can enroll in or switch your plan at any time)
- Lose your Extra Help status
- Join or switch to a plan that has a 5-star rating
- 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.

### Need more information?

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 at [cms.gov/medicare/health-plans/healthplansgeninfo/downloads/mc86c02.pdf](https://www.cms.gov/medicare/health-plans/healthplansgeninfo/downloads/mc86c02.pdf).



When You Can Join or Switch MA Plans	
<b>5-Star Special Enrollment Period (SEP)</b>	<ul style="list-style-type: none"> <li>▪ Can enroll in 5-star Medicare Advantage (MA), Prescription Drug Plan (PDP), Medicare Advantage Plan with prescription drug coverage (MA-PD), or Cost Plan</li> <li>▪ Enroll at any point during the year               <ul style="list-style-type: none"> <li>• Once per year</li> </ul> </li> <li>▪ New plan starts first day of month after enrolled</li> <li>▪ Star ratings given once a year               <ul style="list-style-type: none"> <li>• Ratings assigned in October of the past year</li> <li>• Use Medicare Plan Finder to see star ratings                   <ul style="list-style-type: none"> <li>▫ Look at Overall Plan Rating to find eligible plans</li> </ul> </li> </ul> </li> </ul>
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- Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall star ratings to plans. Plans get rated from 1 to 5 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 (MA)-only plan, a 5-star MA 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.
- The Centers for Medicare & Medicaid Services (CMS) also created a coordinating SEP for prescription drug plans. This SEP lets people who enroll in certain types of 5-star plans without drug coverage choose a prescription drug plan, 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 [medicare.gov/find-a-plan](http://medicare.gov/find-a-plan). 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.

**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.

## When You Can Leave Medicare Advantage Plans

**January 1 –  
February 14**

- You can leave MA Plan
- Switch to Original Medicare
  - Coverage begins first day of month after switch
- May join Part D Plan
  - Drug coverage begins first day of month after plan gets enrollment
- May not join another MA Plan during this period

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Medicare Advantage Plans and Other Medicare Plans

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.
- 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.

You may not join another MA Plan during this period. It's important to remember that anytime you enroll in a new MA 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.

## Special Enrollment Period Trial Rights

- People who join a Medicare Advantage Plan for the first time
  - When first eligible at 65 or
  - Leave Original Medicare and drop Medigap policy
- Can disenroll during first 12 months
  - Return to Original Medicare
  - Have guaranteed issue rights for Medigap

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Medicare Advantage Plans and Other Medicare Plans

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

- Joined an MA Plan when first eligible for Medicare at 65
- Were in Original Medicare, enrolled in an MA Plan for the first time, and dropped a Medigap (Medicare supplement insurance) 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 policy.

## **Types of Medicare Advantage Plans**

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

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Medicare Advantage Plans and Other Medicare Plans

There are six types of Medicare Advantage Plans:

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

<b>Medicare Health Maintenance Organization (HMO) Plan</b>	
<b>Can you get your health care from any doctor or hospital?</b>	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.
<b>Are prescription drugs covered?</b>	In most cases, yes. Ask the plan. If you want Medicare drug coverage, you must join an HMO Plan that offers prescription drug coverage.
<b>Do you need to choose a primary care doctor?</b>	In most cases, yes.
<b>Do you need a referral to see a specialist?</b>	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.
<b>What else do you need to know about this type of plan?</b>	<ul style="list-style-type: none"> <li>▪ If your doctor or other health care provider leaves the plan, your plan will notify you and you can choose another plan doctor.</li> <li>▪ If you get health care outside the plan's network, you may have to pay the full cost.</li> <li>▪ It's important that you follow the plan rules. For example, the plan may require prior approval for a certain service.</li> </ul>
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- 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 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.
- There are other things you should be aware of:
  - 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. For example, the plan may require prior approval for a certain service.

Medicare Advantage Plans 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.

<b>Medicare Preferred Provider Organization (PPO) Plan</b>	
<b>Can you get your health care from any doctor or hospital?</b>	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.
<b>Are prescription drugs covered?</b>	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.
<b>Do you need to choose a primary care doctor?</b>	No.
<b>Do you need a referral to see a specialist?</b>	In most cases, no.
<b>What else do you need to know about this type of plan?</b>	<ul style="list-style-type: none"> <li>▪ PPO Plans aren't the same as Original Medicare or Medigap.</li> <li>▪ Medicare PPO Plans usually offer extra benefits than Original Medicare, but you may have to pay extra for these benefits.</li> </ul>
05/01/2014 Medicare Advantage Plans and Other Medicare Plans	

- In a Medicare Preferred Provider Organization (PPO) Plan you have PPO network doctors and hospitals; however, you can also use out-of-network providers for covered services, usually for a higher cost.
- In most cases, prescription drugs are covered. If you want 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.
- You don't need to choose a primary care doctor and don't have to get a referral to see a specialist.
- There are other things you should be aware of:
  - PPO Plans aren't the same as Original Medicare or Medigap (Medicare supplement insurance) policies.
  - Medicare PPO Plans may also offer extra benefits that aren't available under Original Medicare, but you may have to pay extra for these benefits.

Medicare Advantage 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.

<b>Medicare Special Needs Plans (SNPs)</b>	
<b>Can you get your health care from any doctor or hospital?</b>	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).
<b>Are prescription drugs covered?</b>	Yes. All SNPs must provide Medicare prescription drug coverage (Part D).
<b>Do you need to choose a primary care doctor?</b>	Generally, yes.
<b>Do you need a referral to see a specialist?</b>	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.
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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 need to choose a primary care doctor.

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

Medicare Special Needs Plans (SNPs)	
<b>What else do you need to know about this type of plan?</b>	<ul style="list-style-type: none"> <li>▪ A plan must limit plan membership to people in one of the following groups:               <ul style="list-style-type: none"> <li>• Those living in certain institutions</li> <li>• Those eligible for both Medicare and Medicaid</li> <li>• Those with specific chronic or disabling conditions</li> </ul> </li> <li>▪ Plan may further limit membership</li> <li>▪ Plan should coordinate your needed services and providers</li> <li>▪ Plan should make sure plan's providers that you use accept Medicaid if you have Medicare and Medicaid</li> <li>▪ Plan should make sure that plan's providers serve people where you live, if you live in an institution</li> </ul>
05/01/2014	Medicare Advantage Plans and Other Medicare Plans

There are other things you need to know about Medicare Special Needs Plans (SNPs):

- 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
  - People who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease, 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's doctors or other health care providers you use accept Medicaid.
- If you live in an institution, make sure that plan's doctors or other health care providers serve people where you live.

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 Private Fee-for-Service (PFFS) Plan

<b>Can you get your health care from any doctor or hospital?</b>	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.
<b>Are prescription drugs covered?</b>	Sometimes. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan (Part D) to get coverage.
<b>Do you need to choose a primary care doctor?</b>	No.
<b>Do you need a referral to see a specialist?</b>	No.
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- 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.
- 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.
- Prescription drugs are sometimes covered. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan 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.

## Medicare Private Fee-for-Service (PFFS) Plan

### What else do you need to know about this type of plan?

- 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.

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

Other things you need to know about Medicare Private-Fee-for-Service (PFFS) Plans:

- 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.

## Private Fee-for-Service (PFFS) Access Requirements

- Employer PFFS Plans must meet access requirements
  - Plans may meet access requirements
    - Through a contracted network of providers
- Where two or more network-based Medicare Advantage Plan options exist
  - Non-employer PFFS plans must meet access requirements through contracts with providers

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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* 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 two network-based plans are operating with enrollment for a given plan year.

## Less Common Medicare Advantage Plans

- Health Maintenance Organization Point-of-Service Plans
  - May allow out-of-network services
- Medical Savings Account Plans
  - Combine high deductible plan with bank account
  - Medicare deposits money into account
  - Use money to pay for services

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

There are other, less common types of Medicare Advantage Plans:

- Health Maintenance Organization Point-of-Service 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 MSA Plans, visit [medicare.gov/pubs/pdf/11206.pdf](https://www.medicare.gov/pubs/pdf/11206.pdf) to view “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.



## Medicare Advantage (MA) Plan Network Changes

- Many types of MA plans have provider networks
- Plans may change networks at any time
  - Must protect beneficiaries from interruptions in medical care
  - Must maintain adequate access to services
  - Must notify beneficiaries who see affected providers
    - At least 30 days prior to termination
- Mid-year network changes aren't a basis for a Special Enrollment Period

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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.
- Loss of a provider network during the year isn't 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.

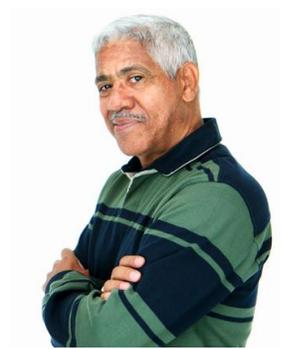
CMS doesn't get involved in contracting disputes.

## Check Your Knowledge—Question 1



Medicare Advantage Plans are sometimes called

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



Refer to page 65 to check your answers.

## Check Your Knowledge—Question 2



For most people, when you enroll in a Medicare Advantage Plan, you are no longer required to pay your monthly Medicare Part B premium.

- a. True
- b. False



Refer to page 65 to check your answers.

## Lesson 2 — Other Medicare Plans

- Medicare Cost Plans
- Medicare Innovation Projects and Pilot Programs
- Programs of All-Inclusive Care for the Elderly

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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

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

## Other Medicare Plans

- Other types of Medicare health plans that provide health care coverage aren't part of Medicare Advantage
  - But are still part of Medicare
  - Some provide Part A and/or Part B coverage
  - Some provide Medicare prescription drug coverage

05/01/2014

Medicare Advantage Plans and Other Medicare 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 plans. Instructors are encouraged to insert slides and information specific to the plans available in their area.

## Medicare Cost Plans

- Available in limited areas
- Must have Part B to join
- Can see a non-network provider
  - Services covered under Original Medicare
- Join anytime new members being accepted
- Leave anytime and return to Original Medicare
- Get Medicare prescription drug coverage
  - From the plan (if offered)
  - Join a separate Medicare prescription drug plan

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Medicare Advantage Plans and Other Medicare 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 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 is 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.

### 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 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

- Special projects that test improvements in
  - Medicare coverage
  - Payment
  - Quality of care
- Eligibility usually limited
  - Specific group of people or specific area of country
- Examples of how they help shape Medicare
  - MA Plan for End-Stage Renal Disease patients
  - New Medicare preventive services

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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?

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](https://www.medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



## Medicare Programs of All-Inclusive Care (PACE) Plans

- PACE for the Elderly
- Combine services for frail elderly people
  - Medical, social, and long-term care services
  - Include prescription drug coverage
- Alternative to nursing home care
- Only in states that offer it under Medicaid
- Qualifications vary from state to state
  - Contact state Medical Assistance office for information

05/01/2014

Medicare Advantage Plans and Other Medicare 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 programs provide 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, 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—Question 3



Programs of All-Inclusive Care for the Elderly are a type of Medicare Advantage Plan.

- a. True
- b. False



Refer to page 65 to check your answers.

## Lesson 3 — Rights, Protections, and Appeals

- Guaranteed Rights and Protections
- Appeals
- Required Notices
- New Medicare Advantage Plan (Part C)  
Explanation of Benefits

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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

- Guaranteed Rights and Protections
- Appeals
- Required Notices
- New Medicare Advantage Plan (Part C) Explanation of Benefits

## Guaranteed Rights

- To get needed health care services
- To receive easy-to-understand information
- To have personal medical information kept private

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

All people with Medicare have certain guaranteed rights and protections. You have these rights and protections whether you're 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
  - To have your personal medical information kept private

## Rights in Medicare Health Plans

- Choice of health care providers
- Access to health care providers (treatment plan)
- Know how your doctors are paid
- Fair, efficient, and timely appeals process
- Grievance process
- Coverage/payment information before service
- Privacy of personal health information

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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

- To choose health care providers in the plan so you can get covered health care.
- To 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.
- To 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.
- To 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.
- To 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.



### Need more information?

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

## Appeals in Medicare Advantage Plans

- Plan must say in writing how to appeal if it
  - Won't pay for a service
  - Doesn't allow a service
  - Stops or reduces course of treatment
- Can ask for expedited (fast) decision
  - Plan must decide within 72 hours
- See plan membership materials
  - Instructions on how to file an appeal or grievance

05/01/2014

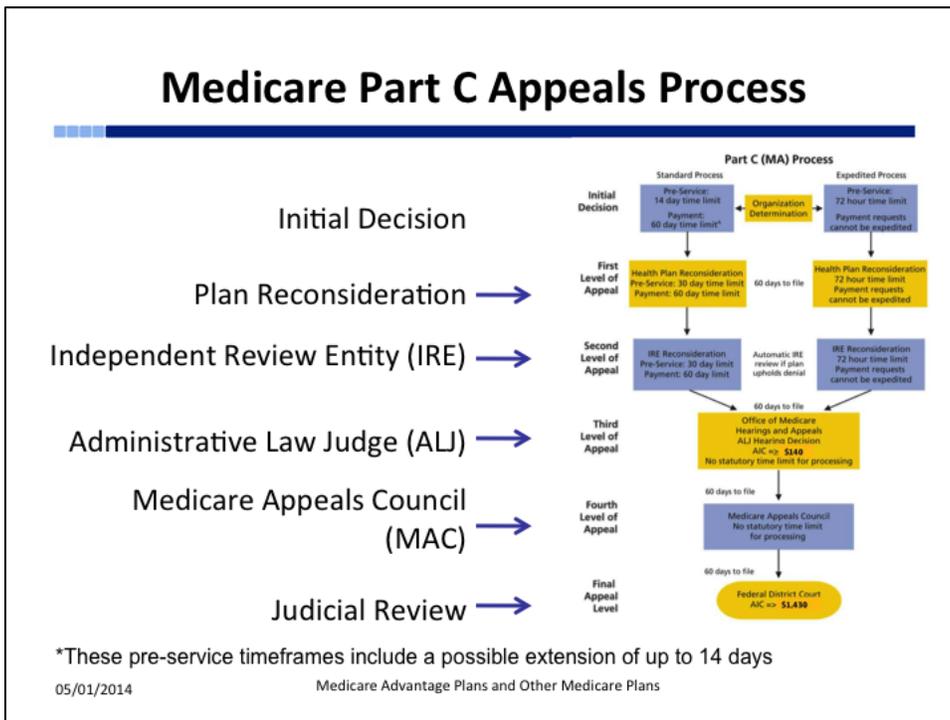
Medicare Advantage Plans and Other Medicare Plans

The plan must tell you in writing how to appeal. You can appeal if your plan will not 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 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 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
- Hearing with the Administrative Law Judge
- Review by the Medicare Appeals Council
- Review by a federal district court (Judicial Review)

See the Appendix for a full-size version of this chart.

## Medicare Health Plan Fast Appeals Process

- “Notice of Medicare Non-Coverage”
  - Provider must deliver at least 2 days before care will end
- If you think services are ending too soon
  - Contact your Quality Improvement Organization (QIO)
- QIO must notify you of its decision
  - Close of business the day after it receives all necessary information

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Medicare Advantage Plans and Other Medicare Plans

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, in a comprehensive outpatient rehabilitation facility, or from a home health agency.

- Providers must deliver a “Notice of Medicare Non-Coverage” at least 2 days before Medicare-covered skilled nursing facility, comprehensive outpatient rehabilitation facility, or home health agency 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 a reconsideration by the QIO if you are dissatisfied with the results of the fast appeal.

## Inpatient Hospital Appeals

- Provider/plan must provide Notice of Discharge and Medicare Appeal Rights (NODMAR)
  - At least the day before services end if
    - You disagree with discharge decision
    - Provider/plan lowers your care level
- Appeal to Quality Improvement Organization (QIO) by noon of first day after NODMAR
- Decision from QIO usually within 2 days
  - You remain in hospital
  - Incur no financial liability until QIO gives decision

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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 for covered services.

- 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.

### Need more information?

More information on the notice and links to download the forms is available at [cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html](https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html).



## Rights If You File an Appeal With Your Medicare Health Plan

- Right to get your files from the plan
  - Call or write your plan
  - Plan may charge a fee

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

You have certain appeal rights if you are 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.

## Medicare Advantage (MA) Explanation of Benefits (EOB)

NEW!

- New for MA Plans (Part C)
- Required use of new Part C EOB by April 1, 2014
- Only required if there is claims activity
- Must send either monthly or on a per claim basis with quarterly summary statements
- Some plans not required to use
  - Section 1876 Cost Plans and Medicare-Medicaid eligible beneficiaries

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

Many Medicare Advantage (MA) Plans already send an Explanation of Benefits (EOB) as part of their normal operations. In an effort to standardize this practice, as of April 1, 2014, all MA (Part C) Plans are required to provide their enrollees the new EOB document. Much like the EOB that has been used in the Medicare Prescription Drug program since 2006, the Part C EOB is intended to ensure that MA enrollees receive important information about their Medicare Part C benefits and services. The EOB document provides beneficiaries with information about services that have been utilized, allowing them to better track their health care and identify any potential fraud.

Part C EOBs are only required to be sent if the beneficiary has claims activity to report.

MA Plans may choose whether to send their EOBs either monthly or on a per claim basis.

Plans that choose to send their EOBs on a per claim basis must also send quarterly EOBs, which are summary statements to show the totals for claims that were processed during the reporting period.

Exceptions to the Part C EOB implementation requirements will be extended to Section 1876 Cost Plans and Medicare-Medicaid dual eligible beneficiaries.

## Check Your Knowledge—Question 4



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, you can do which of the following?

- a. File a grievance
- b. File an appeal
- c. Both a. and b.



Refer to page 66 to check your answers.

## Lesson 4 — Medicare Parts C and D Marketing

- Medicare Marketing Guidelines
- Marketing Reminders
- Disclosure Requirements
- Educational Activities
- Agent Broker Requirements

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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

- Medicare Marketing Guidelines
- Marketing Reminders
- Disclosure Requirements
- Educational Activities
- Agent Broker Requirements

## Medicare Marketing Guidelines

- Policy clarifications and operational guidance
- The Center for Medicare & Medicaid Services marketing requirements apply to
  - Medicare Advantage Plans
  - Medicare Prescription Drug Plans
  - Cost Plans
  - Employer Group Plans
  - Medicare-Medicaid Plans

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

- The Centers for Medicare & Medicaid Services (CMS) Medicare Marketing Guidelines (MMGs), updated and released annually, provide policy clarifications and operational guidance to contracted plan sponsors.
- CMS releases the MMGs at least once a year.
- Requirements apply to
  - Prescription Drug Plan sponsors
  - Section 1876 cost-based contractors
  - Employer and union-sponsored group plans, including employer/union-only group waiver plans
  - Medicare-Medicaid plans (except as modified or clarified in state-specific marketing guidance for each state's demonstration)

### Need more information?

The MMGs are issued as Chapter 3 of the "Medicare Managed Care Manual" and the "Medicare Prescription Drug Benefit" Manual. You can view them at [cms.gov/medicare/health-plans/managedcaremarketing](https://www.cms.gov/medicare/health-plans/managedcaremarketing).



## Marketing Materials

- CMS requires review and approval of certain materials
  - Exceptions are listed in Section 20 of the MMG
  - Plans must maintain materials and make them available upon CMS' request
- CMS creates standardized and model marketing materials

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

- 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 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.

## Marketing Reminders

- Marketing for upcoming plan year
- Marketing star ratings in materials
  - Individual measures may be marketed
    - Communicated in connection with overall performance rating
  - Low performing star rating status
    - Low Performance Icon (LPI) 

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

Marketing for the upcoming plan year may not occur prior to 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) and Prescription Drug Plans receive 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, provided they're communicated in conjunction with a contract's highest performance rating (e.g., MA-PD overall, MA only overall).
- 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 which receives less than 3 stars for their Part C or D summary rating for at least the last three years (i.e., rated 2.5 or fewer stars for the 2012, 2013, and 2014 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

- Medicare Advantage and Prescription Drug Plans must disclose plan information
  - At time of enrollment and at least annually
  - Required Annual Notice of Change/Evidence of Coverage
  - Low Income Subsidy (LIS) rider
  - Comprehensive or abridged formulary
  - Member ID card at the time of enrollment/as needed
- At time of enrollment and at least every 3 years after
  - Pharmacy directory
  - Provider directory
  - Documents for new enrollees must be provided to CMS

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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:

- Standardized Annual Notice of Change and Evidence of Coverage as applicable, that must be received by members no later than September 30 each year
- Low Income Subsidy (LIS) rider
- 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 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

- Nominal gifts
  - Organizations can offer gifts to potential enrollees
    - Must be of nominal value
    - Defined in Medicare Marketing Guidelines
    - Currently \$15 or less based on retail value
    - Given regardless of beneficiary enrollment

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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, Section 70.1.1, as an item worth \$15 or less, based on the fair market value of the item.

## Unsolicited Beneficiary Contact

- Unsolicited Marketing Activities
  - Electronic communications
    - Unless express permission given
  - Door-to-door solicitation
  - Calls/visits after attending sales event
    - Unless express permission given
  - Common areas

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

Plans and Part D (Medicare prescription drug coverage) sponsors may not initiate separate electronic or direct contact to 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, 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
- 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 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., complete business reply card)

## Cross-Selling Prohibition

- Cross-selling
  - Prohibited during any Medicare Advantage or Part D sales activity/presentation
  - Can't market non-health-related products
    - Annuities
    - Life insurance
    - Other products
  - Allowed on inbound calls per beneficiaries' request

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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 rules.

## Scope of Appointment Reminders

- Scope of Appointment
  - Must specify product type
    - MA, PDP, Medigap, or other
  - Prior to marketing and/or in-home appointment
  - Additional products can only be discussed
    - On beneficiary request
    - At separate appointment

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

- 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 Medigap, Medicare Advantage, and Prescription Drug Plans), 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. Documentation of the scope of the appointment by the plan can be in writing or recorded by telephone.
  - 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

- Health Care Settings
  - Marketing allowed in common areas
    - Hospital or nursing home cafeterias
    - Community or recreational rooms
    - Conference rooms
  - No marketing in health care setting
    - Waiting rooms
    - Exam rooms and hospital patient rooms
    - Dialysis centers and pharmacy counter areas

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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.

## Educational Event Reminders

- Educational Events for prospective members
  - No marketing activities at educational events
  - Plans may distribute
    - Medicare and/or health educational materials
    - Agent/broker business cards
  - Distributed material must not contain marketing information

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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 should not 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., same hotel)

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.

## Member-Only Events

- Educational member-only events
  - No marketing activities or enrollment
  - Must target existing members only
  - Plans may distribute
    - Plan-specific information
    - Promotional items

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Medicare Advantage Plans and Other Medicare Plans

Plans and Part D sponsors may conduct member-only events. These events may not include any marketing or enrollment activities and must be done in a way that only targets existing members. Plan-specific information and promotional items may be provided to existing members.

## Promotional Activity Reminders

- Prohibition of Meals
  - Prospective enrollees may not
    - Be provided meals
    - Have meals subsidized
  - At any event or meeting where
    - Plan benefits are being discussed, or
    - Plan materials are being distributed

05/01/2014

Medicare Advantage Plans and Other Medicare 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.

As with all marketing regulation 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.

## Licensure and Appointment of Agents

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- Medicare Advantage and Prescription Drug Plan organization agents/brokers or other marketing representative
  - Must comply with state-licensure and appointment laws
    - Applies to contracted and employed agents/brokers
- Organizations must comply with state appointment laws
  - Plans must give information about agents

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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

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.

## Reporting of Terminated Agents

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- Organizations must report termination of agents/brokers
  - In accordance with state appointment law
  - To state where agent/broker is appointed
  - Must include reasons for termination

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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 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
  - For contracted or independent agents/brokers
  - Designed to eliminate incentives
    - For example, encouraging inappropriate moves from plan to plan
  - Guidelines for plan recoupment of compensation under certain circumstances

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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 defines compensation: includes monetary or non-monetary remuneration of any kind relating to sale or renewal of a policy
  - Compensation Year January 1 – December 1st
  - Initial compensation
    - “Unlike plan type”
  - Renewal compensation
    - “Like plan type”

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

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.

Compensation *doesn’t* include the following: the payment of fees to comply with state appointment laws; training; certification; testing costs; reimbursement for mileage to and from appointments with beneficiaries; and reimbursement for actual costs associated with beneficiary sales appointments, such as venue rent, snacks, and materials.

The compensation year is January 1 through December 31 of each year. Payments must be calculated based on the January through December enrollment year. Payments may not be made based on enrollment years (rolling basis) other than January through December.

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 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 equal to fifty (50) percent of the initial compensation amount for each enrollment. Additionally, a “like plan type” move would necessitate a renewal compensation, continuing the current compensation cycle. 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

- Agents/brokers must be trained/tested annually
  - Medicare rules and regulations
  - Plan details specific to plan products sold
  - Both contracted and employed agents
  - Completed prior to start of marketing season
    - To market after that date
    - Must pass with 85 percent

05/01/2014

Medicare Advantage Plans and Other Medicare Plans

Medicare Advantage Organizations and Part D 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. Training and testing must be completed by passing a test with 85 percent, prior to the start of the new marketing season for the agent/broker to market after that date.

## Check Your Knowledge—Question 5



Who is responsible for training and testing agents and brokers about the Medicare program and proper marketing of Medicare products?

- a. The Centers for Medicare & Medicaid Services
- b. Medicare health and drug plans
- c. State Department of Insurance
- d. Insurance associations



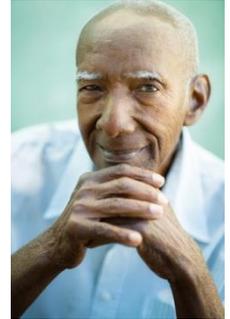
Refer to page 66 to check your answers.

## Check Your Knowledge—Question 6



Agents or brokers are permitted to set up individual marketing appointments at educational events?

- a. True
- b. False



Refer to page 66 to check your answers.

# Resources for More Information

## Resources

**Centers for Medicare & Medicaid Services (CMS)**  
1-800-MEDICARE  
(1-800-633-4227)  
(TTY 1-877-486-2048)  
[medicare.gov](http://medicare.gov)

[cms.gov](http://cms.gov)

**Social Security**  
1-800-772-1213  
TTY 1-800-325-0778  
[socialsecurity.gov](http://socialsecurity.gov)

**Railroad Retirement Board**  
1-877-772-5772  
(TTY 1-312-751-4701)

[rrb.gov](http://rrb.gov)

**State Health Insurance Assistance Programs**  
For telephone numbers call CMS  
1-800-MEDICARE (1-800-633-4227)  
(TTY 1-877-486-2048)  
[healthcare.gov](http://healthcare.gov)

**Affordable Care Act**  
[healthcare.gov/law/full/index.htm](http://healthcare.gov/law/full/index.htm)

**2014 Medicare Marketing Guidelines**  
[cms.gov/medicare/health-plans/managedcaremarketing/index.html?redirect=/managedcaremarketing](http://cms.gov/medicare/health-plans/managedcaremarketing/index.html?redirect=/managedcaremarketing)

## Medicare Products

**“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 [medicare.gov/publications](http://medicare.gov/publications)

Order multiple copies (partners only) at [productordering.cms.hhs.gov](http://productordering.cms.hhs.gov). You must register your organization.

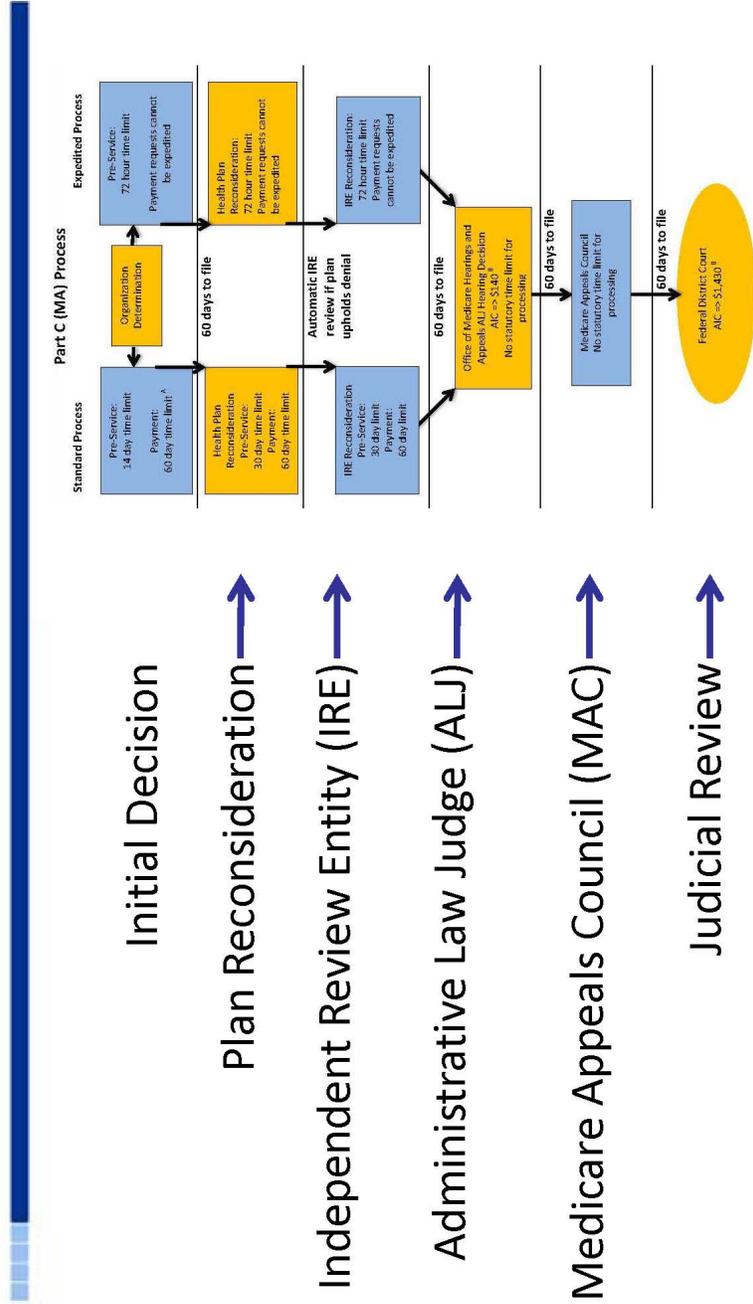
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To view all available CMS NTP materials, or to subscribe to our email list, visit [cms.gov/outreach-and-education/training/cmsnationaltrainingprogram](https://cms.gov/outreach-and-education/training/cmsnationaltrainingprogram).

# Medicare Part C Appeals Process



<sup>A</sup> AIC amounts in Connecticut: All Medicare enrollees (with IRE) is independent of the IRE. For Medicare enrollees in other states, the AIC amount is \$1,430. For Medicare enrollees in other states, the AIC amount is \$1,430. For Medicare enrollees in other states, the AIC amount is \$1,430.



# Check Your Knowledge Answer Key

## Question 1 (page 24)

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Medicare Advantage (MA) Plans are sometimes called

**Answer: c**

c. **Part C.** MA Plans are part of the Medicare program and are sometimes called Part C.

## Question 2 (page 25)

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For most people, when you enroll in an MA Plan, you are no longer required to pay your monthly Medicare Part B premium.

**Answer: b**

**b. False.** If you join an MA Plan, you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2014 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.

## Question 3 (page 31)

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Programs of All-Inclusive Care for the Elderly (PACE) are a type of MA Plan.

**Answer: b**

**b. False.** PACE isn't an MA Plan, but is still part of the Medicare program. It's 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.

PACE combines 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. Based on the circumstances, PACE might be a better choice for some people instead of getting care through a nursing home.

Call your state Medical Assistance (Medicaid) office to find out about eligibility and if a PACE site is near you.

## Question 4 (page 41)

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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, you can do which of the following?

**Answer: b**

**b. File an appeal.** You have the right to 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.

The plan must tell you in writing how to appeal. You can appeal if your plan won't pay for, doesn't allow, 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.

## Question 5 (page 60)

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Who is responsible for training and testing agents and brokers about the Medicare program and proper marketing of Medicare products?

**Answer: b**

**b. Medicare health and drug plans.** Medicare Advantage Organizations and Part D sponsors must ensure that agents and brokers selling Medicare products are trained and tested annually. Training and testing should be 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 by passing a test with 85 percent, prior to the start of the new marketing season in order for the broker/agent to market after that date.

The Centers for Medicare & Medicaid Services (CMS) releases information each year to all Medicare health and drug plans that specify what information should be covered in the training and testing curricula utilized by the plans.

## Question 6 (page 61)

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Agents or brokers are permitted to set up individual marketing appointments at educational events.

**Answer: b. False**

**b. False.** Educational events may not include sales activities. 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. Plan sponsors or their representatives may not

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

## Acronyms

ALJ	Administrative Law Judge
CMS	Centers for Medicare & Medicaid Services
EOB	Explanation of Benefits
ESRD	End-Stage Renal Disease
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
MMG	Medicare Marketing Guidelines
MSA	Medical Savings Account
NODMAR	Notice of Discharge and Medicare Appeal Rights
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
QIO	Quality Improvement Organization
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SNP	Special Needs Plan
TTY	Teletypewriters

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Website: [cms.gov/outreach-and-education/training/cmsnationaltrainingprogram](https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram)

Email: [training@cms.hhs.gov](mailto:training@cms.hhs.gov)

Centers for Medicare & Medicaid Services

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